OFFICE OF THE GOVERNOR
STATE OF MONTANA

MARC RACICOT
GOVERNOR

STATE CAPITOL
HELENA, MONTANA 59620-0801

NEWS RELEASE

Testimony by Governor MARC RACICOT
to the Health Care Forum, Great Falls, April 17, 1993

Good morning. On behalf of all Montanans I want to welcome you to our state.

I very much appreciate your willingness to take the time to visit Montana to see and hear firsthand some of the unique--and human--health care problems and issues that confront the people and government of a state like Montana. And I also appreciate the opportunity to speak to you this morning about the health care issue that looms so large over so many Americans--and so much of our public and private spending.

We have some special characteristics and special problems here in the Treasure State. When Lewis and Clark came through here 190 years ago, they traveled across Montana for weeks without seeing another living soul.

While that is hardly the case today, Montana is the fourth largest state geographically, but it is only the 44th largest in population. We have 94.3 million acres in Montana---and only 804,000 people. That is 32,000 fewer people than live in Honolulu. There are, in fact, three times as many cattle in Montana as there

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are people....

Such Big Skies and open spaces are great for tourism, now our fastest-growing industry. But they create immense problems in many other vital areas of life and government services such as economic diversification and health care.

Quite frankly, some of those cattle may have easier access to quality health care than some of their owners. We have 56 counties in Montana, many of these counties being larger than other states. Unfortunately, several of Montana's counties, have no medical doctors at all. Six counties have no pediatric services and 13 counties have no obstetrical care. There is no medical school in Montana. Would-be medical students must leave Montana to study--and many do not return.

So I share with the Federal government a grave concern with health care costs ever-rising at an astronomical rate, a rate which consumes funds that would otherwise be available for other vital needs such as economic development, education and infrastructure repairs.

But I would hope that as the Federal government designs its new health care proposals in the coming days and weeks, that it realize that for many rural Americans, cost is not the major concern; finding medical care is.

I am concerned that creation, for instance, of a single statewide Purchasing Cooperative would not be an efficient or effective solution for our health care concerns. In some places there is no health care infrastructure; in others, there are no

competing health care providers. Many Montana communities, even regions, would be delighted to have a single hospital, let alone competing medical institutions.

Our state legislature is currently considering health care reform legislation. It is a promising sign of the kind of bipartisan approach to problem-solving that we are seeking to foster in Montana.

And it is the product of significant compromise among various sectors of our state's health care system. It has been endorsed by our state hospital association, medical association, insurance groups, low income consumer groups, labor groups and the leadership of both political parties.

I believe that their acceptance of the basic cost containment tenets of the bill, and specifically the concept of global budgets or expenditure caps, indicates a broadening realization that something significant must be done to reform our health care system.

This is but one of the major areas, along with Tax Reform and repair of our deeply-troubled Workers Compensation system, which we are actively seeking to reform in Montana society. I believe such reforms are the linchpin of progress to move Montana into an era of real job growth with a standard of living that will support a standard of health care that will allow our citizens to raise their families in their home state. From 1985 to 1990, 137,127 Montanans left this state; that's 17 percent of Montana's population.

Although few specifics of our state's new health care

compromise have been completed, discussion so far on cost-controls has focused on strong local participation through regional boards monitoring local expenditures and allocating health resources within their region.

Primary reasons for the regional boards are:

---to allow maximum local control and local consumer-provider input and

---to recognize the social and resource differences among the various regions of our state, from the isolated agrarian crossroads communities of the High Plains in Eastern Montana, to the reservations of our important Native American population, to some of the burgeoning service-oriented communities in the Western mountains attracting many retirees and out-of-staters.

We realize, of course, that true health care reform will be a long, difficult process with no quick fixes. However, we are beginning work toward the goals of: universal access to an affordable basic health benefit package, adequate supply and distribution of necessary medical resources, cost containment that recognizes the expenses of providing care over such a vast area while adjusting to the limited funds available, insurance reform that guarantees issue and renewal, a move toward community rating, insurance coverage portability and administrative simplification.

