MINUTES

MONTANA HOUSE OF REPRESENTATIVES
54th LEGISLATURE - REGULAR SESSION

JOINT SUBCOMMITTEE ON HUMAN SERVICES & AGING

Call to Order: By **CHAIRMAN JOHN COBB**, on February 13, 1995, at 8:00 a.m.

ROLL CALL

Members Present:
Rep. John Cobb, Chairman (R)
Sen. Charles "Chuck" Swysgood, Vice Chairman (R)
Rep. Beverly Barnhart (D)
Sen. James H. "Jim" Burnett (R)
Rep. Betty Lou Kasten (R)
Sen. John "J.D." Lynch (D)

Members Excused: None

Members Absent: None

Staff Present: Lois Steinbeck, Legislative Fiscal Analyst
Connie Huckins, Office of Budget & Program Planning
Ann Boden, Committee Secretary

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

Committee Business Summary:
Hearing: Department of Social & Rehabilitation Services: Managed Care and Primary Care
Executive Action: None

{Tape: 1; Side: A; Approx. Counter: 000; Comments: This meeting was recorder on a Sony machine at slow speed - 2.4.}

OVERVIEW OF EXECUTIVE ACTION TO DATE

Lois Steinbeck, Legislative Fiscal Analyst, discussed the fiscal impact of the executive action taken by the subcommittee to date. **EXHIBIT 1**

OVERVIEW OF PRIMARY CARE

Nancy Ellery discussed primary care and managed care for physical health. **Ms. Ellery** indicated how difficult it was to isolate

primary care from long term care because of their inter-relationships. She described primary care to include everything but institutions. She further explained that the Primary Care Bureau is responsible for about 45 different services; in Medicaid each service has its own reimbursement methodology, limitations and policies. The point being that physician services in primary care are different than dental services or pharmacy services. **Ms. Ellery** discussed the handouts in the packet she distributed. **EXHIBIT 2**

{Tape: 1; Side: A; Approx. Counter: 6.7; Comments: n/a.}

Handout #1 Primary Care in Relationship to total Medicaid Budget. **Ms. Ellery** explained that hospitals are included in primary care for budgetary purposes but organizationally they are in the Budget and Institutional Reimbursement Bureau headed by John Chappuis. Without hospitals, primary care consists of 36% of the total Medicaid budget; with hospitals, it would be approximately 60% of the total Medicaid budget, or an additional $70 million.

Handout #2 Primary Care divided into major service areas. This chart also does not include hospitals. Physician services equal about 30% of the primary care budget.

Handout #3 Primary Care Physician Services. This handout shows a review of the costs of physician services from 1990 through 1994. **Ms. Ellery** reviewed the significant increase in the early 1990s due to implementation of mandates adding eligible. In 1993 and 1994 the costs started to level off at 2%, when the "Passport" program was implemented.

Handout #4 Overheads on Physical Health - Managed Care - "Passport to Health" HMO **Ms. Ellery** reviewed the Passport program which was implemented in January of 1993.

Overhead - Passport Independent Assessment Findings A copy of the report evaluating the first year of the program was provided to **CHAIRMAN COBB**. In summary, this report indicated the Passport program had improved access, quality and cost effectiveness. The report also documented a $5.1 million savings and showed a lower average utilization rate and lower cost per person. It further indicated a need to work on recipient and provider education. **Ms. Ellery** said she anticipated even better results at the end of the second year of the program as there are 37 counties and 40,000 recipients involved in the Passport program. **Ms. Ellery** went on to explain the reasons for moving into an Health Management Organization (HMO). The Special Legislative Session in 1993 gave Medicaid the authority to expand managed care into HMOs and the Mental Health area. They anticipate having the HMO program operational by June of 1995. When it is fully operational they will give clients a choice between Passport and HMO. The clients must choose one or the other or Medicaid will assign them to a program. The clients will not be allowed to

stay on the old program. Currently, there are three HMOs operational in the state of Montana; Blue Cross/Blue Shield, Glacier Community Health Plan in Kalispell, and Yellowstone Community Health Plan in Billings.

Later in the meeting **CHAIRMAN COBB** asked **Ms. Ellery** if the Passport provider would be mandated to go into an HMO. **Ms. Ellery** indicated they would have a choice. If HMO and Passport are both available they can choose between them with one exception; if the client is part of the welfare reform program they would be required to go into an HMO. All others not on the welfare reform program can choose between HMO and Passport; where the HMO is available. But if they are an AFDC employable adult where welfare reform is located they would have three options: choose an HMO if available, take a reduced Medicaid package, or elect to have the department purchase private insurance, in which case Medicaid would pay part of the premium.

Overhead - HMO Public Input Process: The public input process was outlined. The advisory council consists of consumers, providers, and legislators (**SEN. TOM KEATING** and **REP. CAROLYN SQUIRES**) who have worked together to design the managed care programs. In addition to input from the Advisory Council, Mary Dalton, Primary Care Bureau Chief, Department of Social and Rehabilitation Services, and her staff conducted town meetings around the state in September 1994 to obtain more information.

{Tape: 1; Side: A; Approx. Counter: 16.9; Comments: n/a.}

Overhead - Contractor Responsibilities: **Ms. Ellery** detailed how the management of this program was contracted out. Following a competitive bid process the contract was awarded to UNISYS. **Ms. Ellery** introduced **Shelly Ross, UNISYS Project Director, Helena,** indicating she would be available to answer questions. This project was contracted due to the need for expertise in actuarials used to determine rates in managed care. The short implementation time and the flexibility of human resources were also factors considered in contracting. The UNISYS contract is a management contract; UNISYS will not be providing any of the services. The contract provides for UNISYS to research state and federal requirements, recommend services and populations to be included in the program, assist in determining payment rates, implement and manage the quality assurance program, recruit and enroll HMO providers, enroll clients with the providers, and explain options. UNISYS will also operate the consumer and provider hotline beginning in July 1995 and assume day-to-day management of the PASSPORT program.

Overhead - State Responsibilities: The state will make ongoing policy decisions, monitor the program, file all administrative rules and state plan amendments regarding the program. There is a contract with HCFA (Health Care Finance Association) to ensure requirements of the program are met. Montana is establishing its managed care program under a "Freedom of Choice waiver" which is

different from the "Research and Demonstration waiver" used to develop the mental health programs. The waiver already in existence with HCFA for the Passport program was merely amended to allow for the HMOs. Quality assurance will continue to be an important aspect of the state's responsibility. When asked by **CHAIRMAN COBB** if Medicaid has the resources to monitor the quality assurance, **Ms. Ellery** indicated that they do.

CHAIRMAN COBB asked the cost of the contract with UNISYS and **Ms. Ellery** said it works out to be $2.1 million total. The contract began in September 1994 and goes through June 30, 1996. Upon completion of the current contract a new contract would be negotiated. $1,111,373 is budgeted for fiscal 1997.

CHAIRMAN COBB then asked if the UNISYS contract would save the state of Montana $1 million in 1996 and $2.3 million total funds in 1997. **Ms. Ellery** agreed with the figures stated and clarified that the first year of the contract has been spent getting the project up and going, therefore a number of start-up costs have been incurred decreasing the amount of savings to the state. However, as the project continues and more people become involved it is anticipated that more savings will be recognized by the state.

CHAIRMAN COBB asked if "managed care was more efficient than Passport." In response, **Ms. Ellery** explained the two programs are different; Passport is a "fee for service" type of program and HMOs are capitated with a fixed premium. Other states have found the savings recognized by HMOs exceeded those of programs similar to Montana's Passport program. She anticipated that approximately 6,000 clients will be involved in the HMO program in 1996 and 13,000 clients in 1997. About 40,000 clients are currently involved in the Passport program, some of which will switch to HMOs. Under federal regulations HMOs do not require co-pays, which **Ms. Ellery** anticipates will be a major factor in influencing clients to switch from Passport to HMO.

The "Freedom of Choice waiver" requires proof of cost savings over the "fee for service" type of program currently in place. Montana's HMO program projections were based on a 5% savings. From the federal standpoint the "fee for service" programs are the basis of comparison in projecting any savings. In Montana there are clients who receive Medicaid "fee for service" coverage who are not covered under the Passport program. There are currently approximately 40,000 clients covered under the Passport program. In calculating the projected $3.6 million savings, **Ms. Ellery** indicated it was anticipated that one-half of the current Passport population would choose an HMO option thereby creating the estimated savings.

Overhead - Passport vs. HMO: **Ms Ellery** reviewed the overhead. In response to **CHAIRMAN COBB**'s questions regarding drug coverage. **Ms. Ellery** indicated HMOs will not cover prescription drugs primarily because there are already so many utilization controls

on the pharmacy program. Also because of the movement toward a managed mental health contract and the desire to simplify and streamline the process for the physician and pharmacy to obtain authorizations for drugs. HMOs will be able to communicate with the pharmacy programs to insure coordination of care.

The mental health managed care contractors will not be managing the pharmacy portion of the program for the "fee for service" population. However, they will manage it for the expanded population.

Overhead - HMO Eligible: **Ms. Ellery** stated that the AFDC and AFDC-related population will be initially targeted as the HMOs are implemented in fiscal year 1996, followed by the SSI population in fiscal year 1997. Ms. Ellery emphasized the need to move slowly and work with the AFDC population first so that any problems could be worked out along the way. She indicated that, although it is important to provide coverage for the SSI and elderly, they typically represent a more expensive segment of the population. Therefore, in an effort to be fiscally responsible, it makes sense to work out any bugs while providing services for AFDC clients, a less expensive target population.

Overhead - Exempted Recipients: **Ms. Ellery** gave a review of the exempted recipients.

Overhead - HMO Services: **Ms. Ellery** explained that most of the services traditionally managed by HMOs for the private insurance industry will be managed for the Medicaid HMO. Many of the services are listed on the overhead. Some major concerns in designing the program services included ensuring the ability of clients to go to the public health department if they choose, for immunizations and testing for sexually transmitted diseases and other similar services. HMO will be strongly encouraged (not mandated) to contract with all essential community providers.

Overhead - Services NOT in HMO Package: As mentioned before efforts are underway for Mental Health services to be covered under a separate contract. Likewise non-emergency transportation services are not covered by HMOs because they are already covered under a separate contract.

REP. BEVERLY BARNHART asked if a "mid-level practitioner was a nurse practitioner". **Ms. Ellery** explained that a "mid-level practitioner" would include: nurse practitioner, certified nurse midwife, and a physician assistant.

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CHAIRMAN COBB requested clarification regarding the premium rates to be paid for the HMOs. Seeking assurance that the requested budget would cover the entire program's needs, he further asked what would happen to the contract should the growth rate increase faster than projected and/or the inflation rate rise higher than

expected. In response **Ms. Ellery** assured the chairman and the committee that they have already estimated the cost of running the program. She said there would be five to six different premium rates to be determined based on age, condition of patient and other factors. These rates will be finalized within three to four weeks. The contract stipulates that these rates are what the HMOs will receive. She explained that the HMO is a true capitated program and that the contractor must accept the rate paid, if they can manage the cases for less then the difference is theirs to keep.

Ms. Ellery further explained the contract is for a set number of services and obligates the state to pay a specified rate per eligible per month for the term of the contract (contract = rate x eligible x month). The state does however, retain the right to reduce the rate and/or number of services should that be deemed appropriate.

If inflation should rise higher than projected the contract costs would not be altered until such time as it would be renegotiated. But, should the enrollment in the program grow faster than projected, the cost of the HMO program would be higher than budgeted.

CHAIRMAN COBB asked where they money would come from should the HMO program not fall within its budget. **Dr. Peter Blouke, Director of the Department of Social and Rehabilitation Services,** responded, explaining that at the point at which it was determined that funding is insufficient to continue providing services under the HMO program, they would need to take a serious look at where cuts would be made. He indicated it would be a management decision at that point and suggested that since the HMO program would be in its infancy they would probably look to another program for the cuts. He reiterated however, that the state maintains flexibility within the HMO contract to reduce rates and/or services.

Seeking further clarification, **CHAIRMAN COBB** asked if the contractor would be held to the specified rates until fiscal year end even if the costs increased substantially during the year. He wondered if at that point the contractor would indicate to the state a need to renegotiate or if they simply would not renew their contract. He also wanted to know if there was a cost-of-living increase built into this contract.

Ms. Ellery said this contract was like any other the state has. There is no specific cost-of-living increase built into the contract however, the expenses are reviewed annually and some allowances made for growth. The HMO program must still cost less than the fee-for-service programs to meet HCFA regulations.

CHAIRMAN COBB pointed out that a capped flat agreed upon amount is paid for fee-for-service programs and people are complaining about it. He asked if the HMO programs would not be caught in

the same bind as the fee-for-service programs with regards to the caps. **Ms. Ellery** stated, yes, that would be true.

