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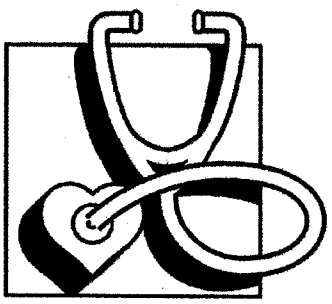

Monitoring Health Care Services in Montana

A final report on the activities of the Children, Families, Health and Human Services Interim Committee

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Executive Summary

The interim committee charged with overseeing the Department of Public Health and Human Services (DPHHS) touches on a vast array of services that, themselves, touch thousands of Montanans each year. During the 2007-08 interim, the Children, Families, Health, and Human Services Interim Committee (Committee) carried out three assigned studies involving various aspects of health care while also keeping up to date on DPHHS activities.

As part of its monitoring duties for DPHHS, the Committee heard regular updates on agency activities, particularly the agency's efforts to put in place several new mental health initiatives funded by the 2007 Legislature.

Over the course of seven meetings, the Committee also heard about programs that:

- provide needy Montanans with assistance for their medical, heating, and living costs;
- seek to keep Montana children safe from abuse and neglect;
- improve public health through programs to prevent chronic diseases;
- provide older Montanans with services that allow them to stay in their homes; and
- provide services to people with disabilities.

The Committee also expressed its consensus views on several general health and human services issues by:

- writing to the Montana congressional delegation about proposed Medicare and Medicaid rules;
- submitting formal testimony to the Centers for Medicare and Medicaid Services; and
- writing to state officials on health information technology and Food Stamp issues.

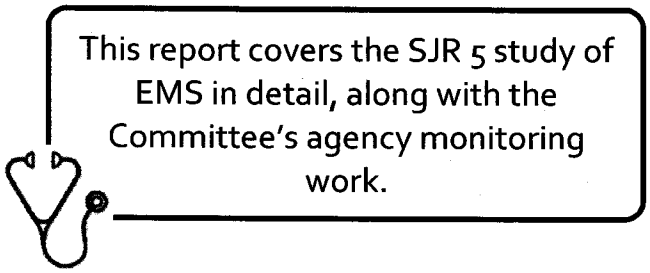
Two of the Committee's three studies stemmed from joint resolutions approved by the 2007 Legislature; the third was funded in House Bill No. 2.

- Senate Joint Resolution No. 5 called for a study of the state's emergency medical services (EMS) system and ways to keep that system viable, particularly in rural

areas. The study resulted in seven bill drafts that will be introduced in the 2009 Legislature, as well as letters to state agencies on EMS-related issues.

- Senate Joint Resolution No. 15 called for a study of the state's health care delivery system, including specialty hospitals. Committee members also focused on consumer access and education issues, including ways to make health care cost information more available and understandable to consumers. The study resulted in three bills for the 2009 Legislature.

- House Bill No. 2 in the May 2007 special session appropriated $200,000 for a mental health study. The Committee issued a Request for Proposals from interested contractors and received seven proposals. The Committee selected DMA Health Strategies of Lexington, Mass., to conduct the study, which was completed in October. The study resulted in four bills for the 2009 Legislature, as well as letters from the Committee to DPHHS, the Department of Corrections, the Indian Health Service, and the state's Indian tribes to ask that they follow up on various recommendations in the report.



This report covers the SJR 5 study of EMS in detail, along with the Committee's agency monitoring work. The SJR 15 and mental health studies are covered in separate reports; the SJR 15 report is entitled *Consumers, Providers, and the State: Their Roles in Health Care Access and Costs*, while the mental health study report is entitled *Report to the State of Montana: Legislative Mental Health Study.* The Committee's actions related to this study are summarized on page 14.

SJR 5 Study of Emergency Medical Services

Background

Montana's system of emergency medical response ranges from private ambulance services that are staffed around-the-clock by paramedics to units that arrive at a scene with volunteer "first responders" who leave their homes or jobs to treat a patient until an ambulance arrives. Depending on where the patient lives, emergency medical technicians (EMTs) may arrive within a matter of minutes in an urban area or within nearly 15 minutes in a rural area. The total time from initial call to arrival at a hospital is nearly double in rural Montana, compared with response times in Montana's cities.[1]

Rural areas face barriers to care not only because of distances, but also because of an increasing difficulty in recruiting and keeping the volunteers who staff many of the EMS agencies.

Mindful that a quick emergency response can mean the difference between life or death for the victim of a heart attack, stroke, or vehicle crash, legislators approved Senate Joint Resolution No. 5 in the 2007 Legislature. The resolution called for a study that would determine the issues that communities and providers face and that would identify strategies for ensuring that services remain in place throughout the state.

Lawmakers ranked the study 11th in their post-session poll of 21 proposed legislative studies, and the Legislative Council assigned the study to the Children, Families, Health, and Human Services Interim Committee.

Mindful that a quick emergency response can mean the difference between life or death for the victim of a heart attack, stroke, or vehicle crash, legislators approved SJR 5 in the 2007 Legislature.

[1] Legislative Audit Division, "Performance Audit: Emergency Medical Services (EMS)", June 2008, p. 20.

At about the same time, the Legislative Audit Division began a performance audit of the two state agencies that oversee EMS in Montana:

> The SJR 5 study was coordinated with the legislative performance audits of the DPHHS and the Board of Medical Examiners to make use of and build on the statistical and other information gathered during the audit.

- the Department of Public Health and Human Services (DPHHS), which licenses and regulates ambulance services and quick-response units, which are units that may treat but not transport a patient; and
- the Board of Medical Examiners, which licenses and regulates EMTs, the people who provide the emergency medical care.

The SJR 5 study was coordinated with the audit process to make use of and build on the statistical and other information gathered during the audit.

EMS in Montana

About 4,600 Montanans provide emergency medical care to people who suffer an unexpected illness or injury. Emergency responders undertake hours of training to reach different levels of licensure, and they work or volunteer for one of several different types of EMS providers.

The Board of Medical Examiners defines EMTs by category, based on the amount and type of training they have received. The licensure levels, as well as the training required, are established by rule. The following table shows the various licensure categories, the estimated number of hours of training required for successful completion of the training program objectives, and the number of EMTs certified at each level as of late 2007.

Table 1: Types and Numbers of EMTs in Montana, November 2007

Category	Training Requirements	Duties	Number
EMT-First Responder (EMT-F)	44 hours	Lifesaving medical techniques at the scene of an injury or accident	935
EMT-Basic (EMT-B)	160 hours	Lifesaving techniques plus ability to safely transport a patient in an ambulance	3,182
EMT-Intermediate (EMT-I)	Basic-level training plus 350 hours	Lifesaving techniques plus endorsement in other advanced techniques	48
EMT-Paramedic (EMT-P)	Basic-level training plus 2,000 to 3,000 hours	LIfesaving techniques plus advanced training to undertake many emergency medical procedures	442
		Total	**4,607**

Source: Board of Medical Examiners, November 2007

In addition, EMTs at each licensure level may receive endorsements in various types of care or services, such as the use of intravenous techniques or intubation, if they have received training in those areas.

EMS Providers

Emergency responders undertake hours of training to reach different levels of licensure, and they work or volunteer for one of several different types of EMS providers.

Nearly 250 EMS providers operate across Montana, but not all offer the same types of services. The majority are ambulances providing ground transport, but nearly as many nontransporting services also exist. These nontransporting services, or "quick response units" respond to the scene of an accident or injury and stabilize a patient until an ambulance arrives.

In addition, six hospitals operate helicopter and/or airplane ambulance services.

By far the largest number of providers operate with volunteers; combined, volunteer fire and EMS services make up nearly 72% of Montana's EMS providers. Although some services pay a stipend to their volunteers, the payments are generally made on a per-call basis rather than as a type of regular wage.

The table below summarizes the types of EMS providers operating in Montana.

Table 2: Types of EMS Providers

	Nontransporting	Ground Transport	Air Transport	Total
Volunteer	35	82		**117**
Fire-Volunteer	45	16		**61**
Private-Paid	6	10		**16**
Fire-Paid	8	8		**16**
Other-Paid	16	11	6	**33**
Tribal		5		**5**
Total	**110**	**132**	**6**	**248**

Source: EMS and Trauma Systems Section, Department of Public Health and Human Services, 2007

The table below summarizes the staffing requirements for the various types of EMS providers.

Table 3: Staffing Requirements by Provider Type

Type	Staffing Requirements
Nontransporting	One EMT-First Responder
Ground Transport	Two people required; one must be an EMT-Basic and one may be an EMT-First Responder with an ambulance endorsement
Rotor Wing Transport	One person required; level determined by licensure level. For example, an Advanced Life Support (ALS) service must have an EMT-Paramedic on board
Fixed Wing	One person required; level is determined by licensure level of service

Source: EMS and Trauma Systems Section, Department of Public Health and Human Services, 2007

Reimbursement

EMS providers typically are reimbursed from one of several possible sources: Medicaid, Medicare, the Indian Health Service, or private insurance. In addition, they may be able to bill patients for the balance of some of the charges or allowable costs.

The level of reimbursement varies depending on the payor. Medicaid reimbursements are set in state law, while Medicare rates are set by the federal government. Most private insurers pay a percentage — typically 70% or 80% — of the billed or allowable charge.

Many of the Medicaid reimbursements for EMS providers actually reflect the Medicare rate, while others reflect an average of typical charges for services provided in Montana over a period of time. A handful of services are still being evaluated by DPHHS before a "relative value unit" is assigned. For those services, the state Medicaid program reimburses at 46% of the "usual and customary charges.[2]"

EMS providers typically are reimbursed from one of several possible sources: Medicaid, Medicare, the Indian Health Service, or private insurance.

