MINUTES

MONTANA HOUSE OF REPRESENTATIVES
54th LEGISLATURE - REGULAR SESSION

COMMITTEE ON HUMAN SERVICES & AGING

Call to Order: By **CHAIRMAN DUANE GRIMES**, on March 1, 1995, at 3:00 p.m.

ROLL CALL

Members Present:

Rep. Duane Grimes, Chairman (R)
Rep. John C. Bohlinger, Vice Chairman (Majority) (R)
Rep. Chris Ahner (R)
Rep. Ellen Bergman (R)
Rep. Bill Carey (D)
Rep. Dick Green (R)
Rep. Antoinette R. Hagener (D)
Rep. Deb Kottel (D)
Rep. Bonnie Martinez (R)
Rep. Brad Molnar (R)
Rep. Bruce Simon
Rep. Liz Smith (R)
Rep. Susan L. Smith (R)
Rep. Loren L. Soft (R)
Rep. Kenneth Wennemar (D)

Members Excused: Rep. Carolyn M. Squires (D)

Members Absent: None

Staff Present: David Niss, Legislative Council
Jacki Sherman, Committee Secretary

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

Committee Business Summary:

Hearing:	SB 158	
	SB 40	
	SB 236	
	SB 84	
Executive Action:	SB 55	DO CONCUR
	SB 120	DO CONCUR

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

EXECUTIVE ACTION ON SB 55

Discussion:

CHAIRMAN GRIMES explained the bill clarified the responsibility of Department of Family Services for payment of administrative costs in non-assumed counties. The issue clarifies who pays for office space and other administrative costs where the department can no longer have office space in the county office, so they move out to a remote location. Counties have been charged for the rent on the remote location.

Motion: REP. KOTTEL MOVED SB 55 DO CONCUR.

Discussion

REP. ELLEN BERGMAN asked for clarification of who was paying the bills. **CHAIRMAN GRIMES** replied that it was the counties that were paying the bill. He said this would resolve the issue but would be dealt with through their appropriations.

REP. DEB KOTTEL pointed out the fiscal note. She said this all came about because of the Attorney General's opinion, issued May 9, 1994, which required non-assumed counties to pay for their proportionate share of administrative expenses.

REP. BERGMAN said that counties have refused to pay. **REP. TONI HAGENER** asked if the county was required to pay under current law. **CHAIRMAN GRIMES** said the bill would have the Department of Family Services assume these bills rather than the county if the appropriation is available to go with it.

Vote: The question was called. **The motion carried unanimously.**

EXECUTIVE ACTION ON SB 120

Discussion

CHAIRMAN GRIMES explained the bill was introduced by **REP. JOAN HURDLE** to rename the Montana Center for the Aged in Lewistown to the Montana Mental Health Nursing Care Center. The purpose would be to include people other than aged people. He said there were no opponents.

Motion/Vote: REP. BOHLINGER MOVED THAT SB 120 BE CONCURRED IN.

Discussion:

REP. BOHLINGER said by expanding the age of the residents in the facility it would be possible to fill the facility. At the present time, there is only a 190-bed capacity and only 140 beds in use. It would be a better use of the facility than to let it

sit vacant. There could be some cost savings involved. They are able to care for people at $80 a day as opposed to $270 a day.

Vote: **The motion carried unanimously.**

{Tape: 1; Side: A; Approx. Counter: 275; Comments: n/a.}

HEARING ON SB 40

Opening Statement by Sponsor:

SEN. STEVE BENEDICT, SD 30, presented SB 40. He said the bill was drafted at the request of the Department of Corrections and Human Services and the Montana Advisory Council on Chemical Dependency. The focus of the bill was to eliminate inappropriate referrals to the Montana Chemical Dependency Center (MCDC) in Butte for inpatient treatment. He explained the parts of the bill including the use of patient placement criteria which can find the most appropriate treatment level or setting for each patient determined in a community setting. He noted that this would result in more cost effective care and out-patient treatments for those that can.

Proponents' Testimony:

Darryl Bruno, Department of Corrections and Human Services, discussed the need for the bill. He said this was at the request of the department and the Montana Advisory Council on Chemical Dependency and would help control costs. **EXHIBIT 1**

Roland Mena, Director, Montana Chemical Dependency Center, Butte, testified in support of the bill. He pointed out the importance of managing appropriate admissions to MCDC. He said the bill recognized the major role of patient participation in treatment outcomes and relapse prevention. The bill would promote access to public treatment services as a benefit instead of an entitlement. It would promote accountability and responsibility and discourage dependency and abuse of the system. **EXHIBIT 2**

Betty Wing, member of the Montana Chemical Dependency Advisory Council, Missoula, testified in support of the bill. She served as Chair of the Delivery of Services Committee. The committee found ways to deliver treatment in the most appropriate, least restrictive and cost effective way. They took a survey of patients at MCDC, using national criteria, to determine if the people should be there or could be treated in local communities more effectively. The survey results found there was a high proportion of patients that were inappropriately placed. Many of the people were being sent there by the courts and probation officers and were not evaluated.

MCDC was not discharging the patients if they found they were not appropriately placed there. She pointed out that a private

program might do that, but this was a state-funded program established to serve the public which makes it politically hard for them to turn people away. She discussed the MCDC program.

{Tape: 1; Side: A; Approx. Counter: 484; Comments: n/a.}

She pointed out that the program was not a shelter or a diagnosis treatment center for mental health problems; it is not a hospital or a detention center or corrections facility. She recommended these separate functions work together to meet the needs of the patients and use resources effectively.

She noted that she was a deputy county attorney and a prosecutor. She said this area of criminal justice needs some attention since they are part of the problem. Treatment is a way out of jail. The bill would make people stop and think before using state resources as an answer to every problem.

Rod Robinson, Director, Gateway Recovery Center, testified in support of the bill. He said the passage of the bill would allow the trained chemical dependency specialist to thoroughly assess, accurately diagnose and appropriately place the patient in the treatment setting that their clinical condition calls for rather than what is convenient at the time. Passage of the bill would also help control the length of stay in the facility.

Kathy McGowan, Chemical Dependency Programs of Montana, testified in support of the bill. She said the program is an association of out-patient and in-patient chemical dependency programs across the state. She pointed out the mental health centers had already dealt with this problem. People were evaluated in the community before sending them to the state hospital. People need to stop thinking that services at state institutions are free.

Pat Melby, Rimrock Foundation in Billings, testified in support of the bill. He said that Rimrock uses national criteria to determine the admission and continued stay of patients and he encouraged the department do the same.

Frank L. Lane, Executive Director, Eastern Montana Community Mental Health Center, submitted a letter supporting SB 40. **EXHIBIT 3**

Robert M. Ross, Executive Director, MHC-Mental Health Center, submitted a letter in support of SB 40. **EXHIBIT 4**

Michael Cummins, MA, Executive Director, Flathead Valley Chemical Dependency Clinic, submitted a letter in support of SB 40. **EXHIBIT 5**

Peg Shea, Program Director, Turning Point, Missoula, submitted a letter in support of this bill. **EXHIBIT 6**

Sandra J. Lambert, R.N., Miles City, submitted a letter in support of this bill. **EXHIBIT 7**

Opponents' Testimony: None

{Tape: 1; Side: A; Approx. Counter: 750; Comments: n/a.}

Questions From Committee Members and Responses:

REP. BOHLINGER asked how an assessment was made. **Mr. Mena** replied that a multi-dimensional tool was used to assess an individual in several different areas such as medical conditions, psychiatric ability, relapse potential, etc. **REP. BOHLINGER** asked how long the evaluation took. **Mr. Mena** replied up to two hours and it was done by an out-patient program within the community. **REP. BOHLINGER** asked if this would provide a 24-day program rather than an open-ended program. **Mr. Mena** said the goal was a systems approach to use the out-patient programs and the various levels of care offered. He said it was important to stabilize, motivate and get the people back into the community so they could receive after-care. **REP. BOHLINGER** asked what it cost the state of Montana to provide a 24-day program. **Mr. Mena** replied about $80 a day.

REP. SOFT asked **Mr. Bruno** about the tracking mechanisms to show the impact of the bill. **Mr. Bruno** said the reporting system they had showed where the individuals were coming from, whether a referred program, courts or whatever. He said they encouraged people to seek aftercare in the community. There is an aftercare process that is monitored to make sure that happens. There is also an evaluation unit that goes out and evaluates all state approved programs to see that they are using patient placement criteria. There are currently 30 state approved programs.

REP. SOFT asked how this bill would reduce the length of stay costs. **Mr. Bruno** replied that by placing people in an appropriate setting, they could be treated quicker and put back in the community. There are immediate cost savings when only those needing appropriate care are treated at the state institution.

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

REP. SOFT asked about the capacity at the program. **Mr. Bruno** said the capacity was 90 beds. The average stay is 21 days. The average daily population is around 70 patients.

REP. SOFT asked **Ms. Wing** about problems resulting in abuse and what action would be taken to curb those problems regarding placement from the criminal justice system or county attorney. The jails are full. **Ms. Wing** said the whole point of the bill was to make sure people had an assessment before they go. **REP. SOFT** asked how that would be communicated to the criminal justice system. **Ms. Wing** replied that when they send someone over to

MCDC they have to call ahead of time to see if there is bed space. They will say the assessment is needed first.

REP. BERGMAN asked **Mr. Bruno** about community based programs. **Mr. Bruno** replied that every county has services available which include intensive out-patient programs. However, if there were no program available, then that person would be sent to the MCDC. He noted that there was a tremendous case load in the community. Chemical dependency is prevalent in all systems in the state. Alcoholics Anonymous is not included, but is part of the recovery process.

REP. MARTINEZ asked **Mr. Bruno** how many visits could one person have, such as for alcohol-related treatment. **Mr. Bruno** replied that the community based programs were the most important, however the person could relapse. **REP. MARTINEZ** asked what amount the individual contributed to their care. **Mr. Bruno** said individuals are billed based on their ability to pay. The department also collects insurance on those that have it. **REP. MARTINEZ** asked about the aftercare. **Mr. Bruno** said the individual is referred back to the state-approved community program. One of the key components of the bill would be to tie that person into the networking community programs and maintain sobriety.

REP. BOHLINGER asked about the 90-bed capacity with 70 in residence. Why would there be a two week waiting list? **Mr. Bruno** replied that there is a problem scheduling people, since it takes a while to get them ready to come into the program, but there really is no waiting list. The current problem with people coming from other systems is that they are "no-shows."

CHAIRMAN GRIMES asked **SEN. BENEDICT** about the single point entry into the system. The screening would be by any certified chemical dependency counselor in the state available in each county. He pointed out that this would affect the judges, county attorneys and probation officers. He asked if they were happy with the bill. He asked if the administrative rule granted in the bill would have an impact on the court assignments and decisions made by probation officers. He noted the language appeared to be broad in the last sentence in the statement of intent and hoped this would not create problems.

{Tape: 1; Side: B; Approx. Counter: 300; Comments: n/a.}

SEN. BENEDICT responded that he worked with the Chemical Dependency Advisory Council and they wanted to make sure they would have a bill that would work. He noted the justice system may feel uncomfortable at first since they are used to "dumping on MCDC's doorstep." However, this will create an extra step in the process. He pointed out that there were members of the judicial system on the task force.

Closing by the Sponsor:

SEN. BENEDICT closed on the bill. He said there is access in every county in the state to the screening program and the out-patient referral program that is funded through the alcohol tax, so this is not a new program. The efforts will be shifted to a more intensive out-patient service. Nobody is trying to keep people out of the program that really need to be there. He said "inappropriate referral" means "somebody that didn't know what to do with a guy that was beating up on his wife over the weekend and got drunk," so the judge said he had a drinking problem and had him "thrown" into MCDC for 24 days. The assessment step should be part of the sentence to determine whether or not there are out-patient treatment services available first.

HEARING ON SB 158

Opening Statement by Sponsor:

SEN. MIGNON WATERMAN, SD 26, said SB 158 had to do with a reform in a fundamental shift in the long-term care system. Seventy-five percent of Medicaid funds provide services for 25% of the clients who are elderly and disabled. In order to address the costs in Medicaid, long-term care needs to be addressed. She pointed out that the state of Oregon had moved to community-based long-term care services and in the process have saved $100 million in their Medicaid budget without sacrificing services.

