

**MINUTES**

**MONTANA HOUSE OF REPRESENTATIVES  
52nd LEGISLATURE - 2nd SPECIAL SESSION**

**SUBCOMMITTEE ON HUMAN SERVICES & AGING**

**Call to Order:** By DOROTHY BRADLEY, CHAIR, on July 7, 1992, at  
10:15 A.M.

**ROLL CALL**

**Members Present:**

Rep. Dorothy Bradley, Chair (D)  
Sen. Mignon Waterman, Vice Chairman (D)  
Rep. John Cobb (R)  
Rep. John Johnson (D)  
Sen. Tom Keating (R)  
Sen. Dennis Nathe (R)

**Members Excused:** Rep. John Johnson

**Members Absent:** None

**Staff Present:** Carroll South, Senior Fiscal Analyst (LFA)  
Bill Furois, Budget Analyst (OBPP)  
Billie Jean Hill, Secretary

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

**Announcements/Discussion:**

**HEARING - SOCIAL AND REHABILITATION SERVICES**

**CHAIR BRADLEY** announced that we are prepared to hear the hospital  
bill until noon.

**Julia Robinson** stated that not having the 2% hospital tax will  
force Social and Rehabilitation Services to make more drastic  
cuts. A sales tax is the answer, but the fear is it will not be  
passed. So much hope is for the sales tax that it will not be  
able to do what is hoped. We do not have excellent social  
services programs any more. Bad infrastructure for state of  
800,000 population, 50,000 less than ten years ago. Montana is  
in the top four of increases in AFDC benefits last year. The  
state could not afford to increase them. We are in top two of  
increases in General Assistance. Because of that we have a 25%  
increase of people from out of state. The following are a few  
ideas for the future. There are too many human services agencies  
at the state level. One fine umbrella agency would improve  
coordination in the state, would take care of financing problems  
with programs, would allow corrections to handle correction

problems, would free up mental health and substance abuse so that they could be part of a health agency. We could do comprehensive planning as far as health lines. This has to be looked at in January. The good social agencies in this country are umbrella agencies. There is a structural problem between S.R.S. and D.F.S. We have to eliminate some programs that Montana has that no other state has. Very few states have G.A. programs left that we have today. We are talking about reducing the months. We increased the months last year and as soon as you do that the rolls went up. Recommending the elimination of G.A. is the kind of choice you're going to have to make in January. We're asking that you cut State Medical even further than the \$1.0 million in the budget. After we have changed the Hospital Tax, we will have to recommend that we trim State Medical another \$2.0 million and all that will be left is a very small program in the 12 assumed counties, a Block Grant Program that we hope the hospitals would work on with us. Look again at taxes on providers to generate money. Many states look at these taxes just for the general fund. For now let us look at the original hospital tax proposal so that everybody understands if you bring in the 2% tax that creates \$14.0 million it goes to a special health care revenue. That \$14.0 million creates \$35.0 million in new federal match money, all of which we were going to dedicate to health care after this first time. That is \$49.9 million in new money for this state. Hopefully, the Hospital Association would look at the options and would want to be part of the planning process. We changed the bill so this would be in our budget, and would have to be approved next January. This is not going to happen. Next January the S.R.S. will be at least \$3.0 million lower than the current base, because without some kind of revenue, it is not possible to build new programs. The only increase in the budget is to the hospitals because we had made a commitment to them. We will be putting in \$1.6 million for rebasing. We also have \$200,000. for the residency program. Because those are increases, there are \$5.0 million in cuts. We are concerned about rural hospitals, but they do have excellent administrative staff. They run well; many have excellent revenues. Programs left out of our budget in January are food stamps, developmental disabilities, some foster care programs. I refuse to put that set of cuts in this budget. That is why we have this proposal for a tax. The governor gave us the option of picking what set of cuts we were willing to support and defend. This is not the Governor's choice. He's backing us. This is our choice, because I simply will not one more time offer up programs that cannot stand that financial impact. There are three proposals. The original proposal would have worked. There was some Block Grant money for rural hospitals. The Block Grants would have been substantial. They would have shored up the rural facilities. That proposal is gone. Today we are proposing a 1% tax, and we will suggest that you cut \$2.0 million from state medical. We will hold the hospitals harmless. We are putting a rural block grant to hospitals in the mid-category in counties with populations 2500, to 19,900, and the small rural hospitals and counties with 2500. or less we will ask for a waiver and they

will not be taxed. We have told the hospital association we will increase their medicaid rate. We will stand by what we told the hospital association we would do. The kinds of things eliminated when calculating the tax are cash discounts and bad debts, uncompensated or charity care or contractual allowances. Psychiatric hospitals will not be taxed. They already pay taxes with the exception of Shodair and one of the psychiatric hospitals in the state does not get Medicaid, so it would be impossible to pay them back. Medical assistance facilities in selected rural hospitals, revenue from nursing homes that combine hospital facilities because we put a bed tax on last year. That's meant a substantial increase in nursing home rates in this state. It's not enough of an increase. It's not enough of an increase and will probably face a lawsuit. The people who benefited most from that tax were the combined facilities with hospitals. They opposed the tax the most as it moved through the session. See EXHIBITS 1 AND 2.

**CHAIR BRADLEY** introduced **Jim Ahrens, President, Montana Hospital Association.** See EXHIBIT 3.

**SEN. KEATING** commented that so far no plan. He will start with the nursing homes and address **Rose Hughes,**. We needed to get a waiver from the federal government in order to implement the taxing of the nursing homes to get the money to increase. We used federal money as federal matching in order to get more federal money and we were only able to apply that to the Medicaid portion of the nursing home users. Then after Montana put it into place, the feds legislated against any more of that. Does Montana continue that practice in the ensuing years?

**Ms. Hughes** replied that the federal government adopted some regulations which set the criteria for the provider tax, such as the nursing home tax. The tax in its current form will not continue. It will change. It has to be more broadbased so that it applies to all the patients of nursing homes not just the Medicaid or it has to be more broadbased so that some of the income comes from outside the providers. So if there were some way to get income other than nursing homes, you would not have to apply it to the non-Medicaid patients. There are options that are there to continue the bed fee, but some change will have to be made in it, and the date is next July or possibly October.

**SEN. KEATING** replied that by the end of the next biennium we are going to have to be looking at some change at how we fund the nursing homes for the Medicaid patients. Since we are going to have restrictions on the federal aid that we have received in the past, we are going to have to come up with more money some place in order to obtain that standard that we have set in the last session.

**Ms. Hughes** replied that there will even have to be a change in the way the tax operates, or there will have to be an addition to the general fund. Something will have to be done to maintain

that level.

**SEN. KEATING** stated that we will have to tax somebody other than Medicaid patients. **Ms. Robinson**, you said there was a window of opportunity whereby we could work a similar tax or revenue for match to obtain federal money, but it would be a one time shot, and it requires a federal waiver. Then if they don't give the waiver, we won't be able to apply the tax for the federal funds you are talking about. Or if they do approve the waiver, and they get wise to what is going on, they change their plans. Then we are stuck with a one time shot and we are stuck with a tax and we are stuck with higher costs and other programs.

**Ms. Robinson** answered that we are stuck with higher Medicaid costs under any of those scenarios. We have to pay usual and customary costs. How are you going to finance these large increases in Medicaid programs when the federal government continues to mandate more services and increases eligibility. The waiver that we got last year when was some question whether we would get a waiver, the bill was under question, we had no trouble getting a waiver. We've had no trouble getting a rural waiver on the proposal that is before you today. You never know that until you apply. The law allows waivers; this administration is interested in helping states do what they need to do. Biggest fear in this state is the government saying that a state can only raise 25% of their Medicaid revenues with provider taxes. The next thing they will do is just cap wherever you are and say you cannot increase this again ever with provider taxes. They will probably cap the Medicaid programs like they did with Title XX, and states will be obligated to finance these programs with entirely general funding.

**SEN. KEATING** said that with your first scenario of the 2% tax and the \$40.0 million return of federal funds would there have been winners and losers in the hospital because of the disparity in treating the Medicaid patients. Medicaid is an entitlement. Medicaid patients can walk into the hospital and say they are sick and demand that the government pay for the treatment. Is that right?

**Ms. Robinson** replied that they got treatment, if they were eligible. There are winners and losers and many more than in the current proposal and still winners and losers today. Billings Deaconness does not deliver babies. And the largest piece of the population is AFDC and babies. You can tell who are the biggest winners by whose delivering babies on these charts. Senator Eck wants to increase eligibility from 130% to 180% so we will be paying for almost half of all babies in Montana when we do that. By setting up the special health care we will sit down with health providers and put together a package that will fit with the original package. It was what we could in Montana to improve health care. All health care providers are winners when we do that.

**SEN. KEATING** asked if there was anybody here from St. Vincent's Hospital in Billings? St. Vincent's under one of these scenarios would be a \$26,000 winner. We are talking about \$26,000 of flow-threw. My question goes to the administration of this money. Would you have to put on a couple of \$25,000 people to handle the paper work for this plan in order to save the \$26,000?

**St Vincent's Hospital, Billings,** replied that he had not seen the specifics of how this might work, it is difficult to answer the question. We have calculated that the impact might be \$1.4 million to the negative. At the time the charts showed us to be winners by S.R.S.'s calculation. How are the numbers arrived at? The flow through numbers are not close to what we can call to mind at St. Vincent's as to how it is calculated. We have come up with radically different numbers. We are probably the largest baby deliverer in the state and if we are going to be a winner by doing that, we cannot figure just how.

**SEN. KEATING** asked if there was an increase in cost of administration.

**Don Fager, Administrator, Dillon Hospital,** discussed his concerns about the different hospital proposals and administrative cost.

**SEN. COBB** asked **Hank Hudson** where the numbers came from that were generated by the Medicaid Division.

**Kip Smith, Section Supervisor, Medicaid Division,** chose to answer about the numbers. There is confusion about how tax is calculated. We used 1991 medicare cost reports as submitted to Blue Cross-Blue Shield, the medicare intermediary, and from that information on gross revenues we deducted the amounts again that were submitted on both reports or on their financial statement for that period of time that are exempt from the tax. That information was trended forward from 1991 by factoring 8% per year and that trending factor was based on historical increase information provided by the Hospital Association information and also information from the Montana Hospital Review System for 1991 through 1993. That was how we came up with that trending factor. If there is still confusion over those numbers, we are willing to work with those hospitals or hospital associations. Medicaid cost information and medicaid payment used to calculate the payment increase and came from 1989 audited medicated cost reports, and then we are trying to forward by a whole variety of factors that have also been provided to the Hospital Association, and we have provided them to individual hospitals if they don't have them.

**SEN. KEATING** asked if medicaid figures change frequently in the way that they pay for services?

**Mr. Smith** answered that in terms of individual hospitals those things can change. Calculations we make on these present will be different in six months.

**SEN. KEATING** asked **Jim Ahrens** if they have ebb and flow of medicaid patients in the various hospitals or do you find that the medicaid patients tend to congregate in specific areas.

**Mr. Ahrens** answered that the bulk of medicaid work in hospitals is probably done in 13 hospitals, probably 7 hospitals. But there is fluctuation with the economy. People that might have had 5 and 1/2% a year and a half ago, now 10%. There is a concentration in larger hospitals of medicaid patients because that is where the population is.

**SEN. KEATING** stated that no place do we see a decrease overall in medicaid services.

**Mr. Ahrens** answered that they are increasing. It's more a percentage of our business each year.

**SEN. WATERMAN** stated that she had one concern on the hospital tax. With the reimbursement rate increase in a few years with the growth in medicaid, the cost of the reimbursement is going to outstrip the money the tax brings in. So by the biennium after next we may have to put additional general fund money into this program to fund it. **Ms. Robinson**, can you comment on this

**Ms. Robinson** answered that problem has been taken care of.

**SEN. WATERMAN** asked **Mr. Ahrens** if the Hospital Association would be supportive of this tax if all of the money went to health improvement and rural access improvement.

**Mr. Ahrens** said that it would change the debate.

**SEN. WATERMAN** asked whether he would oppose this tax no matter where the money went or are you opposed because it is going to the general fund.

**Mr. Ahrens** answered that we don't know what this study is about. If we are going to use the money for health care reform, the uninsured, and do it for health care programs, that is a different discussion. We would support it. We would certainly talk about it. It would be on a higher level than we are right now. We're committed to better health care. We've done things in rural areas. We'd certainly be will willing to sit down to a discussion on these subjects.

**CHAIR BRADLEY** asked **Ms. Robinson** to answer some of these questions that were raised from **Mr. Ahrens** testimony, and give us some answers to these questions. For example, how would you get the medicaid funding to the hospitals and can you secure a federal waiver. On what criteria is this waiver based, except some kind of Department of Agriculture determination of what a rural county is. There has to be some kind of fair criteria about who gets taxed and who doesn't and we need a federal waiver to do this. We don't want to get into litigation.

**Gregory Gould, Attorney, S.R.S.**, replied for Ms. Robinson. The bill as we are drafting it exempts rural hospitals and that is defined according to certain classifications made by the Department of Agriculture according to the number of urban residents in a county with hospitals located. The federal statute which was passed in 1991 allows states to receive a waiver from certain divisions of that bill. One of the provisions is that the tax must be uniformly imposed and it has to be imposed on all providers within a certain class, hospitals in this case. So we have inserted in the bill requiring the S.R.S. to seek a waiver allowing the exemption of the rural hospitals. We've received some policy material from the Health Care Financing Administration which discusses this waiver and suggests an exemption of rural hospitals. We do not know what criteria they will use in reviewing the approving of waivers, but we have some indication that will look favorably on the waiver request.

**CHAIR BRADLEY** asked if other states have used this same differentiation?

**Mr. Gould** answered that it too early to tell. Health Care Financing Administration is in process of developing regulations under the act and one of the areas they will be addressing is waivers and what criteria is for the requests.

**Ken Fleming, Commissioner, Powell County**, asked if you are exempt on rural hospital if the urban area if 2500 or less.

**Mr. Gould and Mr. Fleming** discussed this item at great length.

**CHAIR BRADLEY** asks **Ms. Robinson** about the business of no more Health Planning Commission and instead a Block Grant Program. What are the mechanics; who gets it?

**Ms. Robinson** answered that the Block Grant Programs go to those counties that are between 2,500 and 19,999 population and the same criteria from the Department of Agriculture. The intention of those Block Grants was to assist with rural access. Some people obviously get an increase, some helps cover the tax. We would have liked to make those Block Grants significantly larger. The problem for Montana is that most of it is rural, and we would have liked to exclude the group between 2500 and 19,000 because we cannot do that because of the complicated formula Medicaid uses for payment. By not paying them actual costs, we hope that we can provide them Block Grants. This would be a cash grant from S.R.S. to the hospital - one time. This is not in perpetuity, and this bill sunsets in July of 1993.

**Commissioner Ken Fleming, Powell County**, summarized his statements by saying that he did not know why Powell County had to pay any taxes at all, because they simply could not afford them.

**Carl Hanson, Administrator, Pondera Medical Center,** stated that they did not know where they were with this bill. They have a problem with cost-shifting and we have two places to go to make up that money. 1). We can go to the county, but they have nowhere to go to find the money. 2). Charge more to private pay patients. The physician he was recruiting was concerned with the provider's taxes in Minnesota, so would not welcome a tax in Montana. He is opposed to the tax.

**SEN. KEATING** asked what else kept hospital going besides medicaid, and third party pay, and private pay. What else?

**Mr. Hanson** The county levies taxes on property owners in the county. We received \$180,000 last year. That is 3 1/2 or 4%. No charitable resources of any significance.

**REP. COBB** asked if the hospital or county tried to leverage that money for medicaid money. Could you use any of that money to try to match medicaid reimbursements or does the state pay you for medicaid reimbursement. Does the county ever try to get federal money using that match money?

**Mr. Hanson** answered that in the 1991-92 Fiscal Year four mills were levied through the poor fund to help make up the deficit in the nursing home. That resulted in \$45,000. We did receive that and although it was earmarked for long term care, it was put in with the rest of the money.