{Tape: 1; Side: A; Approx. Counter: 49.6; Comments: n/a.}

Overhead - Quality Assurance: **Ms. Ellery** stated quality assurance is a critical portion of the program. One of the main objectives of HMOs is to increase access to quality care. The only way to ensure this quality of care is provided is to have a strong quality assurance program. UNISYS is assisting in development of the quality assurance program. Under the HMO regulations there are statutory references, as well as internal procedures, that HMOs adhere to in order to ensure quality of care. An independent evaluation of quality will be built into the program and department staff will also participate in the monitoring process. The HMOs will administer client and provider "satisfaction surveys." Since there are currently 34 states involved in managed care programs, Montana will glean information and direction from these other states. Various outcome objectives will be measured and reviewed to determine the success of the program.

The quality assurance of the PASSPORT program will also be managed by UNISYS. They will analyze reports from providers, compare utilization and use this information as an educational and evaluation tool. Recipient surveys will monitor the impact on clients using the services and review ways the program's quality can be improved. **Ms. Ellery** reviewed the remainder of the data on the quality assurance overhead.

Overhead - Grievance Process: **Ms. Ellery** reviewed the formal and informal grievance processes for HMO and PASSPORT. In summary, **Ms Ellery** stated she does not see managed care as a solution to all of the Medicaid population's health care management problems. She is however convinced, by her experience and the information received from other states, that managed care is a feasible way to maintain quality care access and still contain costs.

SEN. SWYSGOOD asked about the PASSPORT vs. HMO option in welfare reform areas. **Ms. Ellery** again listed the three options available to the clients: they may choose an HMO if available (if an HMO is available they may NOT choose PASSPORT), take a reduced Medicaid package, or elect to have the department purchase private insurance in which case Medicaid would pay part of the premium. **SEN. SWYSGOOD** went on to confirm that PASSPORT only applies to the counties in the control group. **Ms. Ellery** indicated this was correct.

OTHER PRIMARY CARE ISSUES

Resource Based Relative Value System (RBRVS): [RBRVS - Reference page B-70 of the LFA Analysis, #15] **Ms. Ellery** reviewed other primary care issues that are included in the budgeting process as

modifications or present law. In the physician's area there is a modification relating to a study of the physician's reimbursement. Resource Based Relative Value System (RBRVS), is the reimbursement system that Medicare and private insurance is moving toward with regard to physician reimbursement. In the second year of the biennium Medicaid is proposing to contract for a study of the RBRVS system to review its fee schedule and explore its adaptability to Medicaid programs.

The RBRVS has developed a weighted system for assigning values to various services to assist in determining the reimbursement rate. **Ms. Ellery** believed this system would compensate primary care more and specialty care less, thus bringing more balance to the primary care area. If this study indicates RBRVS would work for Medicaid she anticipates they will design an RBRVS proposal. This proposal would be budget neutral, and would most likely be phased in during the out biennium, 1998-1999. **Ms. Ellery** further indicated Medicaid's current physician reimbursement system is outdated, with fees having been set in 1982 and the last increase implemented in 1991 or 1992. The Medicaid physician reimbursement is out of line with private insurance and other government reimbursement schedules.

Ms. Ellery explained that the weights in the RBRVS are based on such things as time involved, value of that service, complexity of service, and who performs the procedure or provides the service, to name some of the factors considered. She presented an example of an office visit in response to a request by **SEN. SWYSGOOD**.

{Tape: 1; Side: B; Approx. Counter: 000; Comments: n/a.}

Children's Dental Services: [Reference page B-69 of LFA Analysis] **Ms. Ellery** stated that of all the areas of in Medicaid involving providers, the area of children's dental services represents the most problems enrolling providers. She believed the problem is due to Medicaid's current reimbursement system. **Ms. Ellery** reviewed the handout titled "Children's Dental Fee Increase," stressing that in many cases Medicaid does not reimburse enough to cover the dentist's costs. She indicated that it is a problem for adults as well as children, however, with limited resources Medicaid has chosen to focus initially on children. Some states have had lawsuits filed against them because the reimbursement is so low that they are not able to enroll an adequate number of providers and thus to prove adequate access to care. **Ms. Ellery** believed Montana could face similar problems if its reimbursement system is not updated. **EXHIBIT 3**

Besides access, Medicaid is looking to improve the authorization system currently in place for dental services. **Ms. Ellery** mentioned the possibility of moving into a managed care system for the dental services. They are working with the providers to determine the level of provider interest.

SEN. SWYSGOOD asked if Medicaid was currently paying 59.75% of the rate. **Ms. Ellery** said that was correct on the whole (the rate varies per service). **SEN. SWYSGOOD** then asked if the Medicaid request was to increase this reimbursement rate by 80%. **Ms. Ellery** stated that although the narrative indicated it was being increased by 80%, the actual request is to increase it from 60% to 80% of charges; a net increase of 20%. This would not be an across-the-board increase on all procedures, rather the most important procedures would be addressed resulting in a net overall increase of 20%. **Ms. Ellery** felt this would be enough to bring more providers into the program.

{Tape: 1; Side: B; Approx. Counter: 7.3; Comments: n/a.}

Outpatient Hospital Services: This is not in the budget, but is an issue that **Ms. Ellery** felt legislators would be hearing about from providers, therefore, she wanted to give some basic information. She reviewed the handout "Executive Summary/January 1995/Montana Medicaid Outpatient Hospital and RTC Study." **EXHIBIT 4**

Ms. Ellery indicated that the recommendations from Abt Associates, Inc. (documented in the handout) will be implemented in phases beginning in July 1995. She also stated that, although they have worked closely with providers throughout the planning process, there are many providers who are not happy with the plan. **Ms. Ellery** felt it imperative that steps be taken now to contain the hospital outpatient service costs as they are projected to reach $35.3 million in 1997.

Generally what Medicaid is trying to accomplish is to move from a cost-based to a perspective reimbursement-type of system. In some areas Medicaid will adopt the Medicare reimbursement rationale. In phase one, areas to be addressed will be emergency room visits, dialysis, laboratory and imaging services, and residential treatment centers. **Ms. Ellery** explained that the general fund for residential treatment centers (RTC) is under the Department of Corrections and Human Services however, Medicaid works with them to determine reimbursement.

CHAIRMAN COBB asked if the 5% rate cut in audit costs was included in the budget. **Ms. Ellery** said some of the savings were included in the cost projections for the 1996-1997 biennium. This appears in the form of lower projection of outpatient reimbursement. **Dr. Blouke** indicated that the 5% savings is not specifically identified.

The outpatient programs were designed to be budget neutral however, until some of the aspects of the program are implemented it is hard to predict what the actual savings will be. **CHAIRMAN COBB** said he could see where this adjustment could be shown in the emergency room reimbursement but asked how the savings in RTC reimbursement was reflected. **Ms. Ellery** indicated that the reimbursement changes for the RTCs will be phased in over the

next three years as the changes are too drastic to implement all at once. These savings are reflected in the modification and estimates of expenditures. In reviewing the three-year implementation process for the reimbursement rates for RTCs **CHAIRMAN COBB** stated that 5% cut represents a big amount of money and it should reflect as a cut in the budget somewhere. **Ms. Ellery** explained the RTC portion of the study will not take place until January of 1996 and they have projected savings on the RTC of approximately $534,000 total. This would only reflect six months of the fiscal year.

CHAIRMAN COBB then asked why this study and reflection could not be done this fiscal year. **Ms. Ellery** stated they must contract out and obtain completed audits of cost reports and make systems changes, both of which take time.

CHAIRMAN COBB wanted to know with a $534,000 savings projected for 1996, what the savings for 1997 would be. The savings go up for the RTC portion of the budget to $1.2 million total. When asked by **CHAIRMAN COBB** if this savings was in the budget, **Ms. Ellery** stated they planned to review it at the time they reviewed all of their adjustments, because the report was not complete at the time the budget was prepared.

Ms. Ellery went on to project that the hospital association would be talking to legislators regarding the new Medicaid reimbursement system. Medicaid's new system is more of a fee-based system and the hospitals think there is an incentive under the fee-based system to provide more volume. Medicaid feels the fee-based system is a big improvement over the cost-based system which they feel presents an minimal incentive for cost containment.

REP. BARNHART asked when the clients, if they are working, would be able to take their children to the doctor, especially if the providers are only open during working hours. She further asked if there was anything in this program to encourage providers to be open longer hours. **Ms. Ellery** complimented **REP. BARNHART** on her observation and indicated this is why one of the provisions of the PASSPORT and the HMO programs mandate 24 hour availability of the provider.

REP. BARNHART asked if the client is instructed to come to the hospital by the provider if they would be charged a hospital charge. **Ms. Ellery** indicated there is a charge because hospitals are obligated under the COBRA law to at least perform a screening exam on the patient.

SEN. LYNCH asked if the Medicaid savings would cost in terms of provider services being available to the clients. **Ms. Ellery** said the system was designed to be budget neutral however, some hospitals will be winners and some will be losers. **SEN. LYNCH** asked what she meant by "losers." He wanted to know if this program would cost the hospitals, and if they would have the

option of refusing services. He recognized that hospitals could only do this (services without receiving full reimbursement for costs) for so long before they would be unable to offer services anymore. **Ms. Ellery** felt with the new system hospitals would be reimbursed adequately. The hospitals can not refuse to treat the patients, so the issue is one of reimbursement for services.

SEN. LYNCH went on to ask if the state's savings were costing the private and insured patients in the "loosing" areas. **Ms. Ellery** indicated some hospitals will be paid more under this system and others less. Hospitals in rural settings will not have this new system applied; they will continue to be cost-based. The urban hospitals will bear the cost shifts. She feels that the rate of growth in the hospital outpatient programs can be controlled. Outpatient program costs can not continue to grow at the current rate without cutting into other Medicaid programs. **SEN. LYNCH** asked if the insurance rates would go up as a result of the implementation of this program. She said that to some extent that would happen.

SEN. SWYSGOOD asked how these rates would compare to the HMO rates. **Ms. Ellery** indicated Medicaid pays the HMO a flat amount per month per eligible and the HMO negotiates directly with the hospital. She further indicated Medicaid's primary interest is in ensuring that hospital care is available to clients under the HMO program.

Ms. Ellery said there is expected to still be a shortage of physicians in the state. The Abt study did not address this issue as it was not part of the contract. Rather they were asked "how do you pay outpatient hospitals to get the most bang for the buck. How do you develop a system that is both equitable and one that will help providers contain their costs while presenting an incentive to reduce costs where ever possible." She said they were happy with the study Apt completed. The Hospital Association criticized Medicaid for the extent of the study, indicating no other state had conducted such a comprehensive study in outpatient services. Other states have however, implemented various systems which were also recommended in the Apt study. She cited Utah and their positive experience utilizing multiple fees for emergency room care. Iowa has implemented the ambulatory surgery part of the proposed program. So while no state has done everything proposed by the study for Montana, other states have tried portions of it. She felt other states are moving in the direction Montana is proposing to go and Medicare is also moving in that direction with prospective reimbursement systems in outpatient services. In summary **Ms. Ellery** felt Medicaid is in line with other states and companies with regards to containing outpatient costs.

CHAIRMAN COBB requested a copy of the phase-in plan. **Ms. Ellery** said she would give him a copy.

REP. BARNHART referenced page **B-59** and asked for clarification regarding these outpatient costs. **Ms. Ellery** stated the contractor insisted in the report that, "like inpatient reimbursement, when you change systems you need to have adequate resources to manage the change." Medicaid currently has one program officer to manage inpatient and outpatient hospital services which amounts to approximately $70 million per year. It is difficult for one person to handle both programs therefore, the budget is proposing an additional FTE to handle one of these programs. She stated they want that person to also do selective contracting. The selective contracting would enable Medicaid to curb out-of-state hospital costs. There are approximately seven to ten out-of-state hospitals that Medicaid pays most of its out-of-state reimbursement to. Medicaid is proposing to send out a request for proposal (RFP) to contract for the services which can not be performed in state.

CHAIRMAN COBB asked what the net savings of the selective contracting would be in the second year. She said the savings would result from a reduction in procedures going out of state and estimated there could be a 10% savings on the services that are provided out of state. For example there are certain neonatal heart problems that can not be addressed in- state and must be provided from an out-of-state provider. The selective contracting would be for intensive particular services such as neonatal heart problems, organ transplants, and other select procedures not available in Montana. If the service is available in Montana, Medicaid will not pay for it out-of-state.

CHAIRMAN COBB asked if more FTEs were funded if they could get more of the program up and running sooner. **Ms. Ellery** reiterated that the program's complexity is the major timing factor not the number of FTEs. She did not feel more people could cause it to come up any faster. She also cautioned that Medicaid wants to progress slowly and carefully to ensure the programs are successful. **CHAIRMAN COBB** asked if the schedule could even be moved up a couple of months. **Ms. Ellery** said that if there are any portions of the program that can be implemented sooner than currently scheduled they will bring them up as soon as they are able. **CHAIRMAN COBB'S** main concern addressed adequate staffing. He asked if the program was ready to implement earlier than planned would Medicaid have the staffing to bring it up earlier and begin saving money.