Recent Surveys

Even before the 2007 Legislature approved the EMS study, Montanans involved in and affected by those services — or the lack thereof — began trying to quantify their concerns. Several groups surveyed their members or constituents in recent years to determine the needs of the system and the possible consequences of a decrease in EMS care. The surveying entities and key findings with relevance to the SJR 5 study are listed below.

- **The Montana Hospital Association** surveyed members in 2004 to obtain more information about concerns expressed by some about possible closure of some volunteer ambulance services. Key SJR 5-related findings: 60% of respondents saw no indication that their local EMS provider was struggling, but 57% did think that difficulties existed in recruiting EMTs and 60% saw indications that training was insufficient.

- **The Montana Cardiovascular Program** of DPHHS surveyed EMTs in 2006 to gauge training and responses related to stroke symptoms and stroke-specific protocols. Key SJR 5-related findings: EMTs had a mean age of 43 and an average of 10 years experience providing emergency care.

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[2] Guidelines governing Medicaid reimbursement rates for ambulances services are contained in Title 37, chapter 86, subchapter 26, of the Administrative Rules of Montana.

- **The Board of Medical Examiners** conducted a 2006 survey of EMTs who had not renewed their licenses to determine why they had not done so. Key SJR 5-related findings: 33% were no longer interested in the field, 13% couldn't stay nationally registered because of education requirements, 8% had moved, 5% did not have the required continuing education, and 14% indicated that multiple factors applied.

- **The EMS and Trauma Systems Section** of DPHHS surveyed EMTs in 2006 to gather information on a broad range of EMS-related questions. Key SJR 5-related findings: 56% of the EMT workforce was 44 years of age or older, while 10% was between the ages of 19 and 28; 31% of EMTs were paid full-time or part-time workers, while 40% were volunteers receiving no compensation and 29% were volunteers with a stipend; 48% found it easy to leave work to answer calls; and 74% planned to continue in the field for 5 or more years.

The View From the Field

The Committee devoted time at its November 2007 and January and March 2008 meetings to listen to EMS providers from virtually every corner of the state, as well as individuals involved in EMS system, billing, and quality review issues.[3]

Over the course of the study, the Committee heard about:

- **the changing demographics of volunteer EMTs**. Stakeholders noted that many volunteers are aging and either have retired or will soon retire. They pointed to instances of EMTs who are in their 70s and still responding to calls.

- **problems recruiting and retaining volunteers**. Stakeholders said the time commitment required to obtain EMT licensure, combined with odd hours and difficult duty, pose problems in recruiting new EMTs. In addition, many families now have two working parents and many Montanans hold down two jobs, limiting the amount of time they have available to volunteer. And many younger people are not as interested in volunteerism as previous generations.

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[3] Appendix B contains a list of stakeholders who made formal presentations to the Committee.

- **training issues.** Stakeholders stressed the importance of high-quality and consistent training, to make sure EMTs are well prepared to respond to emergency calls even when they answer only a handful a year. They also indicated that obtaining the required training is difficult for some EMTs who live in rural areas and don't have the resources to travel to obtain training if they can't get the classes locally.

- **quality control issues**. Stakeholders advocated that EMS runs be reviewed for quality improvement and said that providing confidentiality to the review process could encourage more medical personnel to participate in run reviews.

- **service area issues**. Some stakeholders expressed concern that overlapping service areas exist, particularly between full-time public EMS agencies, such as fire departments, and private ambulance agencies.

- **concerns about low reimbursement rates**. Stakeholders noted that many rates are based off the Medicare payment rate and do not fully cover the cost of an EMS run, let alone the costs of maintaining equipment and training volunteers.

Legislative Audit

The Legislative Audit Division completed a comprehensive performance audit of DPHHS and the Board of Medical Examiners in June 2008 and presented the results to the Committee at that time.[4]

The audit found that gaps exist in available services, particularly Advanced Life Support service in rural areas and for all levels of care in some parts of central and eastern Montana. The audit measured Montana's system against guidelines established by the National Highway Traffic Safety Administration and concluded that the state could do more to meet national standards, particularly for timeliness of response, quality improvement, and medical direction. The audit also suggested steps for strengthening management controls within DPHHS to improve overall EMS activities.

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[4] The audit report is available at *http://www.leg.mt.gov/content/Publications/Audit/Report/07P-11.pdf.*

The audit made 12 recommendations, including:

- identifying and addressing gaps in services across the state;
- enhancing benchmarks for response times to EMS incidents;
- putting a comprehensive computerized system in place for information on EMS incidents;
- conducting a strategic planning process and better aligning DPHHS program activities to coincide with goals and objectives identified in that process; and
- changing state laws to clarify definitions relating to medical direction and to better define responsibility for handling complaints related to emergency medical care.

In response to the audit recommendations, the Committee approved a bill draft on medical direction and EMS complaint matters. It also sent letters to DPHHS and the Board of Medical Examiners, asking that each agency follow up on the audit recommendations and provide progress reports to the 2009-10 interim committee. (See Appendix E.)

Committee Action

At the March 2008 meeting, Committee members expressed interest in pursuing draft legislation to provide incentives to volunteer EMTs and their employers. They also agreed to work on legislation that would deal with other issues raised during the study period. Additionally, after hearing the final audit report findings and recommendations in June 2008, members asked for legislation recommended in the audit.

Senator Laible and Representative Sands provided direction to staff in drafting several bills for commitee consideration. They also worked to define which EMTs would be considered volunteers for the purpose of any incentives offered to increase the pool of volunteers available to small services.

So Who Is a Volunteer?

Defining the term "volunteer" posed several complicated questions for the Committee. For example, many "volunteers" for small rural services actually receive a stipend for each call they answer or a payment for each hour they are on call. Alternatively, some paid EMTs spend time in their off hours responding to calls as a volunteer for a service staffed primarily by volunteers. Moreover, some EMTs employed by private ambulance

companies volunteer in their off-duty hours when their company has an ambulance onsite for a community event, such as a high school sporting event or a rodeo.

The Committee walked a fine line in trying to craft a definition that included as many people as possible, as long as they were providing emergency medical care as a community service, rather than as part of a regular, paid job for a private business or a public agency, such as a city fire department.

To that end, it adopted the following definition that Committee members used as a basis for defining volunteer EMTs in all the bills:

> *"Volunteer emergency medical technician" means an individual who is licensed pursuant to (50-6-202) and provides emergency medical care:*
>
> *(1) on the days and the times of the day chosen by the individual; and*
>
> *(2) for an emergency medical service other than:*
>
> *(a) a private ambulance company, unless the care is provided without compensation and outside of the individual's regular work schedule; or*
>
> *(b) a private business or a public agency, as defined in 7-1-4121, that employs the individual on a regular basis with a regular, hourly wage to provide emergency medical care as part of the individual's job duties.*

This definition allows paid EMTs to be considered volunteers for the purposes of obtaining a special license plate and receiving tax incentives under any of the following scenarios:

- They work for a private ambulance company, private business, or public agency but also volunteer for another EMS provider during their off-duty hours.

- They work for a private ambulance company but volunteer time during their off-duty hours when the company is providing a staffed ambulance as a community service.

- They work for a county- or hospital-based ambulance service but are not scheduled or compensated on a regular basis.

Committee Bills

At its August 2008 meeting, the Committee approved the following bills for introduction in the 2009 Legislature:

- **LC 333**, to create a special license plate for volunteer EMTs who provided at least 120 hours of care in the previous year. The bill also provides a tax credit for the license plate, based on the number of hours an EMT volunteers each year.

- **LC 334**, to allow a lower staffing level for non-emergency medical transports and for all emergency transports in rural areas. This bill is designed to address provider concerns that two EMTs are not always available to take a stable patient from a small, critical access hospital to a larger health care facility several hours away or, in rural areas that rely on volunteer services, to respond to emergency calls during some times of the year or day.

- **LC 335**, to add a volunteer EMT to the Board of Medical Examiners because the Board has resumed the licensing of EMTs after previously delegating that task to DPHHS.

- **LC 336**, to provide tax credits to volunteer EMTs based on the amount of service they provide in a year and tax deductions to employers who allow their employees to leave work to respond to emergency calls.

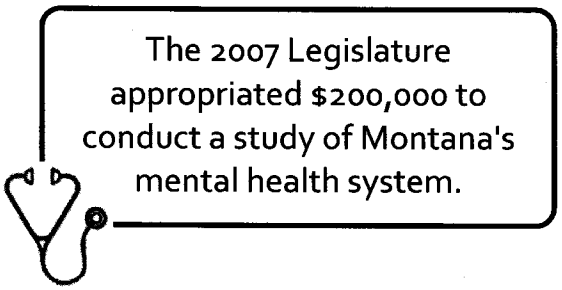
- **LC 337**, to create a $1 million grant program to help volunteer service providers buy equipment and vehicles, so that they are ready to respond to calls for assistance.

- **LC 117**, to authorize DPHHS to request local EMS council medical run reviews for purposes of conducting statewide medical run reviews and allowing for confidential discussion and review of medical run review data by local EMS councils for quality assessment purposes.

- **LC 338**, to clarify existing laws on medical direction for EMTs and EMS providers and on the handling of complaints related to emergency medical services and the care that EMTs provide. The performance audit recommended legislation in each of these areas.

Mental Health Study: Committee Action

The 2007 Legislature appropriated $200,000 to conduct a study of Montana's mental health system. In September 2007, the Legislative Council assigned the study to the Committee. The Committee issued a Request for Proposals for the study, and seven firms responded to the request. Based on the state's scoring procedures, the Committee awarded the contract to DMA Health Strategies of Massachusetts. DMA began work on the study in February 2008 and presented its final report and recommendations at an Oct. 14, 2008, meeting.