**Cal Winslow, Deaconess Hospital, Billings,** wants to make four points. Deaconess Hospital, Psychiatric Departments, is a non-profit hospital and is tax-exempt. Psychiatric Department has become dumping ground for adolescents. For-profit hospitals are sending adolescents to non-profits, because they no longer get the reimbursements they did. They are also tax-exempt and the non-profits are not. If the tax went through, and the psychiatric department would be exempt, it would at least be a little less painful. It would make about \$120,000 difference. The feds are going to have spend more money, and will they approve the waiver and will they approve it. It has to pass by November 1, when that tax goes into place is a real question. You are also being asked to increase medicaid reimbursements for future legislative sessions. It also appears that having reserves is bad management. We think it is good management. The profits are from the community. We're talking about a community facility and the reserves are there to see those reserves exist for the community. The reserves are important today because of the uncertainties of Medicaid and Medicare reimbursements and those reserves keep the cost of the delivery down. Also 15% of our patients come from out of state. They come because we have facilities of quality and they are based on the reserves. There has been some focus on dollars and not on margins. You look at the net profits that are coming out of even larger hospitals. They may look like larger dollars, but if you look at margins, they are not large dollars. We have some problems on

classification. In order to be constitutional, it has to be a fundamental right or it has to be a rational relationship. There is not a rational relationship between 2500 people in a county and profitability of a hospital. The profitability of a hospital is based on a case mix, the kind of patients you have, the kind of reimbursement you have, the kind of management you have. We do not believe that using 2500 population is a rational and dependable position. One percent is just a way to get into the door and if it gets to the end of the session who knows where it's going to end up. We don't question the sincerity of the people; we just think they are sincerely wrong. This is just a bandaid approach and we need to look at something that will help the state of Montana. Hospitals are willing to be players, but not be the singled out industry.

**REP. COBB** stated that if bill dies, then waiver dies.

**SEN. KEATING** asked about the timing of the waiver. We are imposing a tax which would be applied. However, the validity of the formula is determined by the ability to get a waiver and we heard testimony may take 2 months or 2 years. It may be granted and it may be rejected depending upon what happens to the waiver. The money is being collected and the budget is being adjusted according to that formula subject to the obtaining of the waiver. Is that correct?

**Mr. Gould** replied that under the bill the first tax collection would not occur until after the first three months. At the end of January you would have the first calendar quarter and at the end of February the first payment would be due. The way that the waiver provision is written the waiver must be approved prior to November 1, in order for the tax to take effect. There would be no revenue collected under the tax if the waiver did not include prior to that date. So we would not have money paid by the hospitals and have them unable to recover it later.

**SEN. KEATING** stated that if the waiver is delayed or rejected than the plan does not go into effect and we are looking at a hole in our budget.

**Nancy Ellery, Administrator, Medicaid Division,** stated that she can clarify the Medicaid process. The government is required to act on a request from a state within 90 days, so when the tax is to be collected, we feel that there is plenty of time to get action from HCFA on the waiver. The Oregon waiver takes a long time. It is a very comprehensible change to the whole Medicaid system that has implications for the country as well as to the state. This is a fairly routine request for a waiver. HCFA and their guidelines have indicated this would be the kind of category on which they would entertain a waiver for hospitals. They are required to act within 90 days.

**Christine Tremain, Director of Social Services, Central Montana Medical Center, Lewistown, See EXHIBIT 4.**

**REP. COBB** asked Christine Tremain to work together to get numbers to coincide with S.R.S.'s numbers before she left. He would like to know where they were at point of grant.

**SEN. KEATING** asked if they had other sources of funds besides patients?

**Ms. Tremain** replied that they had reserves. They are not large and could wipe them out tomorrow.

**SEN. KEATING** asked what sources are your reserves.

**Ms. Tremain** replied that the sources of reserves are donations, memorials.

**SEN. KEATING** asked if you were skimming patient charges to put into reserves. These reserves are from some other source of revenue. Any county support?

**Ms. Tremain** replied that they received no county support, but it was an option. We would be looking at a county tax to support the hospital.

**SEN. KEATING** stated that when he looks at that chart is the axiom that if you want more of something, you subsidize it, and if you want less of something, you tax it. If we start taxing hospitals, we may have less of them, and if we continue to subsidize medical services, we are going to have to provide more of them. We have to work a balance in all of this, so that we take of the needy and those who cannot take care of themselves. But we do not want to drive out the providers.

**Kyle Hopstad, Administrator, Deaconess Hospital, Glasgow,** stated that they are talking about health care systems for these communities and how fragile they are. They include Home Health Care, Health Education and so on. It is not just an in-patient facility anymore. We are tinkering with a system that controls all health functions and we don't realize what it could do in recruiting health professionals. We may lose who we need to recruit and not be able to retain who we need to retain which will jeopardize our reserves and our financial liability as a community. This cannot be done in a two week period of time. It needs discussion and debate, a lot of thought and a lot of foresight. This could adversely affect rural access, because of the providers we won't have, or attract.

**REP. COBB** stated that he would go back to the original intent which was to get that federal match money, because if they cap our money, we'll be putting more general fund money in medical services when it should be used for education. This all started so that we would not have to cut other services and try to get money so that we don't have hospital suits. We need to pay correct rates in the future, and free up money for education.

Mike Billings, S.R.S., Director, Office of Management, Analysis and Systems, see EXHIBIT 5.

SEN. WATERMAN asked what positions would be left vacant?

Mr. Billings answered that every position that becomes vacant remains vacant. No way to figure which positions will become vacant. There is a level of expertise in some positions that would make a vacancy critical. We would have to spread the load, because that vacancy is vacant for 120 days. We would have to train someone new.

CHAIR BRADLEY asks about loss of federal dollars.

Mr. Billings said that general fund loss is 35% of the total.

CHAIR BRADLEY asked if that was what you would end up with, or can you skirt that?

Mr. Billings said it depends on how they are able to allocate programs, if they fund them at 35% or maybe 25%. The loss will be there and we have not reduced the budget or the loss in dollars. We do not know what that will be. When you talk about 50 positions, you are talking about \$1 1/2 million and 35% is general fund. We will be turning back a lot of federal money. There is no exact estimate.

CHAIR BRADLEY asks about the flexibility issue. What would maximum flexibility do to the Department? What is the best way to track that, and how can you assure the committee that meets here next January that you have not abused it? Are you willing to work with the analyst in documenting your flexibility if we give you? How much good would it do you? It is a time of crisis, and is it the right thing for you to do?

Mr. Billings replied that they had thought about flexibility you obtain when you do not have to worry about personal services versus operations and equipment. Agencies try to find ways of maximizing agency resources and the use of agency resources. It would be easier for them to work more efficiently by moving the money back and forth without worrying about whether personal services is up here and stays up here and regardless of how long you keep those positions open, the money does you no good. Agencies live by their wits. There is a great bounty in government that would improve government, if we would do a lot more automation. In S.R.S. we could not function without our computers. One of the reasons we proposed substantial reductions in personal services is because we can backfill with more productive use of the equipment we have.

CHAIR BRADLEY asked if it was appropriate for you to work with Mr. South and Ms. Smith and the departments as much as possible. Is it possible to come up with the right flexibility language that should be incorporated.

**Ms. Robinson** stated **Mr. Billings** mentioned data processing and flexibility. But when you have to decide between contracting and personal services, sometimes you might be able to hire somebody for a short term on a contract that will take care of that position, and you can put that position somewhere else. We are now managing more positions than we are budgeted for, and now we will be managing less.

**SEN. KEATING** asked if the 900 employees mentioned were FTE slots or about warm bodies. Legislators forget that FTE slots does not necessarily mean somebody is there. Slots may be in personal services budget that are empty, and that is because there is a mandated vacancy savings. The Legislature gives the money and takes it back.

**Ms. Robinson** replied that there were 900 employees when she became the Director of S.R.S. The number they are talking about now are F.T.E. slots. The federal number **CHAIR BRADLEY** is looking for is \$375,070.

**Mr. Billings** stated that when **Ms. Robinson** came in March, 1989, we had 923 warm bodies, some part-time F.T.E. slots, and some temporaries. The appropriation for the 1991 Legislature for the current biennium is at 909 actual F.T.E. slots for this year.

**SEN. KEATING** asked if they have time-share jobs? How much extra cost that is in insurance, and retirement that go with that time-share with a single employee.

**Mr. Billings** replied that there are a few time-share jobs, and the cost is minimal.

**Carroll South** explained the Budget Worksheet. See EXHIBIT 6. Hospital Tax is no longer relevant, and the State Medical will not be relevant before long. The first two accurately reflect the present status of the Executive Budget.

**SEN. KEATING** asked what comprises the other funds under number two AFDC?

**Mr. South** stated that it is a combination of county funds and federal funds in non-assumed counties that match the AFDC payments.

**SEN. KEATING** said that when you say a match by non-assumed counties, are you saying that the non-assumed counties would reduce their expenditure?

**Mr. South** replied that they calculate the county cost at 1.6% of the total.

**SEN. KEATING** asked if the other fund, \$1.3 million, 1.6% is county dollars which they would not pay?

**CHAIR BRADLEY** asked for motion to accept #1, General Budget Reduction, on the Executive Budget, on Operations.

**EXECUTIVE ACTION OF #1 GENERAL BUDGET REDUCTION**

**Motion/Vote:** REP. COBB made a motion to accept #1 General Budget Reduction.

**Vote:** Motion carried unanimously.

**Mr. South** stated that the Executive has a plan. I will try to articulate that plan for you, so that we know what the ground rules are when we meet with the Department. State law prevents an agency from transferring more than 5% from program to program. The Executive would increase that to 10%. State law also prevents an agency from transferring from one first level expenditure category to another more than 5%. From personal services to operation from operation to equipment. The Executive would like to eliminate that law during F.Y. 93 - not in the long term, but just for this year. The appropriation bill has language in it that prevents an agency from transferring any personal services money to any other category with a few caveats. The Executive proposal is to eliminate that altogether so there would be no limit at all relative to what could be transferred between personal services operations and equipment. There is also the six month provision for vacant positions. If the position has not been filled in six months, it can be eliminated. The Executive would like to take that out of the appropriations bill.

**Mr. Bill Furois, Budget Analyst,** stated that there is one more thing and that is the language in House Bill 2 that says the LFA sheets are the legislative intent. There is no law that says we cannot move money from benefits to operating. But there is that intent language and the Budget Office is real hesitant to do that. There was an example in S.R.S. during F.Y. 92, the just completed year where they were able to spend a little in contracted services and save \$600,000 general fund. They actually came up with a very savings. That required us to think about moving money between those two. But the Budget Office did not want to do that because of the language saying legislative intent is this money is for benefits, this money is for operating. So we were asking to get rid of that language as well, or at least loosen it to where it's intent was where it could be moved. All this is for just this fiscal year.

**CHAIR BRADLEY** stated that the best thing would be to discuss this tomorrow, and find out what our guidelines and requests are for appropriations committee when our full recommendations must be done and over with in the subcommittee and we move onto the rest.

**Mr. Furois** said that what the Executive is asking is that we loosen all management restrictions. Obviously, there is going to be compromising situations.

**CHAIR BRADLEY** said that she is interested in pursuing that, but need examples about how that is going to happen and why she should advocate it.

**REP. COBB** said that he needs to be convinced on how you will be better managers.

**Mr. Billings** asked if you were looking for specific kinds of things.

**CHAIR BRADLEY** asked if **Mr. Billings** would put those requests above mentioned in writing. We must leave Operations and move immediately into Welfare.

**Ms. Robinson** asked to clarify a few points. Charts are inserted into **Roger LaVoie's** presentation as help in your deliberations. There are suggested reductions in AFDC and GA. Both programs were increased in July, so this will be a cut from an increase. The AFDC is designed so that participants can keep more of their income if they work. We have a program to change day care. We have a program now called self-initiated day care, and we do not have a day care called at-risk. Self-initiated is to allow participants to go to school, and at-risk is self-explanatory. Because we are encouraging people to go to school, we are providing funds for both day cares. There a number of people here to testify for these day cares. We need outside assistance as to whether these day cares are feasible. We are opening the at-risk day care at this very moment. We have worked out an arrangement with Billings United Way. They will be providing the match money, so that we can at least offer this program in Billings. We have also talked to the other United Ways in Montana to see if they would provide the match money for other United Way matched day cares. In this way we can match the day care and improve the size of the program. Another option we are looking at in this area is to match the Child Protection Day Care at D.F.S. This is not worked out yet. We were able to match that money that we would not see any change in the self-initiated program. We have no desire to reduce day care. It needs to be provided in the future to keep people working and going to school, but we are seeing how we best allocate it. The other part of this proposal is to mitigate the cuts in the General Assistance Program. We do not save any money in this proposal. We are trying to beef up the Project Work Program. We would put substance abuse counselors at every Project Work site. We tested that here in Helena with the Department of Corrections and Human Services. This is very effective, and they've asked for counselors in every other program, but so far we have not been able to fund it. Generally, people are on General Assistance, because of some substance abuse problem. We are putting together a better training program called GRASP. The final change which is a major change in order to find the additional money from the change in the tax proposal this morning is that we would eliminate State Medical altogether. \$100,000 would go to the GRASP program so that people who were getting General Assistance

and in Project Work the programs would have money to fund supportive services, for example, eye glasses, doctor's physical. Those programs could make those decisions with a client and pay for them. \$3.0 million would be the actual cut to the general fund. You have \$1.0 before you and the proposal is for another \$2.0 million. The remaining \$2.0 we would allocate that to the counties by changing the mill levy. The assumed counties are different from the non-assumed counties in that assumed counties send us their mill levy and we have assumed them. One of the things we have agreed to do is to provide State Medical Programs as part of that assumption. So if we are not going to be doing State Medical, we feel we must return that money to the counties. The counties can either use that for a medical program, or for whatever. We've learned from looking at assumed versus non-assumed counties that non-assumed counties medical costs are considerably less than assumed counties. We have run a comprehensive program similar to Medicaid. It is clear that we cannot continue to afford everything. This effects 12 counties, instead of the whole state. It makes the services comparable to the non-assumed counties. It saves considerable general fund dollars, and it continues to grow. We've kept it stable, but it is 100% general fund, and we have not been able to totally stop its growth.

**Roger LaVoie, Family Assistance Division Administrator, S.R.S.**  
See EXHIBIT 7 on AFDC.

Intermittent discussion between committee and S.R.S. staff.

**CHAIR BRADLEY** stated after the presentation on AFDC that she had not seen these new proposals before today. People who are here and most affected by this do not even have copies to read the changes. Let us take informational questions, starting with #1.

**SEN. WATERMAN** asked how many individuals would lose AFDC and Medicaid eligibility with the reduction in benefits percentage. Do you have that number?

**Penny Robb, Bureau Chief, Family Assistance Division,** answered that if the reduction in the poverty level is the only change made by this committee, approximately 50 families would lose AFDC eligibility a month. Fifty caretaker relatives, if they are single parent families would lose medicaid eligibility but the children would not.

**SEN. WATERMAN** asked if we were to implement the whole package, how many would lose AFDC benefits?

**Ms. Robb** answered none. It is a better benefit then families receive now. Families who would currently be closed, because of earned income will no longer be closed because of earned income.

**Ms. Robinson** said she would take total responsibility on the time

limit of benefits. It was specifically asked by the budget office that we put that in there. The reason being is that if this program works correctly and everybody goes to work, than it would cost the state of Montana less money. That would be a benefit to the state, because these are people who are working their way off welfare.

**SEN. NATHE** stated that what **Ms. Robb** is saying is if we just take Item 1 by itself, we will drop 50 families a month off of AFDC, but if we take Item 1 and Item 2 change in the methodology, than no one gets dropped off AFDC.

**Ms. Robb** answered yes. But 86% would have a decrease in benefits. Only about 14% are currently able to work.

**SEN. WATERMAN** asked if they had worked out those numbers of what happens if we leave the benefit level at 42%, but we implement #2. The Standard of Need adjustment is one talked about during a regular session, and there was a study of Standard of Need going on. Is this the recommendation from this study?

**Ms. Robinson** said that their recommendation is considerably higher. The state would have raised the Standard of Need. The cost of this program has gone up astronomically because than you can stay on welfare much longer while you are working. That is a proposal that we had in our budget package, but it is not in there for January.

**SEN. WATERMAN** asked what that Standard of Need would be if we didn't lower it to 48%, left it at 42%, what would be the budget implications?

**Ms. Robb** stated that the Standard of Need is not proposing to drop. The only thing that is dropping to 38% is the payment grant.

**Ms. Robinson** asked if what **SEN. WATERMAN** wanted to know is if we left the grant the same and changed the budget, what would that cost? That will have to be calculated by morning.

**REP. BARNHART** asked if it mattered how old the child was on AFDC?

**Mr. Lavoie** replied that they had not worked it out to that extent.

**CHAIR BRADLEY** stated that AFDC Time Limits was next.

**Marcia Diaz, Montana Low-Income Coalition**, asked an informational question concerning the 14% they report have income. This does not say these people are necessarily working, and we wonder if the 14% represent people employed or if it is a mixture of people receiving low-level child support. Income from intra-sources are something else and yet the only ones who will benefit are the ones who have job, and we would like the 14% clarified. We

noticed in the Legislative Council study of 1988 they reported 12% with income and they did not distinguish between those working and those having unearned sources of income.