Dr. Blouke stated these programs are extremely complicated and inter-related and Medicaid has to take into consideration all the effects the programs will have on various entities as well as other Medicaid components, such as Consultec. Providing additional FTEs will not solve these concerns.

CHAIRMAN COBB stated that, under SB 285 passed in the 1993 Legislative Session, providers said they were for the study and said they were going to knock the health care growth rate down to that of the economy by 1999. **CHAIRMAN COBB** further stated that

1999 is fast approaching and he plans to hold them to their word. He does not feel however, that the responsibility belongs to Medicaid alone, he feels the entire health care community needs to be involved in reaching these goals because the providers committed themselves to a growth rate of 3-4% rather than 8-9% currently being experienced. He explained the reason he is anxious to implement the Medicaid proposed systems sooner than proposed is because when the programs are implemented the providers will be held to their word and be more accountable to slowing the growth rate. **Dr. Blouke** assured the chairman and committee that if additional personnel would cause the programs to be implemented sooner they would have asked for the FTEs. He pointed out that in almost all of the modified requests there are off-setting savings, in almost all cases, that far exceed any increases proposed. He said he appreciated **CHAIRMAN COBB'S** desire to implement the program sooner but again stated that he did not feel additional FTEs would enable them to bring the program up responsibly any sooner than scheduled.

SEN. SWYSGOOD asked if the one additional FTE's activities and the proposed programs would have the potential of creating additional costs for the hospitals. In particular would hospitals have to change or update their computer systems. **Ms. Ellery** answered that any change made to an existing system requires change by both Medicaid and the providers. She felt however, that it is important to make these changes because if they did nothing the budget would rise too high. There will be some changes required in the provider's computer systems involving some cost.

SEN. SWYSGOOD stated that Medicaid directed much of the inpatient, more expensive care, to the outpatient services and now the outpatient services costs are growing. So with this increase he wondered if these Medicaid programs were going to penalize the providers. **Dr. Blouke**, indicated that Medicaid is NOT intending to penalize anyone. Rather they are proposing a methodology of reimbursing hospitals they feel will put Medicaid in a better position to predict and control these services to a reasonable rate of growth in outpatient hospitals. He stated Medicaid is currently reimbursing outpatient services in hospitals in Montana at 93% of costs, which is a higher rate than most of the surrounding states. He does not believe that this methodology will cause additional unnecessary or inappropriate costs to the hospitals, even though there will be some costs associated with adjusting to the new system.

REP. BARNHART asked how much all the proposed changes would impact the growth rate. **Lois Steinbeck, Legislative Fiscal Analyst**, explained she had prepared a handout for the committee's review that showed each of the proposed changes and the associated fiscal impact. It does not however, say that a particular portion of the proposed program would reduce the growth rate by a certain percentage. **REP. BARNHART** also asked how the savings, due to reduction in growth rates, are reflected

in the budget. **Ms. Steinbeck** reassured the committee members that the savings would be listed on the table included in the handout. The table shows the net impact of the new proposal because some of the proposals show an increase in operating and reduction in benefits. She cited #3 of the new proposals, page B-68, "Personal Health Managed Care Management Contract," includes increases in operating but reductions in benefits. This in essence takes a net reduction out of the budget because the increase in operating is more than off set by the decrease in benefit reductions. This will be laid out in the table to be handed out.

Personal Health Management System: [Reference page B-68 of LFA Analysis] **Ms. Ellery** reviewed client education efforts in Medicaid. The primary goals being to increase client responsibility and to provide information regarding options for personal health care. One successful tool in other states has been "Personal Health Management Systems." This is a system where clients are given a 24-hour, toll-free number staffed by registered nurses who can answer questions and provide information and suggestions regarding personal health care. They do not diagnosis but they can assist the client in making a health care decision. The "Ask A Nurse" program in Montana is similar to what this program would be. There has been success with this type of program in Oregon and it has been in place long enough that they have some excellent outcome data. A study in Oregon revealed that 92% of those who called had intended to go to the emergency room but were able to receive appropriate treatment in a lower cost setting. This decision was made after talking with a nurse responding to the toll-free number. Medicaid proposed to try this system on a pilot basis. This program would not be available to anyone on an HMO because Medicaid is paying the HMO to manage those cases. This telephone-based service would be available to those on the PASSPORT program, as well as people in rural areas who are not on PASSPORT or HMO. This will provide an excellent resource for those areas without other managed care options. It is believed it will also help enroll more PASSPORT providers, as it will assist in screening some of the provider' calls. Access to an audio tape library via this phone number will also be a benefit.

SEN. SWYSGOOD asked how the $1.6 million in savings was calculated. **Ms. Ellery** explained the Oregon Medicaid population data was used plus the experience of companies experienced in these types of programs. From this data it was concluded that 25% of the emergency room visits could be avoided with this telephone resource. These cases would be treated in a lower cost setting. She felt this was a conservative estimate, as Oregon realized 92% after just one year of operation. **CHAIRMAN COBB** asked if the 25% reduction would be realized the first year and 25% the next, what would happen if the estimate were raised to 50% for the second year. **Ms. Ellery** indicated that it would probably double the savings but stated that was not the issue as it is not possible to have the entire system up and going state-

wide immediately. She said it took Oregon at a year to get the program up an running.

REP. BARNHART asked how much more it would cost if the resource were available to the public, not just Medicaid recipients. **Ms. Ellery** answered that in many states HMOs use this type of service because they know that this service helps contain costs. **REP. BARNHART** went on to ask how the nurse would know the person calling was Medicaid eligible. **Ms. Ellery** responded that other people could buy this service but that Medicaid does not intend to pay for this for the general population. In developing the program Medicaid has talked with other programs, such as worker's compensation, to see if they wanted to partner on the development and maintenance of the program. She indicated that when a Medicaid client calls the hotline number they will be required to give an identification number.

SEN. SWYSGOOD asked if there would be a live operator answering the calls. The answer was yes. He then asked where the cost for this personnel was located in the budget. **Ms. Ellery** replied the cost was netted out of the fee per eligible. She said there would be an adjustment later because the actual services contracted ended up being more comprehensive than those originally budgeted. Even with the per member per month cost this program still nets significant savings for the overall Medicaid program as a result of lower utilization of the higher cost treatment options. When asked if this would be considered a primary care benefit she responded that it would be a benefit to everyone on Medicaid, except those on an HMO.

SEN. SWYSGOOD expressed a concern that the primary care budget of $35 million represents a number of different programs and it seemed there is no way to determine which programs are effective and which are not. Further there does not seem to be a way to directly link costs and savings to each of these various programs. **Ms. Ellery** said these savings would show up as a reduction in the utilization of hospital emergency room and outpatient reimbursement and in the decrease in utilization of specialty physicians. She went on to point out that there is a separate line item for hospital services and for many of the other services in the budget. She also stated it is important to maintain the flexibility in the budget to move things around.

SEN. SWYSGOOD stated that there are only line items if the legislators asked for a program to be line item.

CHAIRMAN COBB clarified the flexibility vs line item issue by explaining that they will insert language requiring Medicaid to track the hospital expenditures. If they have extra money this will give them the flexibility to move it around, and if there are insufficient funds to move monies into the program. Medicaid will to track the exact expenditures but for budgeting purposes but the flexibility would be maintained.

SEN. LYNCH asked where the nurses would be located that would be responding to this toll-free line. **Ms. Ellery** said this would depend upon who the contract is awarded to. This would be a negotiable segment of the contract.

SEN. LYNCH asked what would happen if a patient is misdiagnosed per the telephone call and necessary treatment is not sought based on the recommendation of the nurse. In response; the companies competing for the contract use nationally established protocol that are symptom based. These companies do carry liability insurance but, **Ms. Ellery** went onto state, often in these situations everyone could get named in a lawsuit. The company **Ms. Ellery** is most familiar with has never been sued because of the standard protocol. If there are any doubts at all they tell the clients to go to the emergency room.

SEN. LYNCH asked if the Medicaid recipient is required to follow the advice of the nurse on the telephone. **Ms. Ellery** said absolutely NOT, the nurse goes to great lengths to make suggestions but does not direct or indicate that a person must do anything.

{Tape: 2; Side: A; Approx. Counter: 000; Comments: n/a.}

Caring Program for Children: **EXHIBIT 5** Medicaid has been working with Blue Cross/Blue Shield (BCBS) to find a way cover more uninsured children. **Ms. Ellery** reviewed Exhibit 5, "Caring Program for Children (CPC), Concept Paper." This issue is not in the budget anywhere but the department feels it is important to explore options for the children. The Caring Foundation package would cover children who are not covered by Medicaid or any other type of insurance. The focus would be on primary and preventive care, it would not pay for inpatient hospital care. She suggested that children in need who do not qualify for Medicaid would be automatically referred to this program.

REP. BARNHART asked if dental care would be included in this package.**Mr. Butler, Blue Cross/Blue Shield**, said that preventative dental care is not covered. However, dental care connected to an accident is covered.

REP. BARNHART then asked if clients on AFDC would be able to access the nurse telephone services currently offered by BCBS. **Mr. Butler**, said they would have access. **REP. BARNHART** inquired as to the cost of the telephone services if the entire population in the state of Montana were to have access. He said he did not have that figure but could research it and get back to the committee with an answer.

REP. KASTEN asked how the children would be assessed for eligibility for the CPC program. **Mr. Butler** answered that the children are accepted into the program on a first come first serve basis and services are provided as long as funds are available in the foundation. The average cost per child is $276

per year. **REP. KASTEN** asked who refers the children to the waiting list. **Mr. Butler,** explained that referrals primarily come from churches, schools, pediatricians, school nurses, family practitioners, emergency room personnel and the Medicaid district offices.

REP. KASTEN asked if the children already had medical conditions requiring attention when they are referred to the program. **Mr. Butler**, said that is correct. A study reviewing what services were most delivered in 1994 showed the bulk of services were immunizations and well child visits. However, there were several thousands of dollars worth of outpatient lab and x-ray services and hospital emergency rooms.

REP. COBB requested clarification with regards to the $500,000 per year and the 4,500 children served per year. **Mr. Butler** explained the BCBS would put up 75% of the funds and match it with 25% of funding from private sector contributions to equal the 100% funding. **Ms. Ellery** further explained that they would go from serving 600 to 4,500 over the biennium calculated at $270 per child per year. If you look at the 10,000 uninsured in families under 200% of poverty, this program calculation would allow you to service almost half of the population at one third of what it would cost to use the Medicaid program. Even though the CPC services are not as comprehensive as those offered by Medicaid it is still a very good package of primary and preventative care. It also provides a worth while project for local communities to get behind.

REP. COBB asked if it would be legal to have the family contribute as they are able according to a sliding scale. **Mr. Butler** said the program is at "no cost" to the family or child. The funding that is raised "tax-free" is used for medical expenses for the child at no cost to the family.

REP. COBB then referred to Arizona, being one of the last states to come onto the Medicaid program, and their use of a sliding scale type of assessment. He asked if Montana Medicaid could do a similar program. **Ms. Ellery** said that you are allowed to do a sliding scale for premiums if you have a waiver and then only for families above 100% of poverty.

REP. COBB then asked if the program could be expanded under this mode and if the waiver is hard to obtain. **Ms. Ellery**, "the waiver is hard to get but that does not mean that they should not try to obtain it." The kind of waiver required is the 1915 fee waiver, the "Research and Demonstration Waiver". This is the same waiver required by the mental health program. In order to obtain this waiver you have to prove the program is cost neutral and that you would be demonstrating something. She did not feel there would be any difficulty showing neutrality. Most states that have gotten into managed care have used savings experience from the managed care program to expand the Medicaid population.

Mr. Butler commented on the cost shift issue, stating many of the hospital, physicians, nurse practitioners and physician assistants in the state have agreed to accept a lower level of reimbursement in the CPC. **REP. COBB** referred to a recent study reviewing the Department of Health, Maternal and Child Block Grants that indicated if they had some matching funds at the county level they could do quite a bit of the preventative health care for these children at the county level. They could possible use the Medicaid match money as an option to maximize the services provided for the money.

Steve Yeakel, Montana Council for Maternal/Child Health, urged strong support for the CPC. He indicated that of all the issues important to them the most important are the public/private partnerships. Those where the private sector is involved in making a government program work better and serve more efficiently. He is anxious to have this population of children cared for across the state.

{Tape: 2; Side: a; Approx. Counter: 20.1; Comments: n/a.}

CHAIRMAN COBB asked **Shelly Ross, UNISYS Corporation,** to explain what their role would be and how specifically they would be saving the state money by managing the HMO program. She first addressed the issue of specific saving, saying that she did not have the figures with her but would get back to the committee. When asked by **CHAIRMAN COBB** what UNISYS had done in other states, **Ms. Ross** responded that UNISYS is a partner with Lewin VHI, the entity putting together the information on the HMO program. UNISYS administers managed care programs for Medicaid in Vermont, Oklahoma, and Iowa. The Montana HMO program is loosely patterned after the program in Iowa because Montana has a large rural population much like Iowa.