The elderly need some alternatives to nursing homes. She said SB 158 had three components. It declares guiding principles of the state of Montana, demands cooperation between state agencies to provide those services, and reports to the Legislature in two years. This will develop a wide array of services that Montanans need and want and will be cost beneficial to the state.
EXHIBIT 8

Proponents' Testimony:

Peter Blouke, Director, Department of Social and Rehabilitative Services, testified in support of the bill. He said that Montana Medicaid spent over $100 million on long term care services in FY 94 which is one third of the entire budget. Since there are a high percentage of nursing home residents that qualify for Medicaid payments, this has put a strain on state finances and will become worse as more of the population becomes eligible for long-term care services. The bill would address the need for private financing of long-term care and implement solutions.
EXHIBIT 9

Bill Olson, American Association of Retired Persons (AARP), testified in support of the bill. He said the implementation of long-term care reform research shows that Society is aging and

the demands of that will be enormous. He said this bill would be a step in meeting solutions to this problem.

Don Allen, Montana Area Agency on Aging Association, testified in support of the bill. He said there were concerns by older Montanans. Since long-term care now includes home and community based care as well as institutional care, the concept of continual care stresses the need of the chronically ill elderly that there are different levels of care as health conditions and degree of care varies. This continuum of care implies a choice of the most appropriate services. Increased provision of community alternatives help to assist those elderly people that need help to function at the highest possible level of well-being in the least restrictive setting. The idea is to foster the most self-sufficiency and independence as possible.

Charles Rehbein, Department of Family Services, spoke in support of the bill. He pointed out the bill would address the planning process.

Denzel Davis, Administrator, Health Facilities Division, testified in support of the bill.

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

Kate Cholewa testified in support of the bill.

Ed Caplis, Executive Director, Montana Senior Citizens Association, spoke in favor of the bill. He said long-term care is the cost driver of the Medicare program and that costs were increasing. This is a step towards controlling those costs.

Kay Kosow Fox, Montana Low Income Coalition, testified in support of the bill. She said they feel that Medicaid costs are skyrocketing and there must be some cost controls.

Opponents' Testimony: None

Questions From Committee Members and Responses:

CHAIRMAN GRIMES asked **SEN. WATERMAN** if this bill sets up policies and goals the departments have to follow, would they have to come up with a delivery system. **SEN. WATERMAN** replied that was correct and it would be state policy to make it a community-based system as opposed to relying on just nursing homes.

REP. BERGMAN asked **SEN. WATERMAN** if this meant a move towards smaller groups. **SEN. WATERMAN** replied that it was like a boarding home model, assisted living centers, or social model like individual apartments with common areas. Respite care and adult foster homes are other examples. She said there is a wide variety that could be developed into additional services to assist people to live independently in their own home or with as little assistance as possible.

REP. BERGMAN asked if this meant less money to nursing homes and more to other areas. **SEN. WATERMAN** said that was where the shift was. Currently, 62% of Medicaid funds are spent on nursing home long-term care. She pointed out that in other states, nursing homes have opposed this because it was seen as a threat. However, nursing homes in Montana are full to capacity and it will help some rural communities maintain their medical facility or their nursing home.

REP. SIMON questioned the community-based services language that was mentioned frequently but not mentioned in the bill. **SEN. WATERMAN** replied that the language was in HB 2, but talks about people living independently in the community. **REP. SIMON** said this was the least restrictive and least expensive, but the bill when codified, the definition terminology was not in the bill. **SEN. WATERMAN** pointed out on page 2, line 9 and 10, about the development of community services that would allow a person to choose to live in their own residence or in the least restrictive setting.

REP. SIMON asked about elderly persons with disabilities obtaining insurance or private financing. **SEN. WATERMAN** said that currently, because of the class of services, most people end up in nursing home facilities. They end up impoverished very quickly or there are great incentives to shelter their assets and become Medicaid eligible. They need to move away from that and plan for their own long-term care. She noted that another bill would develop quality long-term care insurance for seniors.

REP. SIMON asked **Mr. Blouke**, about Section 53-6-402 part 4, that already shows direction and authority for the department which is what this bill is about. He wondered what was lacking in order to coordinate and implement programs for community based services. **Mr. Blouke** replied that one of the major benefits of SB 158 was the clear articulation by the legislation of the need for a coordinated, interdepartmental development and effort to develop this continuum of services. The department can establish community-based programs, however the services for the elderly are not just in SRS.

REP. SIMON questioned page 1 of the bill about whether this would create an entitlement for the elderly to have insurance. **Mr. Blouke** replied that they are entitled to the opportunity to gain insurance. People should have the choice. **REP. SIMON** wondered if this could be construed to assume people would have a right to community-based programs that may not be available in their community. This may prove to be an obligation to create programs that are not in existence presently or in the future because of this language.

{Tape: 2; Side: A; Approx. Counter: 355; Comments: n/a.}

Mr. Blouke replied that it was not their intent to offer a full range of services. The process would take many years. The

intent, over a period of time, would be to develop a full continuum of services to the extent the resources are available. He pointed out that nursing homes are considered an important part of that continuum. He said this would provide goals and directions.

REP. SOFT inquired about the Legislative intent of the 1993 session about the continuum care and long term services. **Mr. Blouke** said that the tremendous growth in the Medicaid program was reviewed to try to control growth and provide more appropriate services with the available resources. An advisory committee to deal with the long-term care issue was created that involved providers, advocates and legislators. This committee has developed issues that deal with long-term care solutions.

REP. SOFT asked if this meant that the Legislature had to get involved with continuing care as opposed to the development of the services. **Mr. Blouke** replied that the continuing care was not developed fully. To develop the continuum of care would take a number of years.

{Tape: 2; Side: A; Approx. Counter: 540; Comments: n/a.}

REP. SOFT asked what the continuum of care was that had been developed and was there a reduction of expenditures in long-term care as a result of this, since the 1993 session. **Mr. Blouke** replied that it was difficult to determine reduction in expenditures. However, through the waiver program, the long-term care nursing home costs have been stable in Montana as opposed to many other states for the last 5-6 years. Part of that stability can be attributed to the services developed under the waiver program, such as home-based community services. He pointed out that part of the problem was how to deal with the licensure issue. Some ideas are in place for development of alternatives to nursing homes.

REP. SOFT asked if this bill would set forth the principles and policies for the system. He noted that these ideas had been talked about for two sessions, but had not reached the actual services portion. **Mr. Blouke** replied that there were some appropriations to begin the process. He said this bill represented a major change in the direction in which the state is dealing with the long-term care issue. Long-term care has been nursing homes, however, this represents an opportunity for the state to deal with these issues.

REP. SIMON asked **SEN. WATERMAN** about the report that was going to be put together to reform licensing of facilities. **SEN. WATERMAN** discussed the background of the issues.

{Tape: 2; Side: A; Approx. Counter: 800; Comments: n/a.}

She said there may be some licensing issues that need to be dealt with next session. There are a broad array of issues identified

in the report. If a full spectrum of services were developed these issues might need to be addressed, one of which was the licensing issue.

REP. SIMON asked what the bill was implementing. **SEN. WATERMAN** said this was a systemic shift in the way services were delivered and the way long-term care is viewed. This was a philosophical shift based on what people need, not on the services which are funded through Medicaid. Presently, services are driven for the elderly and disabled on what they are eligible for and who will pay for it. The kind of services they get depend on who is paying for it in the state of Montana, not necessarily on the services needed. This would be a fundamental reform.

REP. MARTINEZ asked how this would differ from the foster homes for the elderly. **SEN. WATERMAN** said they would be a part of the array. She told about a situation where an individual was left over the weekend in an adult day care facility due to an emergency. However, the facility was only licensed as a day care. This was a gap in the services, however, there needs to be that option available as part of the system.

Closing by the Sponsor:

SEN. WATERMAN closed on the bill. She said the bill sets the policy for an array of services.

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

HEARING ON SB 236

Opening Statement by Sponsor:

SEN. MIGNON WATERMAN, SD 26, presented SB 236. She discussed the fundamental shift in the last biennium and the allocation of $1 million dollars to expand the community-based waiver for elderly and disabled in the state. They were able to provide some services to some brain-injured people and those people who were at risk of going into the nursing home. The home and community-based waiver will provide home and community services for people who would, without those services, end up in a nursing home. She said that SB 236 would bring Montana into compliance with federal laws concerning a state recovery. More importantly, it would preserve Medicaid funds for those who truly need those services.

She explained that Medicaid was established to assist low income people, yet it has become a first payer for not only Montanans, but Americans. SB 236 would prevent people from sheltering their assets. It would require recovery of Medicaid costs from the estates of Medicaid recipients. It would allow a lien to be placed on a recipient's home, but only if there is no spouse or no dependent children residing in that home at the time the lien is established. The lien can only be executed after the death of

the recipient. Depending on how the waiver is funded, the expansion of services available can happen. She pointed out the importance of planning for long-term care. The state cannot pay for everyone's long-term care. Medicaid dollars must be protected for those that are truly needy and can't afford the care.

Proponents' Testimony:

CHAIRMAN GRIMES noted that most of the proponents or opponents would testify on March 13th just prior to Executive Action. He said the reason for this is the hearing did not make it on the docket prior to the transmittal break so there were some people that would like to testify but were not able to make this meeting.

{Tape: 2; Side: B; Approx. Counter: 200; Comments: n/a.}

Peter Blouke, Director, Department of Social and Rehabilitative Services (SRS), testified in support of the bill. **EXHIBIT 10** He pointed out that this was not intended to deny Medicaid services or payment to individuals that meet Medicaid criteria. There can be some savings and an expansion of those community-based services.

Hank Hudson, Director, Department of Family Services, testified in support of the bill. He explained the department houses the state office on aging that provides services and advocacy to the aged. The issue on balancing people's responsibility to pay for their own long-term care and at the same time protect them from getting totally wiped out by long-term care costs is one that the department has wrestled with for a long time. They try to provide assistance to older people in planning and purchasing long-term care insurance and making decisions on how to manage their estate or approach the issue of paying for long-term care.

Bill Olson, AARP, testified in support of the bill. He said the AARP members are all volunteer. The success of the program is important to Montanans. **EXHIBIT 11**

Don Allen, Area Agency on Aging Association, testified in support of the bill. He pointed out the difficulties in the issue, but because of the tremendous costs involved if the issue is not dealt with could cause greater problems in the future.

Rose Hughes, Montana Health Care Association, spoke in support of the bill. She said that Medicaid was a program for the poor, yet 62% of the people in nursing homes are on Medicaid, yet 62% of the population is not poor. Many of the people on Medicaid had substantial assets that were sheltered. Those assets would have allowed some years of nursing home care to be paid for. She pointed out the bill would create some timeframes as far as the transfer of assets which would create some ineligibility for Medicaid. In effect, individuals will have to pay for some

portion of their care. There is not enough money for the state to continue to pay universal long-term care. In order to get a handle on costs, they should serve only those in need.

She pointed out that it cannot be controlled by simply not giving providers enough money to do that and for them to shift the costs. This bill would deal only with those in need. The portion of the bill that puts liens on people's homes is the most unpalatable part of the legislation. She discussed historical examples).

{Tape: 2; Side: B; Approx. Counter: 660; Comments: n/a.}

If a person says they are going to be returning to the home, then they are exempt and the state will not sell it. However, the state is still entitled to deal with that asset, but by the time they get to it, it might be sold or gone. The ability to put the lien on helps the state get what it is entitled to get back.

Kay Kosow Fox, Montana Low Income Coalition, testified in support of the bill. She said the coalition supports the bill because Medicaid is a program that is targeted for low income people. She pointed out that although this would close one of the loopholes, it provided a new specialty for estate, trust and probate attorneys to do earlier estate planning. People who have access to attorneys are going to do earlier estate planning. They will set up a trust and there are many ways of getting around the time limits in the bill. She pointed out that there will still be wealthier people that can use the legal system earlier. Many people that are low income will never inherit a home.

Ed Caplis, Montana Senior Citizens Association, testified in support of the bill. He said this was an emotional issue and included class warfare and legacy. It was a heated debate within whole senior citizen organizations. However, this is an issue of fairness. This is a welfare program. Those that can afford to pay for their care should do so.

Kate Cholewa, Human Services Foundation, said they support the bill. It would keep the dollars in the hands of those most in need.

Opponents' Testimony:

The opponents will testify on March 13th.