We are aware that true national health care reform must be a partnership between state and federal governments. However, I am concerned that as the new Federal plan evolves, rural states such as ours will be required to meet federal expenditure targets and

additional restrictive regulations without having the financial and administrative tools to manage our system in compliance with national reform goals and rules.

States like ours will need substantial help in technical assistance, planning grants and funding to build and maintain additional medical resources.

We realize that eight of ten Americans now live in urban and suburban areas. But we do hope that the Clinton Administration's final health care reform plans will give prominent--and sensitive--consideration and flexibility to rural states to address their particular needs and issues, as different as those may be from the majority of Americans. The concerns of the Montanas of America should be none the less compelling because they concern an isolated minority.

Thank you for your time and attention.

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Testimony for Hillary Rodham Clinton, First Lady of Health Care Reform
Forum Sponsored by Senator Max Baucus, 17 April 1993, Great Falls, Montana

Montana is unique. In its huge acreage--145 plus thousand square miles--there are 56 counties and 7 Indian reservations. It is 500 miles across and 300 plus miles deep, with only a sparse population and many miles to be traveled for limited hospital or delivery care in the few cities or towns with available facilities.

As an AARP Assistant State Corrdinator for Medicare/Medicaid Advisory Program, I support AARP's committment to the four points in Health Care Reform: i.e., Access, Affordability, Cost Containment and Long-Term Care/Prescription Assistance. Many lower income residents (particularly widows) must pay for prescriptions instead of food or visa versa. AARP has 110,000 members in this state. I am more than a member of AARP. I have undergone considerable hospitalization myself; my family and I believe keenly that patient rights and choice of care-givers must be maintained.

Rural areas need incentives to attract and keep highly trained, financially competitive professionals. The medical field is no exception. Perhaps the approach the military adopted years ago, where college aid is returned for service, would work. I would urge some type of study assistance for Montana students to pursue their education in medical service (such as doctors, registered nurses, RN practitioners in clinics, LPN and patient attendants). It would bring dividends. If the students are native born, they and their families are more likely to aprreciate Montana's grandeur and sports activities and thus they would be more likely to remain in the state and practice.

Privately

Assistance for the frail elderly to stay in their homes through some type of home health care is much more cost efficient than placing them in a nursing home. These elderly are an independent brand, plus are not pleased at the aspects of leaving their homes. Displacement seldom increases their ability to recover.

Hopefully your Health Care Reform package will give the states the latitude they need and will not mandate services that cannot be implemented in their area. Certainly, health insurance should not be tied to the individual's workplace; there are so many differing lifestyles that have emerged that no one today can predict an employment location in future years.

Submitted by Charlotte M. Hutchinson
17 Hardy Creek Lane, Cascade, MT 59421, 406/468-2730
--Asst. State Coordinator for MT/AARP Medicare/Medicaid Advisory Program;
--Member of the State Advisory Board of the newly implemented HCFA-funded ICA plan (Information, Counseling and Advisory Program);
--Charter member and first Chair of Columbus Hospital's Senior Advisory Board.

Maureen Weeks

Through the Washington Wire and American Hospital Association, there is an indication that the government will cut $40 billion over the next four years in Medicare and $7.8 billion cut in Medicaid over the next five years.

--Our rural hospital currently has 68% patients receiving Medicare and about 50% residents in our long term care facility receiving Medicaid.

--We are having difficulties to survive today with the assistance from the government, how will we survive without it?

--There is an increasing demand for quality care from the public and at the same time, there is an increasing in government rules and regulations for the health care facilities to ensure the quality care is provided to the public. With limited resources and government cuts in Medicaid and Medicare, small rural hospitals and nursing homes will face extreme difficulties to do its job. Some may face closure.

There is an increasing difficulty to recruit Family Physicians into our rural community because the lacking financial incentives for physicians. But it is crucial for rural communities like ours to have Family Physicians.