CHAIRMAN COBB asked if UNISYS had any studies showing how they had saved money in these states. She answered that she was certain that UNISYS does have this information however, she did not know the specifics. **CHAIRMAN COBB** asked her to find out the specifics regarding the savings produced by the managed care programs in these other states and report back to the committee as soon as possible. She assured Chairman Cobb that she would have that information to the committee within the week.

Pam Schlegel, Missoula Dental Access Task Force, spoke to the issue of access for Medicaid recipients to dental care as referenced in the handout "Medicaid Dental Access/Problems and Solutions." **EXHIBIT 6**

REP. BARNHART asked how many dentists would come onto the program if the reimbursement were changed to 80% of costs. After having discussed this issue with many dentists in several communities, **Ms. Schlegel**, felt the general consensus was if managed care is presented without their input they will not participate. If the reimbursement rates continue as they are the

dentists will not participate. She felt that the participation numbers would dramatically increase if the suggestions made by the task force were implemented.

REP. BARNHART asked if the package of suggestions presented by the task force are not accepted and implemented if **Ms. Schlegel** was suggesting that the dentists would not participate in the program. **Ms. Schlegel** said this was correct. Although the intent of the changes being presented by Medicaid is to increase access, the dentist's are concerned as key players in the issue and if they are not involved in a cooperative effort they will not participate.

SEN. LYNCH asked for and received clarification that the dental services reimbursement was being increased to 80%. **CHAIRMAN COBB** asked how the total cost was figured and how that related to the number of children being served. **Ms. Ellery** responded that the costs were calculated using a trend factor which took into account the increase in costs and the increased number of children to be served.

CHAIRMAN COBB asked **Dr. Blouke** specifically for the growth rate used for the budget calculations. **Dr. Blouke** said in terms of dollars the dental services are increasing at 8.4%. He did not have the breakdown in numbers of clients anticipated but assured Chairman Cobb he would obtain them for him. **Ms. Ellery** said with lower reimbursement rates they were having fewer and fewer providers participate each year.

CHAIRMAN COBB said he was concerned the budget reflected the rate increase but not the growth rate in the program. **Dr. Blouke** said the 8.4% increase does not include the mod. **CHAIRMAN COBB** indicated that implementation of the mod would facilitate growth in clients served and therefore require an increase in the budget. He again stated his concern that the budget request adequately take this growth factor into account. **Dr. Blouke** said the dental costs are tended forward and the increase in the budget reflects only the projected reimbursement rate increase. He stated they did not expect a large influx of additional recipients. **CHAIRMAN COBB** felt that if they implement these changes and provide availability to these services the clients will come.

Ms. Schlegel continued stating that the providers remain concerned that the proposed 80% reimbursement be a "real" 80% reimbursement. The current 60% reimbursement structure actually pays between 40% and 60% due to the formula that Medicaid uses to calculate the reimbursement rate. She feels this will be a major issue in providers' decision to participate in the program. **CHAIRMAN COBB** asked if she was saying that the providers 80% was not in fact what Medicaid was calling 80%. **Ms. Schlegel** said yes, that was what she was stating. **Ms. Ellery** explained that when Medicaid calculates charges they use what the plain form says is the "usual and customary" charge for each service. She

further stated that before implementation of the proposed changes Medicaid should do a survey to determine what the "real" "usual and customary" charges are in the state.

Proponents' Testimony:

Lisa Morris, Mission Valley Medicaid, spoke in support of **Ms. Schlegel's** testimony. She has seen a decrease in the number of dentists willing to participate in the Medicaid program. Consequently, Medicaid has had to pay for a client to travel from Thompson Falls and Lake County to Missoula simply to receive dental services. As a result the state is paying much more, with travel reimbursed at $1 per mile, than if they simply increase their reimbursement rate for the dental care. Sometimes these recipients have to travel once a week if they are getting dentures or are receiving extensive treatment. The transportation costs are sometimes double or triple what the dentists' fees were.

Mary McCue, Montana Dental Association, representing approximately 95% of the dentists in Montana, went on record in support of the proposed Medicaid program changes for the reasons previously stated by others.

Mary Lou Abbott, Department of Health and Environmental Sciences (DHES), submitted written testimony written by **Dale Taliaferro, DHES and Health Services Division Administrator. EXHIBIT 7**

Kathryn McLeod, Health Services Coordinator, Head Start, Missoula, supported the proposed changes to the dental program. She said, that to her knowledge, there are no dentists in Missoula currently accepting new Medicaid patients. She submitted written testimony. **EXHIBIT 8** This written testimony also included letters from: **Mari Carrell, R.N., Yellowstone County Head Start Health Coordinator** and **Susan Trout, Bozeman Head Start Health Coordinator.**

Mary Alice Cook, Advocates for Montana's Children, stated that in their "blueprint" for child care includes concerns regarding dental care. She voiced support for the proposed Medicaid changes.

Steve Yeakel, Montana Council for Maternal and Child Health, reviewed his experience with the Army War Conference. United States military officials were pointing out at that time that the Soviet Union as we knew had approximately 16 months before it would collapse. In a series of seminars they showed how life in the Soviet Union was deteriorating. The most unattractive and un-nerving thing he saw was the condition of the people, in particular their children, especially the condition of their children's teeth. He stated the implication was clear; in a nation that will not care for its children's teeth there is concern for how the nation will exist and operate. He concluded by asking for support for the proposed Medicaid changes.

Questions from Subcommittee Members and Responses:

REP. BARNHART asked how much it would cost to provide dental care for adult Medicaid recipients. **Dr. Blouke** answered that in order for Montana Medicaid to receive the waiver it needed for the dental program it must provide "emergency" dental care for adults. The AFDC children, the elderly and the disabled are not affected by this situation. It is the "employable adult" that this waiver addresses.

SEN. LYNCH asked if there was coverage for a former G.A., an indigent. **Dr. Blouke** stated when the legislature eliminated the State Medical Program, it did away with the resources for these individuals. **SEN. LYNCH** stated that there are still some people who are not covered. **Ms. Ellery** said in some communities around the state the dentists and staff volunteer their time to provide limited care for these people.

REP. BARNHART asked for clarification of a proposed amendment for welfare reform that says adults will be cared for, and wanted to know what the amendment would be. **Dr. Blouke** said when there is an emergency the program will provide the coverage, but will not cover routine dental coverage under the welfare reform proposal. **Mary McCue, Montana Dental Association**, answered that in a conversation with **Nancy Ellery,** she understood that all of the adults would not be eligible for dental medicaid.

Jim Morin, President and CEO of the Great Falls Capital Corporation, said he owns a taxi cab and wheelchair company in Great Falls, and is also the co-chair and director of the Montana Passenger and Carrier's Association. **Mr. Morin** addressed a letter he had written to **CHAIRMAN COBB.** It deals with two issues: 1) he represents the non-emergency medical, wheelchair transportation providers in the state. He said they are working under a rate structure that was devised in 1990, and allows them to transport medicaid patients for the amount of $10.06 one way and $17.61 for a round trip. Under this same provision a Medicaid payment of 63 cents a loaded mile when out of the urban area, and 32 cents an unloaded mile. He said with the times and technology changing, they are now under the American Disabilities Act (ADA), and are forced to comply with federal requirements at an excessive cost.

The letter addresses a rate increase that is more in line with surrounding states, i.e., Idaho, and Utah. The request is for $40 base rate in town per destination one way, and a base rate of $40 plus $1.50 per loaded mile for rural transport. He presented some statistics he had received from Terry Kranz, SRS-Medicaid, that will inform everyone how this additional funding will be impacted in terms of the additional dollars that are needed for the company to operate.

He summarized that the company is currently transporting medicaid patients below their cost and have been subsidizing out of their

own capital. If his company goes out of business, it will force the ambulance service to pick up the patients at a much higher rate; 2) SRS has contracted with Integrate Transport Management (ITM) a third party contractor, to develop and operate a medicaid transportation management system.

Mr. Morin's company is averaging 25 to 30 hours a week of additional administrative hours to comply with the paperwork from this third party contractor. He gave an example of his concerns and what is happening. In January 1995 his company was owed $23,000 from Consultec, a third party payor. He said that most of the money owed was for transportation services his company provided in October, November, and December of 1994. He was not allowed to turn in a request for payment in January of 1995 for services because of some technical problems between Consultec and ITM. **EXHIBIT 9**

Lisa Morris, Mission Valley Medical, discussed the wheelchair rates and the cost of purchasing a wheelchair van. She said their business is required by law to have a wheelchair van and asked the committee to support this issue.

SEN. LYNCH asked what happens if a small town does not have wheelchair service. **Nancy Ellery** said they do not allow people to use the ambulance service unless there is an emergency. She said there are resources around the community that help out. The contractor tries to find the least expensive mode of transportation. **Ms. Ellery** discussed the reason the state went to ITM stating that everyone throughout the state was doing their own thing. With ITM there is one person to arrange in a most cost effective manner the best way to transport the clients. **EXHIBIT 10**

{TAPE: 2; SIDE: B; APPROX. COUNTER: 000; COMMENTS: N/a.}

James Michael, Montana Passenger Carrier Association, and Manager of the Kalispell Taxi Service and airport shuttle service, said the general transportation providers were exempt from the ADA regulations when they were implemented in 1991, unless they operate a vehicle with capacity in excess of 10 passengers. He said transportation vehicles for wheelchairs must be in full compliance by 1996, i.e., a 56" headroom within the vehicle which a standard passenger van does not have that without raising the roof. The wheelchair lift must be a specific length and width and a specific weight lift capacity. He said they do not receive any compensation for the cost of the equipment, and no additional reimbursement for these services, nor do they charge any additional fee to the client.

A handout was given to the chair entailing all of the complaints of wheelchair bound people that have had to rely on ITM. **EXHIBIT 11**

{Tape: 2; Side: B; Approx. Counter: 9.2; Comments: SEN. TERRY KLAMPE had to go to another hearing and asked to testify on behalf of the dentist issue.}

SEN. TERRY KLAMPE, SD 31, Florence, addressed the dentists' concerns in regard to Medicaid. He said there is a demand for dental care by Medicaid patients, but fewer dentists are taking Medicaid patients. The only way to handle this problem is preventative care by treating the children and cut back on the adult care, or increase the allowable payment to the dentists so they can treat the Medicaid patients. He offered to visit with the Medicaid program and work out a solution by directing funds to the best cost effective and efficient procedures.

SEN. BARNHART asked if there are any dentists in Montana that have flex hours that would allow a working parent the opportunity to take care of their dental needs. **SEN. KLAMPE** said it is very limited. Most of the dentists take Fridays off and very seldom work at night.

{Tape: 2; Side: B; Approx. Counter: 12.9; Comments: Testimony has now switched back to the wheelchair transportation issue.}

Trudi Hovden, Old Trapper Taxi and Wheelchair Transportation Service, Helena, informed the committee that the wheelchair transportation service offered through her company is currently in a crisis and will not be able to continue further transportation service if the rates set by state are not raised.

Tony Wood, Wheelchair passenger, Helena, said he has not seen a doctor since October 1994 because of the services available for him. He said dial-a-ride will not come into his home to help him with his coat or put his ramp down to get out to the bus.

Judy Erickson, disabled person, Helena, addressed the 1-800 Medicaid number she is suppose to use to receive transportation. The 800 number goes through operators in Billings and the information is not received back here in Helena therefore has missed appointments. She was informed that if the 800 number does not work for her that she needs to speak to the Helena City Council. She suggested that the 800 number be distributed between counties or cities.

John McCrea and MAP Advocates, turned in testimony in regard to wheelchair transportation service. **EXHIBIT 12**

A petition was given to the committee from members and staff of the Montana House here in Helena. **EXHIBIT 13**

ADJOURNMENT

Adjournment: 11:40 a.m.

REP. JOHN COBB, Chairman

for Nancy Meuli, Recording Secretary

Claudia Johnson, Recording Secretary

Note: These minutes were written by Nancy Meuli with help from Claudia Johnson. They were proofread by Lois Steinbeck, LFA.