**Ms. Robb** stated that the 14% represented the AFDC households who have income of any kind. This is earned and unearned or a combination of both. In this budgeting methodology it does not matter if it is earned or unearned income. The accountable income would be subtracted from the Standard of Need.

**SEN. WATERMAN** stated that they had better come up with something better than this. It looks like a work in progress.

**SEN. KEATING** stated that there was a comment made that our General Assistance in the counties had increased by 25%, because out of staters were moving to this state because of generous benefits. If we don't have a time limit on our proposals where we see people moving from states that have time limits to this state to take advantage of no time limits, what happens?

**Mr. LaVoie** replied that by time limits he must mean that in the other states they would lose their benefits because some time limit would expire.

**SEN. KEATING** stated California has a six month time limit on their time limit. What states have a time limit?

**Mr. LaVoie** answered that California is just proposing that at this time, and he does not know of any other state having a time limit.

**Ms. Robb** stated that concerning states asking for time limits there are a number of states in the proposal stage yet. Federal waivers to do that kind of reduction have not yet been granted, but they have been sought. In some cases they do have legislative approval to go forward.

**SEN. KEATING** replied that if they get the federal waiver, they'll get the time limits.

**Ms. Robb** replied that was her understanding.

**SEN. WATERMAN** asked how long the federal waiver would take to get this.

**Ms. Robb** said that right now it is a very cumbersome process to get waivers from Health and Human Services. At least six months is the minimum amount of time we are hearing, although Health and Human Services have indicated that they are in the process of simplifying the waiver request process. But as yet we do not have a timetable on that.

**REP. COBB** asked if this total given to us is all general fund money or what is it?

**Mr. LaVoie** replied that the chart indicated total expenditures.

**REP. COBB** stated that \$1.4 million would be available for self-initiated. That is general fund and federal monies. In a Child Protective Services day care that is 100% state general funds where it says \$700,000 or \$600,000, is that all general fund? Are most of those people eligible for Medicaid reimbursement or federal reimbursement? That money on this chart would be all general fund, and on the other charts it is general fund and federal together, is that correct?

**Jack Lowney, Administrative Officer, S.R.S.**, replied that the majority of Child Protective Services is general fund money. The second column, the Block Grant money, is all federal money.

**REP. COBB** stated that 85% of Child Protective Service people would apply for AFDC and would qualify for federal match. Are most of those people on Child Protective Services would they get day care match money, or could you use some of the general fund money to match federal money so there actually would be more money than.

**Mr. Lowney** attempted to explain.

**SEN. COBB** asked if you could get something in more detail by tomorrow.

**SEN WATERMAN** stated that she would be more supportive of these changes if you could come up with a united proposal from the D.F.S. and S.R.S. on what we do with child care. If you can pull that together by tomorrow morning, we will be quite enthused; but if not, then not so enthusiastic.

**CHAIR BRADLEY** asked if we are ready to go on this program. Do you have something on the map? How do you determine what the administrative guidelines are?

**Ms. Robb** answered that they have already determined the rules for the At-Risk Program to define who these children are. The first thing we look at is family income. Our first priority is families who are losing child care because they are transitional. We are going to try to fund this program on a reasonable basis statewide. We thought at least 200 slots.

**CHAIR BRADLEY** asked how are you going to allocate them?

**Ms. Robb** replied that it would be similar to self-initiated. The applications come into the central office and get approved on a priority basis.

**SEN. WATERMAN** asked if she was correct in assuming that we have too few child care dollars and so we are trying to take some child care dollars to provide an obvious area of need in other areas of child care. Is that a fair estimation of what the

problem is?

**Ms. Robb** answered that was a fair assessment of the situation. We are not able to nail down available federal dollars and we need to find the general fund dollars to do that.

**CHAIR BRADLEY** stated that you have first come first serve here.

**Ms Robb** stated that is correct and is one of the priorities on a monthly basis. We believe we won't have enough slots to go around statewide.

**CHAIR BRADLEY** stated that you assume it would run out.

**Ms. Robb** answered yes.

**REP. SQUIRES** stated that she wanted to know what happened here with self-initiated. My concern is that the Department would like to take 200 slots away from the Self-Initiated and put it over to the At-Risk.

**Ms. Robb** answered that these At-Risk slots will be approved on a yearly basis. However, they must re-qualify every three months to show that they are within the income guidelines.

**CHAIR BRADLEY** said that since they are running a program which is obviously first come, first serve what happens to the person who comes in one notch late. Somebody who gets the information a day late is out of it. Do you have a response?

**Ms. Robb** answered that they wish there was more money so that they would not have to put that kind of criteria.

**Judith Carlson, Lobbyist,** said that she could not see the difference between the At-Risk Program and Child Care Block Grant Program which sounds like they serve the same people.

**Ms. Robb** said that the programs are very similar because the Block Grant Task Force drew up the Block Grant Programs so that they were similar to At-Risk, but there are some significant differences. Under the Block Grant Program you could be an AFDC participant and if other child care is not available for you, you could receive it through the Block Grant Program. You cannot do that through the At-Risk Program. You must not be an AFDC recipient; you must be just at risk. Under the Block Grant Proposal you have to put in a work requirement; you have to be a working individual, and it is for low-income working individual. Your could be going to school and working and receive Block Grant money for both those activities. At-Risk only pays for when you are working.

**CHAIR BRADLEY** said that they would now take testimony from 1 through 4. This is on AFDC. Number one, if your testimony is repetitious, keep it short. Number two, if you have alternatives

to help this committee be creative.

**Rev. Bob Holmes** said that his testimony is on needs. What are the needs that can be postponed and what are needs that cannot be postponed. We can postpone roads, perhaps a college education, but when we talk about food and safe housing and medical care, we are not talking about negotiable items. We are talking about survival.

**CHAIR BRADLEY** asked if there were hungry children out there?

**Rev. Holmes** said that not only were there hungry children in Montana, but most people did not know it and would not recognize it. When he was a pastor of a church in Helena, people would come by for food and they would ask first if they had any work they could do. It is false perception that all people on welfare want a free ride. What they want is what we all want, and that is the dignity of work. The situation is worse than it was five years ago, and that is true of the whole country.

**Judith Carlson, Lobbyist, Human Resource Development Council Directors, Montana Chapter of Social Workers, See EXHIBIT 8.**

**Suzanne Marshall, Montana Low-Income Coalition, Boulder,** gave testimony on increased cuts to poor, nation-wide, and the increase in cases of neglect.

**Harley Warner, Montana Association of Churches,** said that most pastors are experiencing a great influx of people coming to their doors asking for assistance. Churches not able to handle influx. Forty Two percent was bad, but 38% is ridiculous.

**SEN. KEATING** said that Food Banks help people a lot, but is there any organization in the church council or any specific way to help people?

**Mr. Warner** said there is not, but the Board of Directors from the Helena Food Bank are made up mostly of church members. Food drives on the first Sunday of each month, etc. are done by most churches.

**SEN. KEATING** asks if that lightens the load?

**Mr. Warner** answered yes, but that only touches the tip of the iceberg. Habitat for the Homeless helps a little bit. They can only build one house a year at the maximum.

**SEN. KEATING** said that the point he wanted to make was that the Christian people in the churches who were giving the charity are also the people who are taxed in order to fund the programs. The people are not able to pay the taxes that we are levying, in order to fund the programs. So remember that it is not my money on which we are making the decisions, but it is somebody else's money we are deciding to spend.

**Mr. Warner** said that you have to remember that not only are a big percentage of the membership of our local congregation charitable people, but they are also a big percentage of the taxpayers. They sent me here, asking you to fund these programs.

**Connie LaVeck, AFDC mother**, said she did not plan on welfare, has seven children, works part-time, goes to school and cannot make it. Please help us.

**Andy Bird, Helena Food Share Board**, answered a resounding yes to the question of overwhelming need today. This paper is published by a department at the University of Montana, and is available.

**Bobbie Forsinger, AFDC mother, Missoula**, said that welfare women do not want to make welfare a life's work. Being on welfare is not attractive. Welfare housing is wonderful in Montana. Welfare doesn't do a bad job, just not enough money. It's not right to take money away from Self-Initiated and put it into At-Risk. Self-Initiated has been on-going for several years. People are graduating and about to finish, and it will become an almost good program, because we're splitting two programs and making two almost good programs. Education is about the best investment, because in the long run it pays off. You won't see those women on the welfare rolls again. Welfare is there to help you through the tough times, and then to go on and be economically self-sufficient. As for day care, latch key care is almost number one for most mothers. Nobody enforces the Child Payment Enforcement Program, but the collections have gone up 7% this year. If it costs money to work, don't work; if you can make money, then work. You can give me more money for Food Stamps, but they don't buy panty hose, toothpaste, Tampax. How can we go out to the world of work when those are some of the basic needs that we are scrounging every month.

**Judy Smith**, states that she is speaking for Self-Initiated child care. She supports At-Risk child also. All the research that has been done in the country and also Montana shows the absolute benefit of investing in post-secondary education to get people out of poverty. The more education you get, the more money you make. So if you are denied the benefit of your education, you get more of a court settlement. So if we are talking about self-sufficiency and getting people off of AFDC, one of the best investments we can make with very limited resources is to encourage them to pursue post-secondary education. We have the opportunity to do that with the child care program as it is now situated. It has improved considerably over the past year. It is refined, perfected. There are people waiting for the number of slots for which we have the funding, 532 slots. Now only 45 of those who applied will get those slots, if we make a change in program. You already have a successful program, so we need to maximize the limited funds of that program. In Missoula they are going out and finding match money for the At-Risk Program. They've approached county commissioners, and we will approach other groups such as United Way.

**SEN. KEATING** asked if Vo-Tech is considered post-secondary? What is your job?

**Ms. Smith** answered yes. Project Manager for the JOBS Program in Missoula.

**Lee Ann Jordan, Welfare mother**, stated that she is a Vo-Tech student. The cut will put her back on Food Share, and no more new clothes. She has 18 hours before she will become an employable person. She is almost successful. Her esteem is back. With these cuts a lot of people will go back to alcohol, and other forms of comfort. Their children will suffer.

**SEN. KEATING** asked how she would be affected by cuts.

**Ms. Jordan** said they would cut out all extras. These are the AFDC cuts.

**CHAIR BRADLEY** stated that they would do the General Assistance now.

**Roger LaVoie, Administrator, Family Assistance Division**, See EXHIBIT 9 on General Assistance.

**CHAIR BRADLEY** asked how many dollars the state saved by trimming back General Assistance on the basis of employability in 1989.

**Ms. Robinson** answered that they saved quite a bit, but no accurate answer until tomorrow. There is no question but that General Assistance is beginning to rise again.

**CHAIR BRADLEY** asked why it is rising again?

**Ms. Robinson** answered that there were two reasons. 1). They liberalized the program last year. 2). More people are moving into Montana from other states.

**CHAIR BRADLEY** asked how that compares to 4 or 5 years ago.

**Ms. Robinson** they are not moving in now like they were in 1989. The program now is smaller than 1989, but it is escalating so very rapidly

**SEN. WATERMAN** asked why people move into a non-assumed county and one of the largest groups is in Yellowstone County. The benefits there are considerably less.

**Ms. Robinson** answered that people moving in there are with AFDC. It is because the cost of living is less than it would be in a comparable state like California.

**CHAIR BRADLEY** stated that any testimony was welcome now.

**Ms. Diaz** stated that they had no chance to think or react on

these proposals, and no chance to counteract it. Jobs are too scarce to go out and find a job to help AFDC grant. Charts are misleading. Telephone discount is misleading. Food Stamps are misleading. Charts make it look better than it is. Appalled by proposals. With the General Assistance moving to 30 days, it will just mean more homeless people. All of the budget cuts are aimed at the poorest people in the state. The budget of S.R.S. is about \$800. million and they are being asked to cut \$2.0, and cannot do it, unless they do it to the poor. We are talking about survival and basic existence of people.

**Diane Sands, Montana Women's Lobbying**, stated that for the record they opposed most of these measures here, particularly lowering the AFDC and General Assistance. If you are going to talk about delaying payments for General Assistance, why not delay highway construction contracts or something like that with more money in it and does not have the kind of human impact that this does. Child Payment Enforcement Programs should be beefed up, because one of the main sources of poverty for women is the failure to get child support. This country has the highest rate of unemployment in eight years, so how can we expect everybody to get a job.

**Marcia Cates, Chairperson, Montana Low-Income Coalition, and Director, Tri-County Advocacy Council, Cabin, Montana**, told story of woman who didn't realize her rights, was afraid to ask, finally died from diabetes complications. She was afraid to ask about her General Assistance and if she had any medical. She was actually eligible, but didn't live to find out.

**SEN. NATHE** asked why we need alcoholic counselors? Are we going to hire them in those ten sites? Are there no places to contract and we are setting up our own counselling now?

**Ms. Robinson** stated that they did contract with Boyd Andrews. and probably will again. It is better to have a counselor on-site so they can work with a client directly when they arrive if they have a substance abuse problem.

**SEN. WATERMAN** asked if the jobs were out there, could you get all these people out there to work?

**Ms. Robinson** answered that people would take some jobs if they had adequate day care, but would go to school etc.

**Mary Ann Wellbank, Administrator, Child Enforcement Division**, see EXHIBIT 10 Child Support Enforcement Division

**REP. COBB** asked if you still collect \$1.25 in revenue for each dollar expended for administrative purposes?

**Wayne Carlson, Revenue Department**, said that with these proposals we would be lowering the return on the dollar, although the

return on the dollar is expected to be greater.

**REP. COBB** asked for a list of time frame when they are going to do this, and how is it going to be done.

**Ms. Wellbank** replied that she would supply him with a list.

**SEN. NATHE** asked where the money was coming from where, withholding a certain charge?

**Ms. Wellbank** replied that the money would come from the revenue that we would raise through collecting AFDC dollars. And that goes back into the state's special revenue. That is 34% of our budget, and 56% is federal dollars.

**SEN. NATHE** asked if they were asking for \$1.9 million more.

**Ms. Wellbank** replied that yes they were, but none was general fund.

**SEN. NATHE** said that \$1.3 is federal money and \$600,000 is going to come out of the AFDC child support collections. You are going to withhold some of this child support?

**Ms. Wellbank** said that they would not. They think that with these projects we can increase our collections. We could collect more AFDC dollars, bring them back into our state special revenue and use that.

**CHAIR BRADLEY** commented that they gave short shrift to General Assistance. They will go through the executive summary and see if anyone has questions. Does anyone have questions on the new program component, the temporary disability in 55 or over? Do you have any information on numbers of people in these categories?

**Ms. Robb** said to look on page 4 of the Executive Budget, and you will see a chart giving the figures.

**CHAIR BRADLEY** asked how long you will serve these people?

**Ms. Robb** answered that they would serve them for six months out of an eighteen month period.

**CHAIR BRADLEY** asked for discussion on chemical dependency counselor and Project Work Program. Asked for comments on foster care. Any questions on time limits? Any questions on start date for applying penalty? decreasing the amount for non-residents? It was stated that some other states have no General Assistance at all. You've reduced it \$50.00. Why didn't you just eliminate it for a few months?

**Ms. Robinson** said that they were just denying a piece of it. The proposal before you does not save any money for the general fund.

During the general session you will probably see amendments to the General Assistance Program.

**CHAIR BRADLEY** asked if anyone had comments on eliminating State Medical Program.

**Ms. Robinson** said that the At-Risk and State Medical were major changes and should have been sent out earlier.

**SEN. NATHE** asked if they had ever heard from the County Commissioners react to this? Have you ever heard from them?

**Ms. Robinson** said that they had not heard from them, but they were sure that they didn't know how large the new cut was proposed to be.

**SEN. NATHE** asked if the \$2.0 million would cover?

**Ms. Robinson** replied that medical costs are going up all the time. We paid \$2.0 in hospitalization last year.

**Mr. South** stated that the worksheets will follow the bill through the process, and it is clear at the beginning at the process we delineate these in such a way that other members of the Legislature will know what the committee has done. If you will look at #2, because of the way the Executive Budget was presented, all of the changes are rolled up into one line. This will not work well tomorrow. We need to distinguish between changes that require statutory legislation and those that don't. Is it going to be one bill introduced to take care of the State Medical and all the G.A. refinements?

**Ms. Robinson** answered yes.

**Mr. South** stated that was all in one bill. The AFDC reduction in payments, and G.A. reduction in payments does not require a bill.

**Ms. Robinson** stated that all the other things like At-Risk, Self-Initiated, Time limit benefits, can be done by the agency without any legislation. Because they will make such a difference, we put them before the Legislature for discussion.

**Mr. South** stated that if there were no dollars in there, would the Executive be requesting language in the appropriation bill. You can do AFDC time limit without statutory change; you can do that as long as the Legislature gives you some instruction?

