MINUTES

MONTANA HOUSE OF REPRESENTATIVES
53rd LEGISLATURE - REGULAR SESSION

JOINT SUBCOMMITTEE ON HUMAN SERVICES & AGING

Call to Order: By **CHAIRMAN JOHN COBB**, on February 5, 1993, at 7:10 A:M.

ROLL CALL

Members Present:
Rep. John Cobb, Chairman (R)
Sen. Mignon Waterman, Vice Chairman (D)
Sen. Chris Christiaens (D)
Rep. Betty Lou Kasten (R)
Sen. Tom Keating (R)
Rep. David Wanzenried (D)

Members Excused: None

Members Absent: None

Staff Present: Lisa Smith, Legislative Fiscal Analyst
Lois Steinbeck, Legislative Fiscal Analyst
Connie Huckins, Office of Budget & Program Planning
John Huth, Office of Budget & Program Planning
Billie Jean Hill, Committee Secretary

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

Committee Business Summary:
Hearing: DEPARTMENT OF FAMILY SERVICES
Executive Action: SOCIAL AND REHABILITATION SERVICES

EXECUTIVE ACTION ON SOCIAL AND REHABILITATION SERVICES

Tape No. 1:Side 1

Motion/Vote: **SEN. WATERMAN** moved to eliminate all transplants for adults except cornea, kidney and bone marrow. Motion **CARRIED** with **CHAIRMAN COBB** voting no.

Motion: **SEN. WATERMAN** moved to limit nursing home private pay rate to no less than Medicaid rate.

Mr. Dan Shea, Montana State Low-income Coalition, hoped that all hospitals and nursing homes would lower their base.

Ms. Rose Hughes, Montana Health Care Association, answered all questions pertaining to nursing homes and costs.

Mr. Bob Olsen, Montana Hospital Association, said this action presumed that all nursing homes would not take action.

Vote: Motion **CARRIED** with **SEN. KEATING** and **REP. KASTEN** voting no.

Mr. Bob Olsen explained regular nursing home beds as opposed to swing beds that open up sporadically. There would be not be a great savings by eliminating swing beds.

Ms. Rose Hughes explained that they have to hold swing beds for nursing home patients because they go to the hospital and they also go home for therapeutic visits and the beds have to be waiting when they come back.

Motion/Vote: **SEN. CHRISTIAENS** moved to limit personal care days so that no more than one-third of the time would be used for homemaking. Cost savings projected for the biennium would be $530,000. Motion **CARRIED** with **CHAIRMAN COBB** voting no. **EXHIBIT 1**

Motion/Vote: **CHAIRMAN COBB** moved to reinstate one position in Big Horn County removed from the Swysgood list because it was filled on January 29, 1993. Motion **CARRIED** unanimously.

Motion/Vote: **SEN. WATERMAN** moved to add one FTE to the SRS program with the transference of daycare to SRS from DFS, along with the one FTE already going to the SRS from DFS. Also, the department will have the need to spend some of the $820,000 and will need additional federal spending authority for federal funds that become available upon 10% state match for enhancing TEAMS to handle daycare tracking. Motion **CARRIED** with **CHAIRMAN COBB** and **REP. KASTEN** voting no.

Motion/Vote: **SEN. WATERMAN** moved to reconsider the committee's rejection of the executive modification that requested $277,000 for increased funding of MMIS. Motion **CARRIED** with **CHAIRMAN COBB** voting no.

Motion/Vote: **SEN. WATERMAN** moved to consider the rejection of the supplemental request for $75,000 general fund to offset the impact of the reclassification of welfare eligibility staff. She proposed that the $75,300 be removed from the FY 94 and FY 95 personal services budget, $37,500. Motion **CARRIED** with **CHAIRMAN COBB** and **REP. WANZENRIED** voting no.

HEARING ON DEPARTMENT OF FAMILY SERVICES

Mr. Hank Hudson, Director, Department of Family Services, said that the committee would be hearing about problems of the severely emotionally disturbed child.

Mr. Jack Casey, Administrator, Shodair Hospital, addressed the increased costs of inpatient psychiatric services. He talked about possible options and spoke for the "Family of One" rule. **EXHIBITS 2, 3, 4, 5**

Mr. Pat Melby, representing Rivendell Psychiatric Hospital, discussed statistics of the inpatient psychiatric hospitals in Montana and neighboring states, **EXHIBIT 6,** and written testimony by **Mr. Al Smith, Western Region Vice-President, Rivendell Hospitals,** talking about the successes of the Rivendells in Montana. **EXHIBIT 7**

Dr. Chuck Cerny, Psychiatric Rehabilitation, Deaconess Hospital, Great Falls, talked about the importance of the continuum of treatment with these youngsters. Managed care is the key.

Mr. Glenn McFarlane, President of Montana Residential Child Care Association (MRCCA), Yellowstone Treatment Centers, does not want any change in the "Family of One" rule. He advised the committee to look for modifications that would allow parents who are able to pay.

Mr. Larry Stednitz, Juvenile Corrections, spoke to the need to find a place in the state to take care of juvenile offenders.

Mr. Larry Birch, Administrator, Glacier View Hospital, Kalispell, spoke for the "Family of One" rule.

Mr. Charlie McCarthy, Administrator, Community Services Division, Family Based Foster Care, presented statistics on youth that are placed out-of-state. **EXHIBIT 8**

Dr. Joe Rich, Psychiatrist, Deaconess Hospital, Billings, said that he would like to represent hospitals around Montana. Reimbursement is unbalanced, and hospitals would be much more complimentary if the state did away with the "Family of One" rule. The hospitals need a level playing field, equity in reimbursement to free-standing institutions as well as community hospitals. He vowed to work together with whatever managed care is appropriate.

Mr. Chuck Cerny, Great Falls, Deaconess Hospital, said there is a piece of the continuum missing in our community. There is a need for a gate-keeping system to keep our kids in-state.

Mr. John Harwood is a parent of a 13-year-old severely emotionally disturbed child. There is no continuum of care for his son in their community. There is no acute residential care, so he is in home treatment. There is no clear management.

Mr. Tom Carlin, Psychologist for Helena Schools, talked about statistics: three-percent of the school population is severely emotionally disturbed; 479 AFDC families moving into Montana, into state-assumed counties, in 1993. He advocated some kind of

care.

Ms. Cindy Klette, representing Missoula County; Susan Duffy, (PLUK) Parents Let's Unite for Kids; Cindy Bartling, Executive Director, Friends of Youth; Peg Shea, Director, Turning Point; Dan Fox, DFS; Laura Nier, Missoula School System; and Ann Mary Dussault, Missoula County Commissioner, spoke to the problems of severely emotionally disturbed (SED) children in Missoula and how the above-mentioned people and their demonstration programs work together to solve the problem. **EXHIBIT 9, EXHIBIT 10, EXHIBIT 11**

Mr. Paul Meyer, Executive Director, Community Mental Health, EXHIBIT 12 spoke to the "Family of One" rule and why they needed it. He wants a Medicaid waiver to create eligibility/funding for home and community-based services by extending the "Family of One" rule to SED children on the threshold of psychiatric hospital/residential treatment admission.

ADJOURNMENT

Adjournment: 12:00 P:M

JOHN COBB, Chairman

BILLIE JEAN HILL, Secretary

JC/bjh

HOUSE OF REPRESENTATIVES

HUMAN SERVICES **SUB-COMMITTEE**

ROLL CALL **DATE** 2-5-93

NAME	PRESENT	ABSENT	EXCUSED
REP. JOHN COBB, CHAIRMAN	✓		
SEN. MIGNON WATERMAN, VICE CHAIR	✓		
SEN. CHRIS CHRISTIAENS	✓		
SEN. TOM KEATING	✓		
REP. BETTY LOU KASTEN	✓		
REP. DAVID WANZENRIED	✓		

HOUSE OF REPRESENTATIVES

HUMAN SERVICES **SUB-COMMITTEE**

ROLL CALL VOTE

DATE 2-5-93 **BILL NO.** _____ **NUMBER** _____

MOTION: Remove all transplants for adults except Cornea Kidney & blood (Heart, lung, liver removed)

NAME	AYE	NO
REP. JOHN COBB, CHAIRMAN		X
SEN. MIGNON WATERMAN, VICE CHAIRPERSON	X	
SEN. CHRIS CHRISTIAENS	X	
SEN. TOM KEATING	X	
REP. BETTY LOU KASTEN	X	
REP. DAVID WANZENRIED	X	

HOUSE OF REPRESENTATIVES

HUMAN SERVICES SUB-COMMITTEE

ROLL CALL VOTE

DATE 2-5-93 BILL NO. _____ NUMBER _____

MOTION: Limit Nursing Home Rate to No less than Medicaid Rate

NAME	AYE	NO
REP. JOHN COBB, CHAIRMAN	X	
SEN. MIGNON WATERMAN, VICE CHAIRPERSON	Y	
SEN. CHRIS CHRISTIAENS	Y	
SEN. TOM KEATING		X
REP. BETTY LOU KASTEN		X
REP. DAVID WANZENRIED	X	

Passed

HOUSE OF REPRESENTATIVES

HUMAN SERVICES SUB-COMMITTEE

ROLL CALL VOTE

DATE 2-5-93 BILL NO. _____ NUMBER _____

MOTION: Cut Funds personal Care Days so that 1/3 used for Homemaking.

NAME	AYE	NO
REP. JOHN COBB, CHAIRMAN		X
SEN. MIGNON WATERMAN, VICE CHAIRPERSON	X	
SEN. CHRIS CHRISTIAENS	X	
SEN. TOM KEATING	X	
REP. BETTY LOU KASTEN	X	
REP. DAVID WANZENRIED	/	

HOUSE OF REPRESENTATIVES

HUMAN SERVICES SUB-COMMITTEE

ROLL CALL VOTE

DATE 2-5-93 BILL NO. _____ NUMBER _____

MOTION: Big Horn County Reinstate portion ~~of~~ removed from "Impacted list" because it was filed on Jan 29, 1993.