Questions from Committee Members:

REP. SOFT asked what percentage of the 62% were indigent.

{Tape: 3; Side: A; Approx. Counter: 000; Comments: n/a.}

Ms. Hughes replied that it was a question of whether the individual, during their lifetime, had the ability to purchase insurance or had sufficient assets that would have paid for at least some years of their care, and did they do some things to avoid paying for their care. She discussed a Washington study regarding methods to get the percent lower. **SEN. WATERMAN** said that statistics would show that 12% of the population is categorized as poor.

REP. SOFT asked about concerns raised with attorneys doing pre-estate planning. **SEN. WATERMAN** said there was a look-back period in the bill of three years for estates and five years for trusts which is federal law. This must be implemented.

REP. SQUIRES asked about secondary liens and how the state would have a priority. **Mr. Blouke** said the bill did not change any lien priorities that were currently in the law. **Greg Gould, SRS legal counsel,** said under this bill, the first people to file would have priority.

REP. SQUIRES asked if individuals had to save a certain number of dollars to do this for the lien, would it become criteria to be considered indigent. For example, if the city of Missoula had the first lien and it cost $12,000 and the house is worth $42,000, would they still be able to get on Medicaid even though they hold that $12,000.

Mr. Gould replied the lien provision does not affect their eligibility. For purposes of Medicaid, if someone owned a home and returned home, that is an exempt resource. The lien would be put on the home only if the person was permanently institutionalized and there were no spouse or children living there. He explained that what often occurs is that the home gets transferred away. Even though it is an exempt resource, it is not there later to recoup some of the Medicaid interests.

REP. SQUIRES asked about the federal legislation that was upcoming. **Mr. Gould** replied that the bill contained several different pieces. All of the federal legislation that authorizes what is in the bill is already on the books. The lien legislation has been on the books for a number of years and is an optional component under the law. Some of the pieces are mandatory. **REP. SQUIRES** asked if the lien portion would become mandatory later. **Mr. Gould** said no, and provided some background on the federal legislation.

{Tape: 3; Side: A; Approx. Counter: 200; Comments: The hearing for SB 286 resumed at the meeting of 3/13/95.}

HEARING ON SB 84

Opening Statement by Sponsor:

SEN. CHRIS CHRISTIAENS, SD 23 in Cascade County, presented SB 84. The bill would revise services provided by the Montana Chemical Dependency Center.

Proponents' Testimony:

Darryl Bruno, Administrator, Alcohol and Drug Abuse Division, Department of Corrections, testified in support of the bill. He said that SB 84 would change the scope of operations at the Montana Chemical Dependency Treatment Center in Butte. The elimination of the detoxification services for the revolving door alcoholic will decrease state expenditures. The emphasis will be towards community outpatient programs. He said that MCDC could not be all things to all communities, but rather the programs at MCDC must serve the state. **EXHIBIT 12**

Norma Jean Boles, Manager of Standards and Quality Assurance and Medical Coordinator, Department of Corrections, testified in support of the bill. She said the bill was a proactive solution to the escalating costs and problems associated with the provision of detox only services. She cited the reasons for the recommendations. She said the services were regional and did not serve the entire state. The detox only admissions were often inappropriate. Many of the admissions were repeat. The MCDC budget did not provide for the ancillary medical costs that occurred through the utilization of the services. She said that survey results of the programs recommended downsizing and elimination of the detox only services. **EXHIBIT 13**

Roland Mena, Director of the Montana Chemical Dependency Center, presented his views in support of the bill. He said this would focus resources and provide the best quality of services. The use of the detox program has been inappropriately used. For example, the program was used as a mission, shelter, free housing and meals for transients, as an acute care hospital and a detention center. He discussed some of the problems and costs associated with this type of use. He pointed out the bill would not prevent anyone from accessing services at MCDC who meet placement criteria for this level of care. **EXHIBIT 14**

Rod Robinson, Gateway Recovery Center in Great Falls, testified in support of the bill. He said the center was one of the programs that met out-patient services. The quality of care will increase as the revolving door image decreases. Also there will be a cost savings as a result of better treatment. The person in need of receiving medical detoxification prior to receiving primary treatment services is less than 5%. Treatment of the condition can occur rather than just the crisis.

Betty Wing, member of the Chemical Dependency Advisory Council, Missoula, testified in support of the bill. She said this would be the best use of resources and would not cause any unreasonable problems.

Kathy McGowan, representing Chemical Dependency Programs of Montana, testified in support of the bill. She said their members participated with the task force to develop this bill and fully endorsed it.

Frank L. Lane, Executive Director, Eastern Montana Community Mental Health Center, submitted a letter supporting SB 84. **EXHIBIT 15**

Michael Cummins, MA, Executive Director, Flathead Valley Chemical Dependency Clinic, submitted a letter in support of SB 84. **EXHIBIT 16**

Robert M. Ross, Executive Director, MHC-Mental Health Center, submitted a letter in support of SB 84. **EXHIBIT 17**

Sandra J. Lambert, R.N., Miles City, submitted a letter in support of this bill. **EXHIBIT 18**

{Tape: 3; Side: B; Approx. Counter: 000; Comments: n/a.}

Opponents' Testimony:

Bob Olsen, Montana Hospital Association, spoke against SB 84. He pointed out that the state agency responsible for addressing alcohol and chemical dependency says they no longer have enough money to carry out their statutory responsibilities. The bill would not solve the problem of revolving door alcoholics. Instead those people will be taken to community hospitals. The costs for detoxification are usually uncollectible. He said the state should not shirk their responsibilities and pass off the problem back to the communities. **EXHIBIT 19**

Questions From Committee Members and Responses:

REP. SIMON asked about 53-24-304, MCA, regarding physical harm done by intoxicated people. As this would be repealed, what would happen to those people? **Ms. Boles** replied that essentially this was only serving two counties. The emergency commitment is only in force at MCDC. It is not within the communities. The police officer has the ability to take them into protective custody. The officer would decide what to do depending on the condition of the person, but he would not have the commitment papers.

REP. HAGENER asked about the insufficient funding. **Mr. Bruno** replied the funding did not generate additional revenue. **REP. HAGENER** said she had two concerns. One if there were no detox services, then someone would end up paying for hospital care or

jail. She said she was concerned that the local alcohol programs continue to function. **Mr. Bruno** said the services were only used regionally. Other communities were too far away. The state should not be running a regional program for four or five counties in the state. Savings made by MCDC can be put back into the program and they can continue to operate. The only way to eliminate the problems of people needing detox is to provide inpatient and outpatient treatment. Otherwise it is a revolving door problem.

Closing by Sponsor:

SEN. CHRISTIAENS closed on the bill. He said the situation is a lack of money to do what is needed. The question is how to pay for services for chemically dependent people in the state. The tax on alcohol continues to diminish. If the bill does not pass it means a decrease of $100,000 for each year in the next biennium for community programs. Community programs are not functioning at the level that they could if they had the money. Funding would help the 1,500 people who are in the 32 community programs now.

ADJOURNMENT

Adjournment: 5:45 p.m.

DUANE GRIMES, Chairman

for DEB THOMPSON, Recording Secretary

DG/dt

HOUSE OF REPRESENTATIVES

Human Services and Aging

ROLL CALL DATE 3-1-95

NAME	PRESENT	ABSENT	EXCUSED
Rep. Duane Grimes, Chairman	✓		
Rep. John Bohlinger, Vice Chairman, Majority	✓		
Rep. Carolyn Squires, Vice Chair, Minority			✓
Rep. Chris Ahner	✓		
Rep. Ellen Bergman	✓		
Rep. Bill Carey	✓ Late		
Rep. Dick Green	✓		
Rep. Toni Hagener	✓		
Rep. Deb Kottel	✓		
Rep. Bonnie Martinez	✓		
Rep. Brad Molnar			
Rep. Bruce Simon	✓ Late		
Rep. Liz Smith			
Rep. Susan Smith	✓		
Rep. Loren Soft	✓		
Rep. Ken Wennemar	✓ Late		

MRNO

HOUSE STANDING COMMITTEE REPORT

March 2, 1995

Mr. Speaker: We, the committee on **Human Services and Aging** report that **Senate Bill 55** (third reading copy -- blue) **be concurred in**.

Signed: _____
Duane Grimes, Chair

Carried by: Rep. Squires

Committee Vote:
Yes 10, No 0.

491301SC.Hbk

HOUSE STANDING COMMITTEE REPORT

March 2, 1995

Mr. Speaker: We, the committee on **Human Services and Aging** report that **Senate Bill 120** (third reading copy -- blue) **be concurred in.**

Signed: _____
Duane Grimes, Chair

Carried by: Rep. Grinde

Committee Vote:
Yes 10, No 0.

491303SC.Hbk

HOUSE OF REPRESENTATIVES

ROLL CALL VOTE

Human Services and Aging Committee

DATE 3-1-95 BILL NO. SB 55 NUMBER _____

MOTION: Kottel motion "Do Concur".

un

NAME	AYE	NO
Rep. Duane Grimes, Chairman	✓	
Rep. John Bohlinger, Vice Chairman, Majority	✓	
Rep. Carolyn Squires, Vice Chairman, Minority		✓
Rep. Chris Ahner	✓	
Rep. Ellen Bergman	✓	
Rep. Bill Carey		
Rep. Dick Green	✓	
Rep. Toni Hagener	✓	
Rep. Deb Kottel	✓	
Rep. Bonnie Martinez	✓	
Rep. Brad Molnar		
Rep. Bruce Simon		
Rep. Liz Smith		
Rep. Susan Smith	✓	
Rep. Loren Soft	✓	
Rep. Ken Wennemar		

(vote 10-0)

HOUSE OF REPRESENTATIVES

ROLL CALL VOTE

Human Services and Aging Committee

DATE 3-1-95 BILL NO SB120 NUMBER _____

MOTION: John Bohlinger "Do Concur."

unanimous

NAME	AYE	NO
Rep. Duane Grimes, Chairman	✓	
Rep. John Bohlinger, Vice Chairman, Majority	✓	
Rep. Carolyn Squires, Vice Chairman, Minority		
Rep. Chris Ahner	✓	
Rep. Ellen Bergman	✓	
Rep. Bill Carey		
Rep. Dick Green	✓	
Rep. Toni Hagener	✓	
Rep. Deb Kottel	✓	
Rep. Bonnie Martinez	✓	
Rep. Brad Molnar		
Rep. Bruce Simon		
Rep. Liz Smith		
Rep. Susan Smith	✓	
Rep. Loren Soft	✓	
Rep. Ken Wennemar		

10 - 0

EXHIBIT 1
DATE 3/1/95
SB 40

Testimony SB 40

This bill, introduced by Senator Steve Benedict, for the Department of Corrections and Human Services is at the request of the Montana Advisory Council on Chemical Dependency.

SB 40, pure and simple, will eliminate inappropriate referrals to Montana Chemical Dependency Treatment Center (MCDC); the state's public inpatient and non hospital detoxification chemical dependency treatment program in Butte. It requires all admissions to MCDC to be evaluated by a certified chemical dependency counselor, using nationally recognized patient placement criteria and confirmation the appropriable level of care is not available in the community. It will also promote MCDC as a benefit and not an entitlement by discouraging abuse and manipulation of the system while promoting accountability and personal responsibility.

The passage of SB 40 will reduce costs, maintain a reasonable schedule of admissions while decreasing the no show rate at MCDC. It will increase the intensity of care for people in treatment and ensure only persons requiring this level of intensity will be admitted. Passage will improve the linkage for the necessary aftercare and other support services, patients require in the community when treatment at MCDC is completed.

Prior to the 1993 legislature this program was located on the Galen campus of the Montana State Hospital. MCDC is funded from earmarked alcohol tax revenue appropriated by the legislature. MCDC's budget represents about 60% of the total earmarked (state) funding for chemical dependency treatment and prevention services. Therefore appropriate utilization of this program is of prime concern.

Passage of this bill will not prevent any one from receiving services at MCDC if this is the required level of care. It will allow MCDC to control costs and provide a more intense level of care to those individuals that are appropriate for the program.

Providing services to individuals who are not appropriate for the inpatient treatment program at MCDC waste valuable resources including staff hours, cost of physical exams, lab x-rays, travel laundry, food etc;.

Respectfully Submitted by Darryl L. Bruno

Darryl L Bruno

Administrator of the Alcohol and Drug abuse Division
Department of Corrections and Human Services.