Based on the recommendations, the Committee approved the drafting of four pieces of legislation and also made requests for continued followup and action by state agencies. The Committee approved the following bill draft requests:

- **LC 592**, for an interim study of a managed care mental health system;
- **LC 593**, to appropriate up to $2.4 million to provide continued funding to five established "Kids Management Authorities", which seek to provide comprehensive, family-centered community services to children with mental health needs, and to allow for the creation of up to 10 additional KMAs;
- **LC 594**, to clarify the laws governing the establishment and roles of local and regional advisory councils in the mental health system; and
- **LC 595**, to appropriate $250,000 to provide family-centered services for children up to the age of 6 and also to provide community services to high-risk children with mental health and other needs.

In addition, the Committee agreed to ask that bill drafts approved by the Law and Justice Interim Committee be amended to include:

- provisions for allowing grant funding for Crisis Intervention Team training, which is provided to law enforcement officers to help them respond appropriately to people with mental health problems; and

- expansion of a proposed grant program to include collaborative community crisis efforts and provide matching funds to counties that participate in the collaborative efforts.

Committee members also expressed strong interest in ensuring that additional study recommendations were pursued by DPHHS, the Department of Corrections (DOC), and the 2009 Legislature. It agreed to make the Legislature's Joint Appropriations Subcommittee on Human Services aware of funding issues raised in the report. The Committee also voted to send letters to DPHHS and DOC specifically asking the agencies to report to the 2009 Legislature on which recommendations within their authority they planned to pursue and in what manner and to send letters to DPHHS, the Indian Health Service, and the state's Indian tribes asking for additional collaboration and cooperation to maximize Medicaid enrollment among tribal members and Medicaid reimbursement for mental health services.

In addition, the Committee indicated it would like the Children, Families, Health, and Human Services Interim Committee appointed for the 2009-10 interim to continue following up on the study recommendations and additional action needed to put into place recommendations that will improve Montana's publicly funded mental health system.

DPHHS Oversight

As part of its interim duties, the Children and Families Committee has oversight responsibility for DPHHS — an agency made up of 11 divisions and more than 3,000 employees. The agency provides both public health services to all Montanans and a wide array of assistance to vulnerable Montanans, including children and the elderly, needy, disabled, abused, neglected, and mentally ill.

At each of its meetings, the Committee heard updates on departmental activities, including:

As part of its interim duties, the Children and Families Committee has oversight responsibility for DPHHS — an agency made up of 11 divisions and more than 3,000 employees.

- the Medicaid program, which provides payments for medical services to low-income children, blind and disabled persons, and some extremely low-income adults who are not old enough to qualify for the Medicare program. The Committee tracked changes in the number of Medicaid recipients, particularly the continuing increase in the number of disabled Montanans applying for Medicaid. The changes are part of the key indicators posted to the DPHHS Web site at *www.dphhs.mt.gov/dataindicators/index.shtml.*

- the Children's Health Insurance Plan (CHIP), which provides health insurance coverage to children whose families make too much money to qualify for the Medicaid program but too little to afford health insurance. The 2007 Legislature changed the eligibility limits for the program from a family income of 150% of the federal poverty level to 175%. The change resulted in an average of an additional 2,359 children being enrolled in the program each month in fiscal year 2008. Average monthly enrollment went from 13,211 in fiscal year 2007 to 15,570 in fiscal year 2008, representing an 18% increase.[5] Information on the CHIP program is available on the DPHHS Web site at *http://chip.mt.gov*.

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[5] Figures provided by the DPHHS Health Care Resources Bureau, Aug. 8, 2008.

- a pilot project to increase payments for providers that deliver Medicaid personal assistance and private duty nursing services, if those agencies agree to offer health insurance coverage to their direct-care employees. The 2007 Legislature budgeted about $2.5 million for the pilot project. A work group began meeting in January 2008 to establish benchmarks for health insurance coverage and the policy for distributing the funds. DPHHS maintains a Web site with information about the effort at *www.dphhs.mt.gov/sltc/services/communityservices/HCWorkers/Index.shtml.*

- efforts to put into place wage increases for workers who provide services to people in their homes, such as home health care workers and people who work with persons with developmental disabilities. The 2007 Legislature provided funds to raise direct-care worker wages to a minimum of $8.50 an hour. Each DPHHS division worked with providers in its area of service to determine which providers were interested in taking part in the program.

- a new proposal for a Medicaid "buy-in" program, which would allow some people with disabilities to keep buying Medicaid coverage after they obtain a job. At that point, they likely are making too much money to qualify for the program but are not yet able to purchase their own insurance coverage. DPHHS will seek funding and legislation in 2009 to put the program in place. The bill will be drafted as LC 349.

- how the increase in child welfare workers has affected caseloads and services to children involved in neglect and abuse cases. The 2007 Legislature approved funding for 15 additional caseworkers in fiscal year 2007 and another five caseworkers in fiscal year 2008. More children left the child welfare system in the last fiscal year than entered it — a reverse of previous trends.[6]

- the creation of a program to provide early and intensive services to 40 to 50 autistic children between the ages of 1 and 5. The department believes early intervention may allow the children to function at a self-sufficient level when they

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[6] DPHHS Director Joan Miles, in remarks to the Children, Families, Health, and Human Services Interim Committee, June 10, 2008.

reach adulthood. The department is seeking a Medicaid waiver to pay for the services.

The Committee also heard regular updates on the mental health initiatives that the Legislature funded in 2007. Those initiatives included:

- the creation of "presumptive eligibility" that allowed people without health insurance to obtain 72 hours of state-paid mental health care if they were in crisis. The department phased in the program over the biennium, starting with seven counties on March 1, 2008. However, DPHHS had been unable, through August 2008, to hire additional psychiatrists at the Montana State Hospital to provide the telepsychiatry portion of the plan.

- funding for expanded mental health "drop-in centers" for people with mental health needs. DPHHS awarded funding to begin or expand services in Billings, Miles City, Bozeman, and Livingston. In addition, it provided funding to the Montana Mental Health Association to provide a statewide telephone and Internet-based "center".

- the hiring of five half-time "community liaison officers" who either have a mental illness or have had personal experience with the mental health system. The liaisons will provide support services for people who have returned to their communities from the Montana State Hospital. By August 2008, DPHHS had filled all five positions, hiring two liaisons in Butte, two in Missoula, and one in Helena.

- one-time funding for construction of a Behavioral Health Inpatient Facility (BHIF) that would house 16 or fewer individuals requiring inpatient mental health care. Development of the BHIF stalled during the interim because of indications from the Centers for Medicare and Medicaid Services that patients at the facility would be ineligible for Medicaid.

DPHHS regularly updates the status of new initiatives; information can be found on the agency's Web site at *www.dphhs.mt.gov/amdd/projectdescriptions.shtml*.

The 2007 Legislature also required specific reports to the Committee on:

- the suicide prevention plan developed under SB 478, approved by the 2007 Legislature. This bill created a $400,000 suicide prevention program in the department that included funding for an around-the-clock suicide prevention hotline, hiring of a suicide prevention coordinator, and the development of a suicide prevention plan. The plan sets specific goals, including preventing at least 26 suicides a year by 2013, putting an evidence-based suicide prevention curriculum into 40% of Montana's high schools by 2013, and increasing public education and awareness efforts by 2009 through advertisements, broad publication of the suicide hotline phone number, and providing programs targeted to specific risk groups.

- the SJR 7 study that the department undertook with the Department of Justice, to determine how to put in place criminal background checks for direct-care workers. DPHHS created a work group that has prepared a report and proposal for fingerprint background checks, as requested by the Legislature. The proposal includes a list of crimes that would permanently or temporarily disqualify a person from working as a direct-care worker and suggests creation of a secure registry of all direct-care worker applicants so employers could see if a background check had already been conducted on an applicant. The work group also determined that both the state and employers should share the costs of conducting the background checks, and it assessed the possibility of obtaining Medicaid funding to help with the costs. The work group did not develop legislation, but did conclude that the Legislature should take steps to put a public policy on background checks into place.

- the results of the Cervical Cancer Task Force's review of the new human papillomavirus (HPV) vaccine. The Task Force was set to expire in 2007, but the Legislature extended it for a 2-year period specifically to study the effectiveness of the new vaccine and ways to educate the public about the vaccine. The Task Force recommended that the state purchase 3,960 doses of the vaccine, using dedicated funding, and make them available to uninsured or underinsured young women between the ages of 19 and 26. The Task Force also worked on educational materials that are now posted on the Web site *immunization.mt.gov* for

use by parents, school personnel, and health care providers. In addition, it has distributed brochures and fact sheets to school administrators to provide to schools and has also made health care associations aware that the materials are available.

As part of its oversight responsibilities, the Committee also reviewed rules proposed and adopted by DPHHS. The rules review process is designed to ensure that administrative rules comply with the Montana Administrative Procedure Act. Interim committees have the authority to step into the rulemaking process if members have concerns about proposed rules.

As part of its oversight responsibilities, the Committee also reviewed rules proposed and adopted by DPHHS.

During the interim, the Committee reviewed 44 proposed rules and 51 adopted rules. Committee members received a summary of each proposed and adopted rule that contained the key elements of the rule, any public comment received on the rule, and — if applicable — any issues raised by the legal review or by Committee members.