NAME	AYE	NO
REP. JOHN COBB, CHAIRMAN	X	
SEN. MIGNON WATERMAN, VICE CHAIRPERSON	X	
SEN. CHRIS CHRISTIAENS	X	
SEN. TOM KEATING	X	
REP. BETTY LOU KASTEN	X	
REP. DAVID WANZENRIED	X	

HOUSE OF REPRESENTATIVES

HUMAN SERVICES SUB-COMMITTEE

ROLL CALL VOTE

DATE 2-5-93 BILL NO. _____ NUMBER _____

MOTION: Transference of Day Care prog DSRS from DFS requires addition of an FTE to the SRS Econ Assis Prog. — also the Dept will have the need to spend some of the $820,000

NAME	AYE	NO
REP. JOHN COBB, CHAIRMAN		X
SEN. MIGNON WATERMAN, VICE CHAIRPERSON	X	
SEN. CHRIS CHRISTIAENS	X	
SEN. TOM KEATING	Y	
REP. BETTY LOU KASTEN	X	X
REP. DAVID WANZENRIED	X	X

will need additional fed spending authority for fed. funds that will become available upon 10% state match for enhancing Deams to handle day care tracking.

HOUSE OF REPRESENTATIVES

HUMAN SERVICES SUB-COMMITTEE

vote

ROLL CALL VOTE

DATE 2-5-93 **BILL NO.** _____ **NUMBER** _____

MOTION: Reconsider its rejection of the Epes modification that requested $277,000 for increased funding of MMIS

NAME	AYE	NO
REP. JOHN COBB, CHAIRMAN		X
SEN. MIGNON WATERMAN, VICE CHAIRPERSON	X	
SEN. CHRIS CHRISTIAENS	X	
SEN. TOM KEATING	X	
REP. BETTY LOU KASTEN	X	
REP. DAVID WANZENRIED	X	

HOUSE OF REPRESENTATIVES

HUMAN SERVICES SUB-COMMITTEE

ROLL CALL VOTE

DATE 2-5-93 BILL NO. _____ NUMBER _____

MOTION: Consider its rejection of our supplemental request for $75,300 gen fund & oppose the imposition by the reclassification of welfare office eligibility staff. propose that the $75,300 be removed from our FY94 & FY95 personal services budget. $37,500./year

NAME	AYE	NO
REP. JOHN COBB, CHAIRMAN		X
SEN. MIGNON WATERMAN, VICE CHAIRPERSON	X	
SEN. CHRIS CHRISTIAENS	X	
SEN. TOM KEATING	X	
REP. BETTY LOU KASTEN	X	
REP. DAVID WANZENRIED		X

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DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

MARC RACICOT
GOVERNOR

PETER S. BLOUKE, PhD
DIRECTOR

STATE OF MONTANA

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HELENA, MONTANA 59604-4210
(406) 444-5622
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February 4, 1993

To: Lois Steinbeck
Legislative Fiscal Analyst

From: Peter Blouke
Director

Subject: Unresolved issues before the Human Services and Aging Subcommittee

Several issues remain unresolved in the Human Services and Aging Subcommittee at this time. I have itemized these issues below, and attached supporting detail to this memo.

[1] Big Horn County is requesting that a position be removed from the "Swisgood list" because it was in fact filled on January 29, 1993. (Attachment 1)

[2] Senator Waterman requested that the Department draft language for the appropriations bill that would require the Department to investigate alternatives in the delivery of long term care services. (Attachment 2)

[3] Transferrance of day care programs to SRS from DFS requires addition of an FTE to the SRS Family Assistance program budget. Also, the Department will have the need to spend some of the $820,000 of general fund approved by the subcommittee for At-Risk day care for administration of the program. Finally, the Department will need additional federal spending authority for federal funds that will become availzbe upon 10 percent state match for enhancing TEAMS to handle day care tracking. (Attachment 3)

[4] The Department is requesting that the Subcommittee reconsider its rejection of the Executive modification that requested $277,000 in additional funding each year ($69,250 general fund each year) primarily for increased operating costs for MMIS. At the previous hearing on this issue, we mistakenly

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identified the reason for these costs as "inflationary costs" associated with the Consultec contract. In fact, the contractually required contract increases due to inflation are a very small portion of the request. In addition, we have lowered the request somewhat. (Attachment 4, paragraph 1)

[5] The Department is requesting that the subcommittee reconsider its rejection of our supplemental request for $75,300 general fund to offset the impact of the reclassification of welfare office eligibility staff. We propose that the $75,300 be removed from our FY94 and FY95 personal services budgets, $37,500 each year. (Attachment 4, paragraph 2)

[6] The subcommittee has not specified the level of payment for the General Assistance program.

Attachments

EXHIBIT 1
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RECEIVED
DEC 08 1992
PERSONNEL

SRS-PERS-41
(5/90)

COMMITTEE CERTIFICATION FOR HIRING

CLASSIFICATION: Eligibility Assistant ( ) (TEMPORARY)

LOCATION: Big Horn County DPW, Hardin

POSITION NUMBER: 30017 CLASSIFICATION CODE: 195077 GRADE: 8

Mary Evans has been selected for the above
(Applicant)

position. The starting date is 12/21/92.

12/4/92 Date	Committee Member	Committee Member
	Committee Member	Committee Member
	Committee Member	Committee Member
	Committee Member	Committee Member

Supporting statements:

Mary interviewed very well and we are sure that she will be able to perform the duties of the job very well. We had interviewed her for this position previously and she did well at that time also.

Reviewed and approved by Personnel Services:

12/8/92
Date

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My name is Jack Casey; I am the Administrator of Shodair Hospital. A couple of weeks ago this committee again heard how much the costs of inpatient psychiatric services component have increased since 1986. In order to get a true perspective of these costs and related increases, one must look at inpatient psychiatric care since the inception of the Children's Unit at Warms Springs State Hospital. In 1976 the number of children served was 19. The average daily occupancy was 11. This was at a cost of $392,235.00 (direct cost only, of which $388,235.00 were personnel costs). In 1981 the cost estimate for the unit was $1,300,000.00 for 1985, again this was for direct costs only. The costs were estimated to be 2.4 M and 2.7 M in FY 84 and 85, respectively, for the Youth Treatment Center in Billings. The State planned on treating 75 children per year. In 1985, the State planned on spending $36,000.00 per child for inpatient psychiatric services.

In 1992, Shodair Hospital treated 126 children for an average cost of $25,759.00. The State general fund expenditure in 1985 was planned at $36,000.00 per child. Shodair's 1992 general fund expenditure was $7,447.00 per Medicaid child. Shodair alone in 1992 treated 168% more children for approximately 21% of the cost the State was willing to spend in 1985. The present funding mechanism for inpatient psychiatric services is a truly cost-effective method for providing this very necessary service to Montana children and families.

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Healthcare reform is upon us. One of the major components of reform that will be addressed, both on a state level and on a national level, is access. To change the "Rule of One" will very much limit access to this service, a giant step in the wrong direction. To a family with a child in crisis, the system as it now exists is often overwhelming and ineffective for those it is supposed to help. Individuals needing assistance often complain of a general lack of responsiveness to their problems and an unfathomable bureaucracy. Change in that system in a way that will further restrict access is not a wise move at this time. At the present time the system is a maze of eligibility criteria and application processes, delays and difficulty in gaining access to treatment, and gaps in available programs present formidable barriers for a child and family already experiencing a crisis. Despite the belief that a continuum of care is the best way to serve very troubled children and even though some effort has been put forth, we are a ways away from a complete system.

Several weeks ago I stated that we have a system problem, and that all providers, all third party payers and the general population are all part of this problem. We need to develop a system in a comprehensive and coordinated manner. We can only do this if all parties are willing to be equal partners in the planning and financing of such a system. As a provider of inpatient services, I realize that if Shodair is going to continue in its mission to serve children and families of Montana, we will have to change and become part of the solution.

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There were four options presented for consideration.

OPTION # 1: Make no change to the "Family of One" Rule.

This makes the most sense economically. Please bear with me as I explain. At Shodair Hospital we treated 24 DFS kids in the first 6 months of this fiscal year. These were children who failed in all less restrictive settings, who were certified by a physician and another mental health professional to be in need of services. These two professionals also certify that the child's needs could not be met in their home community. Neither of these individuals has any affiliation with Shodair. Mental Health Management of America, based in Tennessee, then review the individual case and certify the patient for inpatient services to be paid by Medicaid. Throughout the child's hospitalization, MHMA continuously reviews the need for continued treatment. Medicaid paid $1,555,199 for these children. This translates into $440,566 of General fund Dollars. For the Department to purchase these services with all general fund dollars, which would not have a built-in contractual adjustment or any charity write off, would cost the State $655,200. It doesn't take a rocket scientist to figure out which way is best to pay for the service. By taking the cost difference of $214,634 and leveraging it with Medicaid, it suddenly becomes $757,658 and now we can treat an additional 28 children.

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Costs are escalating and the utilization of services are doing the same. There are some possible solutions to help fund the program.

1. It may be possible for Shodair to make a voluntary contribution to the inpatient program of its private pay and insurance payments. For FY 1992, this would be a payment of $776,682; that would translate into $2,741,687 Medicaid Dollars.

2. If we could transfer 50% of our charity write-offs, this would translate into $1,253,085.

3. After such a transfer Shodair could be made whole thru an incremental rate adjustment.

4. Put a capitation program in place as a demonstration project for children's psychiatric services. Combined with one or more of the above possible solutions, we could see a significant savings to the Medicaid Program.

OPTION # 2: Eliminate the "Family of One" Eligibility Rules for Inpatient Psychiatric Hospitals and Residential Treatment Centers.

The cost savings as presented are not reflective of the effect "RIBICOFF" children would have on the system. I believe that the committee will want some very definitive statistics on the numbers of children that have a very high probability of impacting the system. Children born after October 1, 1983, may qualify for AFDC-related Medicaid coverage even if they are living with both parents and are not deprived of parental support. Under "OBERA '89", States are obligated to make all optional Medicaid services such as inpatient psychiatric services available to children under the age of 21. The "OBERA '89" Early and Periodic Screening, Diagnosis and Treatment provisions are pretty straight forward and pretty clear in saying that under

EPSDT, if as a result of participation in the EPSDT and in getting screened and in getting preventive health care, some problem is detected and the child needs any service which is coverable under Federal Law, the State must provide for it. Parental income and resources are also not counted in determining the eligibility of a child in foster care unless it is actually contributed, nor does the deprivation have to be shown by a child in foster care. Thus the usual requirements of deprivation of parental support and inclusion of parental income and resources will not always apply to persons under 21 receiving inpatient treatment who are in foster care or who can qualify as a "Ribicoff" child.