EXHIBIT 2
DATE 3/1/95
SB 40

Testimony SB 40

This bill, introduced by Senator Steve Benedict, is at the request of the Montana Advisory Council on Chemical Dependency.

SB 40 will establish a single point of entry into the Montana Chemical Dependency Center (MCDC) through a Certified Chemical Dependency Counselor. This will ensure that referrals to MCDC will be appropriate and based on multi-dimensional patient placement criteria.

A review of MCDC files revealed that numerous inappropriate patients where referred to the program without prior assessment and application of patient placement criteria. Many of the individuals where in need of primary mental health treatment and primary medical care. In addition, the review revealed that MCDC has been utilized as a detention center by the criminal justice system and that clusters of individuals have accessed the program after drug busts and other alcohol and drug related crimes to avoid legal consequences rather than seek help. These situations have been extremely disruptive to the other patients and the treatment program and have presented safety issues. It was also determined that many patients could have been assigned a lower level of care and provided treatment in the community.

The passage of SB 40 will ensure that patient placement documentation supporting inpatient care is received from the Certified Chemical Dependency Counselor prior to admission. This will result in appropriate utilization of treatment services and permit MCDC to focus intake and assessment resources toward treatment plan development, case management, relapse prevention, continued stay review and referral to continued care.

Managing appropriate admissions to MCDC in this manner will promote collaboration between the Chemical Dependency treatment providers and community agencies to best serve and monitor the patient for compliance. The MCDC waiting list will be positively affected and can be managed to under two weeks while providing treatment on demand for critical populations. When the scheduled admission list is managed in this manner the show up rate increases.

With the linkage between the Certified Chemical Dependency Counselor and MCDC the average length of stay can be reduced (It is currently 24 days) moving the patient into least restrictive levels of care in the community.

The patients participation in continued care plays a major role in treatment outcomes and relapse prevention. This bill strengthens the linkage between the patient, community based programs, and MCDC. The linkage improves case management of patients as they move through the continuum of care and promotes patient accountability and responsibility to follow through with continued care in the community.

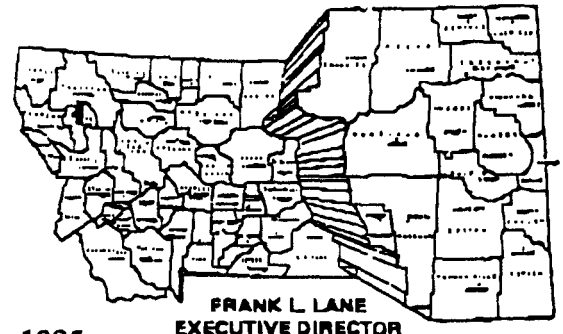
Final, this bill promotes access to public treatment services as a benefit instead of an entitlement. Treating the public patient in a manner that promotes accountability and responsibility places value on the service received and discourages dependency and abuse of the system.

Respectfully Submitted by, Roland M. Mena

Director of the Montana Chemical Dependency Center
Alcohol and Drug Abuse Division
Department of Correction and Human Services

EASTERN MONTANA COMMUNITY MENTAL HEALTH CENTER

REGIONAL ADMINISTRATIVE OFFICE
BUSINESS AND STATISTICAL OFFICE
P.O. Box 1530
2508 Wilson
Miles City, Montana 59301
Ph. (406) 232-0234
Fax (406) 232-0235



FRANK L. LANE
EXECUTIVE DIRECTOR

February 28, 1995

EXHIBIT 3
DATE 3/1/95
SB 40

Representative Ellen Bergman
House Human Services Committee
House of Representatives
Capital Station
Helena, MT 59620

Dear Ellen:

The House Human Services Committee will be considering two bills which will impact the delivery of Chemical Dependency Services in Montana. I believe both bills have the potential to provide significant cost savings to the State of Montana and positively impact the ability of local Chemical Dependency programs to function.

I am referring to Senate Bill 40 and Senate Bill 84.

Senate Bill 40, as I understand it, would require the inpatient certification by a local approved program before a person could be admitted to the Montana Chemical Dependency Center in Butte. This would significantly reduce inappropriate admissions to the Center. We already do this for the mentally ill by requiring community certification before admission to the Montana State Hospital. I strongly urge your support of SB40.

Senate Bill 84 would close the detox unit at the Montana Chemical Dependency Center. All counties are in favor of this bill except for the two counties which use it the most. This detox unit is essentially unavailable for all of the Eastern Counties. Closure of this unit would save money and free up funds for community treatment programs. Please vote for SB 84.

I hope the session is going well for you. If you have any questions, please feel free to contact me.

Sincerely,

Frank

Frank L. Lane
Executive Director

FLL/ram

EXHIBIT 4
DATE 3/1/95
SB 40

MHC
Mental Health Center

February 28, 1995

Darryl Bruno
Alcohol and Drug Abuse Division
Department of Corrections and Human Services
1539 Eleventh Avenue
Helena, MT 59620

RE: SB40

Dear Darryl:

I would like to offer my support for SB40 introduced by Senator Steve Benedict during this legislative session. I think it is extremely important that Montana adopt a consistent, statewide approach to managing referrals to state run programs. As you know, in the mental health system, all individuals being referred to Montana State Hospital are required to have a screening by a certified mental health professional before admission to the hospital. The purpose of the screening is to determine the appropriateness of the referral to the State Hospital. I think it makes sense to have a similar screening process for all admissions to the Montana Chemical Dependency Center. What we have found in the mental health side is that such a screening does, in fact, eliminate inappropriate referrals and it also gives the community providers an opportunity to provide alternatives to state run institutions. Based on our experience with the mental health screening process, I have no doubt in my mind that the passage of Senate Bill 40 will reduces costs and develop a much more efficient system for admissions to MCDC. I am also quite certain that it will give more treatment opportunities in the community for those individuals who would normally have been referred to the Butte program.

Sincerely,

Robert M. Ross, M.S.,LPC
Executive Director

RMR:lm

EXHIBIT 5
DATE 3/1/95
SB 40

FLATHEAD VALLEY CHEMICAL DEPENDENCY CLINIC

P.O. Box 7115
1312 N. Meridian Road
Kalispell, MT 59904-0115
(406) 756-6453
FAX (406) 756-8546

North Valley Office
P.O. Box 2418
6 - 9th Street
Columbia Falls, MT 59912
(406) 892-7900

Human Services Committee
House of Representatives
March 1, 1995
Testimony: S.B. 40

We are in support of Senate Bill 40 which revises provisions for assessment and admission to the Montana Chemical Dependency Center.

This bill will improve proper utilization of a scarce resource and assist with cost containment.

Respectfully Submitted,

Michael Cummins, MA
Executive Director
Flathead Valley Chemical
Dependency Clinic

MC/dnm

cc: Susan Smith

EXHIBIT 6
DATE 3/1/95
SB 40

TURNING POINT
500 NORTH HIGGINS
MISSOULA, MT. 59802

406-543-8623 FAX 406-728-0831

FEBRUARY 27, 1995

Chair Duane Grimes
Capitol Station
Helena, Mt. 59620

Dear Chairman Grimes:

I am writing in support of SB-40. I am the Program Director of Missoula County's publicly funded outpatient substance abuse treatment facility, Turning Point.

SB-40 sets up a system whereby trained professionals assess individual's treatment service needs based on nationally recognized placement criteria. What this does is to insure that the most expensive and restrictive substance abuse treatment model (inpatient) is recommend only for individuals that are most in need of this service. As you are aware MCDC is an inpatient model.

Missoula County is one of the more frequent users of MCDC inpatient treatment services. That is so, in part, because we do not have a system for assessment and placement recommendations set up for all the referring players (i.e.. attorneys, courts, general public, etc.,). Over the past three years we have worked hard at establishing a good working relationship with the courts and other important referral sources. I do believe that if SB-40 becomes law Missoula County will be able to establish a referral system that is responsive and fiscally responsible.

Given the demand for substance abuse treatment services and the paucity of treatment resources we need to have a system of care established where the client who can best benefit from inpatient treatment is given that opportunity. SB-40 begins to address that system development need. Please support this sound policy.

Respectfully Submitted,

Program Director

cc
Representative Carolyn Squires
Representative Ken Wennemar
Representative Bill Carey

EXHIBIT 7
DATE 3/1/95
SB 40

March 1, 1995

Representative Ellen Bergman
Human Services and Aging Committee
Montana House of Representatives
Helena, MT

Dear Ellen,

As a member of the Montana Chemical Dependency Advisory Council and a resident of eastern Montana, I am seeking your support of SB40 and SB84. These bills will result in more equitable use of Chemical Dependency funds, especially for parts of Montana remote from Montana Chemical Dependency Center.

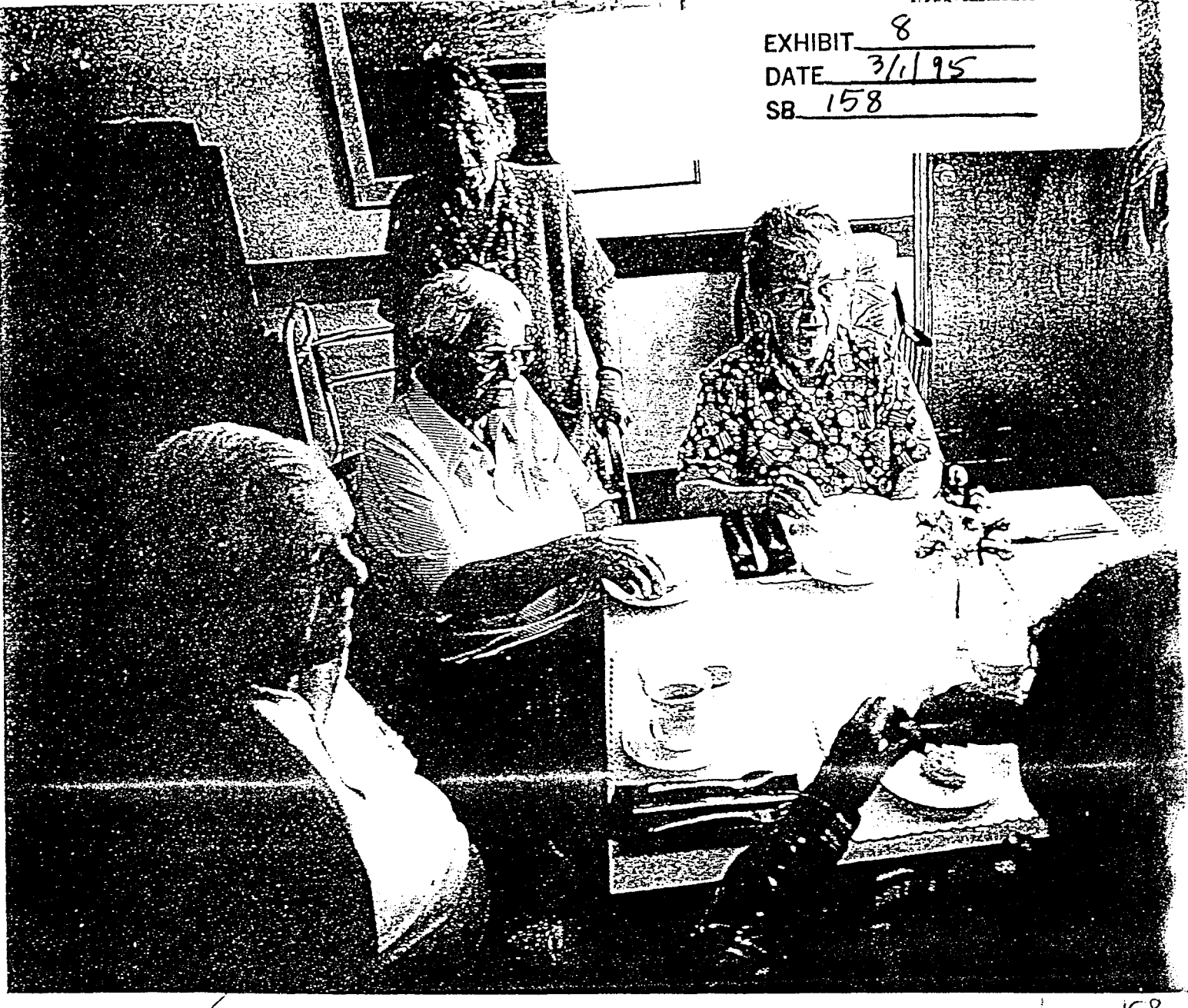
Thank you,

Sandra J. Lambert

Sandra J. Lambert, R.N.
816 S. Center
Miles City, MT 59301

SL/bb

EXHIBIT 8
DATE 3/1/95
SB 158



158

Senator Waterman
Register

Nursing Homes And Common Sense

For decades, nursing homes have been the primary providers of long-term care. But are states spending billions of dollars on sophisticated care that most of the elderly don't need?