--What incentive ~~programs~~ the does government have to encourage physicians to serve in the rural communities?

--What role will the government play in medical education reform and to encourage students studying to become Family Physicians rather than specialist?

The definition of rural communities in Montana is quite different from other states; it is more appropriate to call our rural community a "last frontier" in America. Without our particular health facility, over five thousand people will have to seek care at other health care facilities at least 50 miles away. In an emergency situation, life may be threatened.

We would like to see the government come up with a better health care reform package for the rural communities, and consider the impact it will have for the rural communities if we lose our health care facilities because of the cuts proposed in Medicaid and Medicare.

To: Hillary Clinton
From: Mareen Wicks
Rural Health Forum
Gt. Falls, Mt.
April 17-93

Good Morning Mrs. Clinton and welcome to Montana!

I share your concerns about rural health care -

I am Mareen Wicks and my husband Russ and I are farmers. Eleven years ago when our daughter Kali was born on a cold February afternoon, we had to drive 100 miles in a raging blizzard to get to the hospital - there were snow drifts two feet deep across the road - this is not a unique experience, others in Montana have had similar experiences.

Ever since that afternoon, I have paid close attention to rural health care facilities.

We currently farm in Liberty County, which is larger than the state of Rhode Island and is served by one eleven bed hospital located in Chester -

Our farm is 27 miles south of Chester, 17 of which are gravel - going the other direction, we are 60 miles north of Great Falls on the Bootlegger trail; 50 of which are gravel and often impassible in the winter. This is not different from most of Montana's other 55 counties.

Weather, distance, and transportation all play a part in rural health care -

We need to keep our rural facilities open. They are "reachable" for our rural people when they need them most; in case of heart attack, farm accidents, or child birth. You can plan ahead - to drive 100 miles for a doctor check-up, but you can't plan ahead for a heart attack and you can't always count on good weather or air transportation; I know.

We need our facilities to be well staffed - for our physicians, nurses, and nurse practitioners to be compensated and their fee schedules competitive with other states.

The high cost of health care and heath insurance also concerns me. Our health insurance costs have doubled over the past 8 years - the price of grain has NOT! For self-employed farmers, ranchers, and small businessman this has left some with serious choices - to buy seed or to buy health insurance. People are having to choose between health insurance and their livelihood. That is not right.

Their costs must be controlled (there should be a tax deduction or tax credit). Because of a family members preexisting medical condition, we cannot "shop around" for a better health care plan - we are locked in - we need an insurance industry that is more accessible, one that we can work with.

As you look at health care reform and make decisions that will affect all of our lives -
Please -

* help us attract and keep good medical personnel

* control the cost of health insurance and make health insurance more accessible
Keep what is good in our current system.

* keep our "reachable" rural health care facilities open

Thank you and good luck!!!!

Mareen Wicks
Box 48
Ledger, Mt. 59456

Jim Paquette
Lane Basso

COMMENTS RELATING TO RURAL HEALTH CARE
VISIT BY HILLARY CLINTON
BILLINGS, MONTANA
APRIL 16, 1993

I. ENVIRONMENT

- State of Montana Acute Care Setting
  53 Hospitals - largest - 288 beds, smallest - 6
  54% (29 hospitals) <30 beds
  6 hospitals >90 beds
  All but 4 are classified as rural by HCFA

- South Central Montana
  * Billings serves as a regional tertiary center for a 300 mile radius (this includes portions of Northern Wyoming and Western North Dakota)
  For some services this includes a population of up to 450,000 people

  * In Billings there are approximately 300 physicians representing all major specialties.

  * Two hospitals combined operate approximately 500 beds. Tertiary services provided in the Billings community include:

Peri-Natal	Chronic Dialysis
Cardiac	Mental Health
Neuro	Cancer Care
Major Orthopedics	Pulmonary
Diagnosis and Monitoring	

And a host of services provided by the hospitals and other hospitals.

