MINUTES

MONTANA HOUSE OF REPRESENTATIVES
54th LEGISLATURE - REGULAR SESSION

JOINT SUBCOMMITTEE ON HUMAN SERVICES & AGING

Call to Order: By **CHAIRMAN JOHN COBB**, on January 10, 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: Maternal and Child Care
Various Department Issues
Aging Services Network
Nursing Home Services
Montana Hospital Association
Caring Program for Children - Blue Cross/Blue Shield

Executive Action: None

{Comments: There is no tape recording for the first portion of this meeting.}

HEARING ON MATERNAL & CHILD CARE

Steve Yeakel, Montana Council for Maternal & Child Health (MCMCH) provided and discussed information regarding the MCMCH, some statistics for Lewis and Clark County outlining key facts for high risk families, and the 1995 Children's Agenda. **EXHIBIT 1**

He spoke about the trauma registry in Montana and felt it was a very credible source of data and an important data resource. He talked about MCMCH's concerns regarding Montana's Initiative for the Abatement of Mortality in Infants (MIAMI) Project. He said the Montana Children's Alliance supports the Governor's budgeted amount to be appropriated for comprehensive prenatal services in 33 sites, infant mortality review and Medicaid changes that will continue to lower barriers to care for low-income women.

He touched briefly on child care issues, the availability, quality and reimbursement rate. He spoke in favor of an increase for child care providers to the 75th percentile.

Mary Alice Cook, Advocates for Montana's Children, Inc. handed out a Blueprint for a Future Worthy of Montana's Children. **EXHIBIT 2** She said some of the legislative issues the Advocacy was concerned about were youth and family, child health, poverty and child care issues. She emphasized that "we are woefully failing our children, which results in a failure of our country." She stated that children are society's most precious asset and it is necessary to do whatever is possible to provide for and nurture them. She claimed the Blueprint was designed for a basis of action and hoped the legislators would carefully consider the information provided in it.

SEN. JIM BURNETT commented that the approach seemed to be that the government is becoming a parent. **Ms. Cook** responded that it is not the government's responsibility to become a parent, but it is their responsibility to provide full support for helping its citizens become independent in order to avoid poverty.

HEARING ON VARIOUS DEPARTMENT ISSUES

Sharon Hoff, Montana Catholic Conference, said the church is very supportive of welfare reform. She said one of the church's concerns was the proposed time limits placed on two parent families limiting financial support after 18 months. She mentioned that child care is another aspect of welfare reform that is imperative and "needs to be put in place." She was concerned that if federal changes regarding block grant programs were not available, the family could suffer.

Kate Cholewa, Montana Women's Lobby, spoke in support of funding and policy decisions for programs within or connected with the Department of Family Services (DFS), Social and Rehabilitation Services (SRS), the Department of Labor (DOL) and the Department of Health and Environmental Sciences (DHES). She outlined the Montana Women's Lobby concerns for certain proposals in the Governor's budget as outlined in the written testimony provided. **EXHIBIT 3**

Bob McLaughlin, President, Human Resource Development Council provided and read from his written testimony. **EXHIBIT 4**

REP. BETTY LOU KASTEN asked in what way the Community Service Block Grant funding was used in Glendive. **Mr. McLaughlin** answered that the funding is used to support programs and facilities for the aging as well as for administrative support.

CHAIRMAN JOHN COBB asked what the total budget of HRDC is. **Mr. McLaughlin** replied that all ten HRDC Districts spent $1.9 million. **CHAIRMAN COBB** asked how much money HRDCs deal with. **Mr. McLaughlin** said he was unable to give a definite answer, but estimated between $30-50 million.

Elizabeth Bozdog Roeth, Chairman, Healthy Mothers Healthy Babies, The Montana Coalition, stressed that there has been a catalyst of change in the past ten years with the program. Some of the accomplishments are the establishment of the program in 20 communities and the Baby Your Baby campaign. She reported that the Kellogg Foundation had funding available for FY96 to address the problem Montana is facing on the Indian reservations regarding appropriate nutritional and emotional needs for children. She provided the subcommittee with a booklet outlining further achievements and information regarding Healthy Mothers Healthy Babies. **EXHIBIT 5**

Kathy McGowan, Montana Council of Mental Health Centers, gave a presentation on behalf of the mental health community. She discussed a broad perspective composition from the Council, the Mental Health Association of Montana, Montana Licensed Professional Counselors, Montana Psychological Association and the Montana Chapter of the National Association of Social Workers about the issues facing mental health. **EXHIBIT 6**

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HEARING ON AGING SERVICES NETWORK

Charles Briggs, Director, Rocky Mountain Agency on Aging and member of the Montana Association of Area Agencies on Aging, gave an overview of the Aging Services Network in Montana. **EXHIBITS 7, 7A and 7B** Approximately 155,000 services are provided per year through the 24 distinct programs. This service represents about 140,000 individual clients. One current shortfall of the services for the aging is that often agencies are not completely aware of what is being provided through other agencies. It is important for the state to provide better access to multiple funding sources at the local level to ensure the necessary cooperative sharing of services and information.

REP. BEVERLY BARNHART asked if the Area Agency Network has considered changing area aging facility sites because if everything is being reformatted to fit into districts, it's confusing to have these "area" offices. **Mr. Briggs** answered that has been noted and the question has been raised about how much longer single county agencies on aging can be funded. The Area

Agency Network is currently, by federal schedule, in the process of reexamining some of the area definitions.

{Tape: 2; Side: A; Approx. Counter: 30.1}

HEARING ON NURSING HOME SERVICES

Rose Hughes, Executive Director of the Montana Health Care Association (MHCA), said MHCA represents nursing homes throughout Montana. She provided an overview of cost factors in nursing home care and current legislative issues concerning nursing homes.

She said many people are concerned about health care costs and nursing home care is a big piece of the Medicaid budget. **EXHIBIT 8** The federal government has been very active in the regulatory arena with nursing homes and those regulations have had a direct impact on the cost of care, which is the one major factor in driving up the cost of nursing home care. As long as the regulatory situation continues to grow there is no way that new or expanded services can be added. It is not possible to compare the same services from previous years because the growth in regulations ask the nursing homes to do things differently. Other factors in cost increases include the nursing home bed tax increases and increases in workers' compensation, which have tapered off recently but grew substantially over a relatively short period of time.

The regulations as written are literally over a foot high. Some of these regulations have been very beneficial to nursing home residents and some haven't. The one trend in nursing home care that those involved with nursing homes are concerned about is the need to hire nursing staff to do nothing but paperwork to meet the requirements of the regulations. There are new enforcement regulations from the federal government which impose major fines and civil penalties if the regulations aren't adequately met. There doesn't seem to be a way to get away from adding staff to do paperwork while not being able to add staff for direct care.

All of the legislative issues relate back to funding in some way. **EXHIBIT 8A** MHCA supports the Governor's budget for nursing homes. There is a modest provider rate increase of around 4% a year and an increased utilization of around 1% a year. Medicaid is projected to pay about $5 less per day than the known cost of care. This means that costs are shifted to the private paying patients, which is an approximate $8 to $9 per day since the ratio of Medicaid residents to private pay residents is almost 2:1. Roughly 4,000 of the approximately 6,000 nursing care residents are Medicaid, which is 62% of the population. It's easy to talk about not wanting to increase provider rates, but then costs get passed along to the private pay residents.

The nursing home bed tax of $2.80 per resident is borne by both Medicaid and private pay residents. The Governor's budget does not call for an increase in the tax but there is a bill pending that will increase this tax. MHCA is very much opposed to any additional increase in the bed tax. It is a major factor in the cost for facilities. MHCA supported the bed tax when it was originally developed because it was a time when the state was in very severe financial straits and using the bed tax to access some federal grant money seemed the best solution to deal with rate increases for the facilities. In 1995 when there's no other tax increases in the budget it seems "really odd" to propose to increase a tax that is basically on old, sick people in nursing home beds.

There are also concerns about the way the bed tax functions. It was assumed that for every $1 there would be a $3 federal match back, which is a good way to fund increases even for private pay residents. Unfortunately because of the way the reimbursement system runs, with differences in private pay census compared to Medicaid census in any given nursing home, different caps on the expenses for those facilities, the private pay limitations imposed previously by the legislature where the private pay rate couldn't be less than the Medicaid rate, facilities are not seeing the money back from the bed tax. For a lot of facilities the tax has turned out to be a pretty unfair mechanism.

MHCA is in agreement with Social Rehabilitative Services (SRS) that a certificate of need helps control Medicaid costs by making sure that any new nursing home beds are needed in the area where they are built. MHCA does not have an opinion about whether the certificate of need program should be transferred to the Health Care Authority as long as the process of orderly growth of nursing home beds is maintained. The Executive budget has added a small amount of additional funding to do better data collection to allow more accurate decision-making capabilities.

HB 109, sponsored by **REP. COBB,** proposes to place a three year moratorium on all construction of nursing home beds. MHCA opposes the moratorium largely because there currently are shortages in areas of actual need and in recent years the growth in nursing home beds has been very slow. If growth isn't allowed in areas of need the law of supply and demand will force prices to rise. Having too few nursing home beds is just as bad a public policy for the state as having too many. A moratorium is not a good way to control the supply, the certificate of need process could have its formula tightened up if that is deemed reasonable.

During the last session the legislature gave the Board of Nursing the authority to delegate some nursing tasks to non-nurses, which could involve some cost savings. The delegation rules adopted were very limited and cumbersome and specifically excluded nursing homes from being able to delegate these tasks. If it's safe and cost effective to delegate tasks in personal home care,

assisted living, schools and other settings, then it's probably safe and cost effective to delegate in a setting where there is on-site supervision by nurses.

MHCA is generally supportive of a full continuum of care available through long-term assisted living programs. MHCA does have some concern about whether there is going to be a level playing field in how these services are treated. The assisted living programs are going to be less regulated than nursing homes, which is fine to an extent because regulations increase costs. One caution is that an eagerness to save money by moving patients out of nursing homes to assisted living environments may cause the process to go too quickly to the detriment of reasonable regulations and precautions.