Committee Action

Because of the issues that were brought to the Committee's attention, members wrote several letters and submitted public testimony on items of ongoing interest. They included:

- writing to the Montana congressional delegation to:
  - encourage a delay in Medicaid rules that would have "unbundled" Medicaid payments from other costs associated with certain types of therapeutic foster care for children; and
  - oppose a proposed 10% reduction in Medicare rates for physicians;

- submitting formal testimony to the Centers for Medicare and Medicaid Services on the proposed unbundling of Medicaid payments;

- writing to state officials to encourage that the state:
  - expand its eligibility criteria for the Food Stamps program, to serve more people; and
  - include funding in the 2010-11 budget to put in place a system to allow the sharing of electronic health records among health care professionals; and

- writing to health care providers and insurers to encourge their participation in a Web site under development by MHA, An Association of Montana Health Care Providers. The Web site is designed to provide Montana consumers with more information on health care pricing and is expected to be online in early 2009.

Other Committee Legislation

In addition to the draft legislation proposed as part of the SJR 5 and SJR 15 studies, the Committee approved legislation to correct some problems in existing laws or address other issues of concern to Committee members. This section summarizes each of those bills.

LC 41: Over-the-Counter Drugs

LC 41 was drafted to correct an error in 50-32-205, MCA, which requires the Board of Pharmacy to exclude a non-narcotic drug from the dangerous drug schedule if 50-31-307, MCA, allows it to be lawfully sold without a prescription. However, 50-31-307, MCA, deals only with prescription drugs, not over-the-counter drugs.

The Committee approved LC 41 to remove the reference to 50-31-307, MCA.

LC 42: Hospital Bed Tax

The 2007 Legislature approved two bills relating to the so-called "hospital bed tax". Money raised by the fee provides funding for increases in Medicaid payments to hospitals. The fee was enacted in 2003 for a 2-year period, but was extended by the 2005 Legislature and scheduled to terminate on June 30, 2007. In 2007, the Legislature approved two bills related to the fee:

- Senate Bill No. 118 extended the fee until June 30, 2009; set the rate of the fee for each year of the extended period; and amended Session Laws to change the termination date of the statute to June 30, 2009.

- Senate Bill No. 525 removed the sunset provision entirely and gradually increased the tax to $50 a day, beginning Jan. 1, 2010.

SB 525 contained instructions to coordinate the language with SB 118 if both bills passed, but it failed to repeal the Session Laws containing the June 30, 2009, termination date. Without corrective action, the law authorizing the fee itself would terminate before the permanent extension of the fee goes into effect.

The Committee approved LC 42 to repeal the termination date for 15-66-102, MCA.

LC 43: Caretaker Relatives and School Enrollment

The 2007 Legislature approved Senate Bill No. 49, which allows a non-parent relative who is taking care of a child to enroll the child in school, discuss certain school-related matters with school officials, and consent to school-related medical care if the person completes a caretaker relative educational authorization affidavit. Although 20-5-503(6), MCA, makes an affidavit effective through the end of the school year, the language suggested for the affidavit itself — in subsection (9) of 20-5-503 — makes the affidavit valid for only 6 months after it is signed.

The Committee approved LC 43 to make the suggested affidavit language in subsection (9) consistent with the time period (the full school year) in subsection (6).

LC 148: Friend of the Respondent in Civil Commitment Proceedings

The Montana Supreme Court issued a ruling in December 2007 in an appeal of an involuntary commitment to the Montana State Hospital. The court held that the District Court had erred in appointing the respondent's mother as the "friend of the respondent". Under statute, the court-appointed "friend" is to represent a respondent's interests during the involuntary commitment proceedings. However, in this case, the respondent's mother had also filed a complaint against him and was called to testify against him during the proceedings.

In its ruling, the Supreme Court urged that the Legislature revise the friend-of-the-respondent laws to ensure that the appointed friend is unbiased and objective.

The Committee approved LC 148 to establish standards for appointment of the friend of the respondent.

LC 149: Principles and Methodology for Provider Rate Review

Senator Christine Kaufmann asked the Committee in June 2008 to consider developing a Committee bill to help establish principles for reviewing DPHHS rates for providers of

human services, particularly children's services. Senator Kaufmann serves on the Commission on Provider Rates and made the request on the Commission's behalf.

In August, Senator Kaufmann withdrew her request so that the Commission could spend more time working with DPHHS on a bill draft. As a result, the Committee canceled LC 149.

LC 150: Clarification of Sponsor Notification of Administrative Rules

Interim committees monitor the administrative rules proposed and adopted by the agencies for which they have oversight responsibility. As part of this process, Committee members discussed the importance of ensuring that legislators know that they can submit comments to the interim committees if they have concerns about proposed administrative rules developed in response to a bill for which the legislator was the primary sponsor. The Committee also decided to draft legislation to clarify the sponsor notification requirements in existing statute.

The Committee approved the drafting of LC 150, which requires that during the rulemaking process agencies:

- contact the primary sponsor to inform the sponsor that the rulemaking process has begun and to obtain the sponsor's comments;
- provide the sponsor with all known dates for the rulemaking process and with information about how to submit public comment, including information on the opportunity to provide public comment to the appropriate interim committee;
- consider comments submitted by the primary sponsor; and
- provide a statement explaining why the sponsor's comments were not incorporated into an adopted rule, if the agency adopts a rule that does not reflect the sponsor's comments.

In August, the Committee decided to refer LC 150 to the State Administration and Veterans' Affairs Interim Committee (SAVA) for consideration as a committee bill because SAVA more frequently deals with matters involving administrative rules.

Appendix A
Summary of Meetings

Appendix A: Summary of Meetings

The Children, Families, Health, and Human Services Interim Committee held eight meetings over the course of the interim. At each meeting, members received regular updates from DPHHS Director Joan Miles and Deputy Director John Chappuis about program activities within that Department. They also heard updates from the DPHHS Addictive and Mental Disorders Division about the Division's progress in putting several new mental health initiatives into effect. And they heard reports from representatives of HealthShare Montana, a group of health care providers working on ways to create and share electronic health records for patients.

Health information technology issues are discussed more fully in the SJR 15 report, entitled *Consumers, Providers, and the State: Their Roles in Health Care Access and Costs,* along with other information about that study. The mental health study is discussed separately in the report entitled *Report to the State of Montana: Legislative Mental Health Study.*

Following is a summary of topics covered at each of the Committee's meetings.

June 26, 2007: Committee members elected Representative Edith Clark as Presiding Officer and Senator Dan Weinberg as Vice Presiding Officer. During this organizational meeting, the Committee reviewed and adopted a proposed work plan that provided an outline of how it would proceed with assigned studies and with DPHHS oversight duties. It also approved a work plan for the SJR 5 study of emergency medical services (EMS), discussed a draft work plan for the SJR 15 study of the health care delivery system, and agreed to ask the Legislative Council to assign the mental health study to the Committee. Members also identified topics on which they wanted further information at future meetings.

Sept. 24, 2007:The Committee began work on its SJR 5 and SJR 15 studies at this meeting. SJR 5 Study: Staff provided an overview of state laws governing EMS agencies and emergency medical technicians (EMTs), as well as a history of how those laws have changed over time. The Committee also heard from DPHHS and the Board of Medical Examiners about their roles in overseeing EMS-related activities and from two local government officials about the local issues facing EMS. SJR 15 Study: Staff provided an overview of ownership issues for entities involved in the health care delivery system, discussed recent court cases involving specialty hospitals, reviewed issues and terms related to economic and physician credentialing by health

care facilities, and provided information on the tax treatment of nonprofit and for-profit health care facilities. Committee members also expressed an interest in pursuing matters related to consumer-directed health care.

Nov. 16, 2007: SJR 5 Study: This meeting focused on panel presentations by several EMS providers who discussed the issues facing their services, how hospitals are affected by the type of EMS care available, and the need for review of EMS runs for quality improvement purposes. Staff also presented a briefing paper with basic information on the number of EMTs in Montana, the number and types of EMS agencies, and key findings from recent surveys of hospitals and EMTs. SJR 15 Study: Presentations focused on ways to inform consumers about health care prices and choices, including a panel discussion on pricing issues and how pricing information is made available to the public. Representative Clark appointed Senator Weinberg and Representative Dutton to a subcommittee to work on the specialty hospital and economic credentialing aspects of the study. Mental Health Study: The Legislative Council assigned the mental health study funded in HB 2 to the Children and Families Committee in late September. At this meeting, the Committee approved the key elements to include in a Request for Proposals from consulting firms interested in conducting the study. The Committee also agreed to allow the study to wrap up in October 2008, past the traditional Sept. 15 deadline for Committee work because a contract would not be awarded until late January 2008.

Jan. 24, 2008: The SJR 15 Subcommittee met with physicians, hospital officials, owners of imaging centers, and physical therapists to discuss ways in which they would propose to structure the health care delivery system. They also discussed economic credentialing issues and specialty hospitals.

Jan. 25, 2008: SJR 5 Study: The Committee heard the first round of information from the Legislative Audit Division's EMS performance audit. The audit information provided an overview of the EMS workforce, system resources, and incident types. The Committee also heard more about EMS reimbursement issues and learned about efforts in other states to address EMS workforce and readiness issues. SJR 15 Study: Presentations focused on a Montana Department of Justice study of hospital charity care, information about the role of community health centers, and billing issues, particularly on ways to make medical bills more understandable for consumers. Mental Health Study: Staff presented Committee members with the results of a staff evaluation committee's review of the seven proposals submitted by

consultants interested in contracting for the mental health study. Based on the evaluation committee's recommendation, the Committee approved the hiring of DMA Health Strategies of Massachusetts to conduct the study.

Feb. 11, 2008: The SJR 15 Subcommittee met to review existing state law on economic credentialing and specialty hospitals, as well as the role of insurers and health care providers in directing patients to different types of providers or care.