JC/nm/cj

HUMAN SERVICES AND AGING

Joint Appropriations Subcommittee

ROLL CALL DATE 2-13-95

NAME	PRESENT	ABSENT	EXCUSED
Rep. John Cobb, Chairman	✓		
Rep. Beverly Barnhart	✓		
Rep. Betty Lou Kasten	✓		
Sen. Chuck Swysgood, Vice Chairman	✓		
Sen. J.D. Lynch	✓		
Sen. Jim Burnett	✓		

LOIS / Doug

EXHIBIT 1
DATE 2-13-95

Legislative Action Compared to Original General Fund Executive Request

Department/Action	Executive Request Fiscal 1996	Fiscal 1997
Net Changes Made to General Fund–SRS and DFS	($5,448,853)	($5,234,361)
Family Services–Original Request	$40,078,080	$41,880,011
Community Impact Grants	($4,059,617)	($4,158,893)
Life Skills Contracts	(372,672)	(372,672)
Transfer for Dually Diagnosed Children	(137,000)	(137,000)
Federal Indirect Cost Revenue	(100,860)	(100,860)
Interagency Coordinating Council	(100,000)	(100,000)
Chemical Dependency	(52,261)	(52,261)
Eastmont Closure–SSI Benefits	0	(45,872)
Double Count Juvenile Corrections Contracts	(44,479)	(44,479)
Juv. Corrections Community Servs. Contracts	(40,534)	(40,534)
Reduce Social Worker FTE Incr.	(27,518)	(25,054)
Various Provider Rate Increases	(22,884)	(22,884)
ROC I&I Income Estimates	(9,213)	(11,341)
Secure Care for Girls	100,000	100,000
Partnership Projects	100,000	100,000
Sex Offender Programs for PHS Boys	200,000	200,000
Sub-Total Changes to DFS	($4,567,038)	($4,711,850)
Revised General Fund–DFS	$35,511,042	$37,168,161
Percent of Total General Fund Request	11.40%	11.25%
Social & Rehabilitation Services–Original Request	$133,933,844	$149,460,393
Eastmont Closure	(640,000)	(818,132)
Mainframe Computer Costs	(288,447)	(288,447)
Voc Rehab Workers' Comp Funding Switch	(192,087)	(192,087)
METS Computer System	(100,000)	(50,000)
Reengineering Study	(50,000)	(50,000)
Welfare Reform Benefit Cost Reduction	(41,371)	(169,848)
LFA AFDC Benefit Estimate	(46,876)	(70,111)
State-Assumed County Funding Mix	(41,466)	(41,770)
State-Assumed County Rent	(35,341)	(54,078)
OTD Rent	(37,621)	(38,153)
Title XX Transfer & TCM Operating–DD	(22,214)	(26,060)
Assistance Payments Rent	(12,105)	(12,407)
DD Provider Rate Increase	625,715	1,288,583
Sub-Total Changes to SRS	($881,814)	($522,510)
Revised General Fund–SRS	$133,052,030	$148,937,883
Percent of Total General Fund Request	0.66%	0.35%

*Only major general fund reductions are included; all increases are included.

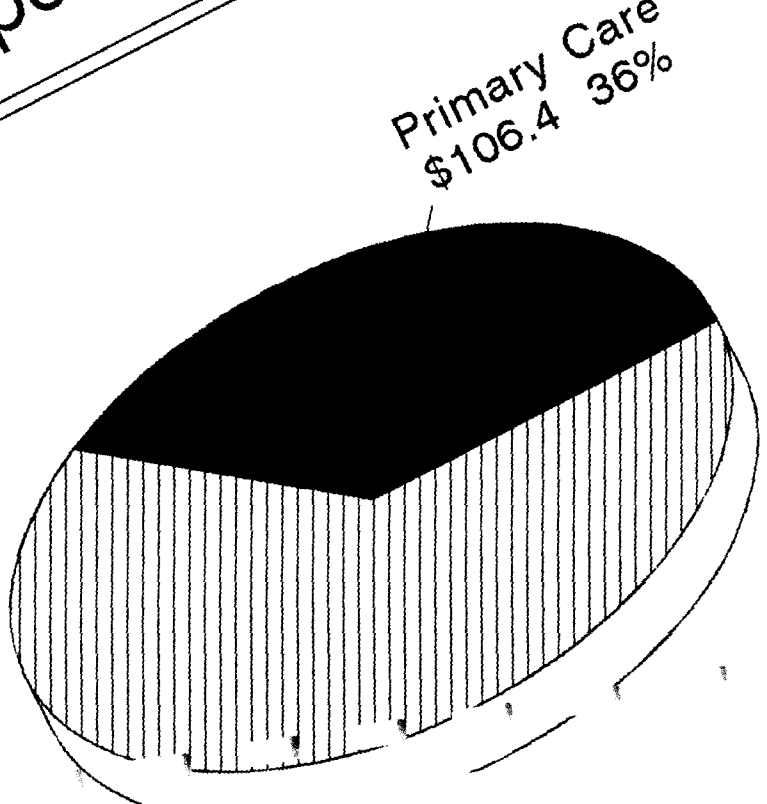
MONTANA MEDICAID PRO

Medicaid Primary Care Expense

MONTANA MEDICAID SERV
Primary Care Physician Services
Cost in Millions
$35
$30
$25
$20
$15
$10
$15.74
$19.74
$26

MONTANA MEDICAID PROGRAM

Medicaid Expenses for FY 1994



PHYSICAL HEALTH MANAGED CARE:

PASSPORT TO HEALTH HMO

EXHIBIT 2
DATE 2-13-95

PASSPORT Independent Assessment Findings

- First Year's Experience - 1993 - PASSPORT and non-PASSPORT recipients
- **Access**: Patients had better continuity of care, used more appropriate places of care, and had greater access to their doctor after hours
- **Quality**: Passport patients rated quality of care equivalent to non-Passport patients; Passport providers reported quality of care under Passport greater than without Passport
- **Cost Effectiveness**: Lower average utilization rates and cost per person; Net savings of $5.1 million
- **Areas for improvement**: recipient and provider education

HMO PUBLIC INPUT PROCESS

- Quality Care Advisory Council
  - provider, client, and state agency representation has been meeting since February 1994
  - Series of town meetings
  - Provider associations presentations
  - Consumer group meetings

CONTRACTOR RESPONSIBILITIES

- Research state and federal requirements
- Recommend services and population to be included in HMO
- Calculate HMO premium rates
- Develop, implement, and manage quality assurance program
- Recruit and enroll HMOs as Medicaid providers
- Enroll recipients with managed care providers

STATE RESPONSIBILITIES

- Make policy decisions based on Unisys' recommendations
- Rule making process
- Work with HCFA to meet federal requirements including state plan waiver
- Make necessary computer systems changes
- Conduct ongoing analysis of effectiveness of HMO program
- Ensure coordination with other Medicaid managed care programs

EXHIBIT 2
DATE 2-13-95

PASSPORT VS. HMO

- PASSPORT
- Provider:
  - enrolled by Medicaid
  - continue to bill Medicaid
  - paid by Medicaid
- Recipients:
  - have copayment
  - fewer services managed by PASSPORT provider
- Medicaid:
  - enrolls providers
  - assumes full administrative responsibility

PASSPORT VS. HMO (cont.)

- HMO
- Provider:
  - enrolled, billed, and paid by HMO
- Recipient:
  - no copayment
  - may have access to services beyond what Medicaid currently covers (eg. smoking cessation)
  - most services managed by HMO
- Medicaid:
  - enrolls HMOs
  - pays HMO and accumulates encounter data
  - much of administrative responsibility shifted to HMO

EXEMPTED RECIPIENTS

- Nursing home residents
- People with other insurance including Medicare
- Medically needy
- Residents of institutions
- Hardship
- On Medicaid less than three months

HMO SERVICES

- Ambulance
- Ambulatory Surgical Center
- Chiropractor
- Diagnostic Clinic
- Dietitian
- Family Planning
- FQHC
- Home Health
- Hospice
- Inpatient Hospital
- Lab & X-ray
- Mid-Level Practitioners
- Occupational Therapy
- Outpatient Hospital
- Physical Therapy
- Physician
- Podiatry
- Private Duty Nursing
- Public Health Clinics
- Respiratory Therapy
- Rural Health Clinics
- Targeted Case Management for Pregnant Women
- Well Child Screens

Services Not In HMO Package

- Audiology
- Dental
- Durable Medical Equipment
- Drugs
- Eyeglasses
- Freestanding Dialysis Clinic
- Hearing Aids
- Home & Community Based Waiver Serv.
- Home Dialysis Attendant
- Indian Health Serv.
- Mental Health inpatient and outpatient
- Non-emergency Transportation
- Optometric
- Personal Care Attendant
- Targeted Case Management for Developmentally Disabled

QUALITY ASSURANCE

- HMO
  - Unisys develops and operates quality assurance mechanism (report due 3/1/95):
    - Define what QA activities HMOs need to report
    - Recommend how to monitor quality based on information in encounter data

EXHIBIT 2
DATE 2-13-95

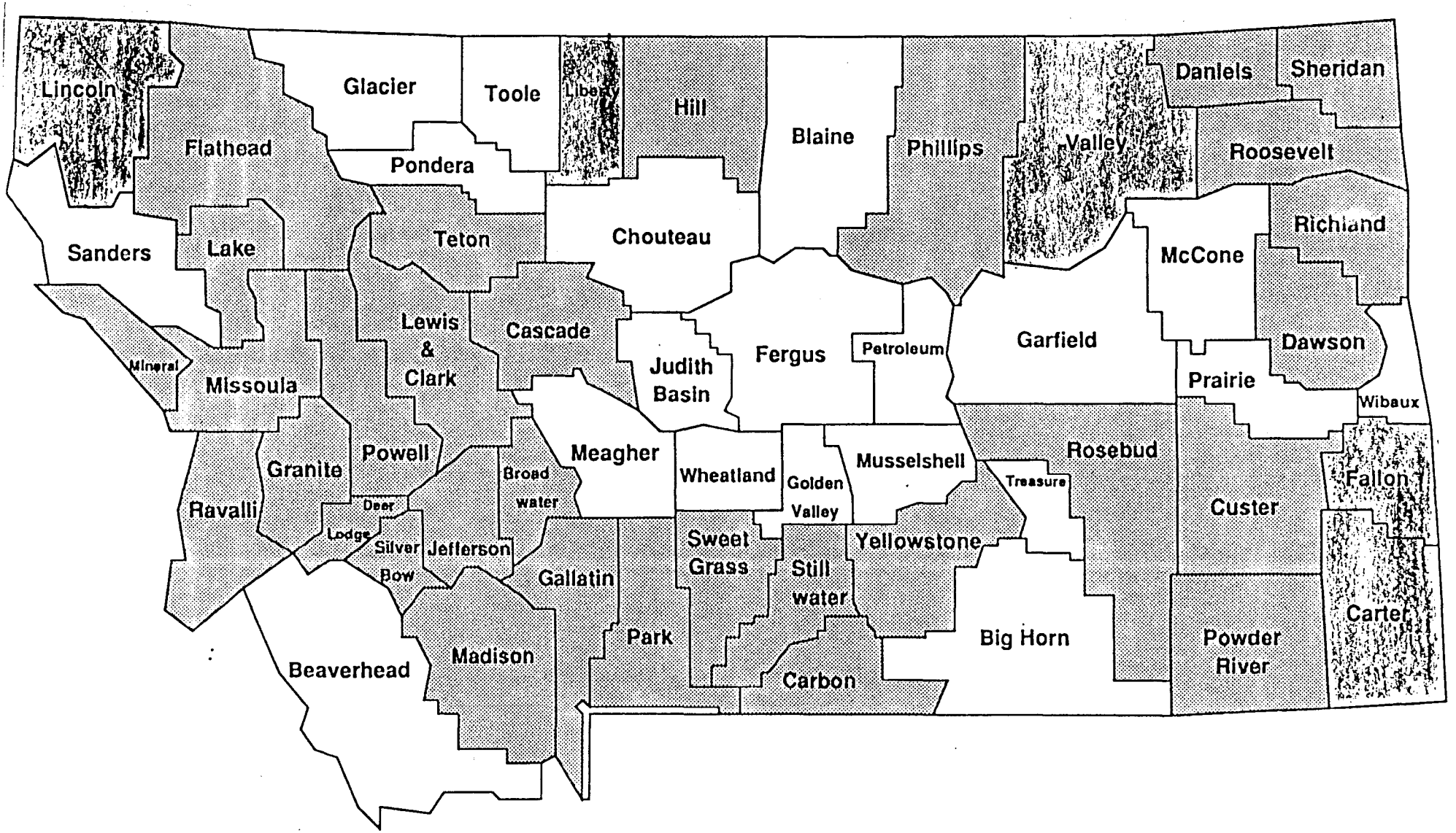
QUALITY ASSURANCE (cont.)

- **PASSPORT - Operated by Unisys**
  - Analyze provider utilization reports to identify over and under utilization
  - Conduct monthly recipient surveys to monitor impact on recipients and identify ways to improve program
  - Monitor PASSPORT provider 24-hour availability
  - Develop and staff PASSPORT peer education review committee
  - Review quarterly recipient change report

GRIEVANCE PROCESS

- **Step 1:**
  - HMO: Required to have internal grievance process
  - PASSPORT: State maintains informal in-house process
- **Step 2:**
  - Fair Hearing

Passport Counties as of March 1995



MEDICAID "PASSPORT TO HEALTH" PROGRAM

PASSPORT TO HEALTH is a coordinated care program for Medicaid recipients. Its goals are: 1) to improve the quality of care Medicaid recipients receive; 2) to improve their access to the health care system itself; and 3) to contain costs. A portion of the savings from PASSPORT will be returned to providers in the form of a case management fee above and beyond their regular fee-for-service reimbursement.