With long-term care reform the legislature should make it clear that there are choices in care services, but the choices must be balanced with cost effectiveness and the state can't always afford to put people in the most expensive setting. Often nursing homes are more expensive than other care situations and there are also times when nursing homes are the most cost effective and best setting for the patient.

SEN. J.D. LYNCH commented that the least restrictive environment, even if it does cost more, is often best for the patient. "I don't believe nursing homes are the best place to be if there are alternatives."

REP. BEVERLY BARNHART asked if increases in the minimum wage have significant impact on nursing home costs. **Ms. Hughes** answered that minimum wage is almost not an issue anymore because very few employees in nursing homes are minimum wage workers.

REP. BARNHART asked if MHCA represents county rest homes. **Ms. Hughes** said yes, MHCA represents all types of nursing homes--profit, non-profit, county homes, church-sponsored homes etc.

REP. BARNHART asked if nursing homes make a profit on the prescription drugs provided. **Ms. Hughes** answered that the small number of facilities that run pharmacies do have the ability to mark up drugs as other pharmacies do.

SEN. LYNCH asked if nursing home facilities make a profit on non-prescription drugs, such as aspirin, and can patients provide their own drugs. **Ms. Hughes** answered that a number of non-prescription drugs for Medicaid patients are part of the daily rate so they can't be charged. Private patients can be charged for any service provided. Nursing homes are required by federal law to keep track and have control over all the drugs in the facilities, so most facilities have policies that at least govern what happens if they bring it in, such as keeping it under lock and key. That varies from facility to facility.

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HEARING ON THE MONTANA HOSPITAL ASSOCIATION

Jim Ahrens, President, Montana Hospital Association, presented the budget concerns of hospitals during this session. **EXHIBITS 9 & 9A** The hospitals have saved several million dollars over the past two years. These savings aren't coming back to the hospitals; a fair amount of the savings are directed to the Family Services Division.

Currently HB 2 has given SRS carte blanche authority to introduce the Managed Care Program. Because there's no legislation governing Managed Care, the Montana Hospital Association is asking the legislature to consider a bill to insure payment schedules are appropriate and there is legislative oversight on the program.

The Montana Hospital Association agreed to a study with SRS to determine if hospitals can be moved off a cost-based out-patient payment system. The study came back without many of the suggestions that were recommended by the Montana Hospital Association. No other state in the union has done an out-patient payment system prospectively. This is a complicated issue because it involves emergency room services and payments. Reducing emergency use could be very beneficial and it is preferred that patients don't use hospital emergency rooms for out-patient procedures. The Montana Hospital Association encourages the legislature to not fund this system at this time. If the managed care issue is accepted along with this system of payments based prospectively, it possibly would be seen as a waste of money.

SRS is proposing to adopt a $20 fee for screening in emergency rooms and outpatient settings. Emergency rooms already have to do the screening or be cited for "dumping" patients. It costs more than $20 to do these screenings and that's part of the issue tied up in the outpatient discussion. The proposed Medicaid outpatient payment system is probably going to be more costly than the proposed savings.

{Tape: 2; Side: A; Approx. Counter: 70.0}

HEARING ON CARING PROGRAM FOR CHILDREN BLUE CROSS/BLUE SHIELD

Chuck Butler, Blue Cross/Blue Shield of Montana, spoke about the Caring Program for Children. **EXHIBITS 10 & 10a** The Caring Program for Children helps children from newborn to age 18 who "fall between the cracks" in health care services. The Caring Program is a non-profit foundation which raises money to provide preventive benefits, well-child visits, sick visits, lab and x-ray services, immunizations and the like. It is estimated that there are 14,000 children in Montana who don't qualify for

Medicaid or any other government programs and their families don't have the means to afford health insurance.

The Montana Health Care Authority's number one listed priority is that Medicaid eligibility should be expanded to 200% of poverty for pregnant mothers and children ages 0-6 years and, in conjunction, the state should provide matching funds to the Caring Program for Children Foundation to provide coverage for children ages 7-18.

Through conversations with SRS administrators it is clear that the Caring Program is something this administration is very interested in, from the concept that more children could benefit.

In a nutshell, for $276 annually the Caring Program can enroll a child and provide comprehensive preventive services. The Caring Program is not insurance, there are no co-payments, deductibles or premiums. The Caring Program, through agreements with most of the hospitals and primary health care providers in Montana, pay the costs of services to the providers. Large hospitals have agreed to accept 85% of cost as payment, smaller hospitals receive 90% cost and physicians, nurses, physician assistants, etc. accept 75% of cost.

Another benefit of the Caring Program is in the area of cost shifting. When patients can't afford to pay their bills, that cost gets "shifted" to higher rates for patients who can afford to pay. In the long run, cost reimbursement through the Caring Program should help decrease the amount of "shift" that takes place.

{Tape: 2; Side: A; Approx. Counter: 81.6}

OTHER SPEAKERS

Wayne Lewis, Montanans for Social Justice, spoke in criticism of the SRS welfare reform plan. The time limits imposed are too strict and arbitrarily derived. Successful reform programs in other states have been implemented over periods of at least three years with safety nets in place for errors and failures. There's not enough revenue in SRS to implement a successful plan and it would be more costly to go ahead with the current proposed plan which will cause many people to remained unserved.

Other plans that have been successful don't just cut off benefits after a specified time, but insure participants that the plan is there to carry them through transition. If a participant loses a job the benefits will be restored and the program works with the participant to find out what went wrong and try it again. Transitional plans also make up the difference if a participant's job earns less than the welfare benefits, which is a real incentive. The plan SRS has adopted doesn't seem to offer these incentives or security for the transitions. Participants say

over and over that they want to be working and self-sufficient, but this plan doesn't offer that.

Art Krum, private citizen, said that he has been low income most of his life and the SRS welfare reform program doesn't look as though it has enough funds available to implement it effectively. The plan encourages two-parent families to split up for the two years because they'll receive less benefits if they stay together. SRS doesn't have the money to provide the child care services that would be needed to make this plan successful. The welfare system doesn't need to be changed right now, it needs to be evaluated and studied more closely before changes are made. Montana prides itself on the fact that family values are a resource and implementing this SRS welfare reform is going to make it worse on Montana's low-income families.

ADJOURNMENT

Adjournment: 12:00 P.M.

REPRESENTATIVE JOHN COBB, Chairman

ANN BODEN, Secretary

JC/ab

HUMAN SERVICES AND AGING

Joint Appropriations Subcommittee

ROLL CALL DATE 1-10-95

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	✓		

Montana Council for Maternal & Child Health

54 North Last Chance Gulch, Suite 4 • Helena, Montana 59601-4122 • 406-443-1674

EXHIBIT 1
DATE 1-10-95
HB

WHAT IS "MCMCH"??

The Montana Council for Maternal and Child Health is a coalition of health care professionals and community-based organizations, dedicated to improving health care for mothers, children and families across Montana, through public policy analysis and advocacy.

We educate and inform policy makers in and out of government who make laws, write regulations and implement policies which affect the health of babies, children and their mothers.

The Council is a broad-based coalition. Its goals are:

- To stimulate the development or revision of state, local and federal laws and regulations, in order to improve maternal and child health,

- To educate officials in the legislative and executive branches of state, federal and local government,

- To provide timely information to members about public policy issues affecting maternal and child health, and

- To serve as the focus and catalyst for other groups concerned with maternal and child health.

Key Issues of Concern to MCMCH

- Infant Mortality
- Prenatal Care
- Access to Care
- Birth Defects
- Low Birth Weight
- Prevention
- Family Planning
- Smoking, Alcohol and Substance Abuse

Sustaining Members

Community Medical Center, Maternal & Child Health Services, Missoula
Montana Deaconess Medical Center, Maternal & Child Health Services, Great Falls
St. Vincent Hospital and Health Center, Women's Health Services, Billings
Healthy Mothers, Healthy Babies, the Montana Coalition
March of Dimes, Big Sky Chapter
Montana Academy of Family Physic
Montana Chapter, American Acader
Montana Section, American College

Working together fo

EXHIBIT 2
DATE 1-10-95
HB

Blueprint for a Future Worthy of Montana's Children

MONTANA WOMEN'S LOBBY

P.O. BOX 1099 HELENA, MT 59624 406·449·7917

EXHIBIT 3
DATE 1-10-95
HB

1/10/95
To: Joint Subcommittee of Health and Human Services
From: Montana Women's Lobby
Contact: Kate Cholewa, 449-7917 or 443-5261

The MWL supports the following funding and policy decisions for programs within, or connected with DFS, SRS, DOL, and DHES.

Child Care

In order to provide enough child care to enable families to achieve self-sufficiency, the MWL supports the following:

*Assure enough dollars in the welfare reform plan for adequate child care for all participants
*$40,000.00 in general funds for a 3 to 1 federal match to contract with the Child Care Resource and Referral Agencies (R & Rs). The R & Rs have been performing the work for the JOBS program child care without the payment they were told they would receive. The R & Rs do the paper work and vouchers for JOBS child care, recruit providers who will provide state child care, and assist families in finding child care providers. There will be even greater need for these services under welfare reform. We would not expect a contractor who worked on Montana highways to work without compensation. We should cease to de-value the work of child care workers in this manner.
*$30,000 for a 3 to 1 federal match for child care for At-Risk families. These are low-income families who without assistance with child care are at risk of ending up on public assistance.
*Raising the reimbursement rate to licensed child care providers to 75% of market rate as required by Federal regulation.

AFDC Rates

The MWL supports the LFA budget for AFDC rates. AFDC recipients currently receive 40.5% of the poverty rate. That is, AFDC payments could increase by almost 150% and these families would still be living in poverty. An old excuse for such rates was that the cost of living in Montana was much less than in other parts of the country. This is no longer true, especially in the

more urban areas of Montana where housing costs are escalating. Although the MWL believes that it is only humane to raise the AFDC rates to 50% of poverty, we acknowledge political and fiscal realities. However, we believe it would serve to undermine, and that it runs contrary to, the goals of welfare reform to send families into deeper poverty by decreasing their AFDC checks and then, in turn, expecting them to dig themselves out.