**CHAIR BRADLEY** stated that **Ms. Robinson** was getting her one piece of information on what we saved on the G.A. modification. Would you get the savings you calculate from the numbers who have left AFDC with the help of the JOBS Program since its inception. S.R.S. will be first tomorrow morning. We will examine the possibility of flexible language late.

ADJOURNMENT

Adjournment: 4:35 P.M.

  
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DOROTHY BRADLEY, Chair

  
\_\_\_\_\_  
BILLIE JEAN HILL, Secretary

DB/bjh

HOUSE OF REPRESENTATIVES  
HUMAN SERVICES SUBCOMMITTEE

ROLL CALL

DATE July 7, 1992 (10-12)

NAME	PRESENT	ABSENT	EXCUSED
REP. JOHN COBB	✓		
SEN. TOM KEATING	✓		
REP. JOHN JOHNSON			✓
SEN. DENNIS NATHE	✓		
SEN. MIGNON WATERMAN, VICE-CHAIR	✓		
REP. DOROTHY BRADLEY, CHAIR	✓		

Draft Copy

Printed 10:59 am on July 7, 1992

LC12  
DATE 7-7-92

\*\*\*\* Bill No. \*\*\*

Introduced By \*\*\*\*\*

A Bill for an Act entitled: "An Act IMPOSING A REVENUE TAX ON HOSPITALS BEGINNING NOVEMBER 1, 1992; AUTHORIZING THE DEPARTMENT OF REVENUE TO COLLECT THE TAX; PROVIDING FOR THE ASSESSMENT, COLLECTION AND REFUND OF THE TAX; REQUIRING PROCEEDS FROM THE TAX TO BE DEPOSITED IN THE GENERAL FUND; DIRECTING THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES TO IMPLEMENT INCREASED FUNDING FOR MEDICAID REIMBURSEMENT OF INPATIENT HOSPITAL SERVICES; AUTHORIZING THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES TO MAKE GRANTS TO CERTAIN HOSPITALS; PROVIDING APPROPRIATIONS; AND PROVIDING EFFECTIVE DATES, AN APPLICABILITY DATE, AND AN EXPIRATION DATE.

STATEMENT OF INTENT

A statement of intent is required for this bill because [Section 16] grants the department of revenue authority to adopt rules necessary to implement and administer [Sections 1 through 15].

It is the intent of the legislature that, in adopting rules, the department:

(1) provide procedures for reporting revenues that are subject to payment of the tax imposed in [Section 2];

(2) establish requirements for the maintenance of records and other documents required to ensure proper payment of the

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HB

revenue tax;

(3) provide a process for the estimation and collection of delinquent or unpaid taxes;

(4) provide a process for the reconciliation of disputes relating to the payment of revenue taxes, and

(5) provide other procedures for the efficient administration of the revenue tax.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. Section 1. Definitions. For purposes of [Sections 1 through 16], unless the context requires otherwise, the following definitions apply:

(1) "Calendar quarter" means the periods of 3 consecutive months ending January 31, 1993 and April 30, 1993, and the period of 2 consecutive months ending June 30, 1993.

(2) "Department" means the department of revenue.

(3)(a) "Hospital" or "facility" means a health care facility, other than a rural hospital and other than a medical assistance facility as defined in 50-5-101, licensed by the department of health and environmental sciences as a hospital with some or all facility beds designated as general acute care hospital beds.

(b) The term includes such hospitals whether they are:

(i) operated as nonprofit or for-profit facilities;

(ii) freestanding or part of another health care facility;

or

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(iii) publicly or privately operated.

(c) In the event the federal government notifies the state that exemption of licensed hospitals without general acute care hospital beds prevents the hospital revenue tax from being considered a qualifying broad-based health care related tax under the provisions of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, Pub. L. 102-234, and any regulations and policies implementing those amendments, then the term "hospital" or "facility" includes all such facilities licensed as a hospital, without regard to general acute care bed designation.

(4) "Report" means the report of revenues required in [Section 4].

(5) "Revenue" means all revenue from any payment source, including but not limited to individuals, insurance companies, medicare, medicaid or other private or governmental payers, for any health care services or items provided within the state by a hospital. The term includes all such revenue regardless of form, whether in the form of money, credits or other valuable consideration, without deduction for the cost of services or items provided, interest, taxes, losses or any other expense whatsoever, except as specifically provided in this section. The term does not include cash discounts allowed and taken on services or items provided, either in cash or by credit, uncollectible accounts written off from time to time, uncompensated or charity care, or contractual allowances for medicare, medicaid and other governmental payers. The term does

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not include revenue accrued with respect to the provision of items or services by a health care facility licensed by the department of health and environmental sciences as a long-term care facility which is associated in any manner with a hospital.

(6) "Revenue tax" or "tax" means the tax required to be paid by hospitals, as provided in [Section 2].

(7) "Rural hospital" means a hospital located in a county designated by the U.S. department of agriculture under its rural-urban continuum codes for metro and nonmetro counties as having less than 2,500 urban residents.

NEW SECTION. **Section 2. Hospital revenue tax.** A hospital in the state shall pay to the department a tax in an amount equal to 1% of the hospital's revenue accrued on or after November 1, 1992.

NEW SECTION. **Section 3. Waiver of federal requirements.** Within 30 days following [the effective date of this section], the department of social and rehabilitation services shall seek a waiver from the U.S. secretary of health and human services, in accordance with the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, Pub. L.102-234, and any regulations or policies implementing those amendments, to exempt rural hospitals from the tax imposed by [section 2].

NEW SECTION. **Section 4. Reporting and collection of tax.**

(1) A hospital shall report to the department of revenue,

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following the end of each calendar quarter, the amount of revenue in the facility during the quarter. The report must be in the form prescribed by the department and is due on or before the last day of the month following the close of each calendar quarter. The report must be accompanied by a payment in an amount equal to the tax required to be paid under [Section 2].

(2) The department of health and environmental sciences shall provide the department with a list of facilities defined in [Section 1(4)], and at the end of every calendar quarter shall provide the department with a list of any changes to the list initially provided.

NEW SECTION. **Section 5. Audit -- records.** (1) The department of revenue may audit the records and other documents of any hospital to ensure that the proper revenue tax has been collected.

(2) The department may require the facility to provide records and other documentation, including books, ledgers, and registers, necessary for the department to verify the proper amount of the tax paid.

(3) A facility shall maintain and make available for inspection by the department sufficient records and other documentation to demonstrate the amount of revenue in the facility subject to the tax. The facility shall maintain these records for a period of at least 5 years from the date the report is due.

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## NEW SECTION. Section 6. Periods of limitation.

(1) Except as otherwise provided in this section, a deficiency may not be assessed or collected with respect to the quarter for which a report is filed unless the notice of additional fees proposed to be assessed is mailed within 5 years from the date the report was filed. For the purposes of this section, a report filed before the last day prescribed for filing is considered filed on the last day. If, before the expiration of the period prescribed for assessment of the tax, the facility consents in writing to an assessment after the 5-year period, the fee may be assessed at any time prior to the expiration of the period agreed upon.

(2) A refund or credit may not be paid or allowed with respect to the year for which a report is filed after 5 years from the last day prescribed for filing the report unless before the expiration of the period, the facility files a claim or the department has determined the existence of the overpayment and has approved the refund or credit. If the facility has agreed in writing under the subsection (1) to extend the time within which the department may propose an additional assessment, the period within which a claim for refund or credit is filed or a credit or refund allowed in the event no claim is filed is automatically extended.

NEW SECTION. Section 7. Penalty and interest for delinquent taxes -- waiver. (1) If the tax for any facility is not paid on or before the date upon which the report is due under

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[Section 4(1)], a penalty of 10% of the amount of the tax due must be assessed unless it is shown that the failure was due to reasonable cause and not neglect.

(2) If any tax due under [Section 2] is not paid when due, interest is added to the tax due at the rate of 1% per month or any part of a month from the due date until paid.

NEW SECTION. **Section 8. Estimated tax on failure to file.** (1) If a facility fails to file the report as required by [section 4], the department may make an estimate of the taxes due from the facility from any information in its possession.

(2) For the purpose of ascertaining the correctness of any report or for the purpose of making an estimate of revenue in any facility where information has been obtained, the department may:

(a) examine or cause to have examined by any designated agent or representative any books, papers, records, or memoranda relevant to the information required to be included in the report;

(b) require the attendance of any officer or employee of the facility with knowledge of the information required to be included in the report; and

(c) take testimony and require production of any other material for its information.

NEW SECTION. **Section 9. Tax review procedure.** Section 15-1-211 applies to the tax imposed by [section 2] .

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NEW SECTION. Section 10. Closing agreements. (1) The director of the department or any person authorized in writing by the director may enter into an agreement with any facility relating to the liability of the facility in respect to the tax imposed under [Sections 1 through 16] for any period.

(2) An agreement under this section is final and conclusive, and except upon a showing of fraud or malfeasance or misrepresentation of a material fact:

(a) the agreement may not be reopened as to matters agreed upon or modified by any officer, employee, or agent of this state; and

(b) in any suit, action, or proceeding concerning the agreement or any determination, assessment, collection, payment, abatement, refund, or credit made in accordance with the agreement, the agreement may not be annulled, modified, set aside, or disregarded.

NEW SECTION. Section 11. Credit for overpayment -- interest on overpayment. (1) If the department determines that the amount of taxes, penalty, or interest due for any year is less than the amount paid, the amount of the overpayment must be credited against any taxes, penalty, or interest then due from the facility and the balance must be refunded to the facility or its successor through reorganization, merger, or consolidation or to its shareholders upon dissolution.

(2) Except as provided in subsections (2) (a) and (2) (b), interest is allowed on overpayments at the same rate as is

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charged on delinquent taxes due from the due date of the report or from the date of overpayment, whichever date is later, to the date the department approves refunding or crediting of the overpayment. Interest does not accrue during any period during which the processing of a claim for refund is delayed more than 30 days by reason of failure of the facility to furnish information requested by the department for the purpose of verifying the amount of the overpayment. No interest is allowed:

(a) if the overpayment is refunded within 6 months from the date the report is due or from the date the return is filed, whichever is later; or

(b) if the amount of interest is less than \$1.

(3) A payment not made incident to a discharge of actual tax liability or a payment reasonably assumed to be imposed by [Sections 1 through 16] is not considered an overpayment with respect to which interest is allowable.

NEW SECTION. **Section 13. Warrant for distraint.** If the tax, interest, or penalty is not paid when due, the department of revenue may issue a warrant for distraint as provided in Title 15, chapter 1, part 7.

NEW SECTION. **Section 14. Disposition of tax proceeds.** All proceeds from the collection of the hospital revenue tax imposed by [section 2], including penalties and interest thereon, must be deposited in the state general fund.

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NEW SECTION. Section 15. Relation to other taxes and fees.

The tax imposed by [Section 2] is in addition to any other taxes and fees required by law to be paid by a hospital.

NEW SECTION. Section 16. Rulemaking authority. The department of revenue may adopt rules necessary to implement and administer [Sections 1 through 15].

NEW SECTION. Section 17. Grants to hospitals. The department of social and rehabilitation services may make grants of up to \$5000 each to hospitals located in counties designated by the U.S. department of agriculture under its urban-rural continuum codes for metro and nonmetro counties as having at least 2,500 but less than 20,000 urban residents, and which are not contiguous to a standard metropolitan statistical area. A hospital may receive only one grant pursuant to this section.

Grants must be made by the department on or before the date of expiration of the tax provided in [section 2].

NEW SECTION. Section 18. Appropriations. (1) The following amounts are appropriated to the department of social and rehabilitation services to fund increases in medicaid and general relief medical rates for inpatient hospital services during the period November 1, 1992 through June 30, 1993:

Fiscal Year 1993  
(November 1, 1992 - June 30, 1993)

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<u>medicaid</u>	<u>general relief medical</u>	<u>total</u>
-----------------	-------------------------------	--------------

state general fund

federal funds

Total funds

(2) \$115,000 is appropriated from the general fund to the department of social and rehabilitation services for the period of November 1, 1992 through June 30, 1993, for the purposes of grants to hospitals authorized by [section 17].

(3) \$9,232 is appropriated from the general fund to the department of revenue for the period of November 1, 1992 through June 30, 1993, for the purposes of collecting and administering the tax provided in [sections 1 through 16].

**NEW SECTION. Section 19. Codification instruction.**

(1) [Sections 1 through 16] are intended to be codified as an integral part of Title 15, and the provisions of Title 15 apply to [Sections 1 through 16].

(2) [Section 17] is intended to be codified as an integral part of Title 53, chapter 6, and the provisions of Title 53, chapter 6 apply to [section 17].

**NEW SECTION. Section 20. Contingent voidness.** (1) If the federal government notifies the state that the hospital revenue tax provided in [Section 2] fails to meet the requirements of the

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Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, Pub. L. 102-234 (the "act") and any regulations or policies promulgated under the act or that the federal government will reduce the total amount of funds expended as medical assistance under the medicaid state plan by the amount of revenues received by the state under the hospital revenue tax, [Sections 1 through 19, 21 and 22] are void as of the date of such notification.

(2) If [Sections 1 through 19, 21 and 22] become void under the provisions of this section:

(a) all rate increases required under [Section 18] terminate immediately and all unaccrued funds appropriated under [Section 18] revert to the general fund; and

(b) all taxes received or collected by the department prior to the date upon which [this act] becomes void must be deposited in accordance with [Section 14] and a hospital may not receive a refund of taxes received or collected by the department prior to the date upon which [Sections 1 through 19, 21 and 22] becomes void.

(3) If the U.S. secretary of health and human services does not notify the state prior to November 1, 1992 that the secretary has approved the state's waiver request submitted pursuant to [section 3], then [sections 1 through 19, 21 and 22] are void effective November 1, 1992.

NEW SECTION. **Section 21. Severability.** If a part of [this act] is invalid, all valid parts that are severable from the

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invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. Section 22. Effective dates -- applicability -- expiration.

(1) [Sections 3, 16, 19 through 21, and this section] are effective on passage and approval.

(2) [Sections 1 and 2, and 4 through 15, 17 and 18] are effective November 1, 1992, and apply to all revenues accrued on or after November 1, 1992.

(3) [This act] expires July 1, 1993.