PASSPORT is based on the primary care case management model of coordinated care. In this model, recipients choose a primary care provider, then must get certain services directly from or authorized by that provider. The PASSPORT TO HEALTH Advisory Council is overseeing the process. It includes representatives of the groups affected by PASSPORT.

BENEFITS OF THE PASSPORT TO HEALTH PROGRAM

TO PROVIDERS:
* Eliminates "shopping around," in which patients seek treatment from more than one provider for the same medical problem
* Improves coordination and continuity of care
* Decreases unnecessary use of medical services
* Improves Medicaid reimbursement for primary care

TO RECIPIENTS:
* Improves access to care by ensuring they know there is a provider who will see them
* Develop an ongoing relationship with a single provider who knows their medical history
* Each member of the family may choose a different primary provider to meet their particular needs

TO MEDICAID:
* Cost savings, primarily due to drop in use of unnecessary services such as inappropriate use of the emergency room

OBLIGATIONS UNDER THE PASSPORT TO HEALTH PROGRAM

FOR PROVIDERS:
* Agree to arrange for 24 hour coverage
* Provide primary care
* Refer for specialty care
* Be enrolled as a Medicaid provider

FOR RECIPIENTS:
* Choose one primary care provider
* Make and keep appointments with that provider
* Get authorization from primary care provider before going to other providers
* Always bring Medicaid card to appointments

FOR MEDICAID:
* Inform recipients of program
* Enroll recipients on behalf of providers
* Make available a toll-free hotline for both providers and recipients

Who Can Be a PASSPORT Primary Care Provider? Physicians, certified nurse practitioners, certified nurse midwives, physician assistants, and clinics may enroll as primary care providers.

Will PASSPORT Create a Lot of Extra Paperwork? No. The only extra paperwork is the contract a primary care provider signs agreeing to participate and setting the maximum number of recipients she or he is willing to case manage.

Which Services Will the Primary Care Provider Manage? Inpatient hospital; emergency room; outpatient surgeries; physician; nurse specialist; rural health clinic; federally qualified health center; Indian Health Service clinic; and for individuals under 21: chiropractors and well child screens. Exceptions to this list are: obstetrical care, family planning, mental health, vision, immunizations, blood lead testing, STD testing/treatment in designated clinics, radiology, anesthesiology, and pathology. Recipients may obtain all other Medicaid services without the authorization of their PASSPORT provider.

Which Recipients Will Participate? Approximately 80% of Medicaid recipients will be required to participate, except those in areas where not enough primary care providers can be enrolled.

How Often May Recipients Change Their Primary Care Provider? Once a month. However, frequent changing will be reviewed by the Department.

How Many Recipients Will Each Provider Have To Accept? Each provider will designate how many Medicaid recipients he or she is willing to accept.

How Will Medicaid Reimbursement Change? PASSPORT providers will bill and be reimbursed as usual for services rendered. In addition, the Medicaid program will automatically pay the $3 case management fee for each recipient enrolled with a PASSPORT provider, whether or not the provider saw each enrollee that month. Providers billing for PASSPORT-managed services for someone else's PASSPORT patient must obtain authorization from the patient's PASSPORT provider to be reimbursed.

Who Will Enroll Recipients? The Medicaid program, with the help of County Human Services Office, will be responsible for enrolling recipients. Providers may also enroll recipients. Providers will be notified each month of which recipients are enrolled with them.

Where Is PASSPORT Available? PASSPORT is now operating in 34 counties and will be operating in 37 counties by the end of March 1995. Other counties will be brought up as soon as enough providers enroll to cover the target population.

For More Information:
Call the toll-free PASSPORT hotline at 1-800-362-8312 during regular working hours.

1/95

EXHIBIT 2
DATE 2-13-95

MEDICAID HMO FACTSHEET

Who? Recipients currently mandated to participate in PASSPORT will now have the option of choosing between PASSPORT and HMOs. During the first year HMOs will be offered as an option to AFDC (Aid to Families with Dependent Children) and AFDC-related recipients. During the second year SSI (aged, blind, and disabled) clients will become eligible to enroll. Recipients will be educated about the differences between the two managed care options. Nursing home residents, people who have other insurance including Medicare, medically needy, and residents of institutions such as Montana Developmental Center will not be served by PASSPORT or HMOs.

What? HMO stands for Health Maintenance Organization. HMOs are businesses which deliver a comprehensive set of health care benefits on a prepaid, risk basis. Medicaid will actuarially determine capitation rates by age, sex, and eligibility category. The HMOs will have to provide the services in the HMO package within the amount included in the capitation rate, or risk having to pay for it themselves.

When? HMOs will first be available June, 1995.

Where? It is likely HMOs will be available in the more urban areas of the state.

Services? The services in the HMO package are: ambulance, ambulatory surgical center, chiropractor, diagnostic clinics, dietitian, family planning, federally qualified health centers, home health, hospice, hospital (inpatient and outpatient), lab and x-ray, mid-level practitioners, occupational therapy, physical therapy, physician, podiatry, private duty nursing, public health clinic, respiratory therapy, rural health clinic, speech therapy, targeted case management for high-risk pregnant women, and well-child screens.

How? Medicaid has contracted with Unisys to develop and operate the HMO program. Unisys has made recommendations on the HMO package of services, and they will set the capitation rates, draft the model contract, develop the quality assurance program, and recruit HMOs to participate in the program. Any licensed HMO willing to meet program requirements and accept the Medicaid capitation rates will be allowed to participate.

1/20/94

EXHIBIT 3
DATE 2-13-95

CHILDREN'S DENTAL FEE INCREASE

The Department is proposing to increase the fees paid for dental services for children to approximately 80% of charges. By increasing provider reimbursement, we hope that more children will have access to cost-effective preventive dental care. Some of the problems, Medicaid is experiencing in the dental program are outlined below:

Medicaid receives on average 10 calls per week from recipients who can't find a dentist who will take new patients.

There are 738 licensed dentists in Montana.
- -390 of these dentists participate in Medicaid.

Of these 390 "Medicaid" dentists:
- -33% (or 130 dentists) had less than 10 children's visits in 1994
- -33% (or 130 dentists) provided the average of 82 visits in 1994
- -only 40 dentists had more than 100 visits in 1994.

Medicaid pays on average less than 60% of what dentists submit as charges.

Many Medicaid dental fees were established in the early 1980's and have had minimal increases since that time. Payments for common procedures are listed below:

Procedure	Medicaid Payment	% Paid/Charged Amount
Oral Exam	$10.72	59%
Space Maintainer	94.42	40%
Filling (amalgam)	16.92	44%
Crown (steel)	54.94	54%
Crown (resin)	54.94	38%

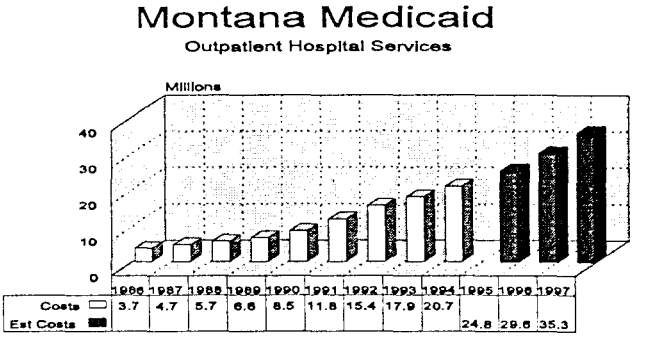
MED/dental

EXHIBIT 4
DATE 2-13-95

EXECUTIVE SUMMARY
JANUARY 1995
MONTANA MEDICAID
OUTPATIENT HOSPITAL & RTC STUDY

OUTPATIENT HOSPITAL SERVICES

Outpatient hospital expenditures grew from $3.7 million in FY86 to $20.7 million in FY94 (see graph). Part of the growth is due to the natural trend toward higher utilization of lower cost settings, thus shifting inpatient services to outpatient. Outpatient services are presently paid at 98.8% of costs for sole community hospitals and 93% of costs for non-sole community hospitals.



In October 1993 the Department contracted with Abt Associates, Inc. from Cambridge MA, to prepare a study and evaluation of current Medicaid reimbursement and recommend alternatives for prospective payment methodologies. In November 1994, Abt Associates delivered their report on the study and recommendations for reimbursement of outpatient hospital services. The recommendations could be described as a "modular" approach, in that different categories of visits would be paid in different ways. The recommendations were specifically crafted to minimize administrative impacts on hospitals while allowing the Department to control costs. The Department has openly encouraged the Montana Hospital Association and Montana hospitals to participate in this study. The Department has conducted several meetings and presentations with MHA and Montana hospitals to keep them apprised of the study. We will continue to solicit this involvement from MHA and Montana hospitals.

Highlights of the recommendations are as follows:

- ***Emergency Room and Clinic Visits:*** Expensive, critical care visits would be paid at higher rates than other visits. "True emergencies" would be paid at higher rates than non-emergency and clinic visits. Payment rates would be bundled to include all services except for imaging procedures and lab tests, for which hospitals could

bill separately. Sole community hospitals would be protected against unusually high-cost cases through the creation of a stop-loss pool. ER and clinic visits that include procedures listed in the ambulatory surgery category would be paid for using the ambulatory surgery rates. A triage fee (screen fee) would compensate hospitals for unauthorized care provided to Passport enrollees.

- ***Ambulatory Surgery:*** Visits that include surgery and certain other procedures (e.g., endoscopies and chemotherapy) would be assigned to one of 65 groups, using the Day Procedure Group (DPGs) grouping program. Payment rates would be based on Montana data, except for several rarely used programs. These rates would cover all services provided during the visit, including lab and imaging. Another stop-loss pool would protect sole community hospitals against high-cost cases.

- ***Dialysis:*** The few but costly visits for which Medicaid is the primary payor would be paid for using the well-established method used by Medicare. Each hospital would receive a "composite" rate per visit plus $10 per 1,000 units of Epoietin plus the cost of non-routine drugs and tests.

- ***Psych Day Treatment/Partial Hospitalization:*** Following the methodology of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), the full-day payment rate would be set at 40% of what Medicaid pays for inpatient psychiatric acute care. In 1993 this rate would have been $178.

- ***Therapy:*** The various types of therapy - physical, occupational, speech, audiological and psychological - would be paid for using a partly prospective approach. Each hospital would be paid the lower of its costs (times a factor depending on whether it is a sole community hospital, as is true now) or an aggregate annual limit based on rates for each type of therapy. This recommendation reflects the nature of these services (which are often provided together and over several weeks or months) and certain problems in the data we used.

- ***Stand-alone Observation Beds:*** Observation beds would generally be bundled into the payment rates for ER visits, ambulatory surgery visits, etc., but there are instances of observation-bed use that do not fit into these broader categories. We will monitor the use of observation beds in these circumstances and pay these services using rates based on the average cost of an inpatient bed.

- ***Lab and Imaging Services:*** A large number of visits include only lab and/or

imaging services. ER, clinic and therapy visits also include a large number of tests for which we would allow hospitals to bill separately. Lab and imaging services will be paid using fee schedules based on the Medicare fee schedule. Payment for a relatively small number of other diagnostic services (such as electrocardiograms) would also be based on Medicare payment principles.

All other services not included in these categories would be paid at cost subject to limits. In addition, the recommendations provide for the following general considerations:

- Exempt rural hospitals from the prospective payment system. (These are the same hospitals that are exempt from inpatient hospital DRG prospective payment system.)
- Out-of-state facilities would be paid using the same approach recommended for in-state hospitals.
- Favor Sole Community Hospitals with a stop loss on bundled rates

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RESIDENTIAL TREATMENT CENTER'S (RTC)

The Medicaid program made payments to three in-state and five out-of-state RTC's in fiscal year 1994. Residential treatment became an approved benefit of the Medicaid program in July 1, 1990 and the financial history of the program is very limited. In the first ten (10) months of fiscal year 1994, Medicaid interim payments totalled $7.9 million dollars (annualized at $9.5 million a year). Currently RTC's are reimbursed on a cost based retrospective methodology.

Abt Associates recommendation for reimbursement of residential treatment centers are as follows:

The Medicaid program will move as quickly as possible to audit the cost reports for the three in-state facilities recently submitted. Prospective rates will be set at 95% of each facility's audited cost, expressed on a per-day basis. These facility specific rates will be replaced with a state-wide rate over a three year period. In the second year, facilities whose rates exceeded the state-wide average will receive a rate that was half-way between the facility specific rate and the state-wide average. In the third year, facilities whose specific rate exceeded the state-wide average will be paid the average rate. In all cases, the rates would be "fully bundled." That is, a facility would be responsible for paying for all mental-health services used by its residential patients except for physician services.

EXHIBIT 5
DATE 2-13-95

Caring Program for Children
Concept Paper

Meeting the Health Care Needs of Montana Children
One Child at a Time

I. ISSUE - This paper will explore how the Montana Caring Program can be expanded through a public/private partnership to improve access to primary and preventive care for Montana's uninsured children.