Welfare Reform

The welfare reform plan is the product of much hard work and has many merits. The Job Supplement Program and increased child support collection could help people from ever needing to enter the system. Elimination of the 100 hour rules stops our punishing families who work. However, we also have concerns in regard to the plan. These include inadequate child care for participants, increase of workload at welfare offices, elimination of medicaid services, and availability and definition of community service.

Availability and definition of community service is of particular concern as some communities may allow for 4 years degree programs and other may not (See attachment on post-secondary education impact on AFDC households). We are concerned, too, that Montana may be opening itself to an increase in legal and fair hearing costs due to inconsistencies in community service options, lack of employment and training options and lack of day care for those mandated to participate.

Another concern is the 2 year time limits in specific cases. The purpose of the 2 year time clock in the welfare reform plan is to allow for 2 years for an adult to get the training they need for employment. The MWL recognizes several issues for AFDC recipients that often must be resolved before meaningful job training or search can begin. We would request the following exemptions or postponement to the time clock:

1. Homelessness, until the family is stabilized.
2. Domestic or sexual abuse in the family, until the family is stabilized.
3. Teens, as they often need the 2 allotted years to finished high school or a GED, and thus miss the opportunity for advanced schooling or training.

Finally, we need to be aware of what we are measuring. The state's welfare reform plan attempts to address the "culture of the welfare office" and the personal responsibility of recipients via the FAIM contracts. There is no plan for economic development attached to the welfare reform plan, no expansion of job training programs. The economy, as well as many other factors contribute to the need for assistance. We need to remember this as we watch this plan progress. If we haven't

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properly identified the problem, we have not properly identified the solution.

JOBS

Under welfare reform, the JOBS program will be dealing with an even more challenged client. Currently, program operators receive resolutions for those recipients who complete high school and GED programs. It would allow JOBS operators to take on more of those recipients who seek post-secondary education if completion of post-secondary training were an allotted resolution (See attachment on post-secondary education impact on AFDC households).

Housing

Housing in increasing becoming problematic for not only low-income, but even middle income individuals. Rents are high, and there is a shortage of housing. Housing eats up nearly 70% of low-income families' budgets. The MWL recognizes this as growing problem in the state which needs examination and address before we are dealing with a crisis.

In light of this, we believe the $50 cut last session from those AFDC recipient families who had shared or transitional housing penalizes those trying to be resourceful under difficult circumstances and those unable to secure permanent housing. If it is the objective of public assistance to help families achieve self-sufficiency, penalizing them for resourcefulness and penalizing them for a low-rent housing shortage doesn't make sense.

The MWL would like to see this decision of the committee reversed.

Teen Parent Program

The Teen Parent Program is an intensive case management program to keep teen parents from becoming long-term AFDC recipients. It is a collaborative effort by MJTP, the Department of Labor and Industry, SRS, and OPI. The program is producing excellent results and is beloved of all those participating. Funding for this program ends in June. Plans for continuing it are vague at best. Alternative funding is being explored. The MWL suggests a hearing on this program later in the month after the parties involved have a developed a funding picture. Perhaps this committee could assist with that funding.

The MWL supports the Governor's Budget for the following

programs:

Family Planning

The Family Planning Program continues to provide low cost, quality comprehensive reproductive health and preventive health services to women ages 15-44. Family Planning services are directed toward reproductive health, particularly the detection and prevention of cancer and sexually transmitted diseases in women, the prevention of unplanned pregnancies through contraceptive and abstinence education, the reduction of the incidence of abortion and the improvement of pregnancy outcomes by correcting health problems between pregnancies and by proper timing and spacing of pregnancies.

Family Planning is preventive health. If pregnancies are wanted and planned, expenditures for prenatal care, high-risk infant care, well-child care, WIC, and care for children with special health needs can be reduced. For every government dollars spent on family planning in MT, it is estimated an average of $7.85 is saved the first year as a result of averting expenditures on medical services, welfare, and nutritional services.

The MWL supports the Governor's Appropriation, including the federal funding for a Family Planning Services Coordinator. (See attachment Unplanned Pregnancies Prevented)

Domestic Violence Programs

Domestic Violence programs continue to provide one of the most difficult to provide services. Shelters continue to turn women away due to a lack of space and limited funding. In the past biennium, Billings, alone, turned away over 100 women. With only half the programs reporting, 5738 battered women and 2401 children of battered women were served by domestic violence programs. Over 3/4 of those providing domestic violence services in these programs are volunteers.

Displaced Homemakers

Displaced Homemakers continue to do job training for women recently divorce and new to the work force.

Human Rights Commission

60% of the Commission's workload deals with issues of sex discrimination and housing discrimination. The executive budget supports only the current workload. Any cuts in this area would result in less service to Montanan who have potentially suffered discrimination.

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MIAMI Program

The MIAMI program offers prenatal services in 17 communities and works to reduce infant mortality.

POST-SECONDARY EDUCATION
IMPACT ON AFDC HOUSEHOLDS

**60% of families headed by women with high school diplomas live in poverty (7 times the poverty rate of families headed by women with college degrees).

**60% of families headed by women with high school diplomas cycled back on to AFDC within 5 years after employment.

**Over 50% of Montana JOBS participants are enrolled in post-secondary education programs (includes IV-A Self-Initiated Program), yet the JOBS program contains no performance standards for post-secondary education and, in order to meet employment performance standards, program operators must limit the number of clients entering post-secondary education.

**AFDC college grads report increases in self-esteem, and 80% in one study say their degree got them their job.

**89% of employed AFDC recipients with college degrees in the same study have been employed since graduation with:
- --75% earning over $10,000 annually
- --42% earning over $20,000 annually
- -- 6% earning over $30,000 annually

*In Missoula the wage breakdown for single-parent JOBS participants is:
- --$10.83 hr. w/4 yr. degree
- --$ 6.31 hr. w/2 yr. degree
- --$10.90 hr. w/non-trad. training and placement (Gearing Up)
- --$ 5.62 hr. w/HS degree or less

**From Welfare to Independence: The College Option, Howard Samuels State Management and Policy Center, The Graduate School and University Center of The City University of New York, March 1990.

*Missoula County JOBS program, single-parent program, Options Unlimited

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UNPLANNED PREGNANCIES PREVENTED

In 1992 the 14 family planning programs in Montana prevented an estimated **17,985 unplanned pregnancies.** These pregnancies would have resulted in **12,144 births, 2,555 abortions** and **3,286 miscarriages.** This would have included approximately **364** infants with congenital abnormalities, **156** infants with hypoxic brain damage, **61** infants with chromosomal abnormalities and **814** high-risk premature deliveries.

PROGRAM	PREGNANCIES PREVENTED	BIRTHS PREVENTED	ABORTIONS PREVENTED	MISCARRIAGES PREVENTED
Billings	4,204	2,839	597	768
Bozeman	2,933	1,981	416	536
Butte	1,279	864	181	234
Glendive	445	301	63	81
Great Falls	1,671	1,127	238	306
Hamilton	192	130	27	35
Havre	650	440	92	118
Helena	1,246	841	177	228
Kalispell	1,006	679	143	184
Lewistown	222	150	32	40
Libby	388	261	56	71
Miles City	456	308	64	84
Missoula	3,090	2,085	440	565
Polson	203	138	29	36
STATEWIDE	17,985	12,144	2,555	3,286

SOURCE: Contraceptive Technology, 16th Revised Edition, Table 27-1, T. James Trussell.

HRDC

Montana Human Resource Development Council Directors Association

Bob McLaughlin, President
Gene Leuwer, Vice President
Eileen Sansom, Treasurer
Patty Callaghan, Secretary

P.O. Box 1509
Havre, MT 59501
(406) 265-6743 Office
(406) 265-1312 Fax

EXHIBIT 4
DATE 1-10-95
HB

January 10, 1995

To: Human Services Sub-Committee, Rep. John Cobb, Chairman
From: Montana HRDC Directors Assoc., Bob McLaughlin, President

Mr. Chairman, members of the committee:

My name is Bob McLaughlin, I am the Executive Director of District IV Human Resource Development Council in Havre and current President of the Montana HRDC Directors Association.

I thought that as this Committee discusses the issues of poverty and the delivery of human services in Montana it would be important to gain a better understanding of the HRDC's, their role as locally controlled non-profit organizations offering human services statewide, and some of the activities we undertake in that role.

The goal of the HRDC's broadly stated is to "provide a range of services and activities having a measurable and potentially major impact on the causes of poverty.."

In order to obtain that impact, individual HRDC's have evolved a mix of programs and services that may differ from district to district depending on the needs of area, what other service providers operate in the community, and the resources available. All Montana HRDC's operate the Community Services Block Grant program, the Weatherization program, the Fuel Bill Assistance program (or LIEAP), distribute money for and provide services to the homeless, and provide youth employment programs. Some of the HRDC's also operate Head Start programs, Day Care programs, Family Planning Clinics, JOBS programs, JTPA programs for adults, older workers, and displaced homemakers, a variety of Senior Citizen programs, Micro Business Loan programs, the Youth Conservation Corps, Domestic Abuse programs, a wide assortment of housing programs - from Rental Assistance to the actual construction of low income housing, Family Preservation programs, Surplus Commodities Distribution, and Food Banks.

The HRDC's adopted this multi-service approach to human services long before "case management" and "one stop shopping" became human service buzz words. This unique aspect of the HRDC's is the direct result of local control. Every HRDC **must** have a local governing Board that is made up of one third low income representatives democratically selected, one third local elected officials or their appointees, and one third private sector representation.

Furthermore, each HRDC is required to perform an annual assessment of the needs of the low income population of their service area and to use that assessment in the development of a "work plan" that addresses the expressed needs of the community. These work plans must be offered for review to not only the governing Board, but to the County Commissions of each county in that HRDC's district, as well the Department of SRS.