Nurses are on duty. Doctors are on call. The hallways, tiled in ammonia-scrubbed linoleum, are lined with groups of elderly people sitting in wheelchairs or shuffling behind walkers. Some are making their way to the large dayroom where a television set is the focal point of their social life. Meanwhile, nursing aides check on bed-bound and coma-

BY PENELOPE LEMOV

Kristin Finnegan photographs

Some states are creating systems that offer the elderly less-institutional services.

tose patients—changing their linen, feeding them meals, administering their medications.

Staffed and equipped for the needs of their sickest residents, nursing homes are the overwhelmingly dominant provider of basic medical care and intensive supervision for the very frail, chronically ill and the physically disabled.

The problem is that most of the people in nursing homes do not need this level of service. Rather, what they require is help with some of the routine tasks of daily life. In fact, experts estimate that somewhere between 60 and as many as 75 percent of nursing home residents could be cared for in a more appropriate and less expensive way.

Nursing homes are certainly a necessary part of any long-term care system. They are essential for people, elderly and otherwise, whose disabilities demand 24-hour-a-day medical supervision, such as the elderly person in the last stages of a dementia disease like Alzheimer's or the disabled person on life-support systems.

But nursing home care comes with a big price tag. Today, the average cost per person is $37,000 a year. States, through their share of the Medicaid program, spend roughly two-thirds of their long-term care dollars to cover this type of care. While states might once have been able to afford these costs, the fiscal constraints of the 1990s and the demographic trends of the 21st century are poised to overwhelm systems that depend on nursing homes as the primary providers of care.

Demographically, the peak of the baby-boom generation will reach age 85 in the year 2040. And given that modern medicine is enabling folks to live longer than ever, the number of elderly needing some form of long-term care is expected to more than triple in the coming decades. Long-term care lurks as the sleeping giant of the health-care system and states that fail to re-order their long-term care programs may awaken to a nasty fiscal surprise.

"The reality is that there will be additional financial burdens, and states that are struggling now will struggle more," says Joshua Wiener, a senior fellow at the Brookings Institution. "But this is manageable if we have the political will to maintain our current level of expenditures and create a more balanced system that provides people with choices other than just nursing home care."

About a dozen states—Arkansas, Georgia, Illinois, Maine, Massachusetts, Minnesota, New York, Pennsylvania, Ohio, Oregon, Washington and Wisconsin among them—have been leading the movement to adjust their systems to current and future realities. They have closed nursing home beds or placed restrictions on the building of new beds and have reallocated money from institutionalized care to new and less expensive services such as personal care, home health, adult day care, adult foster care and assisted living.

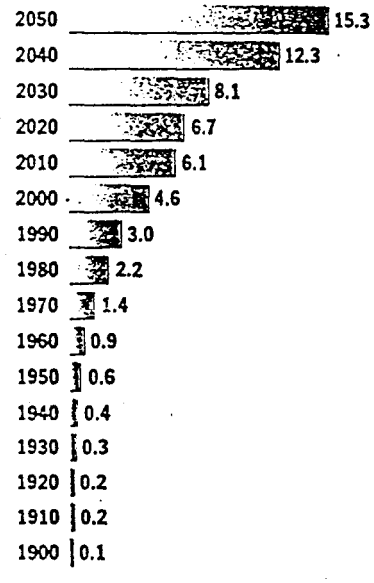
None of this has been easy. There are both political pressures and fiscal concerns that make it risky to expand services. And that has slowed progress in most states.

Long-term care never used to be the political issue it is today. In the first half of the century, elderly people either lived with their families or in boarding houses where landlords provided the occasional assistance, some more humanely than others. Then, in 1950, Congress passed an amendment that forbade Social Security payments for residents of institutions if those institutions did not provide health care. Boarding

GROWING OLDER

U.S. Population 85 Years and Over

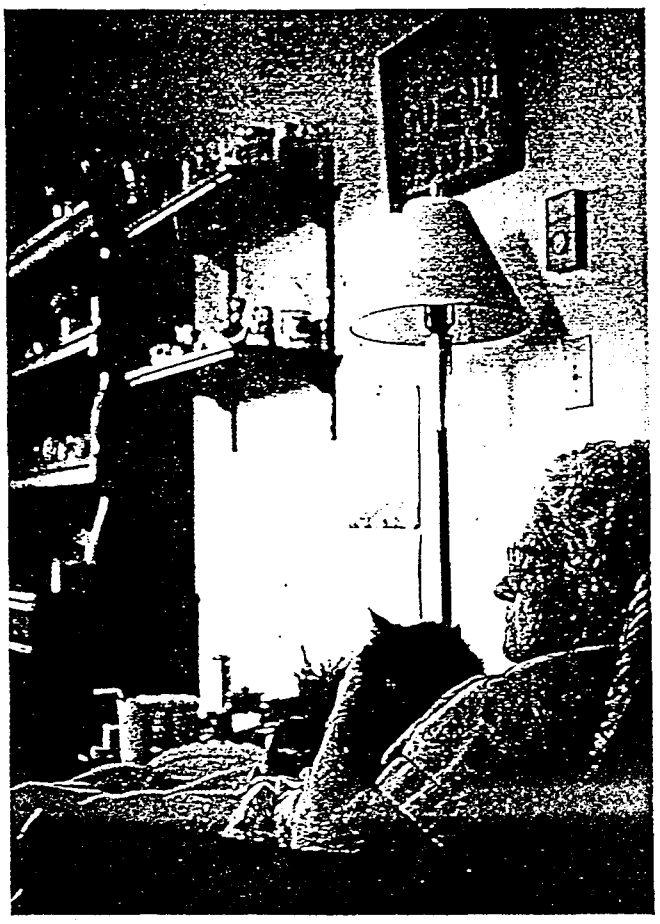
(in millions)



Source: U.S. Census Bureau

end to see community-based care in general, and programs like assisted living in particular, as a threat to their livelihood. With assisted living arrangements, personal, social and medical care are provided on an as-needed, fee-for-service basis to residents who live in private apartments in specially designed and staffed buildings. Obviously, as the availability of such facilities expands and more people can be served in this way, nursing homes may not be quite as full and, for profit-motivated chains, it will be more difficult to justify the need to build more of them.

The funding stream plays into the politics. In most states, Medicaid dollars flow into welfare or public health departments for use in purchasing nursing home care, making those departments more or less captives of the industry. To free itself, a state has to push its agencies to obtain federal waivers that allow them to reallocate the money. In some states, it also means asking the legislature to change laws or write enabling legislation.



With assisted living, older folks can live in private apartments and pay only for the care they need.

Oregon started down that road in 1981 with a seemingly innocuous move: The legislature passed a law that consolidated Medicaid funding for long-term care with all other state and federal money targeted for elderly care. The underlying philosophy was that if one agency controls all the elder-dollars, it would be easier to allocate them. Over a period of time, the division that handles senior and disabled services has, in effect, taken money away from nursing homes—the overall head count for nursing home beds has shrunk accordingly—and put money into developing resources for community-based alternatives.

Politically, putting money into nursing-home alternatives is very difficult to do, says Elizabeth Kutza of Portland State University.

"Politically, this is a very difficult thing to do," says Elizabeth Kutza, director of the Institute on Aging at Portland State University. "It doesn't make the nursing homes happy, and they have clout." In many states, they exercise their influence subtly and without leaving many footprints. They may not lobby directly against legislation to consolidate funding or fight the development of alternatives by opposing them head-on. Instead, nursing homes often ally themselves with other groups interested in a particular subject and target a side issue such as safety or regulation. In effect, they can kill a proposal with seeming kindness and concern for the elderly.

For example, rather than rail against assisted living outright, they might provoke a fight against enlarging the roles of nurses—a reform that makes care in assisted-living units possible. Or they may argue that, for safety's sake, assisted living should be subject to the same regulations as nursing homes.

There is a legitimate question with this new breed of facility about where to draw the line on protecting elderly people from possible abuse and over-regulating to the point of institutional rigidity. There is also a need to look at regulation in a different way. "Most of our rules have to do with measuring objective things—the height of ceilings, the degree of water—things surveyors can look at and measure," says Richard Ladd, Texas' commissioner of health and human services who headed up Oregon's long-term care reform efforts in the 1980s. "They're important, but they don't tell you a lot about the quality of care." What Oregon and others dealing with assisted living are trying to come up with is a results-oriented approach, but that would mean constructing guidelines that are more subjective.

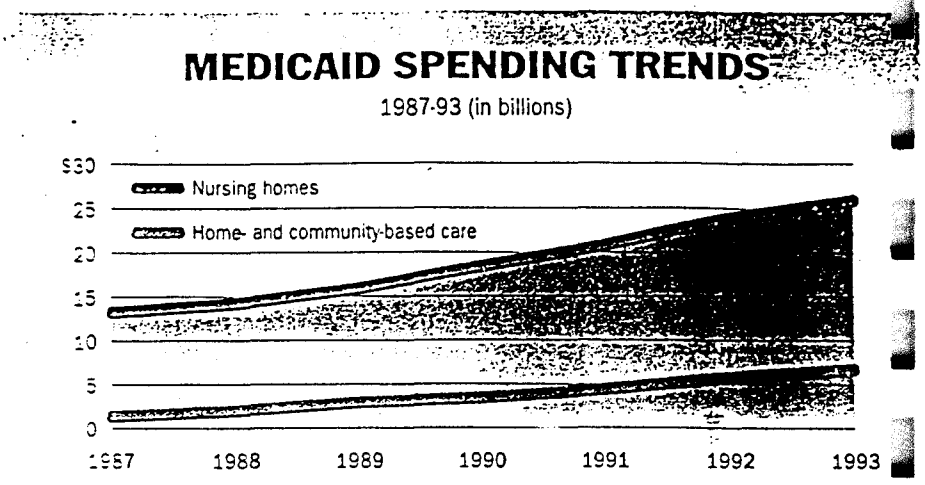
Regardless of this dilemma, there is hardly anyone, apart from nursing home lobbies, who would like to see assisted living laden with the same kinds of regulations that burden nursing homes: Certainly not consumers, or advocates for the elderly and disabled, or state and local officials who deal with long-term care services on a day-to-day basis. Almost everyone agrees that nursing homes are now over-regulated—to the detriment of the atmosphere and environment in which residents of the homes must live. To do more of the same for assisted living would clearly be counterproductive: If all the staffing and medical personnel requirements of a nursing home were laid on an assisted living facility, the price for care would creep up and into the nursing home range.

But political pressure is not the only countervailing influence. A major reason states are not moving even faster to add to their array of services is a widespread and perhaps not unfounded fear that adding the services

houses did not: nursing homes did.

Out of such small bureaucratic change is a new world born. Boarding houses just about disappeared; new nursing homes were built and flourished. In 1965, nursing homes got another boost when Medicare and Medicaid were signed into law. Medicare helped nursing home fortunes only peripherally: it paid nursing home bills only if care followed a hospital stay and was brief in duration. But Medicaid, the federal-state partnership for the poor, had the mandate to become the great provider. It could pay for chronic care at nursing homes for as long as such care was needed—and that could be the rest of an elderly person's life. With public money to pay the tab, modern nursing homes hit pay dirt and became the dominant force in long-term care.

They also worked their way into the public psyche. "Somehow, between 1965 and 1975, we decided the only place an older person was safe was in a nursing home," says Jim Wilson, who heads up Oregon's Senior and Disabled Services. "Now we're having a hard time getting people to see that it isn't necessarily so."



Source: GOVERNING calculations based on U.S. Health Care Financing Administration data supplied by SysteMetrics.

Those who see that—the elderly, their advocates, the majority of long-term care experts and a slew of state and federal health-care officials—have had a hard time turning around Medicaid funding so that it covers something other than nursing-home care. It wasn't until 1981 that states could hope to win federal approval to pay for home services under Medicaid. Eventually, almost all the states applied for and gained such waivers, but only on a limited basis. Oregon is the major exception: It has been able to offer its elderly and disabled population a comprehensive selection of home- and community care options and to cover them under their Medicaid program.