As of December 21, 1992, the educational component of inpatient psychiatric services are now covered by Medicaid. To try to eliminate the service will further contribute to the deficit in another budget. The educational cost at Shodair for the next biennium is $983,700. By using Medicaid, the State general fund will save $705,031 by leveraging $278,669. (This will be the General Fund Cost).

OPTION # 3 - Parental Participation in First Month of Treatment.

DFS - No Fiscal Impact - Not Really an Option

OPTION # 4 Amend the Rules to limit Medicaid eligibility for only those Inpatients of Residential Treatment Facilities.

Problems:
1. EPSDT
2. "Ribicoff" Children
3. As pointed out earlier, the cost to the General Fund to provide these services would soon exceed

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present costs and the increased cost would treat less than 50% of the children who will get services by way of another avenue, be that the Youth Court, the foster care system, or maybe we can now send these children out of state for treatment.

As the only in-state provider of both residential treatment, and inpatient psychiatric hospital services, I can tell you that all levels of the continuum must be funded. For years we would hold kids without payment because of no funding availability at various levels of the continuum.

What we need to do is to plan a system that will work for Montana and our children. Lenore B. Behar, Ph.D. of North Carolina, has shared a manuscript with me that, I believe, is a good document that will help us develop the kind of system that can be cost effective and be funded with no increase in General Fund expenditures.

It is a formidable task that you and we have ahead of us, to erase this huge deficit. In doing so, it may be wise to expand all Medicaid Services and maximize the leveraging capability while we can. If we are going to truly make long term economic sense out of our healthcare system in Montana, we better do what we can now because even though President Clinton has given states a lot of flexibility, it will come to a screeching halt within the next 270 days, as will our ability to take advantage of leveraging Medicaid. Now is the time to request waivers to help fund Medicaid. Now is the time to request waivers to do a pilot program as a demonstration project to demonstrate how, with

proper utilization of a comprehensive and flexible continuum of care, costs can be held at present levels, if not reduced.

I am sure most of you have heard of TQM and CQI. If properly applied to our mental health system and by focusing on outcomes with at least the intensity we focus on the dollars, we will, and can't help but, make progress. **(Figures on Outcomes: Total Treated 156, 22 readmitted. Residential Treatment recommended 77 times, obtained 44: 57%. Therapeutic Foster Care recommended 18 times, obtained 4: 22%. Foster Care Requested 6 times, obtained 0.)**

For children and their families, the system's response is often ineffective and sometimes actually harmful. Lack of an integrated response to their problems, and gaps in available services contribute to the system's inadequacies. Failure to consider and treat the child in the context of the family is especially damaging. Many of these shortcomings are the result of a lack of coordination across complex systems and a failure to develop a flexible approach for systems to respond to individual children and families.

Children and family policy has been developed largely in reaction to crisis. Categorical programs are created to address specific problems or populations, and narrow funding streams provide resources. The result is a maze of mostly uncoordinated programs, services, and facilities that are administered by various local, state, and federal entities.

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The legislative process itself has contributed to this proliferation of categorical programs and funding streams. Usually, several legislative structures examine different aspects of children and family issues, creates problems, and oversees agencies. The appropriations process reinforces this division of services among entities that vie for more funds and fewer mandated responsibilities.

The effect of these and other factors is a myriad of organizational structures serving children. The complexity within the state is often overwhelming -- not only to those who need services, but also to administrators, staff, and lawmakers as we attempt to monitor and improve operations.

We now have an opportunity to make some everlasting improvements to the system. To make major changes such as those being considered without an effective safety net and a complete continuum of services will only exacerbate the problems with the system and the fiscal underpinnings.

I would urge the committee to fully fund the psychiatric program so we will be given an opportunity to work with other providers and the state agencies to fully develop a true continuum. I also urge you not to change the "Family of One" Rule and restrict access to this very vital service.

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This is one hearing you will not see the people most affected by your decision, for they don't know of this process and even if they did, they couldn't begin to tell you what it means to them. The people I speak of are the children, our children, these programs are here to help.

Thank you for your time.

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5110. BASIC REQUIREMENTS

OBRA 89 amended Secs. 1902(a)(43) and 1905(a)(4)(B) and created Sec. 1905(r) of the Social Security Act (the Act) which set forth the basic requirements for the program. Under the EPSDT benefit, you must provide for screening, vision, hearing and dental services at intervals which meet reasonable standards of medical and dental practice established after consultation with recognized medical and dental organizations involved in child health care. You must also provide for medically necessary screening, vision, hearing and dental services regardless of whether such services coincide with your established periodicity schedules for these services. Additionally, the Act requires that any service which you are permitted to cover under Medicaid that is necessary to treat or ameliorate a defect, physical and mental illness, or a condition identified by a screen, must be provided to EPSDT participants regardless of whether the service or item is otherwise included in your Medicaid plan.

The statute provides an exception to comparability for EPSDT services. Under this exception, the amount, duration and scope of the services provided under the EPSDT program are not required to be provided to other program eligibles or outside of the EPSDT benefit. Services under EPSDT must be sufficient in amount, duration, or scope to reasonably achieve their purpose. The amount, duration, or scope of EPSDT services to recipients may not be denied arbitrarily or reduced solely because of the diagnosis, type of illness, or condition. Appropriate limits may be placed on EPSDT services based on medical necessity.

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5122. EPSDT SERVICE REQUIREMENTS

The EPSDT benefit, in accordance with Sec. 1905(r) of the Act, must include the services set forth below. The frequency with which the services must be provided is discussed in Sec. 5140.

A. Screening Services.--Screening services include all of the following services:

-- A comprehensive health and developmental history (including assessment of both physical and mental health development);

-- A comprehensive unclothed physical exam;

-- Appropriate immunizations according to age and health history;

-- Laboratory tests (including lead blood level assessment appropriate to age and risk); and

-- Health education (including anticipatory guidance).

Immunizations which may be appropriate based on age and health history but which are medically contraindicated at the time of the screening may be rescheduled at an appropriate time.

B. Vision Services.--At a minimum, include diagnosis and treatment for defects in vision, including eyeglasses.

C. Dental Services.--At a minimum, include relief of pain and infections, restoration of teeth and maintenance of dental health. Dental Services may not be limited to emergency services.

D. Hearing Services.--At a minimum, include diagnosis and treatment for defects in hearing, including hearing aids.

E. Other Necessary Health Care.--Other necessary health care, diagnostic services, treatment and other measures described in Sec. 1905(a) of the Act to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services.

F. Limitation of Services.--The services available in subsection E are not limited to those included in your State plan.

-- Under subsection E, the services must be "necessary . . . to correct or ameliorate defects and physical or mental illnesses or conditions . . ." and the defects, illnesses and conditions must have been discovered or shown to have increased in severity by the screening services. You make the determination as to whether the

MEDICAL NECESSITY DETERMINATION

STANDARDS

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46.12.306 DETERMINATION OF MEDICAL NECESSITY (1) The department shall only make payment for those services which are medically necessary as determined by the department or by the designated review organization.

(2) In determining medical necessity the department or designated review organization shall consider the type or nature of the service, the provider of the service, and the setting in which the service is provided.

(3) Experimental procedures are not a benefit of the program. (History: Sec. 53-6-113 MCA; IMP, Sec. 53-6-101, 53-6-111 and 53-6-141 MCA; NEW, 1980 MAR p. 1491, Eff. 5/16/80.)

From ARM 46.12.102:

(2) Medically necessary service, or services, means a service reimbursable under ARM, Title 46, chapter 12, subchapters 5, 7, 8, 9 and 20 or any service listed separately on a hospital claim which is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions in a patient which:

(a) endanger life, or
(b) cause suffering or pain, or
(c) result in illness or infirmity, or
(d) threaten to cause or aggravate a handicap, or
(e) cause physical deformity or malfunction and, there is no other equally effective, more conservative, or substantially less costly course of treatment more suitable for the recipient requesting the service or, when appropriate, no treatment at all.

From ARM 46.12.590(2):

(k) "Hospital inpatient psychiatric care" means hospital based active psychiatric treatment provided under the direction of a physician. The individual's psychiatric condition must be of such a nature as to pose a significant danger to self, others, or the public safety, or one which has resulted in marked psychosocial dysfunction or grave disability of the individual. The therapeutic intervention or evaluation must be designated to achieve the patient's discharge from inpatient hospital status to a less restrictive environment at the earliest possible time.

(l) "Residential psychiatric care" means active psychiatric treatment provided in a residential treatment facility, to psychiatrically impaired individuals with persistent patterns of emotional, psychological or behavioral dysfunction of such severity as to require twenty-four hour supervised care to adequately treat or remediate their condition. Residential psychiatric care must be individualized, and designed to achieve the patient's discharge to less restrictive levels of care at the earliest possible time.