Through this consistent involvement of local decision makers and clients, the HRDC's have developed a delivery system that has the ability to perform statewide but is specifically tailored to each district's unique requirements and resources.

Every year SRS gathers together the work plans of all ten HRDC's and these plans, along with reports on the accomplishments of the HRDC's in the past year, make up the bulk of Montana's application for Community Services Block Grant Funds. The HRDC's rely on the CSBG funds to provide the glue that holds each Agency together, providing operating costs, supplementing and supporting current programs as well as other community groups and providing special projects with seed money.

I'd like to give a few examples of the some of the accomplishments CSBG funding helped make possible in 1994.

Based in Glendive, Action for Eastern Montana in their Senior's program, provided 104,022 congregate meals, 56,799 home delivered meals, 54,355 transportation services, 19,664 homemaker hours, 13,535 health screenings, 2,087 personal care hours and 4,134 skilled nursing hours.

District IV HRDC in Havre marshalled the services of 347 community volunteers resulting in 31,362 hours of service to low income families in activities ranging from Head Start classroom assistants to support personnel at the Haven, a shelter for women and children who are homeless as a consequence of Domestic Violence. 72 families were sheltered in 1994. Haven operating costs are covered with CSBG, Homeless, and United Way funds.

Opportunities Incorporated in Great Falls receives on average over 4 individuals or families every day who need emergency services. In 1994 Opp Inc workers helped 1,101 individuals or families resolve emergencies through funds to relocate for employment, temporary shelter and referral and advocacy with other service providers.

District VI HRDC in Lewistown has successfully combined employment and training programs from three sources. Locally coordinating JTPA, JOBS, and Food Stamp Job Search programs, the Lewistown HRDC provides opportunities for its clients to end dependency on public assistance. District VI's JTPA II-A Adult program served 52 displaced homemakers last year achieving an entered employment rate of 77% at an average wage of $7.10 an hour.

District VII HRDC in Billings provided a $10,000 grant of CSBG funds to the Community After School Program to assist in the provision of day care activities for families in need.

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Rocky Mountain Development Council in Helena used over $11,000 of its CSBG budget providing operating support for Helena Food Share and providing for the bi-monthly distribution of surplus commodities to approximately 2,500 individuals in District VIII.

District IX HRDC of Bozeman has focused the past several years on the housing crisis affecting Gallatin & Park Counties. The Bozeman HRDC created Montana's first Community Land Trust allowing development of affordable homes for 30 single family and 24 multi-family units. They have also partnered with private sector developers, using the Low Income Tax Credit program, to construct an additional 60 units under the management of the HRDC. Bozeman received one of only two National YouthBuild grants, in the amount of $970,000, to combine employment and training activities with the actual construction of these affordable homes.

Northwest Montana Human Resources in Kalispell uses about $3,500 of their CSBG funds annually supporting grant writing activities. Recent grants awarded include a $280,500 HOME grant and $388,500 HUD grant. These grants will allow Northwest to acquire or construct a four-plex that will house pregnant or parenting adolescent mothers, 16 units for homeless individuals and families, and 36 units for low and very-low income individuals and families.

District XI HRDC in Missoula used $8600 of CSBG in its Children's Summer Feeding Program; leveraging $25,300 from the Office of Public Instruction and forging cooperative agreements with senior citizens centers and school districts to act as feeding sites. Over 6600 lunches were served in the three county district. The Missoula HRDC also serves as fiscal agent for homeless funds from FEMA, HHS, and HUD and allocated over $16,000 in FY 94 to Domestic Violence Centers in Missoula and Ravalli Counties.

District 12 Human Resources Council recently completed the renovation of a facility in Butte that will provide transitional living and self-sufficiency services to 14 single men, 14 single women and four families in their "Homeward Bound" program. Using approximately $26,000 of CSBG funds over the past two years for planning and development, the Butte HRDC has generated a program that will provide a million dollars in services over the next five years.

I hope I've given the Committee a sense of the diversity of the programs and services offered by Montana's HRDC's. Like all of Montana, we are bound together by common threads and yet we maintain the unique flavor of our individual communities.

Thank you.

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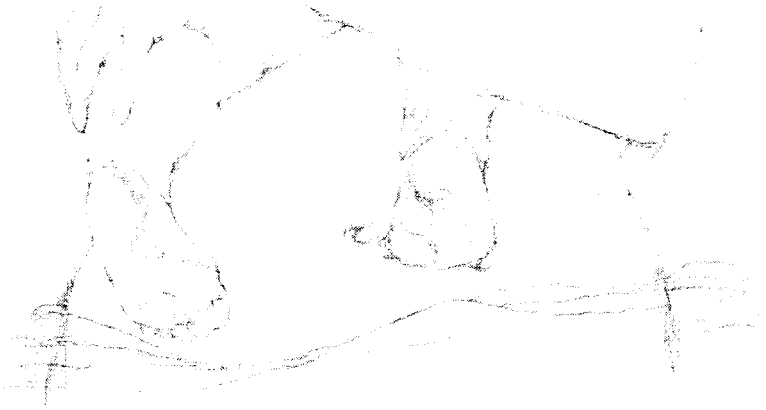
HEALTHY

HEALTHY



MAKING A DIFFERENCE

FOR MOTHERS AND CHILDREN

IN MONTANA

1984 - 1991

MONTANA

COALITION

EXHIBIT 6
DATE 1-10-95
HB

Presentation to the Human Services Appropriations Subcommittee by Kathy McGowan, on behalf of the mental health community

Introduction -- Kathy McGowan, Montana Council of Mental Health Centers

David Hemion: Mental Health Association of Montana

Mary McCue: Montana Licensed Professional Counselors

Gloria Hermanson: Montana Psychological Association

Bob Torres: Montana Chapter, NASW

I have solicited input from other members of the mental health community and I believe that the information I present here today is consistent with the platforms they have developed.

Broad perspective in a limited time about the issues facing mental health:

Mental health issues are spread across and among three state agencies: Departments of Corrections & Human Services, Social and Rehabilitation Services, and Family Services. We have issues that are specific to each of those departments but they are also very much inter-related and integral to the success or failure of our mental health system.

Representative Cobb did not ask me to draw a picture of Montana's mental health system, but a basic understanding of the system is important if you are to understand our issues. I will not weigh you down with statistics. The state agencies will provide you with plenty of those when they give their presentations.

Mental health centers are the biggest players in the area of public mental health at the community level. There are five mental health regions in the state of Montana, with headquarters in Helena, Missoula, Great Falls, Billings, and Miles City. The Centers have satellite offices in rural localities throughout the state, and those satellite offices are designed around the needs of the particular community. Mental health centers are clinics that are required to engage the services of physicians in a supervisory capacity. Some mental health centers employ psychiatrists, while others contract for psychiatric services. In eastern Montana, the mental health center has the rather unique but exciting tele-medicine opportunity whereby psychiatrists in Billings actually can interact with consumers and staff in Miles City and other sites.

Mental health centers contract with the Department of Corrections & Human Services to provide services based on priority populations. The two highest priority populations, and thus the populations on which the greatest number of dollars are expended, are adults with serious mental illnesses and

children with serious emotional disturbances. Generally, the people who are served with DCHS funds are those who are not Medicaid eligible or those who require services for which Medicaid cannot reimburse.

The Department of Corrections and Human Services contracts with the five mental health centers to administer the MRM (Managing Resources Montana) program that was created 1 - 1/2 years ago. You will hear much more detail about MRM when you meet jointly with the Institutions Subcommittee.

Mental health centers also contract with the Department of Family Services to provide family based services. In addition, they are Medicaid providers. They provide outpatient therapy, day treatment services, and targeted case management to Medicaid eligible clients.

Another valuable community resource are the private therapists who choose to be Medicaid providers. The licensed professional counselors, psychologists, and social workers serve a significant number of Medicaid clients. Mental Health Centers have sub-contracted with private therapists to provide specialized services to MRM kids.

Before I address our issues I would like to point out some significant trends in the mental health system over the past several years:

•We have experienced significant changes within community programs with the addition of intensive case management and crisis stabilization.

•These significant changes within in communities have helped to facilitate a decrease in the population at Montana State Hospital.

•The consumer movement has been a relatively new but exciting and welcome addition. Consumers have become involved in decision making and they have contributed to a much enhanced understanding of consumer needs. Consumer-run alternatives, such as support groups and drop-in centers have made their way into the mental health system.

•Kids' services have changed dramatically. MRM (Managing Resources Montana) was created. Intensive case management and day treatment are relatively new but important community programs for kids.

October is Mental Health Month. Several mental health organizations went together this year to purchase some billboards and the message on those billboards was: Treatment Works. We know what works and what we need to do to attain the goal of serving people most appropriately and in the least restrictive setting. Our issues are three basic things that stand in the way of our achieving that goal:

One obstacle is the critical lack of affordable housing. It's quite simple: without a place to live, it's very difficult for the person with a serious mental

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illness to survive in the community.

A second obstacle is insufficient crisis stabilization services in our communities. We know good crisis services work. In the communities where we have crisis stabilization, it has made a significant difference. Without them, it becomes increasingly difficult to keep children or adults in their home communities when they have crises.

A third obstacle is the lack of flexibility within the payment system to deliver the most appropriate and cost effective services. For instance, a Medicaid client who has a serious mental illness can be hospitalized, can access outpatient therapy, can receive case management services, or day treatment services. In the case of children, therapeutic group home care also is a reimbursable service. All are necessary services to have in place, but there is no "one size fits all" when it comes to mental health services. Sometimes, for example, it's entirely appropriate and desirable to stabilize a child or an adult in a crisis stabilization program rather than a hospital. Sometimes support services such as respite are the key to a family's ability to cope. Case managers are encouraged to be creative about the ways they can make services more consumer friendly and save the system money, but the system itself is a deterrent. The present system will not reimburse the kinds of services I just described.

This same lack of flexibility throws up roadblocks to consumers' abilities to access good vocational rehabilitation opportunities and potential employment. The system as we have known it has been a good caregiver system, but the design has not encouraged independence.