- Patients routinely travel up to 140 miles to receive services such as chronic dialysis, therapeutic radiation and obstetrical services.

- Physicians and hospitals have worked to consolidate many of the more expensive technologically advanced services including MRI, Radiation Therapy, Litho-tripsy and training of emergency medical personnel.

II. RELATIONSHIP OF PRIMARY SECONDARY AND TERTIARY PROVIDERS

The Billings health care community serves to improve the access to quality health care services in rural areas through the following:

- Assistance with primary care physician recruitment and temporary physician staffing (locum tenens)

- Supporting, both through planning and financial support, the establishment of a Family Practice Residency Program in Montana. A residency program will be designed to incorporate rural training sites.

- Provides transportation for specialty physicians to provide outreach clinics in rural communities. These clinics help support the local health care economy and reduce the inconvenience of travel cost of rural residents needing specialty care.

- Provides continuing education opportunities in Billings and in rural communities for a variety of health professionals - physicians, nurses, emergency medical technicians, etc.

- Communication technologies to link rural providers with urban professionals for consultation - toll free 800 telephone lines, two way interactive video conferencing (telemedicine) remote diagnostic services, (EKG's, holter monitor, EEG etc.)

- Consulting services to rural physician practices to assist them keeping up to date with reimbursement and regulatory agency requirements.

- Provide coordinated air transport.

III. POINTS TO CONSIDER IN REFORMING HEALTH CARE IN A RURAL SETTING.

- Improve access and quality of care in rural settings by continuing initiatives such as those listed in II above.

- To access primary services in tertiary centers that could be offered more efficiently in rural areas.

- Managed cooperation should be applied to achieve goals improving access and quality of care in frontier states like Montana and Wyoming where entire state is considered rural.

- To assure quality of care and access patient and physician preference needs to be given priority over political and territorial considerations. In this particular region, 15% of Billings patients come from Wyoming.

- We recommend that frontier states like Montana be given wide latitude to develop options or their own unique solutions to providing health care reform. This would be done with the understanding that factors contributing to limited access, quality or care and utilization of resources be addressed.

COMMENTS OFFERED BY

Lane Basso, President
Deaconess Medical Center

James T. Paquette, President
Saint Vincent Hospital and Health

SaiNT Vincent

MRS. CLINTON, AND MEMBERS OF THE COMMITTEE:

MY NAME IS FRANK MICHELS, I AM A FAMILY PHYSICIAN AND CURRENTLY ACTING DIRECTOR OF THE MONTANA FAMILY PRACTICE RESIDENCY, WHICH IS, A TRAINING PROGRAM , CURRENTLY BEING DEVELOPED, WHICH WOULD TRAIN GRADUATING MEDICAL STUDENTS TO BE BOARD CERTIFIED FAMILY PHYSICIANS. MONTANA IS ONE OF ONLY TWO STATES WHICH DOES NOT HAVE A FAMILY PRACTICE RESIDENCY.

THE RESIDENCY IS A THREE YEAR PROGRAM, WHICH, WOULD, HAVE,
THE RESIDENTS DOING THEIR TRAINING IN LARGER MONTANA MEDICAL COMMUNITIES DURING THEIR FIRST YEAR, AND, THE MAJORITY OF THEIR TRAINING DONE IN RURAL AREAS THROUGH RURAL ROTATIONS, OR A NEWER CONCEPT CALLED RURAL TRAINING TRACKS, IN THERE 2ND AND 3RD YEARS.

THE MONTANA FAMILY PRACTICE RESIDENCY IS BEING MODELED AFTER THE SPOKANE'S "FAMILY PRACTICE RESIDENCY". THIS HIGHLY REGARDED RESIDENCY STARTED DOING RURAL TRAINING TRACK S 4 YEARS AGO.