March 17-18, 2007: SJR 5 Study: The Committee continued the information-gathering phase of the study by hearing from additional stakeholders before reviewing a summary of testimony and options presented by stakeholders. Senator Laible and Representative Sands offered to work with staff on bill drafts to address volunteer workforce issues. SJR 15 Study: The subcommittee met to discuss proposed bill drafts on economic credentialing and specialty hospitals before bringing the proposals to the full Committee at this meeting. The full Committee also covered consumer-related health care issues involving early childhood access to health care in the schools and end-of-life care provided by hospices. Mental Health Study: DMA Health Strategies provided its first update to the Committee, outlining its proposed work plan for the mental health study and the steps taken to date. In addition, the Committee heard about the work of the Billings Community Crisis Center and also about DPHHS's success in having Missoula designated as a health professional shortage area after the retirement of a psychiatrist. The designation makes it possible to offer incentives to recruit mental health providers to the area. Other Issues: The Committee reviewed and approved three bill drafts to correct issues involving the hospital bed tax, caretaker relative educational authorization affidavits, and existing law on prescribing of narcotic drugs.

June 10-11, 2008: SJR 5 Study: The Legislative Audit Division presented the results of its EMS performance audit, which included 12 recommendations for strengthening EMS in Montana. Committee members also reviewed and took public comment on six bill drafts designed to provide tax incentives to volunteer EMTs and their employers and to assist with the costs of readiness by creating a grant program that would provide local EMS providers with funds to buy vehicles or equipment. Committee members asked staff to revise the drafts to take into account issues raised during the public-comment period and by the performance audit. SJR 15 Study: The subcommittee continued its work on draft legislation, which included conflict-of-interest disclosures, anti-kickback language, and economic credentialing revisions. The full Committee

heard a panel presentation on the ways in which insurance companies credential physicians and decide which physicians may be included in an insurance network. Mental Health Study: DMA Health Strategies provided an update on its activities to date, including preliminary analysis of claims submitted to the state for mental health services and how they might indicate where gaps in service exist. Staff provided short updates on Montana's mental health parity laws and on the children's system of care. Other Items: The Committee heard reports on food and nutrition issues in Montana and asked that a letter be sent to DPHHS asking the agency to change eligibility requirements for Food Stamps to allow more people to qualify for the program. It also approved the drafting of bills to set principles for provider rate increases, clarify friend-of-the-respondent appointments for involuntary commitment proceedings, and clarify sponsor notification requirements for the administrative rulemaking process.

Aug. 21-22, 2008: SJR 5 Study: The Committee reviewed revised bill drafts on incentives for volunteer EMTs and their employers and on an EMS grant program and also reviewed a bill draft clarifying laws on medical direction and EMS complaints, as recommended in the legislative performance audit. After taking public comment, the Committee approved the introduction of seven bills and agreed to send letters to DPHHS and the Board of Medical Examiners to follow up on other audit-related isues. SJR 15 Study: The Committee split the economic credentialing and conflict-of-interest legislation that it had been considering into three bill drafts. The three bill drafts preserve elements that revise and extend the existing law on economic credentialing, prohibit kickbacks and conflict of interest for health care providers, and require a health care provider to disclose any investment or employment interests when making a referral. Members did not act on committee legislation on specialty hospitals because bills that could resolve the issue are still pending in Congress. The Committee also agreed to introduce a bill requesting funding for electronic health records, as well as a resolution that would be introduced if the funding is included in the Governor's budget, instead. Mental Health Study: DMA Health Strategies provided an update that included some preliminary findings and recommendations in advance of its final report, scheduled for October. The Committee also heard more about the wrap-around philosophy of providing services to children with multiple needs, including mental health needs, from the perspective of a provider and DPHHS. Other Items: The Committee heard reports, as required by law, on the new statewide suicide prevention plan, the work of the Cervical Cancer Task Force, and the SJR 7 study of criminal background checks for direct-care workers.

Oct. 14: 2008: DMA Health Strategies presented its final report on the mental health study. The Committee also heard responses from DPHHS and Department of Corrections officials about recommendations involving their agencies and took comments from the public on the report's many recommendations. The Committee asked the agencies to continue to report to the Legislature on their activities to put report recommendations into effect and also authorized the drafting of four bills related to the mental health study, including a resolution for an interim study of a managed care system.

Appendix B
SJR 5 Stakeholder Presentations

Appendix B: SJR 5 Stakeholder Presentations

From September 2007 through March 2008, Committee members heard from a number of stakeholders about various facets of emergency medical services (EMS) in Montana. Following is a list of the topics covered at each meeting and the people who presented information during formal presentations.

Sept. 24, 2007

EMS at the State Government Level

- ✓ Role of the Board of Medical Examiners
  - *Jeannie Worsech, Executive Director, Board of Medical Examiners*
- ✓ Role of DPHHS
  - *Jim DeTienne, Supervisor, DPHHS EMS and Trauma Systems Section*

EMS at the Local Government Level

Jamie Doggett, Meagher County Commissioner
Randy Brodehl, Kalispell Fire Chief

Nov. 16, 2007

EMS Perspectives: Volunteer and Private Providers

Teresia Moore, Roosevelt Medical Center Ambulance, Culbertson
Joleen Weatherwax, Blackfeet Tribal Emergency Medical Service
Delbert Abbey, Philipsburg Volunteer Ambulance Association
Mike McGree, A-1 Ambulance Service, Butte
Dave Kuhn, Missoula Emergency Services

EMS Perspectives: Hospitals

Scot Mitchell, Administrator, Wheatland Memorial Hospital
John Bleicher, Trauma Services Coordinator, St. Patrick Hospital, Missoula

Jan. 25, 2008

Issues in Reimbursement

John Ungaretti, General Manager, Montana Healthcare Consultants, Inc.

EMS Elsewhere: Ideas and Approaches

Nels Sanddal, Critical Illness and Trauma Foundation

March 17, 2008

Quality Review of EMS Cases: Issues and Options

Debbie Ogden, Missoula EMS Council

A Personal Perspective of EMS

Ken Threet, Board of Medical Examiners and Volunteer EMT

Stakeholder Proposals

Cliff Christian, American Heart Association/American Stroke Association

Appendix C
Summary of Reports

Appendix C: Summary of Reports

Legislative staff prepared a number of reports related to Committee studies and other health and human services issues, as follows:

SJR 5 Study of Emergency Medical Services
EMS Performance Audit, Legislative Audit Division, June 2008
Memo on EMS-Related Issues, Legislative Audit Division, June 3, 2008
Summary of EMS Testimony, Sue O'Connell, March 7, 2008
EMS in Montana, Legislative Audit Division, Jan. 25, 2008 (PowerPoint presentation)
EMS by the Numbers, Sue O'Connell, November 2007
The Evolution of Montana's EMS Laws, Sue O'Connell, September 2007

SJR 15 Reports
Statutory Requirements in Selected States: Health Care Facility Pricing, Quality, and Insurance Information, Pat Murdo, August 2008
Hospital Lending Practices: Memo and Summary Table, Pat Murdo, August 2008
Physician Credentialing: Staffing, On Call, and Insurance Issues, Pat Murdo, June 2008
Health Care Facility Survey Update, Pat Murdo, March 2008
Hospices and End-of-Life Care in Montana, Pat Murdo, March 7, 2008
Charity Care and Other Community Benefits, Pat Murdo, March 7, 2008
State Statutes: Specialty Hospitals and Economic Credentialing, Jan. 24, 2008
Tax Treatment of Nonprofit Entities, Lee Heiman, September 2007
Review of Related Court Cases, Lisa Mecklenberg Jackson, September 2007

Mental Health Study
Montana's History with Managed Mental Health Care: Sue O'Connell, October 2008
Parity: General Overview, Sue O'Connell, June 2008
Children's Systems of Care, Sue O'Connell, June 2008
Overview of Montana's Publicly Funded Mental Health System, Sue O'Connell, March 7, 2008
Montana State Hospital Update, Lois Steinbeck, Legislative Fiscal Division, February 2008
Review and Recommendation of Mental Health Study Proposals, Sue O'Connell, Jan. 25, 2008
Mental Health Study Request for Proposals, issued Nov. 27, 2007
Rhode Island's Integrated Family and Community System of Care, Sue O'Connell, November 2007
Mental Health Study Plan, Susan Byorth Fox, September 2007

Other Staff Reports
Committee Work Plan, Adopted June 26, 2007
Summary of 2007 Health and Human Services Legislation, Sue O'Connell, June 21, 2007

Copies of all staff reports are available on the Staff Reports page of the Committee's Web site, at *http://leg.mt.gov/css/committees/interim/2007_2008/child_fam/staff_reports/reports.asp.*

Appendix D
Summary of Legislation

Appendix D: Summary of Legislation

Following is a list of legislation that will be introduced at the request of the Children, Families, Health, and Human Services Interim Committee in the 2009 Legislature, by topic area.