This brings me to managed care --- indeed, a very big issue for mental health. In all honesty, the mental health community is scared to death. The changes that will come with managed care are monumental and will affect everyone. Obviously, they will affect the consumers of services. They will affect every single provider that chooses to be a part of the delivery system. The authority of the mental health center governing boards, consisting of county commissioners or their designates, consumers, and family members, will change radically.

Despite our fear and trepidation, the Mental Health Centers have supported the concept of managed care. The reason we have supported it relates back to some of our issues. We know we are not serving consumers the best way we could and we know we could give the state a bigger bang for its buck if a good managed care system is implemented. The flexibility in the payment system is critical to us. Creation of more crisis stabilization programs and other community alternatives are critical. These are the things we need to succeed.

Positions other groups will take during the session: Some of the groups have serious problems with the proposed Montana State Hospital plan. I prefer to let them address that issue if you have questions.

There is no group that does not recognize the need for increased crisis stabilization and housing support. Similarly, community programs for kids still have some major deficiencies. We support the Governor's recommendation for additional support for MRM and for the Community Impact concept.

The Montana Council of Mental Health Centers continues to support the managed care concept, with the caveat that managed **care** is what we are talking about as opposed to managed **dollars**. Acceptable outcomes for consumers must be the primary goal. Some groups initially opposed the managed care concept. Again, I would prefer to let them address it individually if they still are opposed.

Thank you to Representative Cobb for inviting me to present this information. I especially thank him for his efforts to schedule joint meetings between this subcommittee and the Institutions Subcommittee.

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HUMAN SERVICES APPROPRIATIONS SUB-COMMITTEE
JOHN COBB, CHAIR
AGING SERVICES NETWORK OVERVIEW
Presented by
CHARLES BRIGGS, DIRECTOR
ROCKY MOUNTAIN AGENCY ON AGING
HELENA, MONTANA
January 10, 1995

Mr. Chairman & Members of the Committee:
I appreciate the honor to speak before you today about the aging services network in Montana.

Because of federal initiative, mainly through the Older Americans Act, Montana is able to offer a wide array of social, as well as protective, services to its older citizens. Generally, these services are coordinated through the DFS Office on aging, which contracts with eleven (11) public or non-profit area agencies on aging. Through these planning entities, access services, in-home services, and otherwise community-based services are provided through over 1,000 local service providers to citizens 60-years and older in all fifty-six (56) counties, most visibly through community senior centers. These services are provided through a blending of local (city and county) funds, donations, and contributions, as well as federal and state funds. More specific detail will be provided during the aging office portion of the DFS budget, as scheduled.

Suffice to say, there are currently twenty-four (24) distinct programs serving in excess of 155,000 older clients (as indicated in FY 1993). In addition to these direct services, there is also an area information, outreach and assistance (usually listed as "information & referral") service; a long-term care ombudsman program (which provides resident advocacy in nursing homes); food stamp outreach; an elder health promotion initiative; and elder insurance counseling assistance. Also, there is a statutory adult protective service system in place, which will be discussed at a different time by DFS.

* In the 1996-97 Biennium, area agencies are seeking additional funding for aging in-home services. While senior groups like Legacy Legislature and MSCA have endorsed a soft drink sales tax, area agencies are seeking to obtain additional general fund dollars for aging in-home services. Also, we seek to be players in coordinating local services as part of long-term care reform, which we believe to be most cost-effective. For example, spending for Medicaid waiver services average $12,000 per client statewide ($9000 for elderly).

The mission of area agencies, indicated both by the federal act and the 1987 Montana Older Americans Act, is to be the lead advocate as well as serve as the primary focal point and local access point for older adults. While in many ways the aging network may be described as "informal", that is because the federal mandates for local planning requires considerable involvement of older adults in the planning and direction of services. I believe that one of the key strengths of area agencies is citizen participation through advisory councils and boards. This is where people live, and that network, in order for there to be local ownership for the programs, must be flexible and adaptable to the living environment of each locale, rather than merely imposing a grid that is the same. Nevertheless, there is accountability required, and the Office on Aging monitors monthly reporting from the agencies on aging, reviewing over ninety (90) different reports.

Mr. Chairman and members of the Committee: We are witnessing a human service infrastructure that is in a state of tremendous transition, whether you refer to the Buchanan task force recommendations, or congressional initiatives, or the requirements imposed by the 1993 Montana Session, that SRS, along with DFS, take a hard look at the way we provide long-term care, both in the institutional setting and in community-based alternatives. There will be considerable discussion in the next few weeks about system reform, departmental consolidation, and, I believe, it is a most positive opportunity to seek to provide a better way to serve people AND save the State money in the long run. This applies whether we are talking about people trying to live independently while grappling with the problems of a traumatic brain injury, or individuals over seventy-five years of age who, despite physical limitations in performing activities of daily living, only seek to remain in their home, their community, with familiar surroundings with a dignified degree of independence.

I must ask: why can we not truly use the energy of government to undergird that informal, family and neighborhood support system for all ages, without impoverishing both the family and our state budget? I know we can.

The federal government has created a care system upon a medical model, emphasizing what are a person's limitations in order to reduce risk and promote safety. This is what has driven Medicaid since 1966 - and the commensurate escalating costs. I must posit this notion: instead of defining a person by what they cannot do, we should work with their abilities, and then tailor local, support services to what they actually need for assistance.

During the last ten years we are witnessing considerable change along these lines, particularly in states like Oregon and Colorado, among others. The September 1994 General Accounting Office report on long-term care reform indicated that state agencies on aging and their Medicaid agency counterparts agree the largest proportion of older adults with severe disabilities need "nonmedical" services,

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such as personal care and housekeeping.

The 1993 legislative mandate I mentioned a few moments ago required SRS to develop a "continuum of care" which will limit the growth of state expenditures for long-term care for people who are elderly or disabled. As part of their response, the Medicaid Services Division has established goals for Montana's long-term care system based on this mandate. Based on the work of two committees - one initiated by SRS and one by the Governor's Council on Aging - they have concluded the system will: 1) recognize and respect each individual; 2) include a choice of services designed to support independence; 3) provide access to the changing needs of the individual; 4) provide access to services through a local single entry point; and 5) deliver efficient and effective services. Further, an SRS study regarding service assessment and consumer access concluded in October 1994 that "Montana implement a single point of entry" and that "the State implement a process where a single local agency is designated as an access point for long-term care...in the case that people do not know where to go."

What this sounds like is the aging services network. For more than twenty (20) years area agencies on aging have fostered the following components for a humane, consumer-oriented service structure: 1) planning focused on the best interests of the consumer; 2) is "value driven" emphasizing dignity, choice, privacy, and individuality; and 3) involves the consumer and their family in decision-making regarding choices and service arrangements that enhance their independence. What the aging network does b est through the area agency structure is: 1) consumer advocacy; 2) community access through a single-point system linked by community focal points (usually senior centers); 3) independent assessment of service needs; and 4) regionalized, coordinated service planning. One thing the aging network needs to do, however, is to formalize the varied "care management" and monitoring role it serves with uniform recipient assessment and structuring of an individual plan of care. The state must provide much better access to multiple funding sources at the local level, again, through uniform assessment, to ensure that people get the most appropriate care in the least restrictive setting.

Most of you should have received by mail a short video enclosed with a information sheet from the aging services system, about the crucial role we are playing in providing in-home care to at-risk, older adults. (Let me hand out to you a copy of that sheet.) Along these lines, I haven't even begun to talk about how critical is the role of adequate nutrition in reducing risk and fostering independence - and today, in America, one out of four senior citizens are malnourished. But, nonetheless, we believe we are working to hold back the tide, for every person who receives nutritious meals and simple in-home services through our system is prevented from having to enter a nursing home, spend down their available resources (national average is less than twenty weeks), and then be maintained on Medicaid at an average range in Montana of $2400-3200 a month).

Families and neighbors cannot meet the need alone. Family caregivers need a break, or respite; they need the skills of someone to enter the home and assist with simple household chores, or in providing personal, hands-on care; help with shopping or transportation to the doctor; telephone reassurance, perhaps daily; or legal assistance, just to name a few. Elders and their families need professionals who can truly help them understand their options so that they can make informed, appropriate choices. That, frankly, is what "good neighbors" are all about.

Finally, I believe what frames the urgency for attention to the provision of services to older adults are the statistics concerning the growth in this population and its increasing care needs. The Office on Aging will provide considerable statistical demographic data to illustrate this point. But, it is noteworthy that, whereas from the 1990 Census, nationally the age-60 and over group comprises 12.6% of the overall population, in Montana that is 17.6% - five percent higher than the national average. In some of your counties (35 of 56 counties) twenty percent and more are over age-60. Add to that, the fastest growing segment of the population are those over age seventy-five. That age group grew nearly forty percent (40%) over the 1980 Census. And further add the fact that of the $300 million we spend on Medicaid in Montana, thirty percent (30%) goes to nursing home care - and about five percent (5%) goes to home or community long-term care. This becomes serious when you realize that while this population constitutes less than ten percent of the overall population, they utilize more than sixty percent (60%) of all Medicaid long-term care. Such implications as this has been well noted in the handout I want to leave with you, the April 1994 report published by the Legislative Council, **"The Provision of Services to Montana's Elderly."**

This report provides an excellent overview and analysis of the current services for older Montanans, and a review of statutory requirements. It notes that "problems associated with the aged can realistically only be expected to grow in the foreseeable future, proportionate to the expanding aging population....funding must expand a proportionate rate if the Office [on Aging] is to continue serving...the elderly at the present level." It provides what may be a prophetic insight, given the change looming at the federal level: "given the present federal situation, it is logical to conclude that the bulk of the burden of providing additional or increased elder services will most likely fall on the State." You have, in place, a system which can intervene and provide modest services before people need to go to a nursing home. It is preventive in nature. The State of Montana should take full advantage of this less costly system, for it will reduce cost in the long run.