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Service Delivery System

Model Developed December 16, 1991

Modified from the work of

Lenore B. Behar, Ph.D.

to meet the demographics of Montana

SHODAIR CHILDREN'S HOSPITAL

CONTINUUM OF CARE FOR CHILDREN

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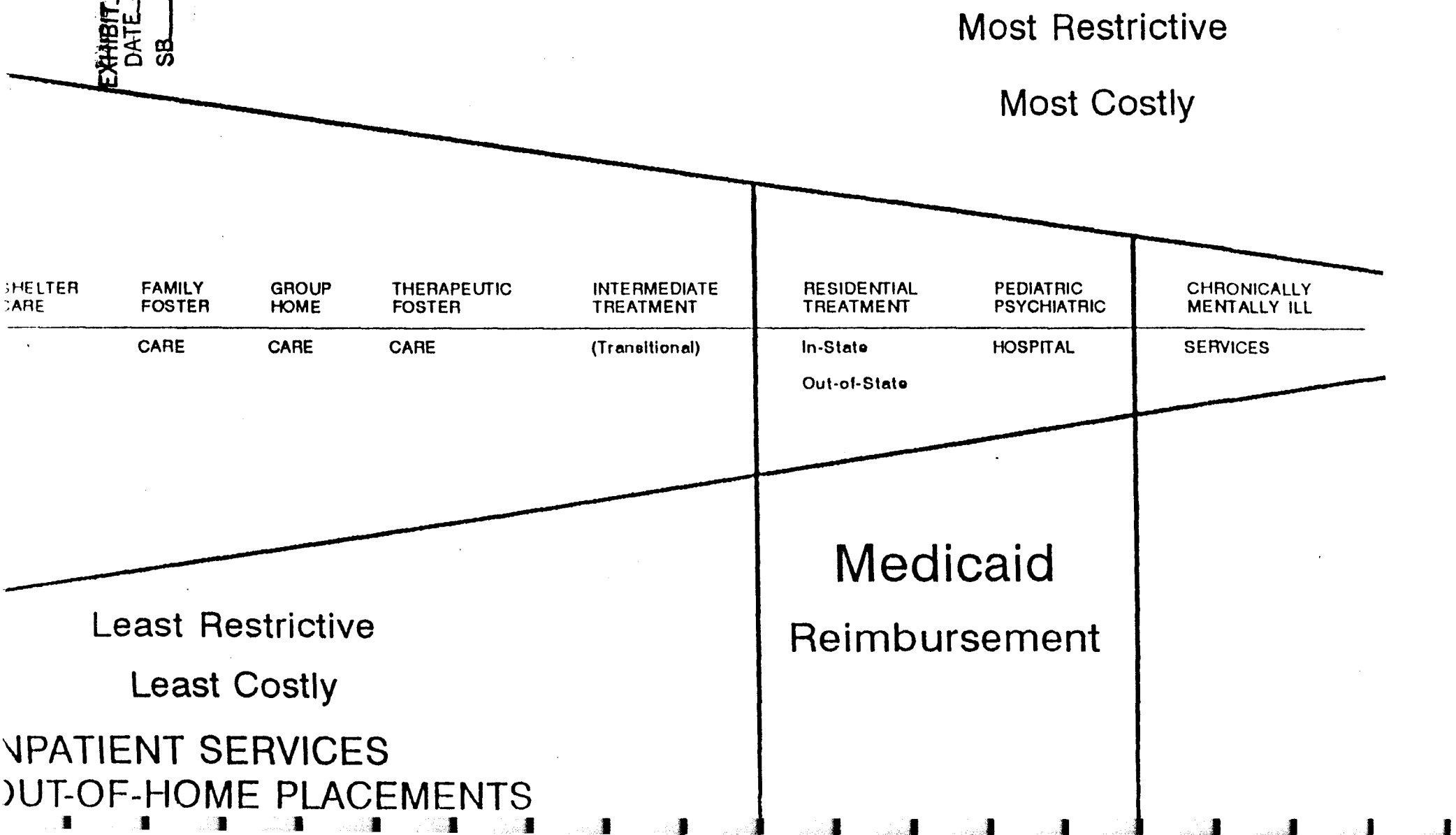

Comparison of Services for a Child with Serious Mental Health Problems for 18 Months of Treatment SHODAIR HOSPITAL

EXHIBIT 2
DATE 2-5-93
SB

Current System

Services	Hospital	Residential Treatment	Living at Home	
	+Inpatient Psychiatric	+Intense Inpatient +Intermediate Inpatient +Theraputic Foster Care +Group Home Care +Shelter Care	+Outpatient for Child and Family	
				TOTALS
# of Days	42 Days	339 Days	167 Days	548 Days
Cost	$25,620	$151,519	$2,895	$180,034
			Average Cost Per Day	$328.53

Average Cost Per Day = $328.53

Residential Costs from Lenore B. Behar, Ph.D. North Carolina Division of Mental Health, Average Cost

Comparison of Services for a Child with Serious Mental Health Problems for 18 Months of Treatment
SHODAIR HOSPITAL

EXHIBIT 2
DATE 2-5-93
SB

Proposed System

Services	Hospital	Residential Treatment	Living at Home	Living at Home	
	+Inpatient Psychiatric	+Intense Inpatient +Intermediate Inpatient +Theraputic Foster Care +Group Home Care +Shelter Care	+Day Treatmentt +Outpatient Treatment for Child and Family	+Outpatient for Child and Family	TOTALS
# of Days	42 Days	170 Days	169 Days	167 Days	548 Days
Cost	$25,620	$27,200	$17,223	$3,553	$73,596
Case Review *	$206	$1,030	$1,030	$1,236	$3,502
					$77,098
				Average Cost Per day	$140.69

* Case Review Every Thirty Days

Average Cost Per Day = $140.69

esidential Costs - Based on Shodair's Costs per Certificate of Need, Page 33.

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DEFINITIONS

Psychiatric Hospital: An entity, either operated as a public hospital by a state (e.g., state mental hospital) or licensed as a hospital by the state (e.g., private for profit/not for profit psychiatric hospital) that is primarily concerned with providing inpatient care and treatment to persons with mental disorders.

Residential Treatment Center for Emotional Disturbed Children (RTC): An organization that must meet all of the following criteria:

A. It is an organization, not licensed as a psychiatric hospital, whose primary purpose is the provision of individually planned programs of mental health treatment services in conjunction with residential care for its patients/clients.

B. It has a clinical program within the organization that is directed by either psychiatrists, psychologists, social worker, or psychiatric nurse who has a master's and/or a doctorate degree.

C. It serves children and youth primarily under the age of 18.

D. The primary reason for admission of 50 percent or more of the children and youth is mental illness, which can be classified by DSM-II/ICDA-8 or DSM-III/ICD-9-CM codes other than those codes for mental retardation, substance (drug) related disorders, and alcoholism.

Freestanding Psychiatric Partial Care Organization: A freestanding organization that offers only day or evening partial care in a planned program of mental health treatment for individuals or groups of patients.

Freestanding Psychiatric Outpatient Clinic: An organization that provides only ambulatory mental health services on either a regular or emergency basis. The medical responsibility for all patients/clients and/or direction of the mental health program is generally assumed by a psychiatrist.

Other Residential Organizations Not Elsewhere Classified (Halfway House, Community Residence, Group Home): A freestanding organization that provides only residential treatment and/or only residential supportive services.

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LEVEL OF CARE DEFINITIONS

Acute Care Facility: A treatment setting providing 24-hour availability of a full-range of diagnostic and therapeutic services, with capability for emergency implementation of life-saving medical and psychiatric interventions. There must be 24-hour availability of a physician, direct daily involvement of an attending psychiatrist in the direction and management of an interdisciplinary treatment plan and 24-hour per day skilled nursing care comprising continuous monitoring and assessment of the patient's condition and response to treatment.

The focus of treatment is on determining and implementing an effective pattern of care which will reverse life-threatening and/or severely incapacitating symptoms, occurring with the the context of a discrete episode of a DSM-III-R, Axis I clinical syndrome diagnosis.

Residential Treatment Facility: A treatment setting providing 24-hour supervision by mental health professionals with periodic medical supervision from a psychiatrist who personally evaluates the patient on admission and at least every 30 days thereafter, devises an interdisciplinary treatment plan and supervises its implementation and evaluates the patient's progress.

The facility must provide for multidisciplinary assessment of the patient, skilled milieu services by trained persons supervised by licensed professional staff on a 24-hour per day basis, individual psychotherapy and/or counseling, group psychotherapy counseling, psychoeducation in facilities which admit children and adolescents, individualized adjunctive therapies, substance use education and counseling as appropriate and pre-vocational or vocational guidance and training when appropriate, all as part of an interdisciplinary treatment plan.

The focus of treatment is on psychosocial rehabilitation aimed at returning a patient to an adequate level of psychosocial functioning. In the case of children and adolescents, this may include rehabilitation in instances where psychiatric or substance use disorders have significantly disrupted the achievement of the expected developmental level.

Partial Hospitalization/Day Treatment Facility: A treatment setting providing an interdisciplinary program of therapeutic services at least four hours per day, four days per week. The program provides individual group and family therapy, special school services for children and adolescents, medical and psychiatric assessment, substance use education and counseling and adjunctive therapies, such as recreational and activity therapy and vocational counseling. The focus of treatment is on reducing the effects of psychological distress and improving and/or preventing deterioration in the level of

psychological, interpersonal and/or occupational/educational functioning.

A patient must have a stable living situation, not necessarily the home environment, adequate support for safety and a level of functioning which enables the patient to maintain program expectations and requirements when not at the treatment facility.

Intensive Outpatient Psychiatric Treatment (Crisis Oriented): There is a discrete episode of a DSM-III-R clinical syndrome. The episode begins with a clearly defined precipitant which causes significantly reduced levels of functioning and/or subjective distress. There may be a high probability for the impending development of life threatening and/or severely incapacitating symptoms. The focus of treatment in crisis intervention, with or without pharmacology, is to reduce the symptoms and/or enhance support systems thereby postponing or negating the need for acute care. The goal is the satisfactory resolution of the crisis situation which returns the patient to the level of functioning which existed before the crisis.

Outpatient services are provided several times a week for a period not normally exceeding three weeks. Services always include ongoing assessment of the patient's mental status and safety and may include either individual or family therapy as well as collateral visits. There should be a plan in place to cover any further deterioration in the patient's condition.

Outpatient Psychiatric Treatment (Non-crisis): There is the presence of a DSM-III-R diagnosis that causes the individual significant distress or that interferes with the patient's ability to fully function in the normal spheres of their life although some degree of functioning is maintained. Life threatening symptoms are absent.

Goals of treatment may range from resolution or reduction of active symptoms to providing therapeutic support that will enable the person to continue some level of functioning to modifying the underlying psychological characteristics of the person. Services are provided on a regular basis and may consist of individual therapy, group therapy, family therapy, behavior modification and pharmacology.

Custodial Services: Services of a non-skilled nature (not requiring special technical and/or professional training) which can safely be performed by the average non-medical person without professional supervision or instruction. These services relate to areas of personal care such as assistance in ambulating, bathing, dressing, feeding, toileting, preparation of special diets and supervision of medication which can be self-administered. Such services might also include general supervision to prevent self-injury or the development of a dangerous situation resulting from the patient's inability to adequately perceive or respond appropriately to environmental

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circumstances. The focus of the service is on providing general assistance or total care to the patient in activities of daily living and/or maintaining a safe environment. The services provided have no relevance to assisting the patient in achieving individualized goals and objectives of treatment for a specific diagnosed illness.

MEDICAL NECESSITY DETERMINATION

STANDARDS

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46.12.306 DETERMINATION OF MEDICAL NECESSITY (1) The department shall only make payment for those services which are medically necessary as determined by the department or by the designated review organization.