II. INTRODUCTION - The Montana Caring Program for Children (CPC) provides primary and preventive health benefits to uninsured children. The Caring Foundation of Montana, Inc., is a non-profit organization responsible for the operation of the Caring Program. The Caring Program is a cooperative effort of participating physicians, hospitals, other health care providers, private contributors, and Blue Cross and Blue Shield of Montana, which administers the program. Children enrolled in the Caring Program must obtain their covered medical care from those health care providers participating in the Caring Program. Participating providers have agreed to accept the Caring Program reimbursement as payment in full for covered services. No additional payment is due from the child or family.

Such an established provider network of hundreds of physicians, nurse specialists, physician assistants and nearly all of the state's community hospitals helps ensure that eligible children receive essential health care benefits in a cost-effective manner. By accepting lower reimbursement, currently between 75 and 90 percent of Blue Cross and Blue Shield allowances as payment in full, these health care professionals are receiving payment for care they may otherwise have written off a uncompensated care. Thus, the Caring Program reimbursement helps reduce the impact of cost shifting in today's health care delivery system.

III. BACKGROUND - The Montana Health Care Authority estimates that one fourth of the state's uninsured population (or 25,000) are under age 18. Estimates are that 40% of these uninsured children are in families with income less than 200% of the federal poverty level (FPL). This means there are 10,000 low income Montana children who do not have access to primary and preventive health care delivery at a time in their life when it is the most beneficial and cost effective. These children currently fall through the cracks of our health care delivery system because their families have too much income to qualify for Medicaid but not enough income to afford private health insurance.

Children covered under current Medicaid policy are eligible under Medicaid if their families have income as follows:

Age 0 - 6	Up to 133% Federal Poverty Level (FPL)
Age 7 - 11	Up to 100% FPL
Age 12-18	Up to 51% FPL

Costs associated to expand Medicaid eligibility to all children under age 18 to various levels of the FPL are as follows:

	150% FPL	185% FPL	200% FPL
FY 96 GF	$1,583,647	$ 3,802,517	$ 4,737,673
FY 96 TOTAL	$5,233,467	$12,566,150	$15,656,552
FY 97 GF	$1,784,612	$ 4,285,057	$ 5,338,884
FY 97 TOTAL	$5,756,814	$13,822,765	$17,222,207

The State does not have the resources needed to expand Medicaid eligibility so other alternatives need to be explored.

At the request of the Montana Health Care Authority, staff from the Department of SRS and from the Caring Program For Children have been meeting to determine the best way to expand children's access to primary care services at the least cost to Montana tax payers.

IV. RECOMMENDATION - The state could contract with the Caring Foundation to provide state funds to increase the number of children receiving care through the Caring Program.

Nearly 600 children have benefited from Caring Program services in the past 24 months. There are currently 400 children enrolled in the Caring Program. Blue Cross and Blue Shield estimates the average cost of providing care is $276 a year.

Under this proposal, no expansion in Medicaid eligibility is required. The Caring Program eligibility and benefit requirements also would not change. To qualify, families must be ineligible for any public funded health care program and have incomes under 150% of the FPL - about $17,800 for a family of three. A million dollar state grant for the biennium would allow the Caring Program to increase the number of uninsured children served from 600 to about 4,500. This funding would help off-set costs of care for children in families with income above the Medicaid levels and below 150 percent of poverty.

The combination of public and private revenue would allow the Caring Program to increase outreach efforts to identify and provide uninsured children with a basic package of primary and preventive care. (See Attachment 1 for covered services). The Caring Foundation will contribute one dollar for every four dollars spent within the state grant.

By addressing the medical needs of children early on, we can avoid more acute problems later.

Covering more children would also reduce the long term costs to the state and help reduce the impact of cost shifting in today's health care delivery system.

Fiscal Impact:

State General Fund

FY 96	$ 500,000
FY 97	$ 500,000
TOTAL FOR BIENNIUM	$1,000,000

CLOSING - This grant would provide an excellent example of the state and local government working with the private sector to provide medical care for the children of Montana's working poor. It is an attempt to solve a problem from the community level up.

EXHIBIT 6
DATE 2-13-95

MEDICAID DENTAL ACCESS

PROBLEMS AND SOLUTIONS

DENTAL ACCESS TASK FORCE:

The Missoula Dental Access Task Force was organized in response to an identified need; access to dental treatment for Medicaid recipients. As we investigated the problem it became apparent that dental access to the Medicaid recipient was not unique to our community but rather a state wide problem. The members of the dental access task force have contacted individuals and organizations from around the state and received their endorsement for the recommendations I am about to present. Those who have endorsed the following proposals are dentists, hygienists, Kathy Kelker of PLUK, Amy Palmer and Mary Alice Cook of Advocates for Montana's Children Inc., our local directors and representatives of the YWCA, WIC, Head Start, and Health Department, as well as Jackie Stonnell, Stephen Nelson and Ann Drenk of the Gallatin County Health Department.

Our effort is based on the following principles:

We believe that dental care is an integral art of health care.

We know that Medicaid recipients have problems accessing a dentist through out most of the state.

Our initial assumptions were that dentists were uncaring self serving individuals. After all they were refusing to treat even children on Medicaid. During our investigation we uncovered the following information.

- Most dentists are generous men and women who want to serve patients in dental need.

- Many dentists do serve some Medicaid patients. However there are many more Medicaid recipient that require dental care.

- The Medicaid reimbursement rate is between 40 and 60% of the dentists actual cost.

- By serving Medicaid patients dentists are donating 40-60% of their service and in fact are loosing money. Dentists over head rate is about 67%.

- Reimbursement rates as set out by SRS are outdated.

- Fee schedules, as they now stand, do not always take into account the need for good dentistry while attempting to contain costs.

We therefore present the following solutions.

EXHIBIT 6
DATE 2-13-95

Proposal articulated by the Social and Rehabilitation Services:

"Medicaid is proposing to contract for the management of the dental services program on a capitated basis in FY96. A dental managed care program will improve the program by reducing administrative burdens for providers, improving access to quality care for clients and containing program costs.

The department is also proposing to increase the fees paid for dental services provided to children. Medicaid currently reimburses less than 60% of charges which has resulted in serious access problems. By increasing provider reimbursement, more children will have access to cost-effective preventive dental care."

DENTAL ACCESS TASK FORCE POSITION:

MANAGED CARE:

I. **We encourage SRS to collaborate with Montana's Dental Community prior to the implementation of Managed Care.**

It is the primary focus of our Dental Task Force to increase dental access for Medicaid patients. We recognize the good intent of managed care. However our perception is that a managed care system is potentially divisive, resulting in continued poor dental access for Medicaid recipients. We believe collaborative efforts toward the implementation of managed care should involve the grassroots i.e. locally based dentists, patients and supportive agencies, as well as the financial administrative body.

II. **We applaud SRS for recognizing the "serious access problem" and their willingness to address fees in their solution.**

An increase in fees is only part of the solution. Our dental task force has looked into this issue very carefully and present the conclusions and recommendations.

A. Medicaid reimbursement for children should increase to at least 80% of dental fees.

Because reimbursement rates have been so low dentists who serve Medicaid patients do so at a financial loss. Their generosity has unnoticed for too long, to say nothing of unappreciated.

Dental overhead costs run at about 67%.
An 80% reimbursement rate will allow for costs at about 13% above overhead.

B. Emergency dental service for able bodied adults serves children and is cost saving.

Medicaid cuts are inevitable for able bodied adults as outlined in the Welfare Reform Bill.
We propose an amendment to the Welfare Reform Bill.

1. Able bodied adults are parents of Medicaid children. Financial responsibility for their children will be difficult in the event of a dental emergency. We do not want money that is intended for a child's food and shelter to be spent on a parent's dental emergency.

2. Dental pain is stressful. Although there is no excuse for child abuse, we know that the potential for abuse is greater when under stress. We do not want children to be exposed to higher risk of physical or emotional abuse due to parent's dental pain.

3. Patient's in dental pain will use hospital emergency wards if access to dental service is financially unattainable. Hospitals are presently legally bound to treat all patients requesting care. The cost of dental service is inappropriately transferred to an already burdened system, with no hope of reimbursement. Ultimately the public pays.

C. Reimbursement rates must reflect current dental fee structures.

The current fee schedule is out dated. SRS recognizes this inequity and has agreed to collaborate with a dental advisory in an effort to address this issue. We remind SRS that a dental advisory would best be selected by Montana's dentists and composed of current Montana dentists, of both urban and rural grassroots.

D. Reimbursement rates must reflect not only cost containing measures but good dentistry.

Currently fees are set according to procedure. This approach fails to take into account the time, detail and difficulty sometimes required to provide service. Fees must reflect procedure, time, detail and difficulty. This is of particular concern when dealing for very young children and emotionally and mentally disabled children.

PROPOSAL SUPPORTERS

George R. Carson, D.D.S. Pediatric Dentistry; Bozeman

Doug Hadnot, D.D.S.; Missoula

James Bigelow, D.D.S.; Missoula

Ralph MacDonald D.D.S.; Missoula

Kathy Kelker, P.L.U.K. (Montana represented)

Amy Palmer and Mary Alice Cook; Advocates for Montana's Children Inc. (Montana State represented)

Melisa Kaiser; Helena

Janet Brooke; Helena

Maggie Yobst, YWCA; Missoula

Kirk Astroth, MSU; Bozeman

Jackie Stonell RN, Director Gallatin County Health Department; Bozeman

Stephan Nelson; Bozeman

Pat Dontigny, RN; Missoula City/County Health Department

Leslie McClintock; Human Services Programs, Missoula County

Mary Feursinger, Director WIC; Missoula

Ann Drenk; Bozeman

Kathryn McLeod, HEAD START; Missoula

Jeanne Twohig, Director and Staff, Partnership Health Center; Missoula

EXHIBIT 7
DATE 2-13-95

DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES
TESTIMONY ON APPROPRIATION BILL, HB2, MEDICAID REQUEST
REGARDING INCREASING REIMBURSEMENT FOR CHILDREN'S DENTAL SERVICES

JOINT COMMITTEE ON HUMAN SERVICES
submitted by Dale Taliaferro
February 13, 1995

My name is Dale Taliaferro, Department of Health and Environmental Sciences, and Health Services Division Administrator. The Department promotes dental health of Montanans through a variety of population-based projects including the school-based fluoride mouthrinse program, distribution of toothbrushes, development and distribution of materials to create awareness of the value of dental sealants, as well as community water fluoridation.

The Department supports increasing Medicaid reimbursement for children's dental services. Hopefully, this increase in reimbursement would enhance access for Medicaid children.

Although the overall amount of dental decay in children has declined steadily since the 1940's, half of the children have had at least some decay in their permanent teeth. Despite advances in the treatment of dental disease it is better to **prevent disease** than to **treat** it. Dental disease prevention is **inexpensive** and the effects are **long-term**. Preventive services may include regular dental examinations, fluoride treatments, dental sealants and patient education on correct oral hygiene techniques and the role of in-between snacking and dental decay. **These preventive dental services are available to Medicaid children if they have access to a provider** and access must be **available if the higher costs of dental restorative treatment is to be avoided.**

The problem of providing access for Montana's Medicaid children is a dilemma that must be addressed with a variety of creative and innovative approaches and raising the reimbursement level is **one** piece on the solution of the problem!!

DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES
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The problem of providing access for Montana's Medicaid children is a dilemma that must be addressed with a variety of creative and innovative approaches and raising the reimbursement level is **one** piece on the solution of the problem!!

EXHIBIT 8
DATE 2-13-95

HEAD START

WHITTIER SCHOOL 728-5460
1001 WORDEN 728-5461
MISSOULA, MT 59802 1-800-223-1841

SUPPORT INCREASING MEDICAID REIMBURSEMENT FOR DENTAL SERVICES TO CHILDREN FROM 60% TO 80%.

Access to dental care for medicaid families has become limited.

* **no dentists** in Missoula accepting **new** medicaid patients.
* 40% of medicaid eligible children enrolled in Missoula Head Start this year had no established dentist, and thus no access to care.
* One half of Head Start programs in Montana indicated access to dental care for families with medicaid is a problem.

Dentists state that low reimbursement is a major factor in unwillingness to accept new medicaid patients.

Dental care is important:

* if "baby teeth" are not cared for, the chances for healthy adult teeth is greatly diminished.
* Children with poor dental health may experience pain resulting in behavior problems, poor performance in school, nutritional problems, low self-esteem and even acute illnesses as a result of systemic infections that began as an infected tooth.
* we must support actions that encourage healthy lifestyle and in the long run support self reliance through example such as promoting good dental health to children, so that it becomes habit and a part of life.

SUPPORT, AT MINIMUM MEDICAID REIMBURSEMENT FOR EMERGENCY DENTAL SERVICES TO ADULTS.

* Dental pain results in reduced capacity to perform.
* Dental pain has been reported to increase the likelihood of domestic violence or child abuse or neglect.
* Cost of dental emergencies will be passed on to emergency rooms.
* Dental problems reduce the likelihood of securing sustained employment.
* Health habits, including routine dental care, are developed through children observing their parents practice them.