SJR 5 Study of Emergency Medical Services
LC 333: Create a License Plate and License Plate Tax Credit for Volunteer EMTs
LC 334: Allow Reduced Staffing Levels for Certain Ambulance Transports
LC 335: Add a Volunteer EMT Member to the Board of Medical Examiners
LC 336: Tax Incentives for Volunteer EMTs and Their Employers
LC 337: Create an EMS Grant Program
LC 117: Confidentiality for EMS Run Review
LC 338: Clarify Laws on EMS Medical Direction and Complaint Handling

SJR 15 Study of the Health Care Delivery System
LC 341: Revise and Extend the Economic Credentialing Statute
LC 342: Prohibit Kickbacks and Conflict of Interest for Health Care Providers
LC 343: Require Referring Health Care Providers to Disclose Investment and Employment

Mental Health Study
LC 592: Interim Study of Managed Care Mental Health System
LC 593: Appropriate Funds to Sustain and Expand Kids Management Authorities
LC 594: Clarify Statutes Involving Local and Regional Advisory Groups
LC 595: Appropriate Funds for the Mental Health Needs of Young and High-Risk Children

Other Health and Human Services Legislation
LC 41: Over-the-Counter Drugs
LC 42: Repeal the Sunset Provision for the Hospital Bed Tax
LC 43: Consistency for Duration of Caretaker Relative Educational Authorization Affidavit
LC 148: Standards for Friend of the Respondent in Civil Commitment Proceedings

Appendix E
Committee Correspondence Related to SJR 5

Children, Families, Health, and Human Services Interim Committee

60th Montana Legislature

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PAT MURDO, Staff for SJR 15

September 9, 2008

Joan Miles, Director
Department of Public Health and Human Services
P.O. Box 4210
Helena, MT 59604-4210

Dear Director Miles:

The June 2008 legislative performance audit of emergency medical services (EMS) in Montana recommended that the Department of Public Health and Human Services undertake a number of activities to improve Montana's system of emergency medical response.

The Children, Families, Health, and Human Services Interim Committee reviewed these recommendations as part of its interim Senate Joint Resolution 5 study of emergency medical services. The committee strongly believes that the Department must follow up on the recommendations to ensure that both Montanans and visitors to our state are assured that their emergency calls will be answered by a workforce that is well trained and properly equipped.

Thus the interim committee agreed on Aug. 22 to introduce legislation as proposed in Audit Recommendations #4 and #5, to clarify medical direction statutes and to clarify the handling of complaints involving emergency medical technicians and EMS agencies.

Because much of the responsibility for ensuring that emergency medical services are ready to respond rests with DPHHS through its oversight and licensing abilities, the committee also agreed to encourage DPHHS to take the following steps:

- Develop an administrative rule as proposed in Audit Recommendation #1, to clearly define the capabilities that an EMS provider must have to be licensed to provide care at the Basic Life Support with Advanced Life Support Endorsement licensure level.

- Complete and put into use a comprehensive information management system as suggested in Audit Recommendation #7 and work with EMS providers to ensure they can and do enter data into the system.

- Work with the Board of Medical Examiners as suggested in Audit Recommendation #8, to ensure that EMS data is shared between the two state agencies to improve analysis and reporting of EMS system issues.

- Report to the Children, Families, Health, and Human Services Interim Committee by Sept. 15, 2010, on any recommendations or changes made as a result of Audit Recommendation #12, to revise the governance structure for EMS.

MONTANA LEGISLATIVE SERVICES DIVISION STAFF: SUSAN BYORTH FOX, EXECUTIVE DIRECTOR • DAVID D. BOHYER, DIRECTOR, OFFICE OF RESEARCH AND POLICY ANALYSIS • GREGORY J. PETESCH, DIRECTOR, LEGAL SERVICES OFFICE • HENRY TRENK, DIRECTOR, OFFICE OF LEGISLATIVE INFORMATION TECHNOLOGY • TODD EVERTS, DIRECTOR, LEGISLATIVE ENVIRONMENTAL POLICY OFFICE

- Provide periodic progress reports to the committee during the 2009-2010 interim on the following audit recommendations:

  - Audit Recommendation #2, which asks the department to collect information on EMS provider coverage areas, staffing activities, and service availability, determine why gaps in Advanced Life Support service exist, and work with stakeholders to address service gaps.

  - Audit Recommendation #3, to improve data collection and analysis of EMS incident response times by establishing response time benchmarks, revising administrative rules to require providers to record and report "at patient" times, and enforcing compliance with the rule requiring quarterly reporting of EMS incidents.

  - Audit Recommendation #6, to work with stakeholders to develop an objective, data-driven oversight approach to evaluate the EMS system and ensure quality improvement efforts.

  - Audit Recommendation #9, to develop and put in place a strategic plan to help in developing the state's EMS system and strengthening management activities.

  - Audit Recommendation #10, to revise the roles and responsibilities of the EMS and Trauma Systems Section staff to better achieve the section's mission and meet national EMS standards.

  - Audit Recommendation #11, to strengthen the management controls of the section's regulatory activities involving inspections, vehicle permits, complaint documentation, and EMS unit licensure fees.

Again, the committee has become well acquainted this interim with the importance of ensuring that Montana's EMS system is not only viable, but also that proper oversight is in place to ensure that EMS providers and individual EMTs are ready to provide a quick and appropriate response when called.

Committee members believe the steps outlined above will help Montana's EMS system meet that goal. We hope DPHHS will support the committee legislation involving Audit Recommendations #4 and #5 (now known as LC 338), undertake the activities recommended by the audit, and provide the next interim committee with the updates we've identified.

Sincerely,

Edith Clark
Presiding Officer

c: Jane Smilie
Todd Harwell
Jim DeTienne

Children, Families, Health, and Human Services Interim Committee

60th Montana Legislature

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PAT MURDO, Staff for SJR 15

September 9, 2008

Keith Kelly, Commissioner
Department of Labor and Industry
P.O. Box 1728
Helena, MT 59624-1728

Dear Commissioner Kelly:

The June 2008 legislative performance audit of emergency medical services (EMS) in Montana recommended that the Department of Labor and Industry, through the Board of Medical Examiners, undertake several steps to work with the Department of Public Health and Human Services toward a coordinated state-level approach to emergency medical services in Montana.

The Children, Families, Health, and Human Services Interim Committee reviewed the audit recommendations as part of its interim Senate Joint Resolution 5 study of emergency medical services. The committee strongly believes that the departments must follow up on the recommendations to ensure that both Montanans and visitors to our state are assured that their emergency calls will be answered by a workforce that is well trained and properly equipped.

Thus the interim committee agreed on Aug. 22 to introduce legislation as proposed in Audit Recommendations #4 and #5, to clarify medical direction statutes and to clarify the handling of complaints involving emergency medical technicians and EMS agencies. These two recommendations were addressed to both state agencies.

The committee also is encouraging both agencies to work together, as suggested in Audit Recommendation #8, to ensure that EMS data is shared between the agencies to improve analysis and reporting of EMS system issues.

During this interim, committee members have become well acquainted with the importance of ensuring that Montana's EMS system is not only viable, but also that proper oversight exists to ensure that EMS providers and individual EMTs are ready to provide a quick and appropriate response when called. Thus we hope the Department of Labor and Industry will support the proposed committee legislation, currently LC 338, and work with DPHHS on Audit Recommendation #8.

Sincerely,

Edith Clark
Presiding Officer

c: Mike Cooney
Jeannie Worsech

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Appendix F

Committee Correspondence Related to the Mental Health Study

Children, Families, Health, and Human Services Interim Committee

60th Montana Legislature

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PAT MURDO, Staff for SJR 15

October 22, 2008

Joan Miles, Director
Department of Public Health and Human Services
111 N. Sanders, Room 301
Helena, MT 59604-4210

Dear Director Miles,

On behalf of the Children, Families, Health, and Human Services Interim Committee, I want to thank you and your staff for attending our October 14 meeting and responding to the recommendations in the DMA Health Strategies study of Montana's mental health system. We understand that the comprehensive nature of the report and recommendations made it difficult to respond fully in the short time period you all had to review the report.

We know that with additional time, the Department of Public Health and Human Services will be able to better identify which recommendations the agency can put into effect on its own and which would be appropriate to pursue, but would need direction from the Governor's Office or the Legislature. Because we feel this study contains valuable information and recommendations, we would specifically ask that the Department take the following steps:

- During the 2009 Legislature, report to the Joint Appropriations Subcommittee on Health and Human Services and to the House and Senate standing committees on human services about which items the Department plans to pursue on its own and which of the items the Department believes would be worth pursuing but would need legislative action. Your report would be most helpful if it not only covered the steps the Department can and will take, but also the support you might need from the Legislature to carry out the recommendations.

- As discussed with you on October 14, we believe the worksheet entitled *Mental Health Study: Items for Possible DPHHS Action* provides a good starting point for your report to the legislative committees. In addition, committee members also specifically requested that your report address the following items:
  - The recommendations related to continuing efforts to eliminate the barriers to creating Behavioral Health Inpatient Facilities by reviewing financing models used in other states and considering limiting liability for non-Medicaid patients;
  - How co-payments and other cost-sharing requirements for mental health services could be eliminated, including the likely fiscal effect of such an action;
  - How the Department plans to increase sharing of data among its divisions and with the Department of Corrections;

- The results of any efforts to re-issue the Request for Information for telepsychiatry or, if the RFI has not been re-issued, the Department's plans for increasing telepsychiatry opportunities in Montana;
  - Whether a Medicaid procedure code has been developed for the mental health services the Child and Family Services Division has obtained for some foster children through use of general fund dollars only; and
  - Ways to expand the use of peer services and to fund them through Medicaid.

- Propose to the Community Health Center Advisory Group that any state funds appropriated for Community Health Center support in the next biennium be used to help finance the mental health services that all CHCs must provide to their patients. A collaborative effort to expand mental health services could focus attention on a core need and help better spread limited resources among the CHCs.

- Share the report and its recommendations with the mental health community across Montana, including consumers, family members, advocates, and providers and develop a plan for using the responses you receive from these constituents.

- Work with the Indian Health Service and tribal governments in Montana to maximize Medicaid enrollment and reimbursement and to help identify the mental health needs of tribal members.

- Report to the Children and Families Committee in the 2009-10 interim on which recommendations the Department has undertaken and the status of those activities, as well as discuss with the Committee any additional recommendations the Department believes should be pursued on either an agency or legislative level.