(2) In determining medical necessity the department or designated review organization shall consider the type or nature of the service, the provider of the service, and the setting in which the service is provided.

(3) Experimental procedures are not a benefit of the program. (History: Sec. 53-6-113 MCA; IMP, Sec. 53-6-101, 53-6-111 and 53-6-141 MCA; NEW, 1980 MAR p. 1491, Eff. 5/16/80.)

From ARM 46.12.102:

(2) Medically necessary service, or services, means a service reimbursable under ARM, Title 46, chapter 12, subchapters 5, 7, 8, 9 and 20 or any service listed separately on a hospital claim which is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions in a patient which:

(a) endanger life, or
(b) cause suffering or pain, or
(c) result in illness or infirmity, or
(d) threaten to cause or aggravate a handicap, or
(e) cause physical deformity or malfunction and, there is no other equally effective, more conservative, or substantially less costly course of treatment more suitable for the recipient requesting the service or, when appropriate, no treatment at all.

From ARM 46.12.590(2):

(k) "Hospital inpatient psychiatric care" means hospital based active psychiatric treatment provided under the direction of a physician. The individual's psychiatric condition must be of such a nature as to pose a significant danger to self, others, or the public safety, or one which has resulted in marked psychosocial dysfunction or grave disability of the individual. The therapeutic intervention or evaluation must be designated to achieve the patient's discharge from inpatient hospital status to a less restrictive environment at the earliest possible time.

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Shodair 2-5 + DFS

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SB

January, 1993

INPATIENT PSYCHIATRIC ELIGIBILITY RULES
(Commonly referred to as the "Family of One" rules.)
ARM 46.12.4002, 46.12.4004 and 46.12.4006

CURRENT SITUATION: Medicaid funding is currently available for **all** individuals under the age of 21 who are admitted to a Free-standing Psychiatric Hospital and/or Residential Treatment Center (RTC) which has been licensed by the Department of Health and Environmental Sciences (DHES) and is enrolled in the Montana Medicaid Program. As of January, 1993, Montana Medicaid providers of inpatient psychiatric services for individuals under the age of 21 consist of:

3 - In-state Psychiatric Hospitals
2 - In-state Residential Treatment Centers
3 - Out-of-state Psychiatric Hospitals
6 - Out-of-state Residential Treatment Centers

Two years ago there were 4 Montana Medicaid Inpatient Psych Providers (the 2 Rivendells, Shodair Hospital and Yellowstone Treatment Center). In the past two years, the number of Montana Medicaid Inpatient Psych Providers has more than tripled, going from 4 to 14 providers.

The General Fund costs for these services have increased proportionally to the increase in the total costs for these services. General Fund costs for inpatient psychiatric services were approximately $264,000 in 1987 and $3,076,000 in 1992. To date, 1993's costs have increased 33% over 1992's cost. If this increase continues the 1993 general fund costs for inpatient psychiatric services will be $4,091,000.

This will require an increase of $590,000 in the current supplemental request.

The General Fund costs for residential psychiatric services have increased from approximately $287,000 in 1991 to approximately $1,023,000 in 1992. To date 1993's projected costs for providers in existence in 1992 have more than doubled 1992's expenditures. Additionally, six more providers have enrolled in the Montana Medicaid Program as providers of residential psychiatric services. As of January 15, 1993 thesE six new providers are serving 47 patients. At this time we anticipate increased general fund expenditures of $962,000 for these new providers. This will result in projected general fund expenditures of $3,511,000 for residential psychiatric services in 1993, 3.5 times the amount expended in 1992.

This will require an increase of $2,200,000 in the current supplemental request.

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SRS and DFS have developed 5 options for the Appropriation Sub-Committee's consideration. Actions needed and fiscal impact are provided for each option.

OPTION # 1: MAKE NO CHANGES TO THE "FAMILY OF ONE" RULES

ACTIONS NEEDED: None

FISCAL IMPACT: (STATE GENERAL FUND)

The Department estimates expenditures for inpatient psychiatric services for 1993 will increase 33% over 1992's expenditures from $3,076,000 to $4,091,000. The Department also estimates 1993 expenditures for residential psychiatric services will increase 3.5 times the 1992 expenditure level from $1,023,000 to $3,511,000. It can be anticipated this trend of increased expenditures will continue since there is an amply supply of beds to serve these patients and new providers continue to enroll in the Montana Medicaid Program. It would seem the only limit to these expenditures is the population of children in need of the service. Attached is a chart which compares the number of children served from July through November of 1992 and 1993.

Given the trend of increased cost in this program, the Department anticipates an additional $5,800,000 will be needed for the 1995 biennium budget. Please see attached chart.

OPTION # 2: ELIMINATE THE "FAMILY OF ONE" ELIGIBILITY RULES FOR INPATIENT PSYCH HOSPITALS AND RESIDENTIAL TREATMENT CENTERS AS A SEPARATE COVERAGE GROUP.

All children receiving this service would have to be otherwise eligible for Medicaid.

ACTIONS NEEDED:

1. ARM amendments
2. Medicaid State Plan changes
3. Changes to the SRS Family Assistance Eligibility Policy Manual

FISCAL IMPACT (STATE GENERAL FUND):

Based upon a sample of the paid claims data on file, the

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Department estimates approximately 30% of the patients receiving inpatient psychiatric services and 16% of the patients receiving residential psychiatric services qualify for Medicaid coverage under the "family of one rule".

Based upon the initial OBPP budget request, implementation of this option would reduce general fund expenditures by $2,755,000 in inpatient psychiatric and $710,000 in residential psychiatric for the biennium.

OPTION # 3: AMEND THE "FAMILY OF ONE RULES" TO REQUIRE THE INCLUSION OF PARENTAL INCOME AND RESOURCES IN THE FIRST MONTH THAT A CHILD/YOUTH IS ADMITTED TO A PSYCHIATRIC HOSPITAL OR RESIDENTIAL TREATMENT CENTER.

ACTIONS NEEDED:

1. ARM amendments
2. Development of additional steps to evaluate/verify parent's income during the eligibility determination process.
3. Enhancements to The Economic Assistance Management System (TEAMS). This would require an impact statement and may be quite costly.
4. Changes to SRS Family Assistance Policy Manual.

FISCAL IMPACT: (STATE GENERAL FUND)

The Department estimates implementation of this option would have no fiscal impact. The savings in benefits paid would be expended to implement and administer the program.

OPTION # 4: AMEND THE RULES TO LIMIT MEDICAID ELIGIBILITY FOR ONLY THOSE INPATIENTS OF RESIDENTIAL TREATMENT FACILITIES.

ACTIONS NEEDED:

1. ARM amendments - both eligibility and Medicaid services.
2. State Plan changes - both eligibility and Medicaid services.
3. Policy Manual changes: eligibility; Medicaid services; and provider manuals.

FISCAL IMPACT: (STATE GENERAL FUND)

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Based upon the initial OBPP budget request the $9,184,736 general fund expenditures budgeted for the inpatient psychiatric services would be a savings for DFS. However, some of these children would be served in the psychiatric unit of acute care hospitals which would require additional general fund monies for the Department of Social and Rehabilitative Services.

Comparison of Services for a Child with Serious Mental Health Problems for 18 Months of Treatment SHODAIR HOSPITAL

EXHIBIT 4
DATE 2-5-93
SB

Current System

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Residential Costs from Lenore B. Behar, Ph.D. North Carolina Division of Mental Health, Average Cost

Comparison of Services for a Child with Serious Mental Health Problems for 18 Months of Treatment SHODAIR HOSPITAL

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SB

Proposed System

Services	Hospital	Residential Treatment	Living at Home	Living at Home	
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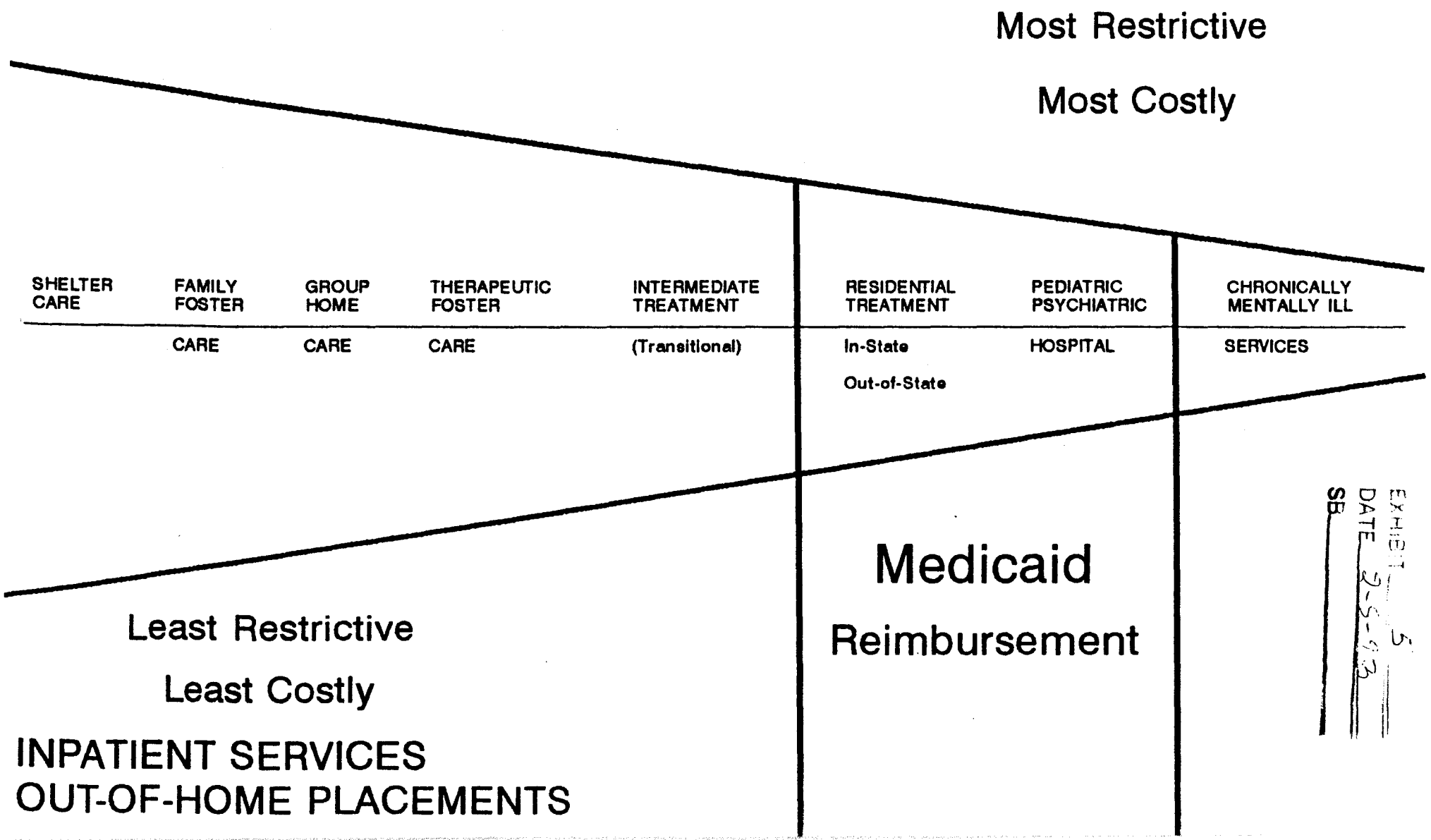
esidential Costs - Based on Shodair's Costs per Certificate of Need, Page 33.