The time is now to marshall the experience and infrastructure of the local aging services system in order to adequately but cost-effectively address this mushrooming need.

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INFORMATION SHEET
PREPARED BY THE
MONTANA AREA AGENCIES ON AGING ASSOCIATION

* Montana's Area Agencies on Aging are public or private nonprofit agencies, designated by the State Office on Aging, to address the needs and concerns of older Montanans at the local level. Every Area Agency on Aging is required to have an advisory council, comprised primarily of older persons, to review and comment on all programs affecting the elderly at the community level.

* The Area Agencies on Aging perform three important activities for Montanans 60 years of age and older: Advocate on behalf of all older persons in their service area; identify the needs of the elderly and create plans for meeting those needs through a system of home, and community-based services which enable the elderly to maintain their independence and dignity; and administer a wide variety of federal, State, local, and private funds which support those services.

* Home-based services are provided home-bound elderly. These services help individuals stay in their own homes and with their families as long as possible. In-home services may include home-delivered meals, home health agencies, homemaker or home chore services, friendly visiting, telephone reassurance programs, and respite care to assist caregivers of the elderly.

* Community-based services are provided at central locations throughout a local area. These services may include adult day care, senior center programs, meals in group settings, legal services, elder abuse prevention, employment services, volunteer opportunities, and long-term care ombudsmen who investigate complaints made or on behalf of residents of long-term care facilities.

* Access services help an elderly person or family members connect with appropriate services. Transportation and information and referral services help elderly persons locate appropriate services and assist in evaluating which alternative forms of care best meet their needs.

* Montana's citizens are seeking alternatives to institutionalization for the large elderly population "at risk". Community based long term care systems provide a way to preserve each elderly individual's independence. They gain freedom to make personal decisions and to have a choice of services enabling them to stay in their own homes and with their families for as long as possible.

* Long term care now includes home and community-based, as well as, institutional care. Each chronically ill elderly person needs a different level of care and the availability of a continuum of care and services implies a choice of the most appropriate services.

* Availability of community alternatives fosters as much self sufficiency and independence as possible and allows the family and community to carry part of the responsibility for care.

* As Montana's population ages, the need for services for older Montanans increases:

    * 17.6 percent of Montana's population is over 60 years of age and each day another 23 people turn 60 years of age.

    * In 35 of the 56 Montana Counties (where statistics are available) 20 percent of each county's population is over 60 years of age.

    * The fastest growing age group in Montana is the group 85 years of age and older.

* To ensure that aging Montanans have the choice of services which will given them independence in their own surroundings for as long as possible, a system of community and home based services provides a viable and cost effective continuum of services.

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THE PROVISION OF SERVICES TO MONTANA'S ELDERLY

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MONTANA
HEALTH
CARE
ASSOCIATION

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FACTORS (OTHER THAN GENERAL INFLATION) DRIVING THE COST OF NURSING HOME SERVICES

All of the following are new requirements or costs *since 1987* which we believe are responsible for much of the increased cost of nursing home care since that time:

1. Nursing home bed fee. The nursing home bed fee accounts for $2 per patient day of the cost increases experienced by nursing homes.

2. Workers' comp premium increases. Workers' compensation premiums have increased 152% since 1987, from $7.49 per $100 of payroll to $18.89 per $100 of payroll. Because nursing homes are labor intensive, salaries and benefits account for 60-70% of all costs experienced by nursing homes.

3. Minimum wage increase. The federal minimum wage increased from $3.35 to $4.25 per hour.

4. OBRA. The federal Omnibus Budget Reconciliation Act of 1987, and subsequent amendments, included major nursing home reform provisions. The Health Care Financing Administration (HCFA) has still not finalized all regulations emanating from the reform law, even though 7 years has passed. New nursing home requirements included in the reform law include:

a. 75 hours of training for nurse aides

b. testing of nurse aides

c. continuing education of 12 hours per year for all nurse aides

d. additional requirements for RN and LPN staffing

e. quality assessment and assurance committees

f. additional assessments, reviews and care planning requirements, including use of a federally mandated "minimum data set" and protocols

g. additional requirements for use of bachelor's degree social workers and dietary, pharmacy and medical records consultants

h. additional requirements for physician involvement

i. new requirements for handling patient trust funds

j. new requirements for reduction and elimination of the use of restraints

k. new requirements relating to the use of drugs

l. new requirements relating to residents rights and choices

m. new standard for the provision of care which requires facilities to provide care and services designed to enable every resident to attain and maintain the "highest practicable level of physical, mental and psychosocial functioning"

*5. **Additional new laws and regulations which add requirements and costs to nursing facility services:***

a. OSHA bloodborne pathogens standard

b. Americans With Disabilities Act

c. Clinical Laboratory Improvement Act (CLIA)

d. Safe Medical Devices Act

e. Patient Self-Determination Act

f. new Tuberculosis Prevention standard

g. Mandated computerization of the MDS (minimum data set)

h. new survey, certification and enforcement rules

*6. **Patient acuity.*** The care needs of nursing home patients continues to increase. This is caused in part by the availability of home health, waiver, and other lower level services to care for those with less intense care needs.

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To Read

NEWSFRONTS

Oregon Foster Care Loses Luster Amid Grim Stories of Resident Abuse

A WOMAN WITH DEMENTIA IS SERIously burned by hot water after being left alone in a bathtub; she dies two weeks later. Patients are ignored and left lying in their excrement, or left tied to beds. A caregiver confesses that he committed four "mercy killings."

These shocking stories came out of Oregon this fall, bringing to light the dark side of the state's adult foster care program. The program, once heralded as a model for other states, is now the focus of major reforms, raising serious concerns about the trend toward commercial home care.

After news of the mercy killings surfaced in August, *The Oregonian* and other newspapers uncovered other patient abuses in the program, which is the largest in the nation. A stinging county auditor's report followed, alleging unsafe conditions in two-thirds of 40 foster homes visited. The auditor's report blamed the poor conditions on inadequate regulation and overzealous promotion of the program, which has more than 9,000 beds. Each home is licensed to care for up to five people at a time.

"We've learned that we have problems to a greater extent than we thought," admits James Wilson, administrator of the state's Senior and Disabled Services Division, which oversees adult foster care.

H. Wayne Nelson, the deputy ombudsman in the state's Office of the Long Term Care Ombudsman, which represents foster home residents, agrees. "Oregon's adult foster care system is flawed," he says. "It's not monitored, it's not regulated, and the training has been a joke. The system is a good idea that needs to be salvaged."

Critics say the state could have avoided many of the problems through more controls on the program's growth and less of a focus on cost savings. In providing an alternative to nursing homes, foster care has saved the state $98 million since 1981, when the program was founded. Patient care in a foster care setting costs as little as $700 a month in Medicaid funding, compared with $3,000 to $4,000 for nursing homes.

"The state is trying to save money, so we've observed it using lots of arm-twisting and coercion to get people to choose foster care instead of nursing homes," says Tim Eide, secretary-treasurer of nursing home operator RASO Enterprises Inc., of Bend. "People on Medicaid are told their care won't be paid for if they don't choose it."

Critics also say that the program must be more closely regulated. The foster care homes are allowed to care for high-acuity cases with minimum staff training requirements. For example, 88 percent of the residents receive care by home operators who are required to have only two years of experience in provider systems.

The state has launched a wide-ranging reform effort. In addition to authorizing a statewide audit by the state attorney general's office, officials have named two committees of industry experts and citizens to assist in the program's reevaluation.

PHOTO ILLUSTRATION BY KERRY MCCOY; HEADLINES COURTESY OF WILLAMETTE WEEK AND THE OREGONIAN

Some new rules are already in effect. After completing the mandatory 18-hour training course, new operators must now take a competency test. If a person fails the test twice, he or she is required to repeat the course. Previously, applicants needed only to attend the 18 hours of training. In addition, licensers now make unannounced visits when they inspect homes for relicensing. Before, critics say, operators were given notice several weeks in advance.

State administrator Wilson says he is also taking a hard look at the policy on criminal background checks for would-be operators. Current rules require checks that go back just five years, and are usually limited to Oregon records. Out-of-state or federal criminal records are checked only if an applicant has lived in Oregon for five years or less.

Wilson says that some of the program's problems can be attributed to inadequate funding, which led to staff shortages. "Five or six years ago, we had an in-house monitoring team that numbered 14 people. Due to state budget cuts, we laid off 25 percent of our staff and we no longer have that monitoring capability. If we still had that team, we probably would have seen these problems coming."

Two new investigators have been hired to protect residents and help shut down foster care homes deemed unsuitable for the program. In addition, nurses working for the state will visit homes where Medicaid patients live to assess the quality of medical care they receive. Only about one-third of Oregon's foster care residents, however, are Medicaid patients.

More measured growth for the program is one goal for Oregon's foster care state sources say. Even advocates of community care say that they found the foster care program's growth to be dizzying in the past. "They've licensed new adult foster care homes in such great numbers that there is a high vacancy rate in the Oregon program," reports lobbyist Grover Simmons, of the Independent Adult Care Providers Association.

"We believe the state's theory is that having lots and lots of homes makes the price of service cheaper and cheaper because providers must compete against one another," Simmons adds. "But a low level of reimbursement attracts an element of people who may not be the most desirable home operators." BY DON NICHOLS

HCFA's Final Enforcement Rule Gives New Muscle to OBRA Quality Standards

A NEW HEALTH CARE FINANCING Administration (HCFA) regulation represent the final phase of implementing the nursing facility reform provisions of the Omnibus Budget Reconciliation Act of 1987. The new rules, which were published in the Federal Register of November 10, address what fines and others sanctions nursing homes may face for violating quality standards as well as issues such as how state and federal inspectors, or surveyors, will monitor nursing homes.

The regulation aims to ensure that nursing facilities comply with federal requirements promoting the quality of care and quality of life in nursing homes. "Enforcement remedies" spelled out by the regulation range in severity from drafting a plan of correction to civil fines of up to $10,000 a day to termination of a facility's participation in the Medicare and Medicaid programs. In extreme cases, the state may close a facility and arrange for the transfer of its residents. Previous enforcement tools were limited to terminating nursing homes from the Medicaid and Medicare programs or denying payments for new admissions until deficiencies were corrected.