The Committee strongly believes that this report provides a road map that the Department, the Governor's Office, and the Legislature can use for several years to help develop a comprehensive and better coordinated mental health system to better serve the needs of Montanans in all regions of our vast state. We hope the October 14 meeting was just the beginning of a wide-ranging and long-lasting discussion of how to put the report's recommendations into effect.

Thanks again to your and your staff for all the time you devoted to helping DMA with the study over the past several months, as well as the time you took to review the report and attend our meeting. We look forward to hearing in the coming months about the Department's efforts to make the most of this study.

Sincerely,

Rep. Edith Clark
Presiding Officer

c: Lou Thompson, Addictive and Mental Disorders Division
Mary Dalton, Health Resources Division
Shirley Brown, Child and Family Services Division
Bonnie Adee, Children's Mental Health Bureau

Children, Families, Health, and Human Services Interim Committee

60th Montana Legislature

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October 22, 2008

Mike Ferriter, Director
Department of Corrections
1539 11th Ave.
Helena, MT 59620-1301

Dear Director Ferriter,

On behalf of the Children, Families, Health, and Human Services Interim Committee, I want to thank you and your staff for attending our October 14 meeting and responding to the recommendations in the DMA Health Strategies study of Montana's mental health system. We understand that the comprehensive nature of both the report and the recommendations made it difficult to respond fully in the short time period you all had to review the report.

We know that with additional time, the Department of Corrections will be able to better identify which recommendations the agency can put into effect on its own and which would be appropriate to pursue, but would need direction from the Governor's Office or the Legislature.

Because we feel this study contains valuable information and recommendations, we would specifically ask that the Department report to the 2009 Joint Appropriations Subcommittee on Corrections and Public Safety and the Subcommittee on Health and Human Services about the recommendations the Department plans to pursue on its own and which of the items the Department believes would be worth pursuing but would need legislative action.

As discussed on October 14, we believe the list of Criminal Justice Recommendations on page 8 of the report's Summary of Recommendations provides a good starting point for your report to the subcommittees. Your report would be most helpful if it not only covered the steps the Department can and will take, but also the support you might need from the Legislature to carry out the recommendations.

Committee members also expressed particular interest in following up on the recommendations to suspend Medicaid enrollment for prison inmates to allow them to obtain Medicaid-covered services as soon as they are released and to continue the programs that currently provide funding for medication and community mental health services to people released from the state's correctional facilities.

The committee strongly believes that this report provides a road map that the Department, the Governor's Office, and the Legislature can use for several years to help develop a comprehensive and better coordinated mental health system to better serve the needs of Montanans in all regions of our vast state. We hope the October 14 meeting was just the

beginning of a wide-ranging and long-lasting discussion of how to put the report's recommendations into effect.

Thanks again to your and your staff for all the time you devoted to helping DMA with the study over the past several months, as well as the time you took to review the report and attend our meeting. We look forward to hearing in the coming months about the Department's efforts to make the most of this study.

Sincerely,

Rep. Edith Clark
Presiding Officer

c: Deb Matteucci, Behavioral Health Coordinator

Children, Families, Health, and Human Services Interim Committee

60th Montana Legislature

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November 3, 2008

Pete Conway, Director
Billings Area Indian Health Service
2900 4th Avenue North
Billings, MT 59101

Dear Director Conway,

The 2007 Montana Legislature commissioned a comprehensive study of Montana's publicly funded mental health system, to identify gaps in services and opportunities for better serving all Montanans with mental health needs. The firm hired to conduct the study, DMA Health Strategies, recently presented its final report to the Children, Families, Health, and Human Services Interim Committee. Because the report touches on mental health services provided through the Indian Health Service and to tribal residents, I'm enclosing a copy of the report for your review.

The Committee felt recommendations in the report involving state, tribal, and IHS cooperation and collaboration were particularly important to better meet the needs of tribal members living in Montana. Committee members voted at an October 14 meeting to ask IHS, the tribes, and the Montana Department of Public Health and Human Services to work together on the following recommendations contained in the report's Summary of Recommendations:

- Continue joint efforts to increase Indian enrollment in Medicaid to maximize Medicaid reimbursement for IHS services and free up IHS funds to serve more people.

- Develop a long-term strategy to enhance IHS, tribal, and state collaborations to better understand the needs of tribal members, enhance cultural competency in services, and make the best use of combined tribal and state mental health resources.

- Determine why IHS billings do not consistently identify mental health visits and whether additional IHS services might be billed to Medicaid.

- Improve the collection and sharing of data to provide a more complete picture of the mental health needs of Montanans, including tribal members. Better and more comprehensive data about these mental health needs would allow policy makers and mental health providers to better understand the issues involved in providing mental health care to all Montanans who need it.

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The Committee believes these steps may not only improve mental health services for tribal members, but also could increase the funds available for all health care services by covering more mental health services through Medicaid. Committee members hope that all parties involved will take the necessary steps to accomplish these recommendations.

Thank you for your consideration of this request.

Sincerely,

Rep. Edith Clark
Presiding Officer

c: Tribal Governments
Tribal Health Facilities

Children, Families, Health, and Human Services Interim Committee

60th Montana Legislature

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October 21, 2008

Rep. Ron Stoker
P.O. Box 1059
Darby, MT 59829-1059

Dear Rep. Stoker,

The Children, Families, Health, and Human Services Interim Committee met Oct. 14 to hear the final report on the mental health study funded by the 2007 Legislature. The report by DMA Health Strategies included recommendations for strengthening the state's crisis services for people with mental health needs and for improving partnerships among local law enforcement, the courts, and mental health providers.

During the meeting, Sheri Heffelfinger updated committee members on the work of the Law and Justice Interim Committee and how the bill drafts approved by LJIC intersected with some of the recommendations made in the DMA report. As a result, the committee voted to ask LJIC to consider amendments to two of the bills that you have agreed to sponsor.

The committee recommended that LC 307 be amended:

1. to include specific language to ensure that county expenditures for Crisis Intervention Team training for law enforcement would be an eligible expense for the purposes of the grant program;

2. to make the grant program available to "collaboratives," such as the Billings Community Crisis Center, rather than just counties; and

3. to match county precommitment costs if the county is an active financial participant in the collaborative.

It also recommended that LC 329 be amended to expand the pilot program for suicide risk screening to include screening for mental disorders.

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If you agree with these changes and would like to make them before the bills are introduced, Sheri and I would work together on the necessary language. If you would prefer that the ideas be proposed as amendments during the legislative session, then Children and Families Committee members would pursue the changes in that manner.

Thank you for considering these ideas. Please let either Sheri or me know how you would prefer to handle them. And please feel free to contact either of us if you have any questions.

Sincerely,

Sue O'Connell
Staff Researcher
406-444-3597 or soconnell@mt.gov

c: LJIC members

Appendix G

Committee Correspondence Related to Other Matters

Children, Families, Health, and Human Services Interim Committee

60th Montana Legislature

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July 1, 2008

Gov. Brian Schweitzer
Room 204, State Capitol
Helena, MT 59620

Dear Gov. Schweitzer,

Over the past year, the Children, Families, Health, and Human Services Interim Committee has closely followed efforts in Montana to create an electronic system for patient health care records. This type of system gives health care providers an important tool in not only treating patients, but also in providing follow-up care to patients with ongoing medical conditions that must be monitored.

HealthShare Montana, a non-profit organization, has spent nearly three years researching how to put an affordable health information technology system into place in Montana. Participating organizations -- including doctors, hospitals, and insurers -- have identified the framework for a pilot project that would create a uniform "continuity of care record" that could be used and shared by healthcare providers. The system also has the potential for saving costs and increasing efficiencies and quality in health care services.

HealthShare Montana has demonstrated to the interim committee how the continuity of care record works, and the committee believes it will allow Montana physicians to provide better care in many ways. For example, a surgeon would be able to determine if a patient has had the pre-operation laboratory work needed for the surgery, if the information is not available when the surgery is to take place. This could eliminate unnecessary tests, and costs, that currently may occur. In addition, a primary care physician can use the continuity of care record to track whether a patient with a chronic condition is following the recommended program of care or is in need of follow-up visits. A physician group can view aggregate data from the records to see how well it is managing the care for a group of patients with the same medical condition -- diabetes, for example.

HealthShare Montana has developed a $1.5 million budget for putting a pilot system in place, to cover initial costs for equipment and staff. The organization believes the system will become self-sustaining in time, possibly through subscriptions, and is working on a business plan to maintain the system's independent financial viability over the long term.

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The Children, Families, Health, and Human Services Interim Committee voted unanimously on June 10 to urge you to include $1.5 million in your proposed budget for the 2010-2011 biennium, to create this pilot system. Health information technology has the potential to benefit not only patients and their physicians but also overall health outcomes for Montanans while improving our state's health care delivery system. For those reasons, we believe it is an important -- and prudent -- use of state funds.

Thank you for your consideration.

Sincerely,

Rep. Edith Clark
Presiding Officer

c: David Ewer, Office of Budget and Program Planning
Joan Miles, Department of Public Health and Human Services

Children, Families, Health, and Human Services Interim Committee

60th Montana Legislature

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July 1, 2008

Hank Hudson, Administrator
Human and Community Services Division
Department of Public Health and Human Services
111 N. Jackson St.
Helena, MT 59601

Dear Mr. Hudson,

The Children, Families, Health, and Human Services Interim Committee has voted to support changes in Food Stamp eligibility standards that will allow more Montanans to take part in this important program. Because food is a basic necessity, the committee members believe it's vital that the state ensures that as many Montanans have access to the program as possible.