SHODAIR CHILDREN'S HOSPITAL

CONTINUUM OF CARE FOR CHILDREN



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(1/15/93)

Home

MONTANA MEDICAID (MT MA)
INPATIENT PSYCHIATRIC FACILITIES
FOR INDIVIDUALS UNDER THE AGE OF 21

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HOSPITALS	# OF BEDS	# MA PATIENTS	PLACEMENT	TOTAL
1. Rivendell of America* Butte, MT	52	3 3	DFS Private Roll-on MA	6
2. Rivendall of Billings Billings, MT	60/licensed 46/actual	15 10 5	Generic MA DFS, Youth Courts Private Roll-on MA	30
3. Rivendall of Utah West Jordan, UT	16	0		0
4. Shodair Hospital* Helena, MT	22	4 4	DFS-Court Orders Private Roll-on MA	8
5. Southwood Hospital Chula Vista, CA	64	0		0
6. Rancho Park Hospital El Cajon, CA	30	0		0
			TOTAL	44

RESIDENTIAL TREATMENT CENTERS (RTC)	# OF BEDS	# MA PATIENTS	PLACEMENT	TOTAL
1. Yellowstone RTC Billings, MT	104	22 22 19 11	Probation DFS Generic MA Private Roll-on MA	74
2. Northwest Childrens Home Lewiston, ID	67**	15 9	DFS, Probation Private Roll-on MA	24
3. Southwood RTC Chula Vista, CA	44	2	Probation	2
4. Rancho Park RTC El Cajon, CA	56/licensed 36/actual	3	Probation	3
5. Charter Provo Canyon RTC Provo, UT	210	6 11	DFS Private Roll-on MA	17
6. Vista San Diego RTC San Diego, CA	32	0		0
7. Rivendell of Utah RTC West Jordan, UT	60	3 1 1	DFS Probation Mental Health Center	5
8. Shodair RTC*** Helena, MT	24	8 12	DFS Private Roll-on MA	20
			TOTAL	145

* Provider unable to report generic Medicaid

** Includes 12 beds at Napa, Idaho Campus

*** Joint Commission Accreditation expected after February 1993, with MA eligibility retroactive to November 1992.

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RIVENDELL PSYCHIATRIC CENTER

A Specialty Hospital for Children and Adolescents

RIVENDELL PSYCHIATRIC CENTER

HEALTH AND HUMAN SERVICES SUB-COMMITTEE

FEBRUARY 5, 1993

This information is being provided to this Committee at the request of Chairman Cobb. The following is a review of the success Rivendell facilities have experienced in Montana. This information is a consolidation of both hospitals. Before I start, let me provide you with an overview of the Rivendell system in Montana. Rivendell of Billings is a 52 bed, acute care inpatient hospital. It primarily serves adolescents between the ages of 12 and 18 years. Rivendell of Butte is a 48 bed, acute care inpatient hospital. It serves both adolescents, ages 12 - 18, and children, ages 5 to 11 years, in two distinct units.

In addition to the inpatient hospitals, Rivendell has outreach office locations in the following cities: Billings, Bozeman, Butte, Glasgow, Great Falls, Helena, Kalispell, Miles City, and Missoula. These outreach offices are staffed by at least one full-time employee and in some cases, two employees. The purpose of these outreach centers are to provide aftercare and follow-up support to the patients and families who have received services from Rivendell Psychiatric Center. Services offered in these communities and the surrounding areas include aftercare support groups, parent support groups, parenting classes, etc. In addition, the resource center works with the local professionals, schools, hospitals, probation offices, DFS staff, etc., to provide coordination with the Rivendell facility. In addition to the outreach staff, Rivendell Psychiatric Center contracts with local professionals or provides staff to conduct support groups in the following communities: Anaconda, Browning, Dillon, Ennis, Livingston, and the Polson/ Ronan/St. Ingnatius area. As you can see, Rivendell has made and will continue to make a strong commitment to the entire state of Montana.

As you have heard, the success rate of the hospital can be looked at in a number of ways. Rivendell looks at success by using the following aspects:

* School attendance since treatment,

* Recidivism since discharge (rate of re-treatment for the same condition),

55 Basin Creek Road • Butte, Montana, 59701 • (406) 494-4183 • (800) 477-1067
701 South 27th Street • Billings, Montana 59101 • (406) 259-3900 • (800) 876-5560

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* Aftercare treatment, which includes receiving and following through on aftercare plan,

* Threat of harm to self/others or the actual occurrence of harm to self/others since treatment (these two items are a significant part of our admission criteria),

* Currently taking medication,

* Living skills improvement, i.e., ability to manage abstracts, ability to complete tasks, etc.,

* Condition change after treatment, and

* Interaction change after treatment.

When all of the above factors are analyzed and averaged together, the Rivendell hospitals in Montana have been experiencing a seventy-one percent (71%) success rate. The above information represents 100 patients that have been discharged with a minimum of three (3) months since discharge.

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Youth Placed Out-of-State

Medicaid-Paid Placements: The growth in out-of-state placements by the public agencies has increased from less than 50 youth on any given day in placement in FY 90 to more than 80 youth in FY 92. The approval of out-of-state residential treatment facilities as Montana Medicaid providers has made out-of-state placements more attractive to DFS social workers and juvenile probation officers because of the availability of the Federal match. Prior to FY 92 the placements were paid from the DFS regional foster care budgets and were either state general funds or a combination of state general funds and Federal Title IVE matching funds for eligible youth.

Because the 1991 legislature approved the expansion of the "residential treatment facility" option under the Medicaid program, the state has also witnessed a very significant increase in the number of youth placed privately out of state by parents. Prior to FY 92, the State had no financial involvement in privately-placed youth out of state. When Medicaid became available to this group, based on the child's income, and when several out-of-state residential treatment facilities became licensed by DCHS and were approved by SRS as Montana Medicaid providers, the State of Montana became responsible for the Medicaid general fund match for the cost of care for both public and private placements.

That general fund match is currently about 28% or about $60/day for residential treatment. It is paid by DFS from general funds appropriated for Medicaid match for the "inpatient psychiatric Medicaid program for persons under the age of 21". Through January of 1992, there were no privately-placed youth out of state who were funded by the State. By January 1, 1993 there were over 20 youth out-of-state whose Medicaid match is being paid by the State.

SRS, DFS, and DCHS are answering inquiries and visiting with more marketing specialists from out-of-state facilities who are coming to Montana seeking patients. As of January, 1993, there are six Montana Medicaid-approved out-of-state residential treatment facilities. There is little reason to think that number will not more than double over the next year. The state agencies are currently trying to identify potential options for solving this dilemma.

Although $60/day is an excellent rate for serving a difficult emotionally disturbed youth, even at this rate, Montana will soon be spending over $1,000,000 in general fund annually to match Medicaid in out-of-state facilities. (The general fund figure as of January, 1993 includes: 20 private placements @$60/day + 20 public DFS and juvenile probation placements @$60/day = $876,000/year). These funds leave the State. If Montana's state

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agencies and private providers could combine their efforts to develop appropriate in-state resources funded by Medicaid, the Montana economy would benefit, and so would the youth and their families who are so much in need of services. Both the general fund match and the additional Federal Medicaid funds would remain in Montana.

Montana has witnessed a significant increase in the number of out-of-state residential treatment placements because:

a. the Medicaid placement cost is less from the regional foster care budget than the mostly general fund cost to pay for treatment elsewhere;

b. appropriate community-based treatment opportunities have not been developed to serve the youth in his or her own home or community;

c. either the youth is too old or has been turned down or expelled from an in-state facility; and

d. the out-of-state residential treatment facilities are not subject to the certificate of need process and are "marketing" parents, placing agencies and Montana facilities for their placements.

Before the Department of Health and Environmental Sciences can approve an application for an in-state residential treatment facility, that facility must obtain a certificate of need (see below); however, there is no such requirement for out-of-state facilities.

Non-Medicaid Placements: Although several youth have been returned from out of state facilities during the year, and many of these youth are being served in newly developed programs, there has not been a reduction in the number of youth being placed out of the state. There still is a need in Montana for a level of care that exceeds therapeutic group home or therapeutic foster care, but is not a at the residential treatment facility level that is funded by Medicaid and subject to "medical necessity" criteria.

DFS is working with potential in-state providers of residential treatment but is faced with several issues that must be overcome if higher levels of service are to be provided in-state. One of the issues to be addressed is that the two out-of-state facilities with the most Montana placements, Home on the Range in North Dakota and Excelsior of Spokane, provide services to Montana at a lower rate than the same service could be developed in-state. This is largely because these facilities are "subsidized" by private donations.

In addition, more than 90% of the youth in out-of-state placements are over the age of fourteen. The in-state providers of higher level services prefer to work with youth age fourteen or younger. A few of the youth out of state are in placements that are specifically tailored to their disability, and there are not enough similar youth in Montana at any given time to warrant the development of a full-scale program.