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THEIR GRADUATING RESIDENTS HAVE SHOWN TO BE AS WELL OR BETTER TRAINED THAN THEIR CONTEMPORARIES AT LARGER RESIDENCIES. THEY HAVE BETTER OBSTETRICAL SKILLS, BETTER TRAUMA STABILIZATION SKILLS AND A GREATER UNDERSTANDING OF THE NEEDS OF RURAL AREAS. ***MOST IMPORTANTLY THEY ARE PRACTICING IN RURAL AREAS.***

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25% OF OUR TOTAL UNITED STATES POPULATION IS CLASSIFIED AS RURAL.

HOWEVER, IN MONTANA 72% OF OUR POPULATION IS CLASSIFIED AS RURAL. CONTINUED ACCESS TO HEALTH CARE, IN OUR RURAL STATE, WILL DEPEND ON THE SURVIVAL OF SMALL AND MEDIUM SIZED HOSPITALS.

PRESENTLY THERE ARE OVER 100 ADVERTISED POSITIONS FOR FAMILY PHYSICIANS IN MONTANA, AND APPROXIMATELY 1/3 OF OUR CURRENT 267 MONTANA FAMILY AND GENERAL PHYSICIANS WILL RETIRE IN THE NEXT TEN YEARS. EVEN WITH THE HELP OF MIDLEVEL PROVIDERS, TO BE OUR TEAM MATES,THERE WILL SERIOUS SHORTAGE OF FAMILY PHYSICIANS.

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OVER A TEN YEAR SPAN, OVER 60 RESIDENTS WOULD GRADUATE FROM THIS PROGRAM. MOST WOULD BE MONTANA NATIVES COMING HOME TO DO THEIR RESIDENCY AND TO GO INTO PRACTICE IN THEIR HOME STATE. THIS WOULD GREATLY IMPACT THE PHYSICIAN SHORTAGE.

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THE CONCEPT OF A MONTANA FAMILY PRACTICE RESIDENCY IS ALSO UNIQUE IN THAT THE TRAINING DONE WITHIN BILLINGS WOULD BE DONE AT THE COMMUNITY HEALTH CLINIC. THEREBY PUBLIC HEALTH ISSUES AND SERVICE TO THE UNDERSERVED WOULD BE COMBINED WITH FAMILY MEDICINE TRAINING.

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which could be removed

THE MAJOR OBSTICALS FOR THIS TYPE OF FAMILY PRACTICE RESIDENCY, WHICH COMBINES RURAL HEALTH CARE TRAINING, MEDICAL CARE TO THE URBAN UNDERSERVED, AND TRAINING AND SERVICE IN THE INDIAN HEALTH CARE FACILITIES IS AS FOLLOWS:

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CURRENTLY THE MONTANA FAMILY PRACTICE RESIDENCY IS PLANNING TO DO ROTATIONS IN, INPATIENT OBSTETRICS AND PEDIATRICS AT THE INDIAN HEALTH SERVICE HOSPITAL AT CROW AGENCY. THERE WILL ALSO BE OTHER AMBULATORY ROTATIONS AT VARIOUS MONTANA IHS SITES.

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1)REMOVAL OF FEDERAL GUIDLINES WHICH RESTRICT THE ABILITY OF PUBLIC HEALTH FACILITIES TO BECOME INVOVED IN RESIDENCY EDUCATION. FOR EXAMPLE, REMOVING THE PROHIBITION FROM THE IHS FOR HELPING PAY RESIDENT EXPENSES ON AN IHS ROTATION.

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2)SUPPORT A PROCESS WHERE FEDERAL GME MONIES COULD BE PAID TO THE RESIDENCY PROGRAM DIRECTLY INSTEAD OF TO HOSPITALS. AS YOU CAN SEE OUR PROGRAM INVOLVES MULTIPLE SITES INCLUDING VARIOUS HOSPITALS AND AMBULATORY SITES MAKING GME REIMBURSEMENT CUMBERSOME.

THANK YOU FOR COMING TO MY FAVORITE STATE AND BIRTHPLACE. AND PLEASE UNDERSTAND THAT MANY SUPPORT YOUR ENDEAVOURS.

Of us