And that has been and continues to be a tough political fight. While various advocacy and consumer groups have been applying pressure for community-based alternatives, they don't generally speak with one voice, and their voices are not as powerful as others. "Reformers," says Trish Riley, who heads the National Academy for State Health Policy, "are outshouted and outspent by the nursing home lobbies."

It is, of course, in the interest of nursing homes to have state long-term care systems dependent on their services. Some nursing homes, particularly nonprofit facilities run by religious or other community groups, have begun to branch out and augment the services they offer—hosting adult day care programs, building apartment complexes designed for assisted living or running home health and personal care programs for elderly people who can then continue to live in their own homes. Daniel Thursz, president of the National Council on the Aging, characterizes these instances of change, which are most prevalent in large cities, as a reflection of nursing homes "facing the fact that they will not be able to survive if they provide only that one service."

But the overwhelming majority of the 22,000 nursing homes in the country

EXH. 8 3-1-95 SB158

THE COSTS OF LONG-TERM CARE, 1993

State	Long-term care costs (in millions)	Long-term care as a % of total Medicaid	Nursing home care costs (in millions)	Nursing home care as a % of total long-term care
Ala.	$471.9	28.8%	$331.4	70.2%
Alaska	55.7	18.9	42.3	75.8
Ariz.	11.5	0.8	10.9	95.0
Ark.	412.1	40.0	251.9	61.1
Calif.	2,295.3	17.0	1,878.5	81.8
Colo.	362.7	34.2	220.1	60.7
Conn.	1,128.9	50.0	727.1	64.4
Del.	107.8	42.6	58.2	53.9
Fla.	1,362.9	27.5	1,011.9	74.2
Ga.	730.2	26.1	531.1	72.7
Hawaii	122.9	32.3	101.8	82.8
Idaho	126.6	43.1	69.0	54.5
Ill.	1,774.0	35.6	1,103.3	62.2
Ind.	1,038.1	36.9	712.7	68.7
Iowa	404.0	40.9	222.9	55.2
Kan.	330.2	37.1	176.8	53.5
Ky.	502.3	27.0	332.2	66.1
La.	886.5	25.4	526.1	59.3
Maine	327.9	38.5	224.8	68.6
Md.	593.5	30.3	401.1	67.6
Mass.	1,638.4	39.7	1,068.8	65.2
Mich.	1,326.5	30.8	922.3	69.5
Minn.	1,269.6	59.6	740.2	58.3
Miss.	299.8	25.1	211.5	70.5
Mo.	645.9	28.7	418.0	64.7
Mont.	133.0	41.1	91.6	68.9
Neb.	$250.3	44.4%	$179.0	71.5%
Nev.	112.4	26.5	73.7	65.6
N.H.	219.0	52.4	147.5	67.4
N.J.	1,576.4	33.5	987.8	62.7
N.M.	167.5	29.3	99.6	59.5
N.Y.	8,189.5	42.2	4,094.8	50.0
N.C.	1,058.8	36.6	585.9	55.3
N.D.	155.0	57.5	92.6	59.7
Ohio	2,060.2	39.8	1,497.4	72.7
Okla.	443.3	40.7	237.5	53.6
Ore.	413.2	43.2	159.1	38.5
Pa.	2,240.7	40.0	1,524.9	68.1
R.I.	395.7	47.7	203.4	51.4
S.C.	424.9	25.3	208.8	49.1
S.D.	131.8	49.5	78.1	59.3
Tenn.	675.3	30.0	524.3	77.6
Texas	1,771.3	24.9	1,050.3	59.3
Utah	150.2	31.4	72.1	48.0
Vt.	111.4	43.6	65.5	58.8
Va.	600.9	33.5	372.8	62.0
Wash.	836.3	36.1	452.7	54.1
W.Va.	315.4	26.3	209.0	66.3
Wis.	1,[illegible]	49.0	[illegible]	63.1
Wyo.	46.4	34.4	25.6	55.2
U.S.	**41,953.9**	**33.4**	**26,116.6**	**62.3**

Source: GOVERNING calculations based on U.S. Health Care Financing Administration data supplied by SysteMetrics.

consumers want, no matter how much cheaper they are than nursing homes, will ultimately increase state costs. The savings that would result from diverting people away from nursing home care could be offset by the widened net of people who are brought into the Medicaid system through the addition of services.

It's called "the woodwork effect," and it's based on human behavior: When faced with a choice of nursing home care or nothing, many elderly people opt for nothing. But if that choice were broadened to include home care or assisted living, they would be more likely to sign on for help.

This issue was raised and studied in the 1970s. At that time, national surveys found that for every person in a nursing home there were at least two others just as ill who were living at home—either because they chose not to go to a nursing home or because a bed was not available. The federal Health Care Financing Administration, which manages the Medicaid program, noted that states that expanded their Medicaid programs to include community-based services might pick up those two other people who wouldn't otherwise have been in their programs.

"States are still worried that if they change the type of service being financed, the services will be so much more attractive to a larger pool of potential users that they won't be able to control costs," says Rosalie Kane, a professor at the University of Minnesota School of Public Health and the director of the National Long Term Care Resource Center.

States worry that expanding services will widen the net of potential users and that they won't be able to control costs.

Oregon, with five years' experience in offering a wide range of community-based programs, is protecting itself from net-widening in two ways: case managers, who oversee home and community-care patients, must assure the state that anyone approved for alternative care could not continue to live at home without assistance. The other strategy is to pair new services with the closing of nursing home beds. And that's been very effective. In the past 10 years, Oregon has reduced the number of nursing home beds by nearly 8 percent, even as the elderly population grew by 40 percent.

One side effect of the greater array of services is that Oregon now covers a larger percentage of all nursing home patients. It paid for 46 percent five years ago when the alternative-care programs started; it pays for 54 percent today. "What that tells me," Wilson says, "is that private-pay residents aren't choosing nursing homes as frequently as in the past."

By covering community-based ser-

vices such as assisted living through Medicaid, the state created a climate in which more services and facilities became available. Private developers saw opportunities for profit—much as nursing home operators built new facilities when Medicaid began covering costs in 1965. And the growth of new community-based facilities for all income levels has been a plus for the state and its Medicaid budget.

"This wasn't a strategy Oregon developed just to reduce costs," Kutza says. "It's a consumer choice as well." She notes that even people who require a lot of personal services and would be considered nursing home care material in almost any other place are able to use alternatives. "What we've done is pushed the boundaries. In other states, you would find nursing homes dominated by people who look like the people in our assisted living or adult foster homes."

When private-pay patients can choose services they like, they're more willing to pay for them, as opposed to nursing homes, where they may transfer assets in order to avoid payment. Since alternative services cost less than nursing home care does, a person's assets and income last longer. An elderly person can handle the $800 a month for community-based services for a much longer period of time than $2,500 a month for nursing home care. "That means they are less likely to spend their way into Medicaid eligibility," Wilson points out. "They end up not coming into our system."

While the demographic threat to long-term care budgets has been building for a long time, there may be a new incentive for states to make faster headway in reforming their programs. It's called national health-care reform, and it would affect state Medicaid budgets whether or not chronic care is part of a universal package of benefits. Here's why: Under almost any measure that Congress passes, hospitals and physicians will be pressured to control their costs for acute care. Among the ways these providers can control such costs, notes Brookings' Wiener, is to either move patients out of acute care and into long-term care or try to redefine what they do as long-term or chronic care. "To the extent you have global budgets as part of health-care reform," Wiener says, "this would be an escape hatch."

As a result, the costs would be passed on from a system in which costs are controlled to one in which there are no mandated limits. The stress of additional patients and new charges for states to cover would come on top of all the demographic changes they will be experiencing.

Whatever permutations there may be in the national or local political climate, the long-term care stakes remain high. "We need to do what Oregon has done and rethink our long-term care policies," says Trish Riley of the National Academy for State Health Policy. "Until we do, the failed policy we have today will continue to eat up scarce resources for services that older people don't want at the expense of critical primary care for poor families, young and old." G

EXHIBIT 9
DATE 3/1/95
SB 158

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

MARC RACICOT
GOVERNOR

PETER S. BLOUKE, PhD
DIRECTOR

STATE OF MONTANA

P.O. BOX 4210
HELENA, MONTANA 59604-4210

TESTIMONY OF THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES BEFORE THE HOUSE HUMAN SERVICES AND AGING COMMITTEE
(Re: SB 158 - Montana Long-Term Care Reform Act)

Senate Bill 158 has three components. First, it sets forth a policy for Montana's long term care system and declares the guiding principles for the development and implementation of services within the system. Second, the bill mandates that various state agencies cooperate in developing, implementing and coordinating state long term care programs. Finally, SB 158 requires a report to the 55th Legislature on the progress of long term care reform.

In 1993, the Legislature mandated the department of social and rehabilitation services to develop a continuum of care designed to limit the growth of state expenditures for long-term care services to people who are elderly or disabled. As the department worked to carry out this mandate, the need for a **system** of coordinated long term care services became apparent.

Montana offers a variety of programs and services within several agencies which supports and assists those people who are elderly or have disabilities and need long term care. Those programs and services, however, are frequently not well coordinated; the result is a structure which is fragmented and confusing for both those seeking services and those providing services. Thus, the lack of a system means that people seeking services must respond to requests for the same information by different agencies. Conversely, because state agencies currently do not have a common intake process nor a shared information database, the agencies cannot serve people in a coordinated manner nor can they determine whether an individual has been served in the most efficient manner.

This bill proposes to remedy these problems by setting forth principles and policies to guide the development of Montana's long term care system. These principles and policies have developed from discussions carried out in several forums. The directors of the departments of family services, health and environmental services, corrections and human services, and social and rehabilitation services have been meeting regularly over the last several months to discuss and move toward coordinated long term care policies and programs. Additionally, members of the long term care subcommittee of the Governor's Council on Aging have considered these issues in depth.

The bill states that Montana's long term care system must:

*respect the dignity of the individual;
*seek to encourage a maximum level of individual independence;

*include community services which allow the person to continue to live at home;
*encourage services which are affordable to all Montanans;
*foster private financing of services; and
*be a system of coordinated services and programs which are accessible and cost-effective.

To ensure the coordination of services, the bill also directs the departments of social and rehabilitation services, family services, health and environmental sciences, and corrections and human services to cooperate in the development and implementation of state programs. Through joint planning and delivery systems, Montana can build a system of cost-effective, accessible programs to assist the elderly and persons with disabilities. Such elements as a common intake and assessment process will provide easy entry of the individual into the system of services and also allow for efficient program management and accountability.

Finally, the bill requires a report to the 55th Legislature which presents progress from these efforts and recommends further changes needed to establish Montana's long term care system.

On behalf of the Department of Social and Rehabilitation Services, I urge you to pass SB 158. Thank you for holding this hearing and listening to my comments.

Submitted by: Peter Blouke, Director
Department of Social and
Rehabilitation Services

EXHIBIT 10
DATE 3/1/95
SB 236

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

MARC RACICOT
GOVERNOR

PETER S. BLOUKE, PhD
DIRECTOR

STATE OF MONTANA

P.O. BOX 4210
HELENA, MONTANA 59604-4210

TESTIMONY OF THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES BEFORE THE HOUSE HUMAN SERVICES AND AGING COMMITTEE

RE: SB 236 - An Act Relating to Medicaid Estate Recovery and Liens.

SB 236 will implement changes in federal law which prevent individuals from becoming eligible for Medicaid long term care benefits by giving away or sheltering substantial assets. The bill would implement changes in federal law which require expanded recovery of medicaid expenditures from estates of deceased recipients and allow recovery of Medicaid expenditures from the recipient's property passing outside the probate estate. The bill would require SRS to place a lien upon real property owned by permanently institutionalized medicaid recipients to preserve the property for later recovery of Medicaid expenditures. This bill will not cause benefits to be denied to any citizen who truly does not have the resources to pay for long term care.

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

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

The proposed bill would require SRS to deny eligibility for a period of time when a person has disposed of assets for less than fair market value during the applicable 36 or 60 - month "lookback" period. The bill requires SRS to establish and "undue hardship" exception process and criteria as required by federal law.