Because of the Department's plans to "downsize" Mountain View and Pine Hills Schools, and because Home on the Range (HOR) is responding to the need for in-state residential treatment above the group home level but not as high as the Medicaid level in Montana, HOR is currently working seriously with Glendive Forward to develop a program in Glendive that will serve Montana youth in Montana who would have gone to the facility in North Dakota, and will likely serve many of the girls who would have gone to Mountain View School. There are several other potential programs in the very early stages of negotiation with the Department. Those "negotiations" will carry over into FY 94.

Proposed Legislation Limiting Out-of-State Placements: The ever increasing number of Montana youth placed in out-of-state facilities for treatment is a growing concern for the legislature and Montanans in general. Legislation will be introduced during the 1993 session calling for a state interagency plan to address this issue and limiting the number of youth who can be placed out of state.

In-State Intensive Treatment Program: The Montana Committee for Emotionally Disturbed Children, the Children's Subcommittee of the Mental Health Association of Montana, and the Montana Children's Alliance will seek funding from the 1993 legislature to provide start-up funding for match for successful local non-profit providers responding to a DFS "Request for Proposals" (RFP) for intensive treatment homes for seriously emotionally disturbed adolescents.

The matching funds of $240,000 would be used in FY 95 by the provider(s) to match Health Facility Authority financing for construction of three community-based 6-bed therapeutic youth group homes. The treatment would be intensive and designed to serve those adolescents who are a danger to themselves or others. A portion of the funds would also be used to contract with DFS for approved start-up costs for the homes, for example, initial training for staff and planned phase-in of eligible youth.

No funds are requested in FY 94, to give DFS time to develop the RFP in conjunction with other agencies and advisory groups, and to enable the provider to obtain the financing for construction. The homes would be constructed in FY 95, with occupancy planned for July 1, 1995. The primary purpose of this program is to provide more appropriate intensive secure care and treatment in-

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state for those youth who, otherwise, would have been sent out of state. The secondary purpose is to develop additional community-based treatment capability within Montana's continuum of services with the resulting economic benefit to the state and local community.

The homes would be expected to meet the licensing requirements of a "therapeutic youth group home" and be under contract with the Department of Family Services. They would then be eligible for Medicaid funding for the treatment component. DFS would pay the board and room costs for adolescents placed by DFS and juvenile probation. Parents, the Bureau of Indian Affairs and other placing agencies would pay the room and board costs of other youth treated by the homes.

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DEMONSTRATION PROJECT FOR COMMUNITY-BASED SERVICES TO CHILDREN AND YOUTH WITH SEVERE EMOTIONAL DISTURBANCE

Summary

I. DESCRIPTION OF CHILD AND ADOLESCENT SED POPULATION

Definition. Children and youth are determined to have severe emotional disturbance (SED) when they meet all of the criteria established in the Montana Public Mental Health System State Plan for fiscal years 1992-1994. For purposes of discussion and fact-finding at the county level, we condensed the definition somewhat and represented it as shown below.

"Children and youth are determined to have severe emotional disturbance (SED) when they meet ALL of the following three criteria:

Criterion I. The person is 17 years of age or younger, or up to 21 years of age and enrolled in school; and

Criterion II. The person demonstrates a need for special care services from two or more human service programs and/or agencies; and

Criterion III. The person meets EITHER of the following two conditions:

Condition A. The person has been identified by an education agency as "emotionally disturbed" according to Section 20-70-401, MCA; or

Condition B. With or without DSM-III-R diagnosis, the person exhibits severe emotional and/or organic impairment which is consistently and persistently demonstrated by AT LEAST ONE of the following characteristics:

1. **Relationships:** the person has failed to establish or maintain interpersonal relationships relevant to his/her appropriate developmental stage(s) and cultural environment; or
2. **Behavior:** the person displays inappropriate behavior relevant to his/her developmental stage and culture; or
3. **Affect:** the person fails to demonstrate a range or appropriateness of emotion or mood relevant to his/her developmental state or culture; or
4. **Isolation:** the person displays behavior sufficiently disruptive to lead to isolation in or from school, home, therapeutic, or recreational settings; or
5. **Intensity:** the person displays behavior sufficiently intense or severe to be considered seriously detrimental to the growth, development, welfare, or safety of self or others."

Unduplicated number of SED children and youth currently being served. To date, we have been able to identify 296 children under the age of 18 who fit the SED definition. This unduplicated count was taken as of 01-31-92 and includes children on active caseloads of the following local providers:

1. Youth Court
2. D.F.S.
3. Friends to Youth
4. M.I.A.D.S.
5. Head Start
6. Watson's Receiving Home
7. Child & Family Resource Council
8. Community Care Youth Services
9. Missoula Youth Homes
10. Western Montana Community Mental Health:
    Elem/Adolescent Day Treatment Programs
    Turning Point AOD Treatment
    Out-patient therapy
11. St. Patrick Hospital:
    Adolescent Partial Hospitalization Program
    Out-patient Mental Health Services
12. Missoula County High Schools
13. Missoula County Elementary & Middle Schools

Projected total number of SED children and youth in Missoula County. Based on work by Robert Friedman and Jane Nitzer, we might expect that 2.7% of all children under the age of 18 experience serious emotional disturbance (SED). If this average holds true for Missoula County, approximately 550 children may be considered SED. Using these same statistical averages, we would guess that as many as 86 middle-school-age children would fit SED criteria.

Survey instruments completed by provider agencies and the schools identified 114 unduplicated SED children who are middle-school age (11-14 years). Approximately one-half of these children have been receiving services for more than 13 months; only about 20 are receiving services from more than one agency; about 60% are Medicaid-eligible; and approximately 70% are males.

II. PLANNING PROCESS--SERVICES FOR SED CHILDREN AND YOUTH

Roles of participants. Before agreeing to accept the challenge of this project, the Board of County Commissioners conferred with administrators on the Roundtable for Children and Youth, and direct service providers on the Youth in Waiting Committee. All agencies and individuals who were approached agreed to give the project their complete support. This was important because fact-finding and program development require considerable commitment of time and effort, and program implementation requires a significant contribution of local resources. It was necessary to have all parts of the service delivery system agree to proceed before we could hope for effective change to occur, particularly since wrap-around services were being considered which would add to the continuum of care and, without question, would require each agency's involvement.

Assumptions of participants. We embarked on the planning process understanding that certain values and assumptions were held by our community. These included: a) sanctioning ability and authority rest with key administrators and policy makers, as represented by the Roundtable on Children and Youth; b) an ability and desire to work together on behalf of SED kids is felt throughout the service provider community; c) improved services can result in a desired return to community for children placed out of it; and d) certain fundamental knowledge of the young SED

population is already held by local providers: we know our community. Among the things we assumed we knew about service delivery needs for children, families and providers were the following:

1. assumed needs for children--
    a. early identification/attention;
    b. more available treatment/therapeutic foster care;
    c. continuity of care and support to continue least restrictive care;
    d. structured after-school & summer programs;
    e. short-term residential/lock-up/partial hospitalization programs; and
    f. more mainstreaming opportunities.

2. assumed needs for families--
    a. in-home therapy/social services that build on family strengths;
    b. respite care;
    c. training to better understand and manage SED needs and behavior; and
    d. reason to trust and respond affirmatively to the "system."

3. assumed needs for providers--
    a. more effective coordination/interagency case planning and management;
    b. staff development;
    c. ways to reduce barriers between agencies;
    d. ways to get families more positively involved; and
    e. more services and/or greater resources.

Survey of Needs and Services. To test and refine these assumptions, the Missoula Roundtable on Children and Youth and other agency administrators agreed to sanction a community planning process, and to consider implementing recommendations that would result from it. Providers in the Youth in Waiting Committee and other groups agreed to contribute time and expertise to fact-finding and needs analysis. With the full participation of providers, administrators, and advocates, and with technical assistance from faculty at the University of Montana, a survey instrument was developed for the purpose of taking an inventory of needs and services as they pertain to SED children and youth. Except that approximately 20% of the DFS caseload is un-reported, 100% compliance was achieved with all participant service providers.

The Center for Population Research tabulated and analyzed the survey data. Findings were presented to public and private service providers convened in an all-day work session on March 19. The purpose of the session was to review the data, discuss their implications, and develop recommendations about how services can be improved for SED children and their families. Based on profiles prepared by DFS staff of children and youth who were currently placed out of community, the group was also asked to write "prescriptions" for services necessary to bring children back to community.

Providers' recommendations were delivered to a group of policy makers and administrators on March 24th. This group, also convened for an all-day work session, was to review and develop responses to the recommendations.

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General survey results. Many initial assumptions about needs experienced by SED children, their families, and the service delivery system were upheld by survey data. But we also learned several surprising new things about ourselves which inspired a great deal of discussion and helped guide program development:

- To qualify as "SED," a child must be determined to be in need of special services from two or more providers. Despite this, only 42 of the 296 SED children served by Missoula agencies were "duplicated," or on caseloads of more than one provider at the time of our survey (children ages 11-14 were most likely to receive services from more than one agency);

- case management was the most-provided service for all age groups, yet it also ranked first as the most important unmet need for SED children;

- only about 40% of all SED children receiving services were 11-14 years old, yet this age group accounted for over half of all DFS placements out-of-community;

- schools and law enforcement were by far the major sources of referral to services for SED children and youth--families followed, making about half the number of placements as either law enforcement or schools;

- although SED children were most often referred to counseling, family therapy and educational services, DFS and Youth Court--which offer none of these--accounted for over 60% of all services delivered in the community;

- funding rarely followed need for SED children, rather most services and resources appeared to be provided incidental to an SED condition; and

- preserving placement in home and community make best economic and programmatic sense over the long term, but funding mechanisms tend to encourage out-placement since more resources are available to serve children who are removed from their homes.

III. IDENTIFICATION OF SERVICE NEEDS

Gaps in service. For every child on their caseload, service providers were asked to identify needs he/she experienced which could not be met in Missoula. These responses--identified as gaps in service--were measured and reported by the Center for Population Research.

Overall, the most prevalent unmet service needs for SED children and youth were:

1) therapeutic case management;
2) residential treatment; and
3) family-based services.

These three were also the greatest unmet needs experienced by middle-school aged children, followed by:

1) child/family support;
2) counseling/therapy; and
3) therapeutic foster care.