YELLOWSTONE COUNTY HEAD START, INC.

Accredited by the National Academy of Early Childhood Programs

P.O. Box 2056 ■ 615 North 19th Street ■ Billings, MT 59103 ■ (406) 245-7233 ■ FAX: (406) 245-1260

DATE: Feb. 6, 1995

TO: Senate Finance & Claims Subcommittee for Human Services
House Appropriations Subcommittee for Human Services

FROM: Mari Carrell, R.N.
Yellowstone County Head Start Health Coordinator

RE: Dental Access for Medicaid Patients

It has come to my attention that your subcommittees will be making recommendations regarding dental access for Medicaid patients. Since the majority of the families that we serve at Head Start are insured by Medicaid, we have a unique opportunity to see how difficult it is for these families to have their dental needs met.

In the Billings area alone, we see the number of dentists who are willing to accept Medicaid steadily decreasing, most of them claiming the low reimbursement rate from Medicaid as their reason for no longer taking Medicaid patients. Since we strongly recommend that the children entering Head Start have their initial dental exam prior to enrollment, we see a number of families that find it nearly impossible to get their child scheduled for an exam. Often times it takes months to get an appointment, or they are only able to call at a specific time each month to try to get an open slot held for Medicaid patients. It can lead to frustration and discouragement, often resulting in the families being unable to meet the Head Start requirements and ultimately, not being able to attend to their child's dental health needs.

We would like to encourage the increase in Medicaid reimbursement for children to the suggested 80%, along with Medicaid maintaining dental care for entire families. Since preventive dental care is such an important step in achieving a lifetime of good dental health, we feel it is especially important for Medicaid to raise the reimbursement rate, which would allow more dentists to cover their costs and increase the number of Medicaid patients that they are willing to see.

Thank you for your attention to this matter of great importance.

EXHIBIT 8
DATE 2-13-95

HUMAN RESOURCE DEVELOPMENT COUNCIL, INC. HRDC

Post-it™ brand fax transmittal memo 7671	# of pages ▸ 1
To Kathryn McCraid	From Susan Trout
Co. Missoula	Co.
Dept. Head Start	Phone # 587-4486
Fax # 758-5566	Fax # 585-3538

Dear Kathryn,

We are very concerned with the continued lack of dentists in our area who are willing to take new Medicaid patients. 70% of our preschool children are on Medicaid and the vast majority of these children have never seen a dentist prior to enrolling in Head Start. It is a federal mandate that every Head Start child receive a complete dental examination and all necessary treatment.

I have been the Health Coordinator in this tri-county program for just 6 months and have seen a major decline in the number of dentists who are willing to take new pediatric Medicaid clients. Out of 30 dentists in this area only 3 will take new medicaid patients (Data from survey of 9 Feb 95). These 3 caring dentists cannot be expected to take 33 new Head Start children on Medicaid. Many of the dentists who used to take Medicaid stated that the reimbursement rate was so low that they had to decrease or eliminate their Medicaid patients.

We have a mere $256.00 in our federally allotted funding to provide dental care to our uninsured children (15%) and to assist with patient deductibles of insured children (15%) if necessary.

Head Start is an early intervention program which assists children and their families with their physical and emotional needs. How are these 99+ children going to cared for if our local professionals refuse to provide services?

Susan Trout
Susan Trout
Health Coordinator
Bozeman Head Start

EXHIBIT 9
DATE 2-13-95

GF CC

GREAT FALLS CAPITAL CORPORATION

BUSINESS ACQUISITIONS & INVESTMENTS

January 18, 1995

Representative John Cobb
Augusta, Montana 59410

Dear John:

I want to take this opportunity to express our appreciation to you for meeting with various members of the non-emergency medical transportation providers in the state. We have organized into a non profit association to be known as: The Montana Passenger Carrier Association (MPCA).

Per your request I am including some information and our request for funding and rate adjustment. This request was unanimously endorsed by our board of directors.

We are requesting that those providers of medicaid non-emergency medical transportation which represent provider codes AO130, Z0007, Z0008, Z0009 and Z0010 receive a rate change from the current $10.06 one way and $17.61 round trip (intown) and $.63/loaded mile and $.32/unloaded mile. We as providers simply cannot continue to operate the transportation of medicaid wheelchair and medical social transportation and comply with ADA guidelines plus the increase in operating costs which we all have experienced over the last 5 years at a rate structure which was introduced in 1990 and has not changed. Our request we believe is reasonable when compared with rate structures in neighboring states. Currently Utah pays a base rate of $30 one way/$40 round trip plus $.90 per loaded mile. Idaho pays $47.30 base rate and $1.36 per loaded mile. North Dakota pays submitted prevailing rates as billed by private carriers.

In view of this information our request is as follows:

A base rate in town of $40 per trip destination (one way) - no mileage.
A base rate of $40 plus $1.50/loaded mile - rural transport.

Current and projected costs are as follows:

# of trips	Year	Cost	Project Cost	Increment Increase
3981	1993	$55,744*		
4454	1994	$62,360*		
7200(est)	1995(est)		$100,000	
8200(est)	1996		$325,000	$225,000
9200(est)	1997		$375,000	$275,000
Total additional funding request for next two years:				$500,000

*Provided by Terry Kranz - SRS- medicaid

The second issue of great importance to us involves the contract that the Montana Department of Social and Rehabilitation Services (SRS) signed with Integrated Transport Management (ITM) to develop and operate a medicaid transportation management system.

At the onset this seemed beneficial to all; i.e. the state, the recipient and the provider. However, after several months of working with ITM and attempting to coordinate our dispatching with theirs, it has fallen short of our expectations. The following issues are burdens that the providers have been forced to endure:

1. We have not received any written instructions or guidelines concerning implementation and compliance with ITM/SRS.

2. Administrative work load to providers has increased 15-20 hours per week.

3. Dispatched information from ITM consistently includes incorrect date, incorrect address and incorrect pickup times and in several instances missed pickup times.

4. All providers have experienced excessive delays in reimbursement from the state and in as yet in many cases non payment for services rendered due to the logistics now employed in this new system.

We, as providers, would desire that the following procedures and recommendations be implemented via legislative mandate to ensure the availability our service to the recipients who require transportation to medical appointments.

1. Written documentation explaining criteria used by ITM to process requests for transportation. This should include detailed information concerning how transportation is requested, determination as to how the provider is selected, and how the request is assessed and approved by ITM.

2. ITM submits billing information electronically to Consultec (third party contractor who acts as payor for state medicaid claims) twice a week. Providers must submit the exact same information to Consultec for payment. This is a duplication of hundreds of man-hours. We are requesting to be paid from ITM's submittals to Consultec.

3. We request a 30 day notification of all policy changes. <u>When this program was first implemented, providers had no more than 72 hours of advance notice!</u> Providers must be allowed sufficient time to make changes within their operation in order to continue to the same level of service prior to policy changes.

4. ITM must be held responsible for the economic mistakes relating to dispatching and clerical errors. Providers must be able to recover all charges to the state for errors in dispatching and the state must be positioned to withhold these charges from their reimbursement to ITM.

EXHIBIT 9
DATE 2-13-95

GFCC

GREAT FALLS CAPITAL CORPORATION

BUSINESS ACQUISITIONS & INVESTMENTS

5. Scheduled daily transports by ITM must necessarily be faxed to the providers no later than 6:00 A.M. Some transports are 50 miles to the recipients home. Scheduling changes involving new recipients or changes to providers current understanding of specific transport instructions involving a recipient need to be given to the provider by ITM up to 30 days in advance if ITM has been given that information. Providers must have sufficient time to schedule additional employees and vehicles to permit quality, timely service.

6. At this time all providers are allowed to bill for an additional passenger or attendee which may be necessary to assist the passenger. If the state will honor our requests, all providers will transport additional passenger/attendees at no charge.

We desire to testify at both the rate subcommittee hearing and the subcommittee you chair to present clearly and vigorously our desire for necessary changes regarding both of these issues. Please advise us when these hearings are scheduled and what pre-registration to testify may be necessary, if any.

Again, we appreciate your interest and assistance and please advise if you need additional data or support material.

Sincerely,

James E. Morin
Co-Chair and Director
Montana Passenger Carrier Association

EXHIBIT 10
DATE 2-13-95

MEDICAID TRANSPORTATION FACT SHEET

WHO? Medicaid is currently mandated to reimburse for transportation to covered medical services when no other means of transportation is available. These services include air and ground ambulance, non-emergency wheelchair and stretcher service, taxi, bus and other commercial carriers, as well as personal vehicle mileage and per diem.

WHAT? Prior to this contract, many transportation services were authorized at the county Office of Human Service. This was a time consuming process and because so many different people were involved in prior authorizing travel , problems were encountered with consistency in travel policy. A contract was initiated with Integrated Transportation Management to address this problem.

WHEN? The contract was initiated on September 1, 1994 and is scheduled to operate thru June of 1996,

WHERE? This contract is state-wide.

HOW? Montana Medicaid awarded a contract to Integrated Transportation Management (ITM) to develop and operate a transportation management system to ensure access to necessary medical care in a cost effective manner. All non-emergent requests for transportation services are prior authorized by ITM to ensure that the transportation is necessary, and performed in the least costly most appropriate method. ITM maintains a 24 hour a day, 7 day a week toll free service to arrange and authorize services. Emergency transportation is reviewed after the service is provided.

104 Broadway, Suite G4 Helena Montana 59601 406-449-4800

CHERYL RONISH
MSW, LCSW
PSYCHOTHERAPY

EXHIBIT 11
DATE 2-13-95

February 10, 1995

To Whom It May Concern,

I am writing regarding transportation provided to Medicaid clients I see in my office. I have two families that use this service and it is very necessary and appreciated. However, there have been difficulties in coordination for both these families. I do not know for sure where the problem lies but the transportation is often late and sometimes not by just a few minutes but by large blocks of time or not showing up at all. Additionally, Integrated Travel cannot tell me specifically what is needed in for my clients because each county is very different. This was a struggle when I worked in a residential setting and families had to travel long distances. I worked with several different counties and they all had a different procedure and requirements. This adds to whatever problems exist in the currect situation between the taxi company and Integrated Travel.

I am hopeful that this can be worked out so that these families can continue to receive this needed service. I will be cooperative in whatever way I can to help with this.

Sincerely,

Cheryl B. Ronish, LCSW

Cheryl B. Ronish, L.C.S.W.

Nov. 30, 1994

EXHIBIT 12
DATE 2-13-95

We Are Not The Crooks!

John McCrea and MAP advocates

1. There was no notification to any Staff of Mentally Ill, doctors, therapists, Montana House, ICM's, members and staff. Plus main the Old Trapper Taxi Service & consumers Medicaid recipients of Helena, Montana.

2. No More Taxi services to the Montana House for medications or therapy appointments, groups.

3. We should have city workers, operators of our county; Helena instead of Billings.

4. More operators are needed. I am and other Medicaid recipients are disgusted and tired of being put on hold. Then they hang upon us and give no response back. (Music should be put on the line so that Medicaid recipients know that they are still in touch and on the phone with the 1-800 No.)

5. Billings office asking us so many questions over every time. (They should have a file data on the computer knowing that we are Medicaid recipients, are qualified. When we call every time!)

WE THE UNDERSIGNED DO NOT AGREE WITH THE STATE OF MONTANA MEDICAID TRANSPORT POLICY

EXHIBIT 13
DATE 2-13-95

Judy L. Erickson (Montana House)
Gene Carkulis
Trace Farrell
Holly Smith
NICHOLAS BONNER (MONTANA HOUSE STAFF)
Patricia Andress (montana House)
STEVE WENDT
Jerry A Price
Alan Gray
Dennis Marks
Peter Alexander Yazak (Minority Legislative Staff)
M. Brett Tibbles
Leslie Turgeon
Patricia Andress montana House
Penny Eidem
CRIS PRESTIANO
Edith Nicolai
Barbara H. Smith (MT HSE STAFF)
John W. Mamo
Michele C Price (MT. Hse STAFF)
Bill Gulbrandsen

HOUSE OF REPRESENTATIVES
VISITORS REGISTER

Human Services & Aging SUB-COMMITTEE DATE 2-13-95

BILL NO. _____ SPONSOR(S) _____

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	Support	Oppose
Shelley B. Ross 100 N. Park, Helena	Unisys Corp		
→ Dearin Bellevue, WA	Hoechst Roussel		
Kathryn McLeod Missoula MT	Head Start		
Pam Schlegel Missoula MT	Missoula Dental Access Task Force		
Jim Morin	Montana Passenger Carriers Association		
James Michael	MPCA - Kalispell area		
Roland & Lisa Morris	Mission Valley Medical		
Mary McCue	Mt Dental Assn		
Mary Lou Abbott DHES	DHES - written testimony		
Mary Alice Cook	Adv. for MT's Children		
Chuck Butler	Coming Program for Children		
Terry Klapel	Dentists 4 Senate		

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

HR:1993
wp:vissbcom.man
CS-14