

EXHIBIT 22
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**MHA...An Association of Montana Health Care
Providers**

**Testimony Before the Joint Appropriations
Subcommittee for Health and Human Services**

Pertaining to House bill 2; General Budget Bill

February 4, 2005

Good morning Madame Chair, members of the committee. For the record, my name is Bob Olsen, Vice President for MHA...An Association of Montana Health Care Providers.

MHA represents the interests of both acute and long-term care providers, including those who operate nursing homes, home health agencies, and hospices. MHA, An Association of Montana Health Care Providers, supports adoption of the Department's Senior and Long Term Care Division budget. We do so for several reasons.

Home Health Agency Services

Medicaid recipients who receive Home Health services do so only if they meet specific eligibility criteria. They must have difficulty in leaving the home, so that the home setting is the most efficient and effective place to deliver the care. They must require a skilled service that cannot be provided by anyone but a licensed professional nurse or therapist (who must be employed by a licensed, certified home health agency). They must have a plan of care from their physician and preauthorization (for limited visits) from the Montana-Pacific Quality Health Foundation for reimbursement.

Home health is an important service because without in home care the person is at risk to be admitted to a nursing home or other facility for care.

Hospice

Hospice care is provided to patients who have an anticipated life expectancy of six months or less if the disease follows its normal course. The care is focused on providing "comfort," not cure. It emphasizes pain and symptom management, and psychosocial/spiritual support.

Care is provided in the patient's home about 98% of the time, by an interdisciplinary team of professionals and volunteers. The model of care is tailored to the needs and wishes of patients and their loved ones.

Hospices receive an "all-inclusive" per diem rate that includes:

- Physician services
- Nursing services
- Medical supplies and equipment
- Drugs for symptom control and relief
- Short-term care in the hospital
- Home health aide and homemaker services
- Social work services
- Counseling and bereavement support

Like home health care, hospice affords the patient an opportunity to be served at home. Without a hospice benefit the person is at risk to be admitted to a hospital or nursing home to receive their end of life care. This care is more expensive than the care provided at home.

Two years ago general funds for hospice and home health benefits were replaced with the Provider Stabilization Account. The Department is seeking I-149 funds adequate to continue the home health and hospice benefit. MHA supports this request. We prefer that this funding be general funds in order to remove the risk that the services will be eliminated if tobacco settlement dollars are inadequate to support these services.

Nursing Facility Services

Nursing homes in Montana face considerable financial pressures for several reasons, including:

- Nursing homes must continue to compete for limited skilled staff, including nurses and nurse aides. Nursing homes also face rising costs of medical supplies, equipment and, more recently, liability insurance.
- Nursing homes continue to face increased regulatory pressures aimed at higher numbers of workers for each patient and a zero tolerance for poor medical outcomes.
- Nursing homes depend upon the Medicaid program to pay for a significant portion of the operating costs. Medicaid insures, on average, 60 percent of all nursing facility residents. When Medicaid does not pay its fair share of costs, private paying residents must pick up the costs in their bills. With so few non-Medicaid patients, that additional cost can add a lot to an elderly person's bill.
- Finally, most nursing homes are serving fewer residents. Occupancy has dropped over time from more than 90 percent to less than 80 percent today. While nursing facilities are caring for fewer people, their care needs have increased significantly. Increased patient acuity means more costs. Seniors who are able, choose to remain in their own homes. Those who require limited medical care are residing in personal care or assisted living facilities.

MHA supports the public demand to improve service quality, promote patient safety and service and maintain adequate numbers of qualified staff. But these efforts cost money. Medicaid has come a long way to improving payments for nursing home residents. MHA supported the Department's efforts to adopt a price-based payment system. Our organization fought hard to implement Intergovernmental Transfers in every Medicaid program as a means of easing State fiscal pressures and putting more money to work in the community medical facilities. We have supported using provider taxes as a means to boost payments to amounts close to costs.

Provider Taxes and IGT Programs

The Committee has heard many people talk about the increased federal scrutiny over State programs that rely on provider or other government funding. The federal Medicaid budget has grown to about \$300 billion per year, and is now larger than the Medicare budget. At least some of that growth is attributed to IGT and provider tax programs. We agree with those that believe the current Administration would like to eliminate these programs as a means of reducing Medicaid spending. Further pressure is not just likely, its for certain.

Provider taxes and IGT programs are authorized in federal law. While CMS may not like their use, States have a right to do so, as long as the programs comply with federal regulations. Montana's provider tax and IGT programs comply with all applicable federal rules.

The main reason for CMS' concern is that some States have engaged in a process known as "recycling" federal Medicaid funds. Recycling schemes involve making a Medicaid payment funded by IGT or provider tax, and then requiring the provider to return all or a portion of the Medicaid payment. Those dollars are then diverted away from health from health care and into other public projects like building roads and bridges. In such cases CMS argues that the Medicaid program is being abused.

Montana does not engage in any recycling schemes with its IGT and provider tax programs. However, CMS is now extending their concern about financial transactions between the facility and the county government. In short, Montana's IGT program may be smaller in the future than under today's

structure. Given CMS's stated desire to end IGT programs, Montana may not have an IGT program in the next two years.

Without the IGT program, the Department's budget will be short of \$1.65 million in State Special Revenue. MHA believes that the Department's budget should not count on the SSR being available in the next biennium.

MHA asks that this Committee take the following actions:

Approve the Department's request for budget authority to continue IGT payments, if possible;

Replace the \$1 million of State Special Revenue currently diverted from IGT funding for community-based programs with a like amount of general funds;

Replace the \$650,000 of State Special Revenue currently diverted from IGT funding for use in the nursing facility base budget with a like amount of general funds;

Approve the Department's request for I-149 funds for a three percent increase in the per day rate and the \$.16 per hour hike for direct care workers; and

Work with MHA and MHCA to increase the assessment on bed days adequate to increase the average Medicaid rate to the cost to provide care.

MHA is prepared to discuss our proposals in detail. Thank for this opportunity to comment on the Senior and Long Term Care Division Budget proposal.