-End-

{ David Niss  
Staff Attorney  
Montana Legislative Council  
(406) 444-3064 }

EX. 2  
 DATE 7-7-92  
 HB \_\_\_\_\_

**HOSPITAL REVENUE TAX SUMMARY**  
**FY '93 IMPACT ONLY**  
**July 7, 1992 (9:30AM)**

*Exhibit 2*

	<u>ORIGINAL</u>	<u>PROPOSAL</u> <u>REVISED</u>	<u>NEW</u>
TAX PERCENTAGE	2%	2%	1%
TAX REVENUE	8.3	8.6	4.3
BASE MEDICAID PAYMENTS	\$ 42.3	\$ 42.3	\$ 42.3
HOSPITAL INCREASE - %	14.7%	30.6%	15.2%
INCREASE EFFECTIVE DATE	1/1/93	11/1/92	11/1/92
HOSPITAL INCREASE-COST	3.1	8.6	4.3
INCOME TO GENERAL FUND	8.3	8.6	4.3
COST OF MEDICAID INCREASE:			
GENERAL FUNDS	.9	2.4	1.2
FEDERAL FUNDS	2.1	5.9	3.1
STATE MEDICAL INCREASE (GF)	.1	.3	---
<b>EXCESS GENERAL FUNDS</b>	<b>7.3</b>	<b>5.9</b>	<b>3.1</b>
USES OF EXCESS GF:			
Health Planning Commission	150,000	150,000	---
Health Planning Grants	1,100,000	---	---
Revenue Dept. Admin. Cost	9,000	9,000	9,000
Galen Tax Impact	66,000	66,000	28,000
Cost of Block Grants	---	---	115,000
SUNSET PROVISION:	NONE	7/1/94	7/1/93

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HOSPITAL NUMBER	HOSPITAL NAME	HOSPITAL TAX @ 1% 1993	EFFECT OF RATE INCREASE	WINNERS/ (LOSERS) TAX	"LESS URBAN" BLOCK GRANTS	WINNERS/ (LOSERS) NET
416673	BARRETT MEMORIAL	29,405	25,803	(3,602)	5000	1,398
417597	BIG HORN COUNTY	11,393	17,008	5,615	5000	10,615
415683	BILLINGS DEACONESS	593,465	360,511	(232,954)		(232,954)
411647	BOZEMAN DEACONESS	149,599	86,805	(62,794)		(62,794)
410163	CENTRAL MONTANA	41,453	27,203	(14,250)	5000	(9,250)
411645	COLUMBUS HOSPITAL	302,302	275,720	(26,583)		(26,583)
412971	COMMUNITY OF ANACONDA	27,652	30,197	2,545	5000	7,545
413478	COMMUNITY MEMORIAL/SIDNEY	70,469	53,007	(17,460)	5000	(12,460)
418275	FRANCES MAHON DEACONESS	57,809	15,050	(42,759)	5000	(37,759)
572468	GALEN STATE HOSPITAL	34,686	1,629	(33,057)	5000	(28,057)
4101695	GLACIER MEDICAL CENTER	9,149	10,520	2,372	5000	7,372
417833	GLENDIVE COMMUNITY	60,546	35,661	(24,885)	5000	(19,885)
419666	HOLY ROSARY	74,024	62,622	(11,402)	5000	(6,402)
418938	KALISPELL REGIONAL	253,751	166,061	(85,690)		(85,690)
418158	LIVINGSTON MEMORIAL	36,508	19,915	(16,594)	5000	(11,594)
417898	MARCUS DALY MEMORIAL	53,213	54,425	1,212	5000	6,212
415909	MISSOULA COMMUNITY	269,762	279,923	10,161		10,161
416793	MONTANA DEACONESS	445,569	591,253	145,684		145,684
416065	NORTH VALLEY	45,080	65,226	20,147		20,147
412308	NORTHERN MONTANA	97,748	255,081	157,333	5000	162,333
411762	PONDERA MEDICAL CENTER	11,388	10,759	(1,130)	5000	3,870
419224	POPLAR COMMUNITY	12,784	27,073	14,289	5000	19,289
4105244	POWELL COUNTY MEMORIAL	7,795	2,871	(4,924)	5000	76
414583	ROOSEVELT MEMORIAL	5,101	4,455	(1,646)	5000	3,354
418340	ROSEBUD COMMUNITY	7,687	6,669	982	5000	5,982
419837	SAINT VINCENT	569,947	596,395	26,448		26,448
418782	ST. JAMES COMMUNITY	223,447	376,206	147,758		147,758
411931	ST. JOHNS LUTHERAN	37,817	54,748	16,932	5000	21,932
4104316	ST. JOSEPH HOSPITAL	22,862	17,711	(5,152)	5000	(152)
412594	ST. LUKE COMMUNITY	30,649	64,980	34,331	5000	39,331
411866	ST. PATRICK	438,763	359,422	(79,341)		(79,341)
417677	ST. PETERS COMMUNITY	236,400	267,224	30,824		30,824
415467	TOOLE COUNTY	16,401	19,437	3,035	5000	8,035
410340	TRINITY	23,225	47,337	24,112	5000	29,112
TOTAL ACUTE HOSPITALS		4,313,351	4,292,920	(20,431)	115,000	94,569

\*\*\* ###

\*\*\* Computed on a tax rate of 1% of total patient revenue.

### Computed on an rate increase of 15.225% of Allowed Medicaid Payments

ASSUMES SAME RATES OF GROWTH IN TOTAL REVENUE, MEDICAID UTILIZATION AND COSTS FOR ALL FACILITIES.

FACILITIES EXCLUDED FROM TAX:

BIG SANDY MEDICAL CENTER	MINERAL COUNTY HOSPITAL	SWEETGRASS COUNTY HOSPITAL
BROADWATER HEALTH CENTER	MOUNTAINVIEW HOSPITAL	STILLWATER COMMUNITY HOSPITAL
CARBON COUNTY HOSPITAL	MADISON VALLEY HOSPITAL	TETON MEDICAL CENTER
CLARK FORK VALLEY HOSPITAL	MISSOURI RIVER MEDICAL CENTER	WHEATLAND MEMORIAL HOSPITAL
DANIELS MEMORIAL HOSPITAL	PHILLIPS COUNTY HOSPITAL	
FALLON MEDICAL CENTER	ROUNDUP MEMORIAL HOSPITAL	
GRANITE COUNTY HOSPITAL	RUBY VALLEY HOSPITAL	
LIBERTY COUNTY HOSPITAL	SHERIDAN COUNTY HOSPITAL	



Exhibit 3

Testimony by  
James F. Ahrens, President  
Montana Hospital Association

EXHIBIT 3  
DATE 7-7-92  
HB \_\_\_\_\_

before the Human Services Subcommittee  
July 7, 1992

Thank you for this opportunity to testify.

Two weeks ago, the Stephens administration shocked all health care providers by proposing to tax hospital gross receipts by 2 percent. In return for \$2.3 million in higher Medicaid payments to hospitals, we were asked to contribute \$6.1 million to the state's financial crisis.

Since then, developments have occurred at a dizzying pace, and the proposal Julia Robinson just described is quite a bit different from the one we first read about in the newspaper on June 24.

But, Montana's hospitals were opposed to the initial proposal, and we are opposed to the one on the table today.

Montana's hospitals appreciate the financial difficulties facing the state. Hospitals would like nothing more than to support a plan that would restore health to the state's budget and bring Medicaid payments closer to the cost of providing care.

But this plan isn't the way to achieve these goals. This plan is simply bad public policy. It is yet another one-shot, quick fix that just puts off finding a long-term solution to Montana's financial problems.

Moreover, this plan does nothing to solve the underlying funding problems facing Medicaid. The state will still pay hospitals at a reimbursement level below the cost of providing care, in continued violation of federal law.

Perhaps nothing illustrates the weaknesses of this plan more than the administration's ability to put it together.

TESTIMONY ON THE HOSPITAL TAX  
CENTRAL MONTANA MEDICAL CENTER  
LEWISTOWN, MONTANA  
Presented by Christine Tremain,  
Director of Social Services

EXHIBIT 4  
DATE 7-7-92  
HB

Central Montana Medical Center is located in Lewistown, Montana, a rural community of approximately 7,000 people. CMMC has 47 licensed acute care beds, including OB, ER and ICU-CCU services, 85 skilled nursing beds, Home Health, Hospice, WIC, Home and Community Services, a rural health clinic in Stanford, and multiple diagnostic and therapeutic services. CMMC employs over 200 persons, the largest employer in Central Montana and generated over 10 million dollars in gross revenue this past year.

Central Montana Medical Center is philosophically opposed to taxing an indiscriminate few, who coincidentally happen to be acutely ill and hospitalized during the tax period. We feel a tax, if any, should be on the general public and not limited to an isolated population.

The tax, as proposed and then as modified, including the proposed increase in medicaid reimbursement, will leave CMMC with an ongoing deficit unless patient charges are substantially increased. The tax is on all of the revenue while the increase in reimbursement is based upon a select percentage of patients receiving medicaid which in our facility is less than 10% of our total admissions.

Specifically:

1. Confusion exists in reconciling SRS' July 2, 1992, memo describing their proposal with their conclusion " effects of increase".

1991 actual gross revenue	\$10,554,148.00
deductions to include contractual allowances bad debt, etc. as described by SRS	- 2,122,366.00
Skilled nursing center revenue	- 1,513,782.00
Total gross receivables	\$6,918,030.00

Using SRS' inflationary rate of 8.5 % per year increases this total gross to \$ 8,144,078.00 for 1993. This number times two % is \$162,882.00.

Page two, testimony

2. SRS projects a tax for 1993 for CMMC of \$82,906.00. Extrapolating this 2% to a gross revenue, produces a total of \$4,145,300.00. We are at a loss to explain the 4 million dollar difference between our figures and those of SRS.
3. In the last ten years, CMMC 's average bottom line has been significantly less than the proposed tax.
4. This tax, if implemented will have serious detrimental effects on provision of health care in Central Montana. Specifically we foresee the following:
  - a. Depletion of Capital Reserves.
  - b. Inadequate funds to even maintain the capital budget.
  - c. Inadequate funds for new program initiation.
  - d. Concern for program/service cuts such as OB care, surgery, community health services and others.
  - e. Ultimate fear for survival of CMMC, a rural Medical center, in a community whose nearest medical center is located over 100 miles from Lewistown.

From the above, as you can see CMMC will have no alternative but to increase our patient charges thereby creating a hidden tax. Ultimately, this will increase health care costs and make it almost impossible for rural hospitals to provide cost effective care.

Thank you in advance for your consideration of this issue and our concerns.

IMPACT OF PROPOSED \$295,529 CUTS TO OPERATIONS BUDGET

Mike Billings, Director

Office of Management, Analysis and Systems

July 7, 1992

Exhibit 9 5  
DATE 7-7-92  
HB

The Executive Budget proposes reductions amounting to \$295,529 in operations expenditures for the remainder of FY93. The Department is in the process of analyzing options for accomodation of these reductions in ways that will disrupt service delivery al little as possible. However, options for this level of reduction are fairly limited; whatever options are pursued will certainly involve significant reductions in personnel, and travel and equipment budgets will also experience severe cuts.

The Department supports proposed changes to the appropriation bill that would provide maximum flexibility in accomodating these cuts-- such as the proposal to allow agencies to move spending authority among expenditure categories, and elimination of the language that forces agencies to fill a vacant position within six months or risk loss of the position. However, in the absence of certainty of adoption of this amendatory language, the Department has developed a preliminary general outline of how the \$295,529 reduction could be accomplished.

Essentially, the Department proposal would reduce the personal services budget by \$200,000 in general fund by not filling positions vacated through termination for at least 180 working days. The remaining \$95,529 would come from reductions in travel, equipment purchases, deferral of audits, and reduction or elimination of certain contracted services.

The personal services savings would be realized by reducing FTE levels from the current level of 880 to 850--which is 59 FTE below the level authorized in the 1991 legislative session--over the next few months through attrition, and then maintaining that level for the remainder of the fiscal year. Pursuing this policy means dealing with some serious staffing issues, such as how to handle the work of "critical one-of-a-kind" positions should a vacancy occur in such a position. It is a certainty that Departmental service delivery and program performance will suffer under this proposal, but it is impossible to accurately estimate the degree of performance degradation, or the areas that will be impacted. We do not have any idea about who will be terminating in the next few months.

Reduced travel implies reduced training and reduced contact with SRS clientele. The ramifications of serious cuts in these areas are again hard to measure, but they are not insubstantial.

Reductions in equipment purchases will tend to push off acquisition and replacement of the "hardware tools" needed for the Departmental mission to a future date. This is proposed only as a short term solution to an immediate budget problem.

Office of Legislative Fiscal Analyst  
Budget Worksheet

Social & Rehabilitation Services		Executive Budget Proposal			Legislative Budget Action			Difference (Leg. - Exec.)			
		Pg	General Fund	Other Funds	Total Funds	General Fund	Other Funds	Total Funds	General Fund	Other Funds	Total Funds
<b>House Bill 2</b>											
1	General Budget Reduction	00	(\$295,929)		(\$295,929)				295,929	No Change	295,929
2	AFDC/GA Benefit Payment Reduction	01	(492,337)	(1,382,435)	(1,874,772)				492,337	1,382,435	1,874,772
3	State Medical Eligibility	07	(1,080,000)		(1,080,000)				1,080,000	No Change	1,080,000
4	Child Support Enforcement	05		1,989,139	1,989,139				No Change	(1,989,139)	(1,989,139)
<b>Other Appropriation Bills</b>											
5	Hospital Rate Increase	07	2,202,000	4,898,000	7,100,000				(2,202,000)	(4,898,000)	(7,100,000)
6	Hospital Gross Receipts Tax	07	(8,300,000)		(8,300,000)				8,300,000	No Change	8,300,000
<b>Totals</b>			(\$7,946,266)	\$5,504,704	(\$2,441,562)	\$0	\$0	\$0	\$7,946,266	(\$5,504,704)	\$2,441,562

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EXHIBIT 6  
DATE 7-7-92  
HB \_\_\_\_\_

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

EXHIBIT 7  
DATE 7-7-92  
HB

Aid to Families With Dependent Children (AFDC) is a program established by the Social Security Act, that provides temporary financial assistance to needy children and their families. The roots of AFDC go back to the early part of this century with the public recognition that it is better for children to be raised in their own homes by their own parents than to be raised in an institution. | Eligibility for AFDC is determined by evaluating specific nonfinancial and financial criteria established by federal and state regulations and laws. |

| As currently structured, the AFDC program provides recipients with a disincentive to work. They currently gain little net dollar benefit by going to work. The Department proposes action to make employment a more attractive alternative and thus reduce the length of stay on public assistance. |

1. AFDC benefit standards are proposed to be reduced from 42% of the federal poverty level (FPL) to 38% for FY93 (\$405 to \$366 for a family of three). The Department would implement this change September 1, 1992. Theoretically, reduced benefits should encourage able-bodied recipients to rejoin the workforce or to

participate in employment and training programs to develop the tools to become self-sufficient. Thus AFDC becomes a less attractive way of life. The safety net of AFDC will remain available for those individuals not able to gain employment, but in reduced amounts.

2. AFDC Budget Method Example:

	FY 93	Proposed
Standard of Need*	\$ 497	\$ 497
Benefit Standard*	\$ 405	\$ 366
Countable Income	\$ 150	\$ 150
Computation	\$405 Benefit Standard <u>150</u> (less) \$255	\$497 Stand. of Need <u>150</u> (less) \$347
Monthly Payment	\$ 255 (Benefit standard less countable income)	\$ 347 (Standard of Need less countable income)

\* This amount is defined by state policy for a household of three.

The budgeting method used to determine the AFDC monthly payment is proposed to be changed. The Department would also implement this change September 1, 1992. To be eligible, the AFDC household's countable income must be below specific income and benefit standards for household size. The monthly payment is then determined by subtracting net countable income from the benefit standard.

In many situations currently, income earned at a minimum wage job

exceeds allowable standards and households lose eligibility. However, these households are not able to sustain self-sufficiency through minimum employment alone and soon come back on the rolls.

The proposed change determines the monthly payment by subtracting net countable income from the standard of need. (The standard of need represents the monthly cost of the family's basic needs, i.e. food, shelter, clothing, household supplies, and personal care items.) This difference is then compared to the benefit standard and the household would receive the lesser amount. The benefit standard remains the value for the maximum payment allowed per household size.

The working AFDC recipient remains eligible for reduced benefits for an extended period. This extension allows a gradual transition from dependence on public assistance to self-sufficiency and reduces the possibility that a return to the rolls will occur. The charts on pages 4 and 5 demonstrate what a typical welfare benefit package is.

June 26, 1992

AFDC WELFARE BENEFIT PACKAGE  
 Non Working Household

Assumptions

3 person household, rent is \$250 per month, 2 bedroom/natural gas and phone, no income.

Program	FY92 (42%)	FY93 (42%)	Proposed (38%)
AF Grant	\$ 390	\$ 405	\$ 366
Food Stamps	269	265	277
LIEAP	17	17	17
Phone Assistance	7	7	7
Subtotal	\$ 683	\$ 694	\$ 667
Medicaid*	\$ 587	<i>Comparable Ins. prem.</i> \$ 587	\$ 587
Total	\$1,270	\$ 1,281	\$1,254

\* Medicaid is not a cash benefit - this is estimated cash value.

Additional benefits (not available to all AFDC participants)

Program	FY92	FY93	Proposed
Day Care (for training or education)	\$ 200	\$ 200	\$ 200
Public Housing	\$ 254	\$ 254	\$ 254

Federal Poverty Level 100% = \$964 per month.

WelBen.jl

June 26, 1992

EXHIBIT 7  
DATE 7/7/92  
HB \_\_\_\_\_

AFDC WELFARE BENEFIT PACKAGE  
Working Household

Assumptions

3 person household, rent is \$250 per month, 2 bedroom/natural gas and phone, working at \$500 per month, 1 child under 2 in day care, and job started 2 months ago.

Program	FY92 (42%)	FY93 (42%)	Proposed (38%)
Income	\$ 500	\$ 500	\$ 500
AFDC	336	351	366
Food Stamps	226	221	217
LIEAP	17	17	17
Phone Assistance	7	7	7
Subtotal	\$1,086	\$1,096	\$1,107
Medicaid*	\$ 587	\$ 587	\$ 587
Total	\$1,673	\$1,683	\$1,694

\* Medicaid is not a cash benefit - this is estimated cash value.

Additional benefits (not available to all AFDC participants)

Program	FY92	FY93	Proposed
Public Housing	\$ 254	\$ 254	\$ 254

Federal Poverty Level 100% = \$964 per month.

WelBen.jl

3. To reaffirm the temporary nature of AFDC and to encourage recipients to move back into the workforce, the Department proposes to seek a federal waiver which would allow the establishment of a time-limited AFDC grant for households headed by able-bodied adults. The AFDC family would receive the time-limited grant during the first 12 months of eligibility. However, if employment of 30 hours per week at minimum wage or above was not obtained after 12 months on AFDC, the grant would be reduced.