At a presentation to our committee earlier this month, Minkie Medora outlined several issues of importance to the Montana Food Bank Network and the Montana Dietetic Association, including an expansion of Food Stamps to a greater number of Montanans. Ms. Medora noted that federal laws and rules give states latitude in setting the eligibility standards for Food Stamps. She also pointed out that many states have taken advantage of this flexibility to increase income and asset standards and to expand categorical eligibility to entire groups of people.

Montana's low-income families are facing increasing economic pressure with the recent rise in gas prices and the corresponding increases in food prices. Montana's food banks are also feeling the pinch, both through increased demand for their services and an increase in their costs of providing services.

All of those factors make the Food Stamp program an even more critical part of the safety net for low-income Montana families. Thus committee members were encouraged to learn that the Human and Community Services Division is looking into this issue.

The Children, Families, Health, and Human Services Interim Committee strongly supports your efforts. The committee voted in June to encourage the department to act as quickly as possible to revise its rules for the Food Stamp program, in order to eliminate the asset test and increase the income eligibility level to the maximum allowed by the U.S. Department of Agriculture guidelines. We hope you will take every possible step to make this program as widely available as possible.

Sincerely,

Rep. Edith Clark, Presiding Officer

c: Brian Schweitzer, Governor
Joan Miles, Director, Department of Public Health and Human Services

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60th Montana Legislature

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PAT MURDO, Staff for SJR 15

March 31, 2008

The Honorable Max Baucus
United States Senate
511 Hart Senate Office Building
Washington, D.C. 20510-2602

Dear Senator Baucus,

I am writing on behalf of the Children, Families, Health, and Human Services Interim Committee to thank you for your efforts to avert the proposed 10% cut in Medicare payments to physicians and to support your efforts to find a solution that will allow Medicare reimbursements to increase, particularly for primary care physicians.

Our legislative committee is concerned that a reduction in Medicare payments to physicians would have severe consequences for Medicare beneficiaries and, potentially, for other Montanans. The proposed reduction would almost certainly force physicians to reconsider their participation in Medicare and possibly limit the number of Medicare patients they accept – a step that would have serious repercussions in Montana. According to the Department of Public Health and Human Services, one-fifth to one-fourth of the residents of our rural, eastern counties are already 65 years of age or older and an estimated 14% of our population will reach or exceed that age by 2011.

The rate reduction also may aggravate the problems that many Montanans – not just Medicare patients – already have in accessing health care, particularly the important diagnostic and preventive care provided by primary care physicians. These physicians are often the gateway for patients to receive the more specialized care they need for serious health problems. Primary care physicians are already struggling in Montana. The Mountain Pacific Quality Health Foundation reports that just 202 primary care practices exist in the state, or an average of less than four practices per county. Most of our rural areas are well below that average.

The Children and Families Committee also supports the idea of an 18-month, rather than six-month, extension of the Medicare rate fix. This longer-term solution would provide physicians with more stability and certainty in planning for the business side of their practices.

Again, our bipartisan committee wants to emphasize that we unanimously oppose the planned 10% reduction in physician reimbursements, and we want to thank you for your efforts on an issue that is important to both physicians and patients.

Sincerely,

Edith Clark
Presiding Officer

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Oct. 11, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-2261-P
P.O. Box 8018
Baltimore, MD 21244-8018

To Whom It May Concern

As chairwoman of Montana's Children, Families, Health, and Human Services Interim Legislative Committee, I am writing to submit comments on behalf of the committee regarding the proposed rule for Medicaid rehabilitative services.

As lawmakers, we understand the need for fiscal responsibility and accountability in government. However, we fear that some of the proposed changes could create gaps in needed therapeutic care for foster children, resulting both in harm to the children and in harm to the continuum of care that we have worked hard as legislators to create for Montana's most vulnerable young people.

Under Montana's Medicaid state plan, Medicaid currently covers the costs of the therapeutic and support services the children receive, in a daily rate. This practice allows the children to receive important therapeutic services in a setting that allows those services to be provided throughout each day as needed, rather than during specified blocks of time in a provider's office. At the same time, the children are able to remain in a community setting, where they can still attend school and take part in extracurricular activities.

We are particularly concerned about the following portions of proposed rule 2261-P/72 Fed. Reg. 45201:

- The definition of qualified providers of rehabilitative services, which could mandate educational levels, licensing requirements, or work experience that many of our therapeutic foster care parents have not attained.

  Montana served about 800 youth in therapeutic foster care or therapeutic family care in the past fiscal year and another 500 young people in therapeutic group care. The change in definition for providers of care has the potential to reduce the number of providers available, thus displacing these youth and perhaps requiring that they be placed in a higher level of institutionalized care. We believe this change could end up removing foster youth from their more appropriate placement in a family and community setting.

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- Exclusion of payment for services that "are intrinsic to elements of programs other than Medicaid." This change could disallow payment for many elements that are critical to therapeutic care for youth in a family setting, because it is so difficult to separate medically necessary rehabilitation services from other services in a successful therapeutic setting.

  Limiting Medicaid payment to only medically necessary rehabilitation services fails to recognize the medical benefits that seriously emotionally disturbed youth in foster care reap in many ways throughout their day while they are in a supportive, therapeutic foster care setting. In addition, the change would be contrary to the children's system of care that Montana has designed to encourage comprehensive, wraparound services to children in the most appropriate and least restrictive setting possible. Medicaid funds have been a critical element of the funding needed to provide wraparound services.

Committee members have already formally expressed to the Montana congressional delegation our concerns about possible changes for payment of therapeutic foster care service and our hope that any changes would occur only after a thorough evaluation of how unbundling of rates has affected other states.

The above-mentioned portions of the rule CMS is proposing for rehabilitative services poses the potential for significant harm to hundreds of children in our state and elsewhere around the country, may shift significant costs to the states that they may be unable to support, and could lead to placement of many children in more restrictive settings away from family and community support systems.

We hope you will take these concerns into account and modify the rule to reduce the impact on therapeutic foster care programs.

Thank you for your consideration,

Sincerely,

Rep. Edith Clark, Presiding Officer
on behalf of the Children, Families, Health and Human Services Interim Committee

Children, Families, Health, and Human Services Interim Committee

60th Montana Legislature

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LISA JACKSON, Staff Attorney
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August 2, 2007

The Honorable Jon Tester
United States Senate
204 Russell Senate Office Building
Washington, D.C. 20510-2604

Dear Senator Tester:

As chairwoman of the Children, Families, Health and Human Services Interim Legislative Committee, I am writing this letter to you on behalf of the committee regarding the federal government's efforts to restrict Medicaid payments for therapeutic group care and therapeutic foster or family care treatment services to eligible children who have mental health needs. The "unbundling" of payment for these therapeutic services could have serious repercussions on not only Montana's budget, but more importantly, on some of Montana's most vulnerable children.

In 11 months of the current fiscal year, Montana has served 789 youth in therapeutic foster care or therapeutic family care. Youth in need of this level of care are either still living at home and receive intensive home-based clinical and support services or they are placed in a therapeutic foster home, where they live with highly trained foster parents and receive a full array of clinical and support services including 24-hour crisis response.

In this same time period, 481 youth were served in four- to eight-bed therapeutic group homes with a structured clinical milieu, where they receive a full array of treatment and support services on a 24-hour basis.

Under Montana's Medicaid state plan, Medicaid currently covers the costs of the therapeutic and support services the children receive, in a daily rate. This practice allows the children to receive the important therapeutic services they need in a setting that allows those services to be provided throughout each day as needed, rather than during specified blocks of time in a provider's office. At the same time, the children are able to remain in a community setting, where they can still attend school and take part in extracurricular activities.

The Centers for Medicaid and Medicare Services (CMS) has already required some states to separate the Medicaid payment for treatment services from the other support services necessary to support children in need of therapeutic care and has notified Montana verbally that this change will be expected to occur starting in October 2007. In Colorado, the first state to be directed by CMS to stop its practice of bundled rates, the legislature recently approved $22 million in state general fund to pay for services no longer covered by Medicaid.

If these changes do occur in Montana, the state may either have to reduce these important community-based therapeutic services or significantly change the models. This could result in additional youth going

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into more restrictive, higher cost, residential settings and may destroy a strong continuum of community-based services.

While we understand that CMS wants to ensure accountability by providers, we believe the Colorado experience shows the approach chosen by CMS may lead to unanticipated consequences that may harm services to children. Thus we respectfully ask that you and other members of the Montana congressional delegation urge CMS to take the following steps before requiring additional states to stop using bundled rates:

- Suspend any further changes until there is time to thoroughly evaluate how unbundling rates has affected the states that have been required to take this approach to date, and

- Provide substantial notice to any additional states that will be asked to unbundle payments, so they can adequately prepare for the significant changes that may result.

Thank you very much for your consideration of this important issue.

Sincerely,

Rep. Edith Clark, Presiding Officer
on behalf of the Children, Families, Health and Human Services Interim Committee

Montana State Legislature

2009 Session

Exhibit 11

This exhibit is a booklet entitled:
Emergency Medical Services Dept of PH & HS and the Board of Medical Examiners.

This exhibit cannot be scanned therefore only the cover and table of content has been scanned to aid you in your research.
The original exhibit is on file at the Montana Historical Society and may be viewed there.

Montana Historical Society Archives, 225 N. Roberts, Helena, MT 59620-1201
Phone (406) 444-4774.
Scanning by: Susie Hamilton

A Report
to the
Montana
Legislature

Performance Audit

Emergency Medical Services (EMS)

Department of Public Health and Human Services and the Board of Medical Examiners

June 2008

Legislative Audit
Division

07P-11

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