SRS currently operates a program to recover medicaid expenditures from estates of deceased recipients. OBRA '93 expands the medicaid expenditures which states must recover from estates. OBRA '93 also allows the state the option of recovering property of the deceased recipient which upon death passes outside the probate estate (for example, property held in joint tenancy with right of survivorship). This closes a significant loophole in prior law which allowed persons to avoid estate recovery by transferring assets into forms of ownership which bypass the probate estate.

The proposed bill would also implement federal law which allows the state to impose a lien upon the recipient's interest in real property for later recovery through the estate, or for recovery upon sale or transfer.

Montana Medicaid spent over $100 million on long term care services in FY 94. This represents about one third of the entire budget. Approximately 62 percent of nursing home residents are eligible for Medicaid to pay their nursing home

bill. This has placed a strain on state finances and will only get worse as more of our population becomes eligible for long term care services. This bill addresses the need for private financing of long term care and implements a solution for Montana.

Montana can save almost one million dollars or more in the up coming biennium and substantially more in future years by implementing and enforcing restrictions on asset transfers, imposing liens on property, and recovering benefits paid from recipients' estates. These savings derive from a combination of hard dollar recoveries and cost avoidance as more seniors choose private alternatives to long term care financing. The provisions of the bill are designed to target public welfare resources to those who need them most while providing a stronger incentive for seniors and their heirs to plan ahead for their long term care needs by purchasing long term care insurance or other private financing and avoid reliance on public funds.

You may recall that during the December, 1993 special session, similar legislation was introduced. (SB 39) The proposed bill passed the Senate and failed in the House. After the special session, the department met with representatives of over a dozen groups which had an interest in the legislation. The department has made many changes in this bill to accommodate the concerns these and other groups raised. These changes include referencing federal law when appropriate, providing clear protection for spouses and other dependent family members, clarifying the establishment of undue hardship provisions, as well as making the legislation less cumbersome.

At a time when the Medicaid program faces potential budget reductions in other areas which impact the access and payment of care for low-income recipients, this bill provides savings without impacting anyone except those who have the means to pay for their own care and their heirs. When many poor women and children below the poverty limit do not now qualify for Medicaid, it only makes sense that people an their heirs who can afford to pay for their own care no longer use limited public assistance dollars.

Passage of this legislation is critically important to our efforts to reform long term care in Montana. Savings resulting from this bill will help finance development of home and community services as alternatives to more costly institutional care.

On behalf of the Department of Social and Rehabilitation Services I urge you to pass HB 236. Thank you for the opportunity to provide these comments.

Submitted by:

Peter Blouke, Ph.D
Department of Social
and Rehabilitation Services

EXHIBIT 11
DATE 3/1/95
SB 236

AARP

Bringing lifetimes of experience and leadership to serve all generations.

MONTANA STATE LEGISLATIVE COMMITTEE

ACTING CHAIR
Mr. Lloyd Bender
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Bozeman, MT 59715
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ACTING VICE CHAIR
Lloyd Erickson
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SECRETARY
Vacant

AARP Testimony
Senate Bill 236
March 1, 1995

Mr. Chairman & Members Of The Committee:

For the record, my name is Bill Olson. Iam representing the American Association of Retired Persons. AARP is known for its supplemental medicare insurance and other national benefits.

However, I represent the 113,000 AARP members in Montana, and the hundreds of community service volunteers who are active in this state teaching drivers training, helping with income tax returns, counseling pre-retirees and helping widowed persons, among other programs. Not one member in Montana sells AARP insurance or has a paid position.We are all volunteers.

The Montana AARP State Legislative Committee(SLC) fought SB 39 in the last special session. Since then, we have had several working sessions with Senator Waterman and SRS concerning what we perceived as problems with that bill. We want to take this opportunity to thank Senator Waterman and the department for their patience and willingness to take our concerns into account.

Almost every concern we had has been taken into account. As a result, the Montana AARP Legislative Committee voted to support Senate Bill236.

We do have uneasy feelings about the rulemaking powers given the department in this very sensitive area.

Finally, we hope that the success of the recovery program is reflected in additional funds being appropriated for assisted living programs designed to keep elderly out of evpensive nursing homes.

For the record, I am submitting a statemenmt of the actions taken in this bill that addressed our major concerns.

We concur in this bill and urge you to give it a "Do Pass" recommendation.

Thank You.

COMPARISON OF PROPOSED LIEN LAW WITH SB 39 OF SPECIAL 1994 LEGISLATURE

The law allows for recovery of the recipient and spouse's assets under certain instances.

1. Liens used prior to death only.

Allows use of liens prior to death only (a) to satisfy a court judgement, (b) to recover from third parties (such as insurance carriers, providers, etc.), and (c) in cases of institutionalized persons, including those in nursing homes longer than 6 months.

The SLC had concerns about liens on personal property of the surviving spouse. Liens are authorized only against the real property of living institutionalized recipients.

The SLC questioned the extent that the surviving spouse was liable for the debts of the deceased recipient. Clearly the surviving spouse is liable according to current law.

The SLC had concerns about impoverishment of surviving spouses, and recoveries from a large number of relatively poor individuals. A spousal exemption of up to $100,000 from the lien on real property is possible, depending upon the value of the property and the personal assets of the surviving spouse. Since eligibility includes consideration of assets (exempting the home) and requires a spend-down, the utility of this exemption may be moot.

In addition, the department can't collect on a lien so long as a surviving spouse or minor or disabled children are alive. This has been expanded beyond the original "so long as a surviving spouse lives in the home."

Furthermore, the amount, type and method of medicaid re-payment may be negotiated with the department.

The SLC had raised questions concerning dismissal from a nursing home. The lien is dissolved if and when a recipient is discharged from the facility and returns home.

The SLC wanted notices and nearings. State must give notice of intent to impose a lien and provide opportunity for a hearing.

The SLC wanted notification. Execution of the lien must be acknowledged.

The SLC raised the question of the order of the lien. The lien is prior to any earlier or subsequent recorded or unrecorded claim.

EXHIBIT 11
DATE 3-1-95
SB 236

2. Claims against estates used after death.

AARP policy is to limit recovery only to what is included in probate. The act expands recoverable assets to those outside probate as authorized but not mandated by Federal law.

The act allows recovery after death by filing a claim. Recoverable assets include everything owned at the time of death, including revocable trusts, life-time estates, bank accounts, etc. The act also authorizes recovery from survivors and divisees through court action.

The SLC wanted the timing of claims clarified. Claims are filed during probate creditor notice period.

The SLC raised questions concerning impoverishment. Department may give hardship waivers, and must notify surviving spouse of right to a waiver.

The SLC wanted a limit on execution time. Three-year time span to collect on a claim.

The SLC was concerned that the department would build up a claims bureaucracy using recovered funds. Claims recovered go to the general fund, not back to the department.

3. Personal funds of a deceased recipient held by a nursing home are confiscated by the department.

4. Excess burial funds of a deceased recipient are confiscated by the department.

5. The Act authorizes application of the same rules to public assistance recovery, and repeals Public Assistance Recovery, Recovery from Estates, and Old Age Assistance Recovery laws.

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EXHIBIT 12
DATE 3/1/95
SB 84

Testimony SB 84

This bill, introduced by Senator Chris Christiaens, for the Department of Corrections and Human Services is at the request of the Montana Advisory Council on Chemical Dependency.

SB 84, will change the scope of operations at the Montana Chemical Dependency Treatment Center (MCDC) in Butte.
The Montana Chemical Dependency Center is the state's public funded inpatient and non hospital detoxification chemical dependency treatment program. MCDC is funded from earmarked alcohol tax revenue appropriated by the legislature. The fy 96 operating budget is over $2,500,000 with a staff of about 47 FTE. MCDC's budget represents over 60% of the total earmarked (state) funding for chemical dependency treatment and prevention services. Therefore appropriate and necessary utilization of this program by the state is of prime concern.

What is this bill all about?
It is about decreasing state expenditures by eliminating a regional program that does not serve the state very well.
SB 84 will abolish detoxification services for the revolving door alcoholic who are from counties adjacent to the program primarily Missoula and Silver Bow (60%), individuals who return to MCDC time and again to sober up and then return to drinking and drug use, some of which have severe psychiatric & medical problems.

The executive budget proposal included a Personal Services Reduction for detoxification services. DCHS priority for chemical dependency services must be inpatient and outpatient treatment. We believe that this reduction is conservative and greater savings will be realized. It is imperative that **state expenditures** from the only state source for chemical dependency services be reduced.

Appropriations for state programs are utilizing more of the earmarked revenue. Less is available to distribute to community out patient programs, the **back bone** of our chemical dependency system. In **Fy 84** state appropriations consumed about **50%** of the total earmarked alcohol revenue, in **Fy 94** state expenditures were **75%** of the total. Projected distribution to counties for approved programs in the executive budget has dropped from $1,330,000 in Fy 92 to $800,000 in fy 96. Community programs need a solid base of earmarked revenue to survive. Every piece of legislation requested by the DCHS/ADAD this session intents to reverse the trend and put earmarked revenue back into community outpatient programs. MCDC cannot be all things to all communities. We believe Programs at MCDC must serve the state.

Respectfully Submitted by Darryl L. Bruno

Darryl L Bruno

Administrator of the Alcohol and Drug abuse Division
Department of Corrections and Human Services.

EXHIBIT 13
DATE 3/1/95
SB 84

DEPARTMENT OF CORRECTIONS AND HUMAN SERVICES

MARC RACICOT, GOVERNOR

1539 11TH AVENUE

STATE OF MONTANA

(406) 444-3930
FAX: (406) 444-4920

PO BOX 201301
HELENA, MONTANA 59620-1301

TESTIMONY FOR SB 84

SB 84 is a proactive solution to escalating costs and problems associated with the provision of detox only services. The Montana Chemical Dependency Center (MCDC) was established to provide detoxification, evaluation, treatment, referral, and rehabilitation to persons in Montana who are referred for the treatment of alcoholism or other chemical dependency.

The overall mission of MCDC is to provide appropriate, intensive and quality inpatient services to all residents of Montana. MCDC has accomplished this mission very well. There have been 1,013 individuals served in inpatient treatment and 294 persons received both detoxification and inpatient treatment for a total of 1307 in FY94. 355 persons were detox only admissions that chose to leave and not avail themselves to further treatment services.

While MCDC strongly believes we must provide detox services to individuals scheduled for inpatient treatment, MCDC must realistically analyze the issues associated with the provision of detox only services and recommend the elimination of detox only services for the following reasons:

. The provision of detox only services is REGIONAL ,not serving the entire State i.e. 215 of the detox only admissions came from two adjacent counties for 60%.

. The detox only admissions tend to be inappropriate and very expensive. A quality assurance review revealed 14 inappropriate admissions in a six month time span. Ten were medically inappropriate i.e., qualifying for acute care status in a general hospital with serious medical conditions e.g., pneumonia, liver failure, and cardiac problems. Three detox only admissions were in need of psychiatric care and one in need of nursing home care. All had to be transferred by ambulance. In an attempt to ameliorate medical costs, MCDC required medical screening at the local level before transfer. Unfortunately, at the local level, the hospital started charging $640 for the screening, which again is just another expense.

. Detox only admissions also tend to be revolving door i.e., 128 of the 355 were repeat admissions to detox. Some individuals were admitted as many as four times.

. MCDC budget does not provide for the ancillary medical costs incurred by the individual utilizing detox only services (transportation, emergency room services , acute care hospital costs and etc.)Historically, the consumer of medical services tends to be the multiple admission patient (revolving door) who leave against medical advice and do not respond to motivational counseling, refusing referrals to inpatient treatment or referrals to services in the community.

In April of 1994,the Detoxification Services Task Force was established as part of this strategic planning effort. The task force made the following recommendations based on the results of a statewide survey of State Approved Chemical Dependency treatment programs:

. The majority of programs (16 of 19) surveyed recommended downsizing MCDC detox. Downsizing as defined as eliminating detox only admissions, as a service, and limiting detox services to individuals scheduled for inpatient treatment.

. The majority of programs surveyed (12 of 19) also recommended NOT spending more on detox services and less on treatment.

. The committee recommended that regional detoxing be explored in depth. The committee recognizes the funding constraints.

Based on the results of the survey and analysis, the committee recommended legislation to eliminate detox only services.

There is consensus between the Department, MCDC staff, Montana Advisory council on Chemical Dependency and community based chemical dependency treatment programs statewide that elimination of detox only services is the prudent way of capitalizing our limited treatment resources and hope for passage of this bill.