AFDC time-limited benefits for households with able-bodied adult(s).\*

Time-limited grant (Recipient for 12 months or less)	\$596**
Basic Grant (Recipient for more than 12 months)	\$507**

\*\* Based on California's proposed changes which limits grants at six months.

Teen parents attending full time high school and families not headed by an able-bodied adult would remain at the time-limited benefit payment until their status changes.

The Department asks the approval of the legislature to seek the

federal waiver, and, if federally approved, to implement this change.

4. The At-Risk Child Care Program is a new child care assistance program which is offered to non-AFDC working families who are low income (below 75% of the state median income - for a family of 3, 75 % of state median income is \$1,779), need the child care in order to work and are at risk of coming onto the AFDC Program. Families must pay a portion of their own child care based on a family income sliding fee scale.

Low income families often pay a disproportionate amount of their income for child care. By providing subsidized child care, this program encourages families to work and remain self-sufficient. The co-payment requirement is also indicative of this program's strategy for recipient responsibility for self-support. By keeping families working and off AFDC, we save the state funds which would have been spent on the AFDC program. We also break the pattern of welfare dependency for future generations by giving young children working parents as role models.

The Interim Finance Committee has given their approval for the At-Risk Program to begin a pilot project in Yellowstone County, July 1, 1992, using a \$44,000 donation from the United Way of Yellowstone County. This money will be matched at the Federal Medical Assistance Percentage rate (FMAP) to the federal funding

available. Since there was no new state funding available to begin this program, alternate private funding was sought.

We are proposing to expand this program state-wide by using funds which would have been used for the Self-Initiated Child Care Program (a program which pays child care for AFDC recipients who are going to school). The Department estimated \$1,430,000 would be available during SFY93 to fund Self-Initiated child care slots for approximately 525 families. The Department intends to use \$530,000 of the \$1.4 million to provide child care assistance for approximately 200 working low-income families through the At Risk Child Care program. Funding of \$900,000 remains available for approximately 325 Self-Initiated slots for post secondary and GED students. We also will continue to seek out other sources of private and non-private funding to match to the federal dollars available. We have chosen to seek legislative approval, rather than making the change administratively.

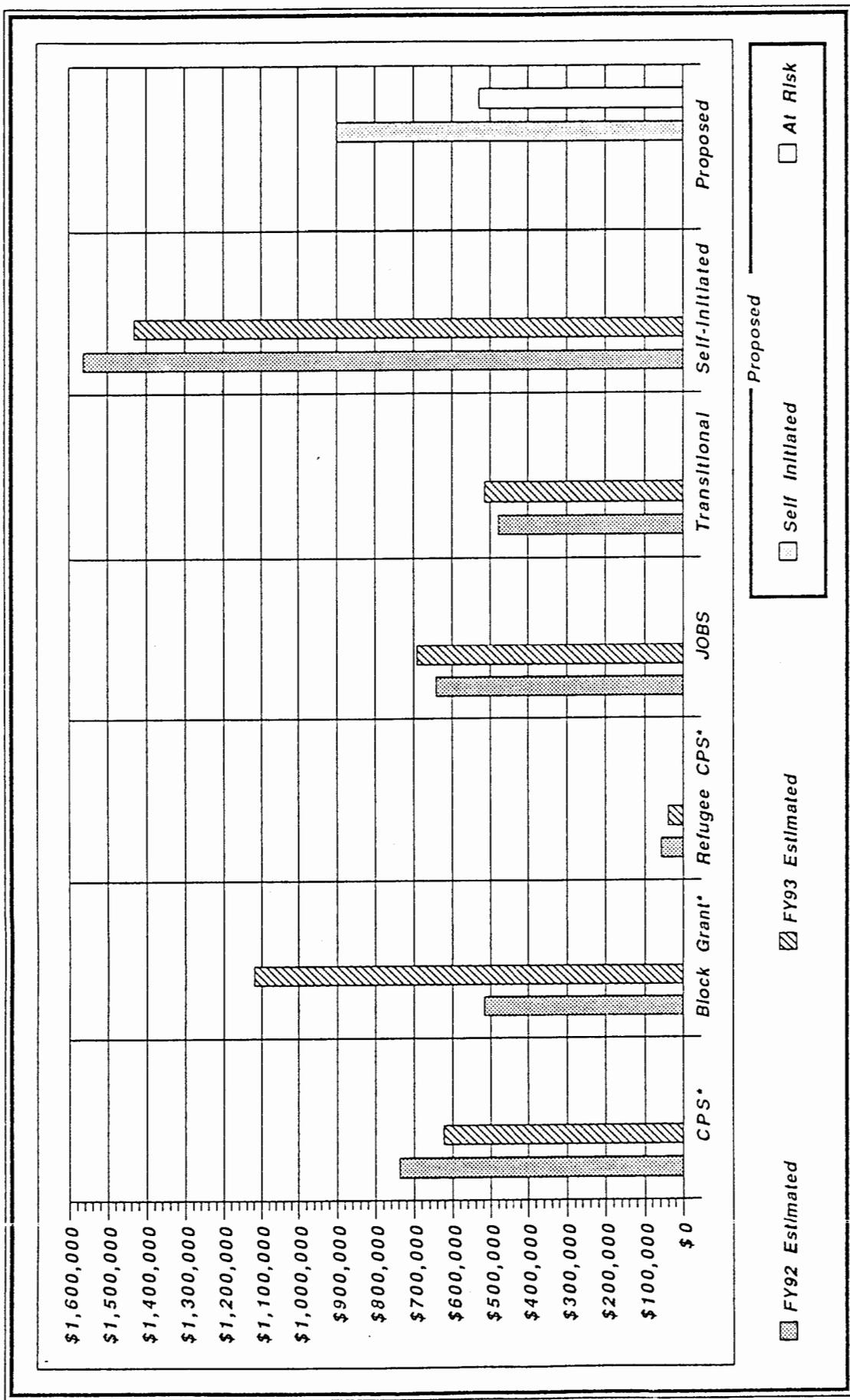
We agree that AFDC recipients who are motivated will often choose schooling, and thus seek that path to self-sufficiency. However, we also believe that with Montana's economic picture, a number of low income working families are at risk of coming onto AFDC. We hope to decrease that risk by implementing this program.

The chart on page 9 shows day care expenditures.

legnar.af1

# MONTANA SRS/DFS DAY CARE EXPENDITURES

EXHIBIT 7  
 DATE 7/7/92  
 HB \_\_\_\_\_



\*Department of Family Services Expenditure.  
 CPS = Child Protective Service

IV-A (AFDC RELATED) CHILD CARE PROGRAMS

(All IV-A Department of Social and Rehabilitation child care programs are funded at the FMAP rate, which is approximately 28% state general fund matched to 70% federal. \* designates Department of Family Services Programs)

- I. Transitional Child Care began in Montana April 1, 1990. This program provides for up to 12 months of child care subsidy for working families who lost their eligibility for AFDC due to increased income, increased hours of employment or loss of time limited disregards. Families pay a co-payment based on their income. Montana is required to provide child care for all families who meet the eligibility requirements for this program.
- II. The JOBS program (Job Opportunities and Basic Skills) began in Montana in July, 1990. Certain AFDC recipients are required to participate in JOBS components which include: education, training, work activities, and supportive services. JOBS child care is provided to all clients who are participating in JOBS and need child care in order to participate. Montana is required to provide child care for JOBS participants.
- III. The Self-Initiated child care program is a program which pays for child care for AFDC families while they are attending training or educational activities. These families start their education or training activities prior to being required to participate in JOBS. Montana is required to pay for child care for families who are approved for participation in self-initiated education or training activities.
- IV. The At-Risk child care program is scheduled to begin in Montana in July, 1992. It will start with a pilot program in Yellowstone County, using private donations as match for available federal funding. This program is designed to subsidize child care for low income families who need child care in order for the family to work and to avoid becoming eligible for AFDC. Families are required to pay a portion of their own child care based on their income.
- \*V. The Child Care Block Grant day care program is 100% federally funded and is for families who are working at least 15 hours per week, and whose income falls below 75% of the State Median Income. It is designed to serve working families in need of child care assistance. A sliding fee scale sets income limits and is used to determine the required co-payment amount each family must pay.
- \*VI. Child Protective Services Day Care is provided to protect children who have been abandoned, neglected or abused. CPS day care gives the family an opportunity to remain together instead of removing the child from the home. These services are funded 100% with state general fund and are determined by the local Department of Family Services or are court ordered.
- \*VII Refugee Child Protective Services Day Care is provided to refugee families for education, training, or child protective reasons for up to 8 months. Funding is 100% federal.

# AFDC/Food Benefit Package

Benefits based on family of three; no income; \$250 rent.

	Jun-92	Jul-92	Proposed
AFDC	\$390	\$405	\$366
Food Stamps	\$269	\$265	\$277

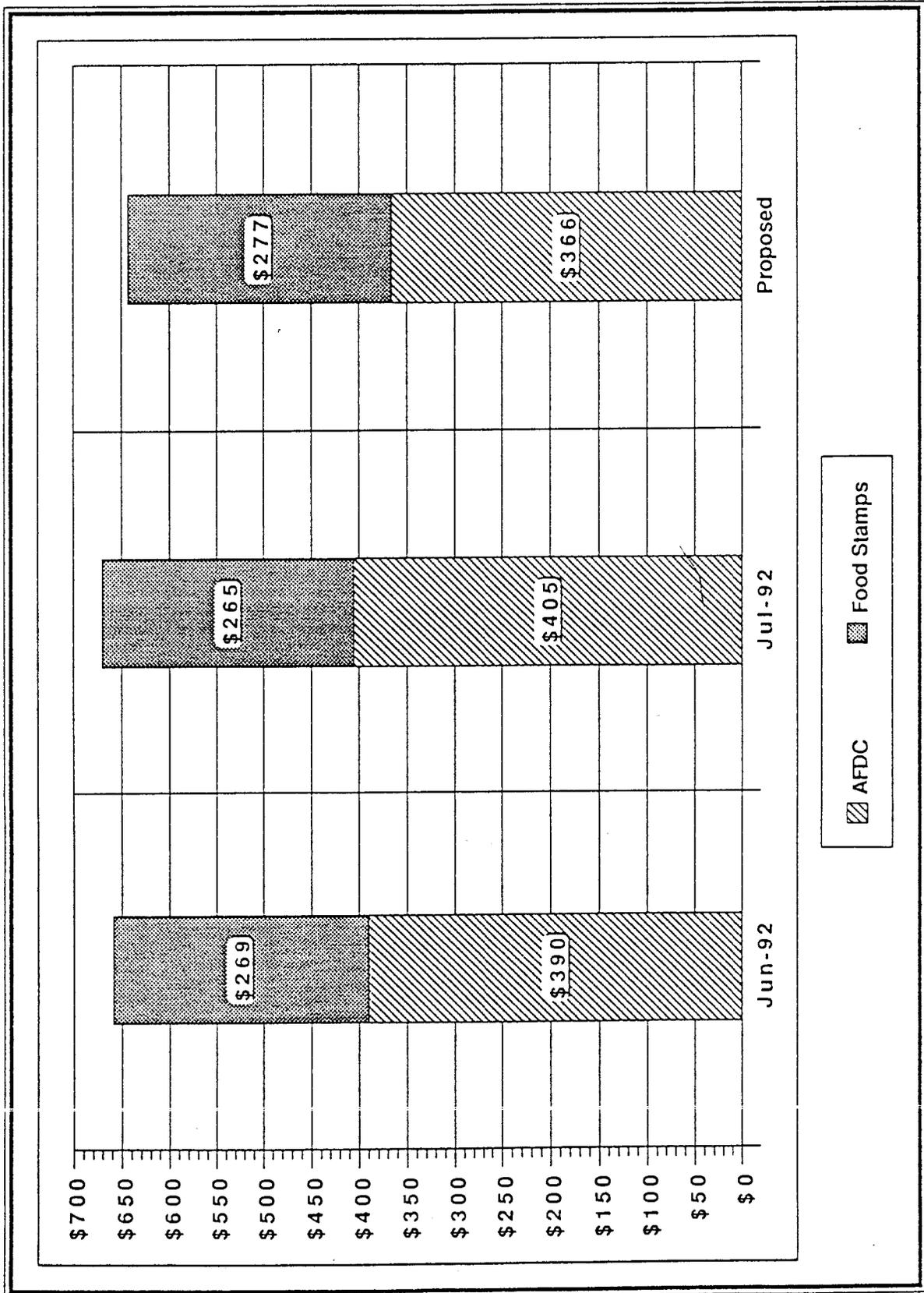
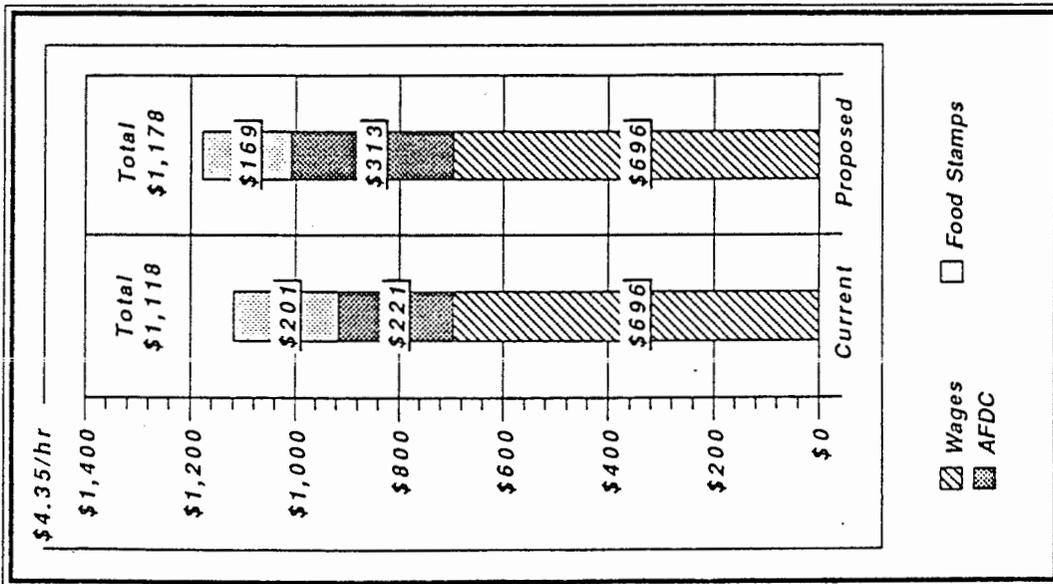
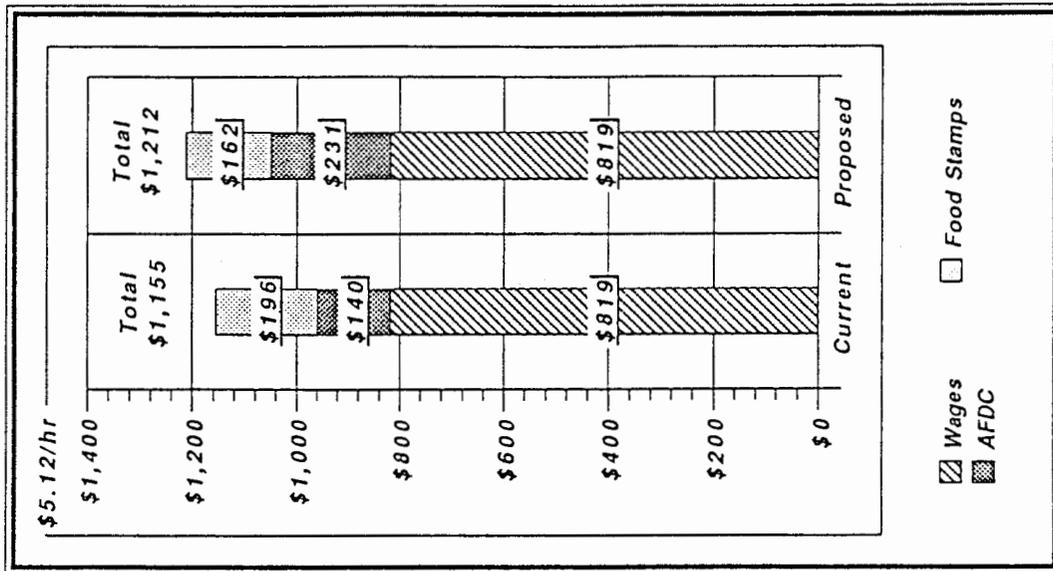
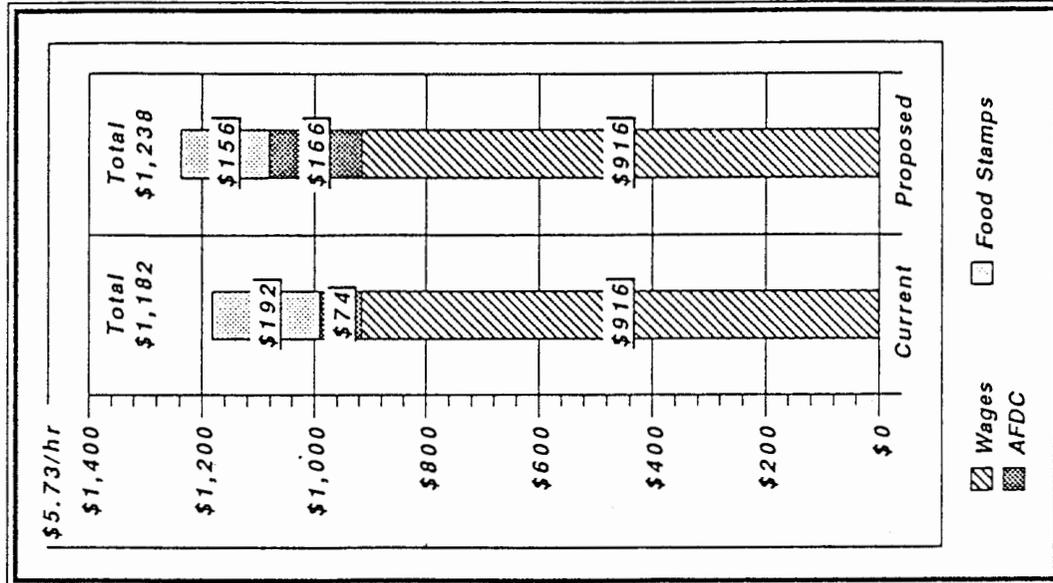


EXHIBIT 7  
 DATE 7-1-92  
 HB \_\_\_\_\_

# AFDC/Food Stamp Benefits

Family of 3 with Earned Income

EXHIBIT 7  
 DATE 7/1/92  
 HB \_\_\_\_\_



Assumptions: Family 1 adult & 2 children; employed 2 months; one child under two in Day Care at \$200/month; rent of \$250/month; employed 40 hrs per week.