HCFA Administrator Bruce C. Vladeck said the regulation "provides the flexibility in each case to apply a remedy that fits the problem," adding that applying penalties is not necessary in most cases because nursing homes act promptly to correct deficiencies.

In addition to introducing sanctions, the regulation spells out the following changes from the current system:

- In determining deficiencies, surveyors will focus on actual outcomes of care rather than on the existence of policies, procedures, and manuals.
- States will be required to develop a systematic approach for determining deficiencies.
- Nursing homes will be allowed informal resolution of disputes for both state and federal surveys. In addition, facilities are entitled to one formal hearing with either the state or HCFA, depending on who rendered the enforcement decision.
- The definition for substandard care will differentiate between serious deficiencies directly related to resident care and lesser deficiencies related to administrative requirements.

The final enforcement rules met with the general approval of the two leading industry organizations, the American Health Care Association and the American Association of Homes and Services for the Aging.

"We believe that the enforcement regulations demonstrate the positive attitude that HCFA has shown in recent years in its effort to improve the survey process," said AAHSA president Sheldon Goldberg. BY YVONNE PARSONS

Five States Vote on Longterm Care Issues

NURSING HOME RESIDENTS AND their caregivers were affected to varying degrees by the fates of five state ballot initiatives around the country. Here's a brief rundown.

PASSED:

☑ **Oregon. Ballot Measure 16,** the Physician-Assisted Suicide Initiative, will allow doctors to prescribe lethal doses of barbiturates to terminally ill patients wishing to end their own lives. The person must be deemed legally competent and request the drugs twice, in writing. Counseling is required in cases of depression or related cognitive disorders.

"We will have to train our social

PHOTO ILLUSTRATION BY KERRY BROOKS; HANDS COURTESY OF WILLAMETTE WEEK AND THE OREGONIAN

MONTANA
HEALTH
CARE
ASSOCIATION

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EXHIBIT 8a
DATE 1-10-95
HB

MONTANA HEALTH CARE ASSOCIATION
SUMMARY OF LEGISLATIVE ISSUES

1. **Medicaid budget for nursing homes.** The Governor's proposed budget includes a rate increase of approximately 4% per year. It maintains the nursing home bed tax at its current level. We support the proposed increase and believe it provides the minimum funding necessary to cover inflation and other cost increases experienced by nursing homes. It is necessary if we are to continue to provide high quality services to our residents.

2. **Nursing home bed tax.** Although the Governor's budget no longer includes a bed tax increase, it is our understanding that a bill drafting request has been submitted for an increase in the bed tax. MHCA strenuously opposes any increase in the bed tax based on the following concepts:

a. MHCA supported the tax as a way to help the state through severe budgetary problems, but does not support fee increases when the state's financial circumstances are improved.

b. MHCA opposes use of tax increases on nursing homes as the sole source of nursing home rate increases. Nursing homes should be treated like every other Medicaid provider, all of whom receive their rate increases from the general fund.

c. MHCA believes that if the tax is continued for nursing homes it should also apply to other long term care services paid for by Medicaid, such as personal care, assisted living and the like.

d. Because of SRS's application of the private pay limitation, all funds appropriated to nursing facilities are not distributed. The effect of this is that facilities are not receiving the full benefit of the nursing home tax.

e. The operation of the tax has not been equitable to all facilities because of differences in Medicaid population, the private pay limitation, and the operation of various caps in

the reimbursement system. Facilities that are paying the tax are not necessarily receiving the benefit of the increased funding.

3. **Certificate of Need.** MHCA supports continuation of the certificate of need process. The executive branch is proposing that the program be transferred from the Health Department to the Health Care Authority. We have not taken a position on where the program should be located but believe that, regardless of where it is located, the following changes should be made to improve the program:

a. Change to include all long term care services from residential care at the low end to subacute care at the high end.

b. Strengthen the program by the commitment of appropriate trained staff, professional hearing officers, and financial resources.

c. Streamline the appeals process to discourage frivolous appeals and delays while allowing due process to those who have legitimate grounds for challenging a decision.

4. **Moratorium on Nursing Home Beds.** A bill has been introduced to place a three-year moratorium on construction of nursing home beds. MHCA opposes this proposal as being an arbitrary restriction on the availability of a very necessary health service. We believe that the certificate of need program in Montana enables the state to control the growth of nursing home beds. However, the CON process allows orderly growth in areas where occupancy is high and there is a demand for nursing home beds. We believe this allows the state to control unnecessary growth while assuring Montana citizens access to needed services. While the proposal is intended to curb Medicaid expenditures for nursing homes, nursing home utilization is not growing at anywhere near the rate of growth of other Medicaid services. SRS anticipates only a 1% per year growth in Medicaid nursing home days over the next biennium. If all other Medicaid services grew at that small a pace, the Medicaid budget would be well under control. The daily rate Medicaid pays nursing homes is also projected to grow at a modest rate of 4% per year. The nursing home program is simply not where the run-away growth is in the Medicaid budget. In addition, a moratorium could actually increase Medicaid expenditures because of the difficulty of placing heavy care patients which is one likely unwanted affect of creating a shortage of nursing home beds. A moratorium is also likely to increase the cost of nursing home services to private pay residents because nursing homes will be able to raise their prices if there is a shortage of beds.

5. **Nurse Delegation.** The 1993 legislature delegated to the Board of Nursing authority to adopt rules relating to the delegation of nursing tasks to non-nurses. The legislature provided no guidance to the Board and our attorney believes the delegation is an unconstitutional delegation of legislative authority to the board. The Board of Nursing has adopted delegation rules which exclude nursing homes, hospitals and physician offices as

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settings in which delegation is appropriate. Rep. John Cobb (R-Augusta) has requested legislation to correct the problems with the delegation statute. MHCA will work with Rep. Cobb and support legislation that provides proper legislative guidelines to the board with respect to delegation and the settings in which it is appropriate.

6. **Medicaid Estate Recoveries and Liens.** SRS will propose legislation designed to comply with 1993 federal legislation which requires states to recover from the estates of Medicaid recipients and allows the imposition of liens on the property of Medicaid recipients. It is intended to curb the use of "Medicaid estate planning" by elderly individuals to divest and/or shelter their income and assets in order to qualify for Medicaid coverage of nursing home care. While we have not seen a final version of this legislation, MHCA will support reasonable legislation dealing with this issue.

7. **Residential care; assisted living; adult day care.** The Department of Health plans to propose legislation which will pull all of the various types of licensed care facilities under the broad definition of "residential care" and to move the licensing of adult foster care from the Department of Family Services to the Health Department. There is no proposal at this time to separately define or license "assisted living" facilities. It is believed they are included in the personal care A and B categories. At this point, the intent is to remove these facilities from the definition of "long term care facilities" which may have a number of implications since Montana's resident rights, abuse, and CON statutes all refer to "long term care facilities" and include residential facilities, unless specifically excluded. MHCA has concerns about the attempt to consider these facilities anything other than "long term care facilities" and about the proper licensing, regulation and inspection of these facilities.

8. **Long Term Care Reform.** SRS plans to propose legislation designed to generally set out the state's "purpose and policy in regards to providing state programs of assistance for the elderly and for persons with disabilities." The legislation makes bold statements about the rights of the elderly and disabled to reside in the least restrictive setting and to maintain independence. The proposal seems to bestow these rights on Medicaid recipients without regard for the costs involved in providing the service. We are still reviewing the proposal and attempting to determine its impact. We are likely to recommend that cost effectiveness be added to the language and that when making cost comparisons among services, the full costs associated with a particular setting be taken into account.

9. **National Child Protection Act.** The 1993 amendments to the National Child Protection Act include new provisions for the protection of children, the elderly, and the disabled which include provisions for background checks, fingerprinting and the like of individuals working with children, the elderly and the disabled. It is up to individual states to decide whether and how to implement the provisions. We expect that legislation will be introduced with respect to these issues but no drafts or detailed information is available at this time. MHCA believes that any legislation mandating background checks for nursing home

workers must include a timely and cost effective way to accomplish them, and not interfere with the ability to hire employees as needed and to use volunteers in our facilities.

This summary covers specific legislative issues of which we are aware. We also expect numerous other pieces of legislation will be introduced dealing with health care reform, malpractice, workers' comp, labor relations, etc. We will, of course, be involved in such legislation to the extent it affects long term care facilities.

1/95

EXHIBIT 9
DATE 1-10-95
HB

PRESENTATION

TO THE

APPROPRIATIONS COMMITTEE SENATE FINANCE AND CLAIMS JOINT HUMAN SERVICES SUBCOMMITTEE

BY THE

MONTANA HOSPITAL ASSOCIATION

JANUARY 9, 1995

INTRODUCTION

Thank you for the opportunity to address the subcommittee and to share with you the budget concerns that hospitals will focus on during this legislative session.

Hospitals have four major priorities for this session:

- **A DRG payment rate increase for inpatient hospital services, as proposed in the governor's budget;**
- **Reinstatement of a hospital payment line item in HB 2;**
- **Enactment of legislation ensuring that Medicaid's managed care plan will provide access to appropriate health care services for beneficiaries and adequate and reasonable payments for providers; and,**
- **A halt to development of the Medicaid outpatient payment system recommended by Abt and Associates.**

We would like to spend a few minutes addressing each of these concerns.

THE MEDICAID BUDGET

Hospitals—like legislators, the Governor's office and Department officials—are concerned about the rate of growth in the Medicaid program's budget. We understand all too well the budgetary realities you face. In recent years, hospitals have served as the pocket into which the Legislature dipped when budget shortfalls forced additional cutbacks in Medicaid services. For example, hospitals have accepted **reduced Medicaid DRG payments, a $100 per admission deductible, and an end to the hospital benefit for youth psychiatric care** which resulted in the closure of Rivendell Hospital in Billings.