Respectfully submitted,

Norma Jean Boles

Norma Jean Boles, Manager
Standards and Quality Assurance
& Medical Coordinator
Alcohol and Drug Abuse Division

EXHIBIT 14
DATE 3/1/95
SB 84

Testimony SB 84

This bill, introduced by Senator Chris Christiaens, for the Department of Corrections and Human Services is at the request of the Montana Advisory Council on Chemical Dependency.

SB 84 provides the Montana Chemical Dependency Center (MCDC) with the opportunity to carry out the mission "to provide primary residential treatment services to those patients meeting level three placement, which may or may not include detoxification" in the most resource focused and cost effective manner by the elimination of detox only services.

A utilization review of the state detoxification service both on the Galen campus and in Butte has demonstrated that the service operates as a regional program for the adjacent counties versus a state service. Further, the present admission policies that reflect MCA has led to inappropriate placements of individuals that are beyond the scope of psychiatric and medical services provided. In addition, the program has been used inappropriately as a mission, a shelter, free housing and meals for transients, an acute care hospital, and a detention and correctional center.

The MCDC budget and program mission does not provide for the continued ancillary medical and associated costs incurred by the detox only patient with little to no effective outcomes. Routinely, patients are referred to MCDC detox with primary medical conditions and related complications.

This has led to 55 transfers to the St. James emergency room in FY 94, with 17 resulting in hospitalization. An example of additional costs incurred to provide services to the inappropriate detox only patients are, ambulance transportation @ $400.00, emergency room cost @ $800.00 to $1000.00, plus additional x-ray, laboratory and pharmacy costs and also, additional staff to provide one on one care to medically unstable patients. In an effort to reclaim medical cost St. James has begun to billed MCDC for medical screening of detox only patients prior to admission at $600.00/patient.

The above descriptions do not include all cost incurred. Cost saving would be substantial with the elimination of these medical costs and a reduction in personal services.

The passage of SB 84 provides MCDC with the authority to appropriately manage admissions to the treatment program while maintaining a safe chemically free environment. The detox only patient is often uncooperative, unpredictable and aggressive. MCDC does not have the facility, resources nor staff to detain, restrain or seclude these patients. The detox only service has also attracted an increased number of transients from out of state as an easy mark. The potential for staff assault and injury is of concern. Local law enforcement has been called on numerous occasions to intervene with combative and threatening patients.

MCDC's mission and philosophy promotes access to public services as a benefit instead of an entitlement. Treating the patient in a manner which expects accountability places value on the service, while discouraging dependency and abuse of the system. The detox only service is inconsistent with, and undermines the programs mission. The system enables repeat admissions to patients not responsive to motivational counseling for continued care.

SB 84 will not prevent anyone from accessing services at MCDC who meet placement criteria for this level of care. SB 84 however, ensures the most cost effective use of limited resources with the best possible outcomes.

Respectfully Submitted

Roland M. Mena, Director
Montana Chemical Dependency Center

EASTERN MONTANA COMMUNITY MENTAL HEALTH CENTER

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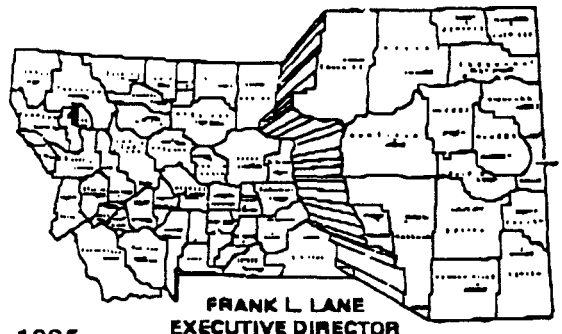

FRANK L. LANE
EXECUTIVE DIRECTOR

February 28, 1995

EXHIBIT 15
DATE 3/1/95
SB 84

Representative Ellen Bergman
House Human Services Committee
House of Representatives
Capital Station
Helena, MT 59620

Dear Ellen:

The House Human Services Committee will be considering two bills which will impact the delivery of Chemical Dependency Services in Montana. I believe both bills have the potential to provide significant cost savings to the State of Montana and positively impact the ability of local Chemical Dependency programs to function.

I am referring to Senate Bill 40 and Senate Bill 84.

Senate Bill 40, as I understand it, would require the inpatient certification by a local approved program before a person could be admitted to the Montana Chemical Dependency Center in Butte. This would significantly reduce inappropriate admissions to the Center. We already do this for the mentally ill by requiring community certification before admission to the Montana State Hospital. I strongly urge your support of SB40.

Senate Bill 84 would close the detox unit at the Montana Chemical Dependency Center. All counties are in favor of this bill except for the two counties which use it the most. This detox unit is essentially unavailable for all of the Eastern Counties. Closure of this unit would save money and free up funds for community treatment programs. Please vote for SB 84.

I hope the session is going well for you. If you have any questions, please feel free to contact me.

Sincerely,

Frank

Frank L. Lane
Executive Director

FLL/ram

FLATHEAD VALLEY CHEMICAL DEPENDENCY CLINIC

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EXHIBIT 16
DATE 3/1/95
SB 84

Human Services Committee
House of Representatives
March 1, 1995
Testimony: S.B. 84

Please accept this written testimony as evidence of our support of Senate Bill 84 which would eliminate detoxification only services at Montana Chemical Dependency Center.

Our experience is that this service is regional in nature and minimally benefits residents of Flathead County.

Respectfully Submitted,

Michael Cummins, MA
Executive Director
Flathead Valley Chemical
Dependency Clinic

MC/dnm

cc: Susan Smith

MHC
Mental Health Center

EXHIBIT 17
DATE 3/1/95
SB 84

February 28, 1995

Darryl Bruno
Alcohol and Drug Abuse Division
Department of Corrections and Human Services
1539 Eleventh Avenue
Helena, MT 59620

RE: SB84

Dear Darryl:

I would like to offer my support for Senate Bill 84 that specifically revises the services provided by the Montana Chemical Dependency Center. On the mental health side of care in our state, we have gone to great lengths to ensure that the utilization of Montana State Hospital for the mentally ill is correct, efficient and appropriate for the types of individuals who are treated at that facility. We have also gone to great lengths in the mental health community to provide immediate emergency services in the community for those individuals who otherwise might be referred to Montana State Hospital on a crisis stabilization basis and then subsequently discharged a few hours or days later. I think it makes perfect sense that we would be consistent in the provision of chemical dependency services at the Montana Chemical Dependency Center. It makes absolutely no sense for MCDC to become strictly a detox center for those individuals who have absolutely no interest or intent in following up with treatment. The general impact of using MCDC as a community detox center is that it takes a great deal of staff resources and tends to be very expensive, with very little gain in regard to treatment or revenue. I feel strongly that the MCDC facility should be reserved for those individuals who have the potential and intent for treatment rather than to simply be detoxified so they can return to their own home environment.

Sincerely,

Robert M. Ross, M.S.,LPC
Executive Director

RMR:lm

EXHIBIT 18
DATE 3/1/95
SB 84

March 1, 1995

Representative Ellen Bergman
Human Services and Aging Committee
Montana House of Representatives
Helena, MT

Dear Ellen,

As a member of the Montana Chemical Dependency Advisory Council and a resident of eastern Montana, I am seeking your support of SB40 and SB84. These bills will result in more equitable use of Chemical Dependency funds, especially for parts of Montana remote from Montana Chemical Dependency Center.

Thank you,

Sandra J. Lambert

Sandra J. Lambert, R.N.
816 S. Center
Miles City, MT 59301

SL/bb

EXHIBIT 19
DATE 3/1/95
SB 84

SENATE BILL 84

TESTIMONY OF THE MONTANA HOSPITAL ASSOCIATION

MHA opposes Senate Bill 84, a bill to terminate detoxification services at the Montana chemical dependency center in Butte. We do so for several reasons.

Senate Bill 84 is proposed because the state agency responsible for addressing alcohol and chemical dependency says they no longer have enough money to carry out their statutory responsibilities. **The bill merely lets the state off the hook for providing services for which Montanans are taxed.** The state thus solves their problem. The tax dollars are spent elsewhere in the system, and the funding shortage is resolved.

But what happens to people who still need services? The state, in the fiscal note, says someone else has to solve the problem of "revolving door" alcoholics. That someone is community hospitals. The state is sending an unfunded mandate to the hospital. The message is clear: The state doesn't have the money to serve these people, let someone else do it. And by the way, the public expects the job to be done for free.

Well, there is no free lunch. The statute currently directs peace officers and others to take intoxicated persons to a health care facility, and also prevents them from placing the individual under arrest. **This means that people who need care are dumped in the hospital emergency room for care and that the public doesn't have to pay for the care.**

Supporters of the bill say this is a reasonable expectation because hospitals that aren't located near the state facility take care of these people today. The bill actually treats them like all other hospitals distant from state services. That is a cynical way to look at the issue. The state should be addressing this issue statewide. **The Department now proposes to turn their back on the issue statewide, claiming this is a fair solution to the problem. But SB 84 simply doesn't solve the problem.**

MHA objects to the state dumping the responsibility of "drunk tanks" on the hospitals. Often times the admission of intoxicated persons to the emergency rooms creates a safety hazard for the nursing staff and other hospital patients. The costs for detoxification are most often uncollectible. The costs are passed on to those who pay their bills.

MHA urges this committee to vote no on Senate Bill 84. The state should not shirk its responsibilities, and pass the mandate onto the community.

HOUSE OF REPRESENTATIVES
VISITORS REGISTER

Human Services & Aging

DATE March 1, 95

BILL NO SB 236 SPONSOR(S) Waterman

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	Support	Oppose
Ed Sheehy	Retired		✓
Charles Rehbein	DFS	✓	
Kate Cholewa	Human Services Foundation	✓	
Bill Olson	AARP	✓	
LARRY AKEY	MT ASSOC OF LIFE UNDERWRITERS	✓	
Ed Caplis	MSCA	✓	
Don Allen	Mt. Area Agencies on Aging	✓	
Charlie Bragg	Mt. Assn. Agencies on Aging	✓	
Kay Kosow Fox	Montana Low Income Coalition	✓	

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

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HOUSE OF REPRESENTATIVES
VISITORS REGISTER

Human Services & Aging

DATE March 1, 95

BILL NO. SB 158 SPONSOR(S) Waterman

PLEASE PRINT PLEASE PRINT PLEASE PRIN

NAME AND ADDRESS	REPRESENTING	Support	Oppose
Charles Rehbein	DFS	✓	
Kate Cholewa	Human Services Foundation	✓	
Denzel Davis	DHES		
Bill Olson	AARP	✓	
Ed Coplis	MSCA		
Milly Gutkoski		✓	
Charlie Briggs	Mt. Assn. Agencies on Aging	✓	
Don Allen	Mt. Assn. of Area Agencies on Aging	✓	
Kay Kasso Fox	Montana Low Inc. Coalit	✓	

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HOUSE OF REPRESENTATIVES
VISITORS REGISTER

Human Services & Aging DATE March 1, 95

BILL NO. SB 40 SPONSOR(S) Benedict

PLEASE PRINT PLEASE PRINT PLEASE PRIN

NAME AND ADDRESS	REPRESENTING	Support	Oppose
Betty Wing, Courthouse, Missoula	Montana Advisory Council on Chemical Dependency	X	
Roland Mena	DCHS - MCDC	X	
Laurie Bruce	DCHS ADHU	X	
Rod Robinson	Gateway Recovery Center - Great Falls	X	
Kathy McGowan	CDPM	X	
Pat Melby	Rimrock Foundation	✓	

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HOUSE OF REPRESENTATIVES
VISITORS REGISTER

Human Services & Aging DATE March 1, 95

BILL NO. SB 84 SPONSOR(S) Christaens

PLEASE PRINT PLEASE PRINT PLEASE PRIN

NAME AND ADDRESS	REPRESENTING	Support	Oppose
Norma Jean Boles	DCHS - ADAD	X	
Betty Wing, Courthouse, Missoula	Advisory Council on Chemical Dependency	X	
Roland Mena	DCHS - MCDC	X	
Carol Brown	DCHS - AWHIS	X	
Kathy McGowan	CDAM	X	
Bob Olsen	MHA		X
Pat Melby	Rimrock Foundation	Neutral	

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