Current: AFDC benefit set at 42% of poverty with current budgeting method.

Proposed: AFDC benefit set at 38% of poverty with proposed budgeting method.

**At \$5.74/hr,  
 40 hrs/week,  
 AFDC Closes**

July 7, 1992

7  
EXHIBIT 8  
DATE 7-7-92  
HB

To: Joint Subcommittee on Human Services

From: Judith H. Carlson for

- MT Human Resources Development Council Directors Assn
- MT Chapter, National Assn of Social Workers

You have before you a proposal that is dubbed "Welfare Reform," a title that is sure to make everyone's heart pump. No one likes welfare; everyone wants to see reform. But one person's "reform" is another person's "reformatory." Would any of us consider it "reform" if we were told to take a 10% cut in our income, be it wages, retirement, social security, or any other benefit? Some of our elected officials have tried to turn down any increase in salaries in keeping with the austere times, but none has offered to take a 10% cut!

There is one proposal in the package that we would consider a real reform. That is to allow AFDC moms to earn money to "fill the gap" between the AFDC payment and the so-called "standard of need." It does provide more money to the family and is an incentive to work. The state also should consider getting a waiver to allow child support money to "fill the gap" as well as other income. We support this proposal.

We vehemently oppose any further erosion in the amount of money AFDC and GA recipients receive. These are people who are eligible for the programs. They are "needy." When we say we want to help the "truly needy," that's the AFDC moms and GA recipients. In Montana, there aren't any needier. YET, the Governor proposes to cut their benefits by 10%!

Economic conditions, unemployment, and lack of money are part of the problem in families where domestic and child abuse takes place.

Cutting AFDC and GA is a pretty sure way of seeing that curve of increased caseload go up for Family Services.

In AFDC, for every dollar of state money saved, 2 dollars of federal money are lost. If we were talking about an unnecessary program, then I'd say, cut it out and lose the federal dollars. But this is bread and margarine. This is money for school clothes. This is money for shelter!

We oppose all the changes suggested in General Assistance. When the law was changed to allow for only 4 out of 12 months eligibility for GA clients, the argument was made that the 4 months would tide a person over the winter, when it was hardest to find work and when the need for shelter was the greatest. Does this proposal mean that Montana will now have winter every year and a half - 18 months for the full cycle of seasons? *This should save on utilities too!*

The proposal to make GA recipients wait for 30 days before they receive any money is a draconian measure - totally harsh and unrealistic. The rationale for waiting 10 days for a check was that transients would move on and not wait around. There can be some measure of reason to 10 days. But 30 days? And this is for people who have nothing to begin with?

The proposal to reduce by \$50 the GA payment to people who have been here less than 2 months has no merit at all. It is spiteful. And it may be unconstitutional according to some...

We question the further cutback in State Medical eligibility. If you have to be a GA recipient to qualify, won't more people apply for GA in order to receive medical care? Or the doctors and hospitals will begrudgingly have to give more free care and then be back for higher medicaid rates?

*to you*

These proposals all represent a reprehensible public policy of "kick 'em while they're down" and should be given short shrift.

Exhibit B

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

EXHIBIT \_\_\_\_\_  
DATE \_\_\_\_\_  
HB \_\_\_\_\_

General Assistance (GA) is a 100% state funded benefit program in the twelve state assumed counties. These counties are identified by the chart on page 10 of your packet. GA cash assistance is used to meet the needs of single persons or families who do not have enough income or resources to support themselves. These people are not eligible for any other state or federal assistance programs.

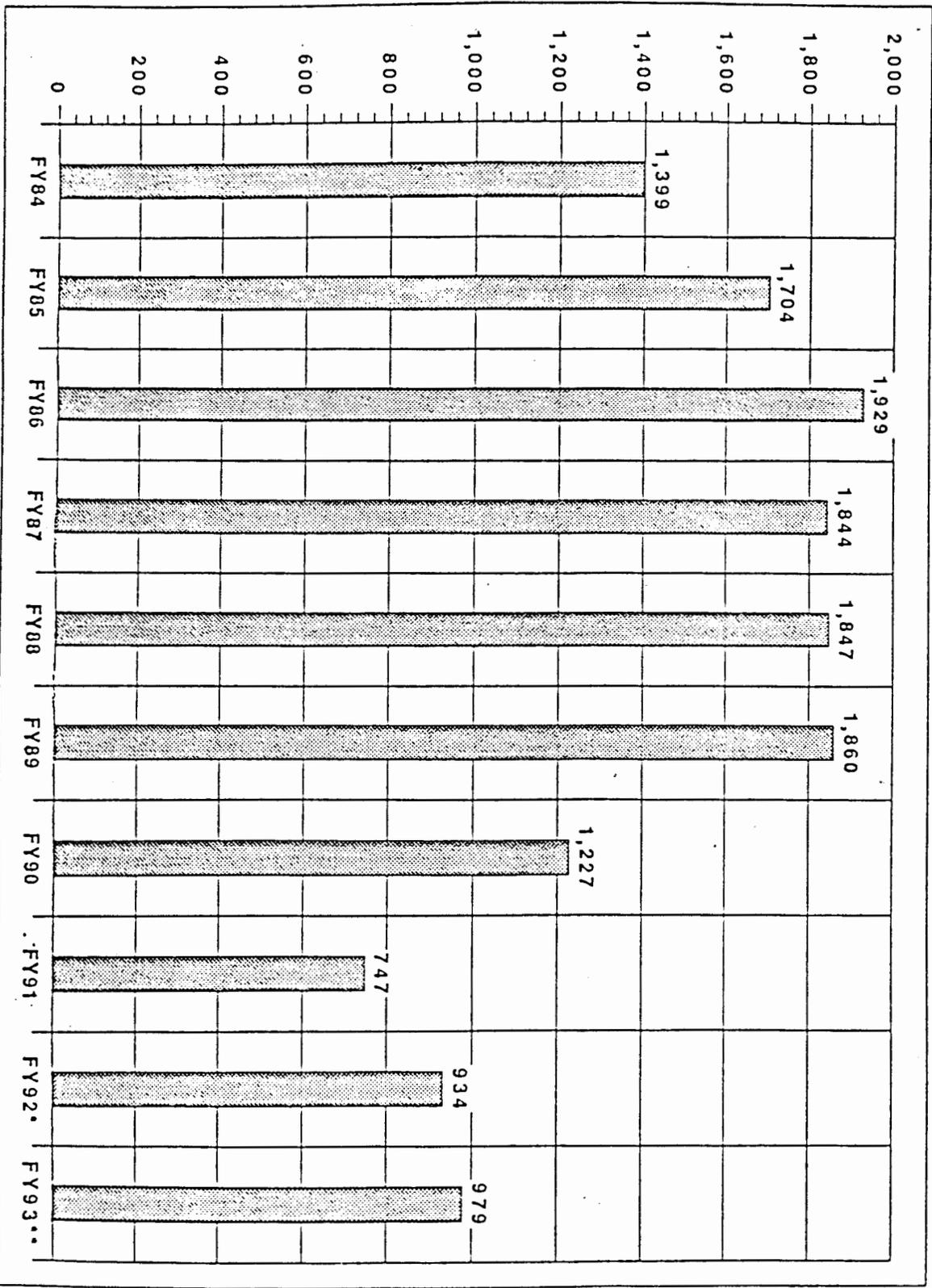
The GA program was substantially changed in July, 1989. Changes were made to allow stricter penalties for GA recipients who refuse to look for work or quit a job. As you will see on by the chart on page 2, the caseload has been substantially reduced as a direct result of those changes.

EXHIBIT

DATE

HB

### General Assistance Average Monthly Caseload State Fiscal Years 84 - 93\*\*



\*July, 1991 to Mid-June, 1992  
\*\*Estimated

EXHIBIT \_\_\_\_\_  
DATE \_\_\_\_\_  
HS \_\_\_\_\_

Other changes took place January 1, 1990. These changes caused persons to be sorted as employable, employable with serious barriers or unemployable. Persons who are employable or employable with serious barriers are limited to four and six months of help, respectively, in a twelve month period. Those who are unemployable have no time limits on benefits.

Persons who are employable or employable with serious barriers are required to participate for 40 hours each week in a program designed to place them into employment. This employment and training program is the Project Work Program (PWP).

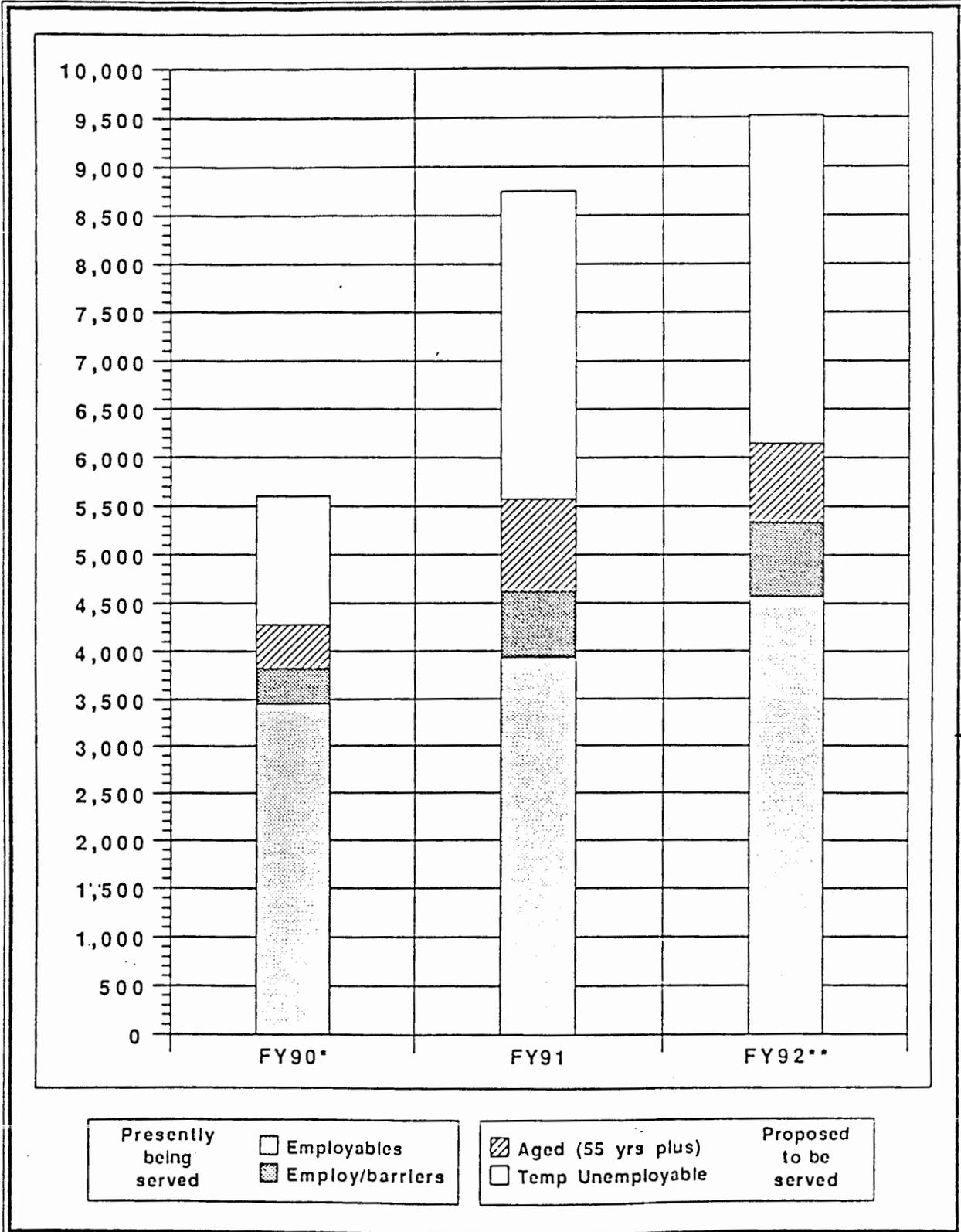
The Department proposes to start a new program component (track) of self-sufficiency services to those who are unemployable because of a temporary disability, and to those who are aged 55 or older who have limited work skills. These individuals currently receive no employment and training services.

This track would enable recipients to remove or alleviate the condition making them temporarily unemployable or to enable them to secure SSI. Besides being able to access all current services through Project Work, these individuals would receive medical services management, chemical dependency counselling as necessary, as well as a self-sufficiency plan designed to make them no longer GA dependent. The chart on page 4 shows the population we are currently serving, as well as those we propose to now add.

GENERAL ASSISTANCE  
 PWP CLIENTS (SERVED AND PROPOSED TO BE SERVED) FY90-91-92

EXHIBIT \_\_\_\_\_  
 DATE \_\_\_\_\_  
 HB \_\_\_\_\_

	FY90*	FY91	FY92**
Employables	3,457	3,936	4,575
Employ/barriers	367	687	763
Aged (55 yrs plus)	454	956	810
Temp Unemployable	1,330	3,166	3,374



\*Program changes began January, 1990

\*\*Mid-June figures (figures for May and June are not complete)

DATE 7-7-92  
HB \_\_\_\_\_

In order to fund the proposed self-sufficiency track and mold the existing GA program into a more responsive, efficient program, we propose to make the following changes:

1. add an on site chemical dependency counselor in ten of the twelve PWP sites (Mineral County would access Missoula County, and Powell County would access Deer Lodge County).

2. reduce the GA payment levels from 42% to 38% of poverty.

Family Size	FY93 42%	FY93 38%
1	\$238	\$216
2	\$311	\$291

3. change time limits on benefits to 4 or 6 months in an 18 month period instead of the current 12 month period, for those individuals who are employable, employable with serious barriers and the new classification of temporarily unemployable.

4. change the start date for applying penalty periods. Currently, when a recipient does not comply with program requirements, the penalty begins the next month. If the non-compliance occurs during the last month of eligibility, it

does not present a deterrent. We are proposing to have the penalty period begin with the next month the person is program eligible.

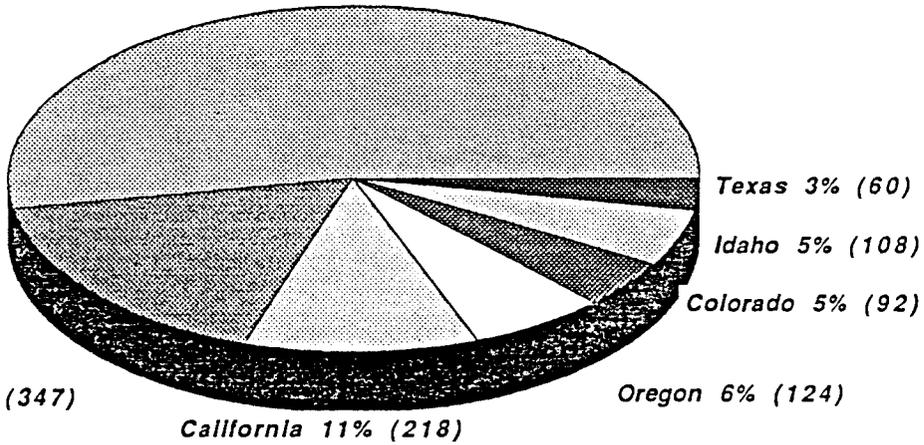
5. change the payment after performance period from two weeks to four weeks.