But for now at least, the hospital sector of the Medicaid program is not the problem; hospital payments are not on a dangerous growth curve. In fact, just the opposite is true. The most recent budget projections indicate that during the current biennium, payments to hospitals have been significantly less than the amount of general fund money appropriated by the previous Legislature. **Over the next biennium, hospitals are expected to consume fewer general fund and total Medicaid funds than in FY 94-95.** These projections include a modest increase in DRG payments that will enable hospitals to offset some of the increases in their costs for treating Medicaid beneficiaries.

Table 1 below demonstrates that the Department overestimated the growth curve attributed to hospital services. Fewer inpatient admissions to hospitals, lower inpatient payment rates and a switch of patient care from inpatient to outpatient settings combined to lower hospital spending from previous years. These trends are reflected in the *1994 Hospitals At-A-Glance* booklet which accompanies this document.

TABLE 1	FY 1993	FY 1994	FY 1995	FY 1996	FY 1997
BUDGET	N/A	$94,149,834	$104,073,551	$84,684,762	$97,196,212
AMT. SPENT	73,855,911	$68,921,990	$74,081,213		
NET		**$25,227,844**	**$29,992,338**		

Source: Medicaid Services Division. FY 1993 from Expenditure estimate 12/20/93. Budget figures for FY 94,94:HB2, special session, FY 96,97:SRS. Amount Spent from SRS estimates, 10-94.

We know this to be true because, at MHA's request, the Legislature in 1993 listed hospital funding separately from other Medicaid spending because we wanted to analyze more closely what was happening in this program. **MHA urges this Committee to again separately identify hospital funding in the Medicaid budget.**

As a result, we can tell you today that the hospital payment portion of Medicaid is not the reason for the Department's request for additional funding for the upcoming biennium. In view of these changes in the utilization of the Medicaid program, hospitals believe further reductions in hospital payments are not an appropriate strategy for controlling the growth in the Medicaid program.

HOSPITAL SUPPORT FOR MANAGED CARE PROGRAMS

Merely reducing the amount paid for health care services does nothing to control cost growth. Hospitals believe the most effective way to control health care cost increases is through market-based reform of the health care delivery system. Specifically hospitals advocate changing the way health care services are delivered to allow medical providers to provide care more efficiently, reduce overhead costs and improve the health status of Montanans.

Hospitals applaud moves such as the development of managed care systems because we believe they can lead to this kind of restructuring of the health care delivery system. **And, in principle, MHA supports the development of a managed care system for the Medicaid program.**

However, any managed care must be constructed thoughtfully and carefully. Access to appropriate care and quality of care must not be sacrificed in an effort to reduce Medicaid payments to providers. For this reason, **MHA will ask the Legislature to approve legislation that will spell out how a Medicaid managed care system should be structured and operated.**

This bill will not try to undo the Department's efforts to develop a managed care program; nor will it strive to carve out market protection for any vested interest. The bill would establish the ground rules for managed care, and seek to address the key interests of medical providers, consumers and the state.

HOSPITAL COST CONTROL EFFORTS

Hospitals are currently enjoying a reprieve from the steep inflationary pressures of recent memory. Hospital inflation rates in 1995 are now about the same as those in the general economy. **According to the U.S. Department of Labor data released December 13, hospital prices increased at just 3.8 percent in the 12 month period ending October, 1994.** MHA believes this improved inflationary picture will continue in the near future.

Montana's hospitals have undertaken many efforts to reduce health care costs. Fewer people are admitted to hospitals and stay for fewer days than in the past as outpatient services and new technologies reduce hospital use. (These trends appear on pages 4-7 of the 1994 Hospitals At-A-Glance.) Lower utilization means fewer jobs in the hospital, but more jobs in home- and community-based settings. Hospitals are also streamlining management and other overhead costs, working together to share resources and avoid duplication of costly technology. Two large hospitals in Great Falls intend to merge operations primarily to reduce health care costs.

The causes of health care cost inflation are complicated; there is no quick fix that will reverse the health care spending trend overnight. This is as true of the Medicaid program as it is of health care costs paid for by private insurance. We are optimistic that hospitals' efforts to control costs will pay off in the long run. In the short run, the biggest mistake the Legislature could make is to reduce Medicaid payment rates in anticipation of savings down the road. **Thus we urge the subcommittee to support adequate payment rates for hospitals until we can determine the impact of the department's managed care project.**

OUTPATIENT HOSPITAL PAYMENTS

The Department, with MHA support, contracted with Abt Associates to study the outpatient hospital payment system. The study was intended to learn what services hospitals provided in the outpatient setting, and whether alternate payment strategies could be developed to control cost growth in this program.

Abt recommended a variety of payment strategies that are neither simple, nor, in our view, do they reduce costs. In fact, they increase hospital costs, while at the same time, reducing Medicaid payments for the basic program. MHA has told SRS that hospitals will oppose implementation of Abt's recommendations. We urge this committee to deny SRS the staff and budget funding needed to develop these new programs.

Our primary reason for adopting this position is that the state's supply of health care

providers just can't provide the kinds of services that would be required under this plan. One of the most important findings of the Abt study was that hospitals provide a tremendous amount of routine, primary care in the emergency room. **We agree that reducing emergency room use can mean substantial savings to the Medicaid program and hospitals alike.**

But reductions in the use of the emergency room for primary care is not something that will happen just by imposing a new payment scheme. It can only be achieved with an increase in the number of primary care physicians willing to treat Medicaid beneficiaries in their office. None of Abt, Associates' recommendations address that issue. Improvements to the Passport program and development of managed care are two important ways to address this concern, but our bottom line is that SRS should not be allowed to proceed with its proposed outpatient payment scheme until the issue is addressed.

Complicating the issue further, new federal regulations make it harder than ever to reduce inappropriate use of emergency room services. So-called anti-dumping rules require hospitals to treat anyone entering the facility. Failure to comply with the laws can mean a fine of up to $50,000 per case in larger hospitals, and expulsion from the Medicare and Medicaid programs.

Compliance with the anti-dumping regulations is expensive and time-consuming. The laws require hospitals to provide at a minimum a medical screening examination to every patient who enters the emergency room—regardless of how minor their complaint might be. Hospitals aren't required to treat cases that aren't true emergencies, but the government decides if the hospital's decision is right after the fact.

As a result, hospitals are being asked to do two very different things by government regulators. On one hand, hospitals should refuse to serve people who misuse the emergency room. On the other, hospitals can be severely penalized if they refuse to serve someone the government later decides should have received care.

SRS is proposing to adopt a $20 fee for the legally-required screening exam in order to "encourage" hospitals to refuse care. MHA opposes this plan. Hospitals could incur many times the proposed fee in providing the legally-required care. This proposal is ridiculous, and we hope you will prohibit the Department from moving forward.

CONCLUSION

In conclusion, we appreciate this opportunity to present our concerns to the subcommittee. As we stated, we have four priorities for this legislative session:

- **A DRG payment rate increase for inpatient hospital services, as proposed in the governor's budget;**
- **Reinstatement of a hospital payment line item in HB 2;**
- **Enactment of legislation ensuring that Medicaid's managed care plan will provide access to appropriate health care services for beneficiaries and**

adequate and reasonable payments for providers; and,

- **A halt to development of the Medicaid outpatient payment system recommended by Abt and Associates.**

Please don't hesitate to call on us if you need additional technical information or if you have additional questions.

Thank you. We look forward to working with you in the weeks ahead as you act on HB 2.

EXHIBIT 9a
DATE 1-10-95
HB

Hospitals At-A-Glance

1994

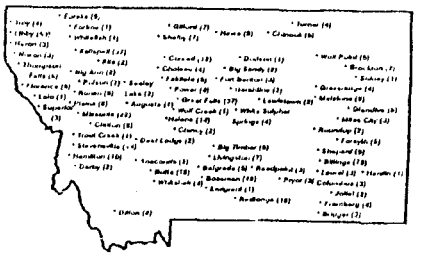
MHA
MONTANA HOSPITAL ASSOCIATION

CARING PROGRAM FOR CHILDREN

℠ Service Mark of Blue Cross of Western Pennsylvania

EXHIBIT 10
DATE 1-10-95
HB

CARING PROGRAM CHILDREN
From 1/1/93 to 1/1/95



The Caring Program for Children provides primary and preventive health benefits to eligible Montana children. A nonprofit organization, the Caring Foundation of Montana, Inc., is responsible for operation of the Caring Program.

Eligible Children

Current enrollment as of January 1, 1995	399
Total number of children served	576
Estimated number of Montana children who could benefit from Caring Program services	14,000

Montana Providers Participating in the Caring Program

Physicians	627
Hospitals	43
Physician Assistants	35
Nurse Specialists	23

Contributions

The Caring Program for Children received contributions from a variety of sources including fundraisers, private foundations, United Ways, and numerous Montana businesses and individuals.

** Total Contributions Received $141,193.00
(as of December 31, 1994)
(Plus matching funds from Blue Cross and Blue Shield of Montana)

United Way Support

* United Way of Lewis and Clark County
* United Way of Cascade County
* United Way of Hill County
* United Way of Silver Bow County
* United Way of Flathead County

P.O. Box 872 • Helena, MT 59624-0872 • Telephone: (406) 444-8400

The Caring Program is a cooperative effort of participating physicians, hospitals, other health care providers, 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 physicians, hospitals, and other 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 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 as uncompensated care. Thus, the Caring Program reimbursement helps reduce the impact of cost shifting in today's health care delivery system.

CPFACT.SHT/1201

EXHIBIT 10a
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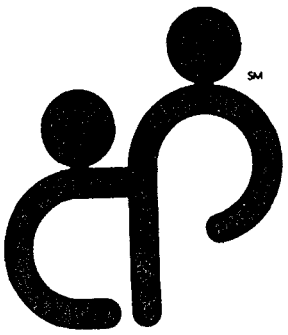

CARING PROGRAM FOR CHILDREN℠

℠ Service Mark of Blue Cross of Western Pennsylvania
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- BENEFIT BOOKLET -

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