6. reduce the benefit for the initial two months for those persons who apply for GA within the first month of Montana residency. Since January, 1990, we have seen a rise in the number of persons who move into Montana and apply for GA within the first month of their residency. The Department proposes to reduce the benefit amount by \$50 in each of the first two months. There may be constitutional issues with this proposal; however, the previous constitutional challenge was the situation where all benefits were denied. The State of California recently passed a law affecting AFDC recipients which limits the amount of AFDC to that which was received in the previous residence state, if that AFDC amount was lower. Federal approval has been requested, but not yet granted. The chart on page 7 shows the number of individuals who have been applying for GA after a recent move from another state.

**GENERAL RELIEF ASSISTANCE**  
**Client Migration Residency Summary**  
**Unduplicated client residency for Fiscal Year 1992**  
**as of Report Date: 06/12/92**

**Residency of Migrating Clients**  
**as percent of US total 2,015**

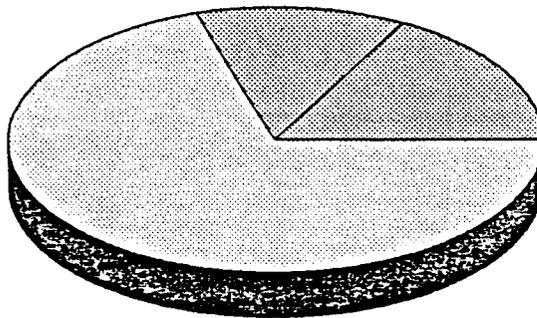
**Other 44 States 53% (1,066)**



*This graph represents this piece of the pie*

**Migrant Applicants**  
**1 to 12 months**  
**13% (849)**

**Migrant Applicants**  
**1 month or less**  
**17% (1,166)**



**Montana Applicants 70% (4,762)**

**Total General Assistance Relief Applicants (6,777)**

EXHIBIT 9

DATE 7-7-92

HB                     

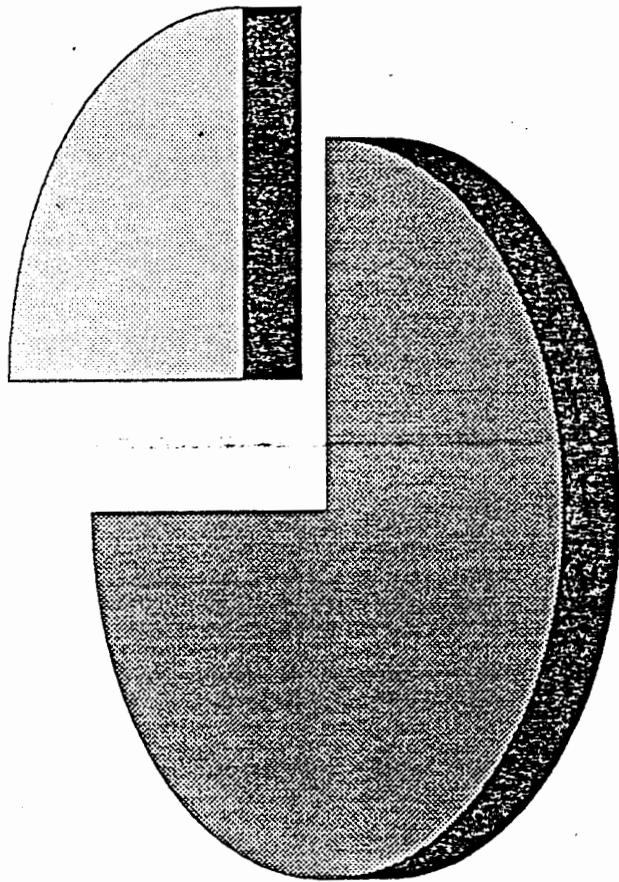
7. eliminate the state medical program. Under this proposal the Department would reduce the mill levy to allow the state assumed counties to retain an amount equal to approximately \$2 million. County Commissioners would be free to use the money as they deem appropriate. For example, they may choose to implement a county medical program of their own design, start a preventive health care program, or reduce the overall mill levy.

# FY91 State Medical Costs

as of 4-30-92

AMOUNT 9  
DATE 7-7-92  
HB \_\_\_\_\_

State Medical Only - 25%  
\$1,468,800  
(Includes resource spend down cases)



General Assistance Recipients - 75%  
\$4,429,609

Total FY91 State Medical Costs \$5,898,755



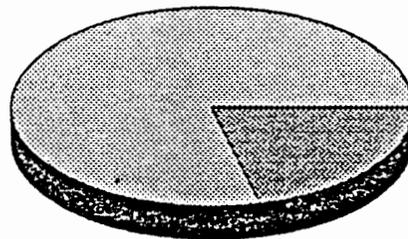
# GRA--RECIDIVISM

Persons closed due to exhaustion of time limited benefits and who come back on GRA.

EXHIBIT 9  
DATE 7-7-92  
HB \_\_\_\_\_

	FY91	FY92*
Closed	391	492
Reopened	105	138
% Reopened	27%	28%

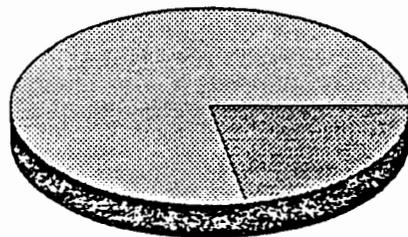
*FY91 Closed and Reopened*



27% Reopened

■ Closed    ■ Reopened

*FY92 Closed and Reopened*



28% Reopened

■ Closed    ■ Reopened

GRA CLASSIFICATION & PROGRAM DETERMINATION

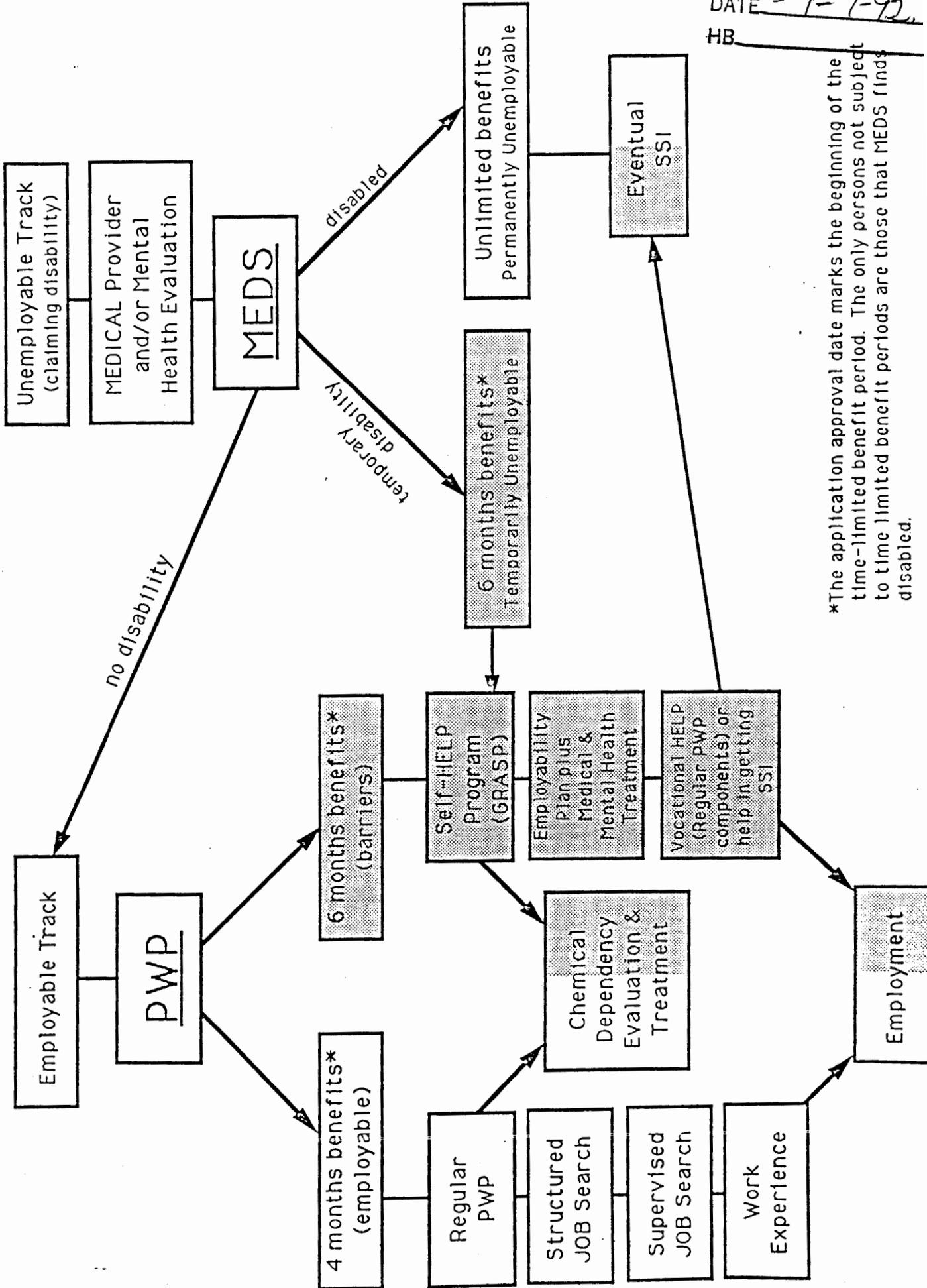


EXHIBIT 9  
DATE - 7-7-92  
HB \_\_\_\_\_

\*The application approval date marks the beginning of the time-limited benefit period. The only persons not subject to time limited benefit periods are those that MEDS finds disabled.

Child Support Enforcement Division  
Testimony

EXHIBIT 10  
DATE 7-7-92  
HB

One of the aspects of the Welfare Reform proposal submitted by this department is a \$2 million non-general fund investment in the FY93 budget of the Child Support Enforcement Division. This investment will permit aggressive collections of child support to repay general fund dollars spent on the AFDC program "dollar for dollar", and to help keep borderline non-AFDC families off of welfare. National statistics show that for every \$5.00 collected for a non-AFDC family, at least \$1.00 in welfare benefits is saved.

The major cause of poverty for U.S. children under age 6 is an absent parent not paying support. Aggressive enforcement of medical support and health insurance will also save the state general fund Medicaid dollars. Our statistics show that CSED collection efforts have saved the state nearly \$1,000,000 per year in state Medicaid payments.

The CSED budget has no general fund. The CSED uses 34% state special funds (its own revenue) and 66% federal funds. The program is entirely self-supporting and returns money to state taxpayers.

At the present time the CSED FY93 budget will not be sufficient to operate the division at its present level even though it will collect approximately \$20 million next year for children. Projections indicate a budget deficit of \$300,000 by June 30, 1993 if the current level of service is maintained. Otherwise, cut backs are anticipated. The caseload is skyrocketing. Cases currently number 34,500, representing a 110% increase since FY88. The caseload is expected to reach a record 51,200 by the end of FY95. If the Legislature allows the division to meet the growing caseload and enhance its operations, more money can be reinvested in the state.

We are asking the Legislature to allow the program to utilize an additional \$680,000 of the revenue we will raise in our special fund, plus increase our federal spending authority by \$1.3 million. This investment will help Montana's children obtain financial support from their parents rather than through state welfare programs. We project a continuing investment of this nature will increase total program collections by \$10 million by the end of the next biennium, This spending authority would be used to fund partnerships between the public and private sectors for CSED projects which are a key aspect of welfare reform. Our results and financial returns would be measured and reported to the 1993 Legislature. Some of the proposed partnerships are identified below:

"Locate Project". \$179,488 total state special and federal dollars. This would be a pilot contract with a collection or investigative agency to find absent parents who are purposely evading child support obligations. Once these parents are

found, establishment and enforcement of child support obligations would be commenced. The contract fee would be recovered from collections.

"Self-Employed Project." \$232,688 total state special and federal dollars. Many parents failing to support their children are self-employed and earning a good living. Because they are self-employed, enforcement is difficult and requires litigation in district court. We propose to enter into a private contract with a firm that would be responsible for taking the self-employer to court and enforcing the obligation.

"Public Awareness Program" \$76,983 total state special and federal dollars. We have targeted three major segments of the Montana public who need more information about child support rights and responsibilities. They are 1) employers, who are legally required to participate in the system to withhold income, 2) teenagers and high school students who need to know the financial ramifications of having children, and 3) absent parents who are not paying support need to get the message that "you can run but you cannot hide". We would like to develop informational materials and media ads to enhance awareness of child support responsibilities.

The remaining \$1.5 million total state special and federal dollars would be utilized to cover the projected \$300,000 deficit and fund additional contracts. The contracts listed below could be implemented and administered easily. Results would be immediate and measurable.

"URESA Contract" The federal Uniform Reciprocal Enforcement Support Act requires completion of lengthy forms for Montana to collect money on some interstate cases. These forms are currently backlogging in our offices, but once they are completed and submitted to the other states they require relatively low maintenance. We propose entering into a contract with a temporary services agency to clean up the backlog and get more money coming into Montana from other states. This "clean up" effort will also resolve a severe compliance problem with federal audit standards.

"Tribal Prosecution Agreement(s)" The CSED lacks jurisdiction in many Native American cases. This results in many children not receiving the child support they deserve. We propose contracting with tribal prosecutors who can pursue these cases in Tribal Court.

"Contract for Hospital Paternity Affidavits" We propose to pay Montana hospitals a fee for every paternity affidavit they obtain on out-of-wedlock births. The hospital would ask the father to formally acknowledge that he is the father at the baby's birth. The acknowledgement would become a permanent part of the birth record. This is a prospective and efficient

solution to a cumbersome and costly process. When the father isn't on the birth record, the CSED must obtain information from the mother as to possible fathers, then locate the alleged fathers, pay for and participate in hearings and obtain blood tests before responsibility for child support can be determined. The proposed hospital contracts also resolve compliance problems with federal audit standards. The main purpose, however, is to achieve a substantial cost savings and to keep kids off AFDC. A recent federal report on AFDC absent parents shows that of the open (undetermined) paternity cases in child support agencies, 31% are AFDC cases. In Montana, births out of wedlock are rapidly increasing. Did you know that nearly 24% of all Montana births are out of wedlock?

"Modifications Contract" We propose to pay a private agency to conduct a preliminary review of support orders for possible modifications and calculation of amounts due for child support under the guidelines. We would also contract development of modifications packets which allow the parents to "self-administer" the process with reduced caseworker involvement. Recent pilot projects in other states have demonstrated that modifications result in larger dollar orders and increased collections. By having a private firm do the initial paperwork, CSED staff will be free to focus on collection oriented activities.

"Health Insurance Enforcement Contract" We propose to contract with a private enterprise to actively identify and enforce mandatory medical insurance for children. This project should save more Medicaid dollars and help children obtain the basic health care they cannot presently afford.

Other areas of private/public sector partnerships have been identified. Routine tasks and procedures that can be performed by a private sector firm with the necessary expertise would be considered for privatization. This partnership with the private sector will allow the CSED to focus on other deficient areas and collect more money to keep children out of poverty and off state financed support. The child support enforcement aspect of our welfare reform plan is prospective and ambitious, but our success will be measurable. At minimum, the projects will break even. We ask for your commitment to leading Montanans off the welfare treadmill and guiding them to the road of self-sufficiency.

HOUSE OF REPRESENTATIVES  
VISITOR REGISTER

HTU SUBCOMMITTEE DATE June 7, 1992  
DEPARTMENT(S) \_\_\_\_\_ DIVISION SRS

PLEASE PRINT

PLEASE PRINT

NAME	REPRESENTING	
Dave Depe ✓	MPEX	
Fenny Robbe	SRS	
John Anthony	Mt Catholic Cong	
Ray Surran	Helena Food Store	
Christie Plenan	CMHC Lewis & Clark	
Judith Carlson	MT HRDC DIR ASSN MT CH NASW	
Colleen Lipke	NASW	
HARLEY WARNER	MONT ASSOC. of churches	
Rev. Ed Holme	Self	
Leann Jordan	Self	

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