Target population. Several factors argue in favor of targeting middle-school aged SED children. Currently they are under-served by the community-based delivery system; their placement rate is disproportionately high for in-patient treatment facilities; they are a population we can expect reasonable success in identifying; and middle-schoolers make up the smallest of the three educational groupings. They also are young enough that effective intervention with appropriate services can produce measurable results in terms of reductions in out-placement; preservation of family units; shortened lengths of stay in residential treatment programs; reduced involvement with law enforcement; and prevention of other negative behavior (drug and alcohol use, etc.). If wrap-around services are developed successfully for this age group, replication to younger and older ages can be accomplished incrementally.

IV. SERVICES TO BE IMPLEMENTED TO FILL GAPS

Proposed services. The four most significant gaps in service to SED children and their families in Missoula are described below. The recommendation has been made, discussed and accepted that Missoula work to fill these gaps. Providers, advocates, administrators and policy-makers agree that all four components must be built before long-term benefits can be derived from changes in our service delivery system.

1. Targeted Therapeutic Case Management -- A centralized, enforced case management system is needed which is sanctioned through inter-agency agreement, joined by all relevant providers, centered around the family unit, and focused on the needs of each SED child.

A case-management agency is planned which will operate under the umbrella of the Community Mental Health Center, but will fall under the direct oversight of an independent Advisory Board. The case management system must have autonomy, authority, and sufficient resources to be effective. Case management must be provided centrally, and services must be billable. Advisory Board membership will include administrative-level representatives from DFS, Schools, Youth Court, County government, the Mental Health Center, possibly a Judge, and a consumer advocate/representative.

Specially trained staff will coordinate teams of providers and families to develop care plans; will monitor follow-through of care plans; will evaluate and re-evaluate program effectiveness; will promote continuity; will act as a liaison for out-of-community providers; and will provide a single point of access for providers and family members involved with each child. A psychiatrist on retainer will oversee medical care and facilitate access to a hospital when necessary. Accountability will be promoted through interagency agreements and management of some service dollars (i.e. for respite care, contingency or "flexible" funds, and family support groups). Interagency agreements will describe involvement of key staff,

delineate lines of authority, and pledge prioritized delivery of services when required for SED children, parents, and/or siblings. Information and perspectives gained through team work may lead to systems or policy changes.

2. Family-Based Services -- A variation of the Homebuilders model of family-based services is needed where skilled staff members are available to work with families in their homes on an intermittent basis over a period--potentially--of several years. Family-based services provide valuable opportunities to observe and respond to family needs and stresses. Case workers can model behavior management and parenting skills, can demonstrate bridges between therapy and daily living, and can help interpret families' needs to other service providers. Family-based service providers can establish relationships of trust and rapport with families that often can be difficult to develop in other settings.

Under contract with DFS, Friend To Youth has piloted a family-based services program in Missoula patterned after the successful Homebuilders Program of Tacoma, Washington. The program is designed to prevent out-of-family placement of children and youth being served by DFS and/or Youth Court. Limited in scope and capacity to 2 families per FTE per 4-6 week period, we believe there is a need to increase the staffing and expand the program to meet the needs of this target SED population. Family-based services will be tied to the case management system.

3. Therapeutic Day-Treatment Program -- This will help meet the need identified for middle-school aged SED children for individual counseling and therapy. It also will close the gap which exists in Missoula between the Elementary Day-Treatment and Adolescent Day-Treatment programs. Middle schools currently lack any equivalent of the successful therapeutic services available at the grade- and high-school levels.

This model program is delivered in a self-contained classroom for SED children staffed by special education teachers, aides, and mental health professionals. More restrictive than a resource room or special ED classroom, it is designed to provide a highly structured environment in which learning and therapy both can occur. Individual, group, and family therapy are also component parts of this program. Rewards are built into the program, and its goal is to continually work to transition children out to mainstream classes. Availability of this option is key to many SED children who otherwise would have no alternative than placement in a residential treatment program.

4. Residential Treatment -- In-patient residential treatment for SED children and youth is not currently available in Missoula. While long-term residential treatment is not a service we plan to develop soon in connection with this demonstration project, short-term secured crisis stabilization/ assessment services are planned. Missoula Youth Homes and St. Patrick Hospital are interested in working to develop this service, which would be tied to the case management system, facilitated by the designated psychiatrist, and available timely by means of standardized protocol. Ultimately, we would like to work towards development of a program not unlike the "Stress Reduction Centers" envisioned by the Mental Health Division of DCHS.

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Reduction of out-of-community placement. Models similar to the one we are proposing have been operating successfully for the past several years in states such as Vermont, Alaska, Wisconsin and Maryland. They have helped prove that wrap-around systems of service delivery are effective in preventing out-of-community placement and, when residential placement is necessary, in shortening lengths of stay.

Under our current system of service delivery, a severely emotionally disturbed child is likely to receive specialized services if: a) his family has means and ability to seek professional help; b) she is unable to function independently in a classroom; or c) he or his family exhibits behavior that is so inappropriate and disruptive that social/legal intervention is considered necessary. Once an SED condition is identified and needs are assessed, the responsibility for accessing services is frequently left to the child's family. Services, once accessed, tend to be issue-specific and delivered by independent agencies or professionals over disjointed periods of time. As long as SED children and families are strong consumers, the current system seems able to offer services in sufficient number and variety to meet their needs. But without the addition of services described in the section above, the system seems unable to respond except with the most extreme measures when crises occur or when family structures weaken to the point that their effectiveness is lost as consumers or self-advocates. In too many cases, too often because acceptable alternatives are unavailable, the response of our system is to remove children from their current environments and place them in foster care, group care, residential treatment, or hospitalized care.

Adding therapeutic day treatment, crisis stabilization and family-based services to the local continuum of care introduces alternatives to out-placement not previously available. Intensive case management ensures effective organization and delivery of services. It reduces need for out-placement by strengthening the community's ability to serve the SED child and by helping to empower or stabilize an SED child's family. And it acts as a gate keeper by ensuring application of intermediate, least-restrictive service options whenever appropriate.

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MODEL WAIVER PROGRAM
FOR MEDICAID SERVICES TO CHILDREN AND YOUTH WITH SEVERE EMOTIONAL DISTURBANCE (SED)
Summary

I. Model Waiver

A. Who?

1. Children who are:
   a. ages 18 and younger; and
   b. severely emotionally disturbed (SED) per the DCHS definition; and
   c. in need of residential and/or acute in-patient psychiatric hospitalization unless alternative community-based (waiver) services are delivered (30 to 90-day re-assessments planned); and
   d. unable to cover the cost of such services with personal income or assets (this is a waiver of deeming--parental income is disregarded for these services as is currently the case for residential services)
2. Waiver is limited to 200 children/year--we expect to serve less than 1/2 that many

B. What?

1. Covers community-based and family-based services in lieu of residential and/or acute in-patient psychiatric services
2. Waives certain Medicaid eligibility and reimbursement rules for purpose of demonstrated cost-savings and/or cost-containment ("Katie Beckett" model)
3. "Cold bed" policy is in effect (To qualify for waiver services, Medicaid must be shown that an empty bed exists in a psychiatric hospital or residential treatment center which could have been used by the child.) (Capacity vs occupancy)
4. Project's aim is to provide children home- and community-based services at a cost equal to or less than it would have cost in in-patient or residential services

C. Where?

1. Waiver of state-wideness allows the project to be limited to a single county--this limits risk and improves manageability of the model
2. Model will be run through community mental health's case management program
3. Successful demonstration can be replicated across Montana

D. Why?

1. New community-based services must be created to adequately complete the continuum of care--the waiver provides needed resources for this
2. Current system encourages expensive and disruptive out-of-home and out-of-community placement for SED children--the waiver offers parents new choices
3. A similar home-and community-based waiver program in Vermont shows improved results at less cost per child; community-based service programs in general have shown positive outcomes for SED children and youth
4. Waiver maximizes gen'l fund through 72/28% match (same as regular Medicaid)
5. Medicaid waiver requires per-child cost savings, which forces fiscal accountability
6. Foundation has been laid for community/family-based service alternatives, inter-agency collaboration, and inter-governmental cooperation--we're ready now

E. How?

1. Application through SRS, prepared by Missoula County in consultation with SRS, DFS, DCHS, PLUK, and local service providers (CASSP support)
2. Waiver requires (legislated?) authority to spend state match
3. Application has 90-day turn around at federal level (national model)
4. Running the waiver requires staff support (SRS? DFS? DCHS? County?)

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ANALYSIS -- MEDICAID SVCS FOR CHILDREN WITH SEVERE EMOTIONAL DISTURBANCE (SED)	INSTITUTIONAL CARE -- 1992 EXPERIENCE			HOME- AND COMMUNITY-BASED WAIVER ALTERNATIVE	
	In-Patient Psychiatric Care*	Residential Treatment**	Total Institutional Care***	Model Waiver Services ****	Waiver + Other SED Medicaid Services*****
1. Number of Children Served *Annualized Total*	39.20	7.75	46.95	47.00	47.00
2. Cost of Care -- All Children	$721,131	$252,300	$973,431	$467,697	$928,814
General Fund	*201,917*	*70,644*	*272,561*	*130,955*	*260,068*
Medicaid Match	*519,215*	*181,656*	*700,871*	*336,742*	*668,746*
3. Avg Cost of Care per Child	$18,396	$32,555	$20,733	$9,951	$19,762
General Fund	*5,151*	*9,115*	*5,805*	*2,786*	*5,533*
Medicaid Match	*13,245*	*23,439*	*14,928*	*7,165*	*14,229*
4. Avg Cost per Child per Day	$470.61	$157.93	$311.02	$110.57	$219.58
General Fund	*131.77*	*44.22*	*87.08*	*30.96*	*61.48*
Medicaid Match	*338.84*	*113.71*	*223.93*	*79.61*	*158.10*
5. Avg Length of Care *Days*	39.09	206.13	66.66	90.00	90.00
6. Turn-Over Rate *Per Bed or "Slot" per Year*	9.34	1.77	5.48	4.06	4.06
7. Average Daily Census *Children Served Each Day*	4.20	4.38	8.57	11.59	11.59

NOTES:

Numbers reflected in this table DID NOT originate with SRS, nor have they been verified by SRS. Data sources are noted below.

This exercise was performed to provide a basis on which to determine if pursuit of a waiver would be a worthwhile endeavor.

* Includes Rivendell Butte & Bllgs, and Shodair hospitals--the only Medicaid-approved psychiatric hospitals for children in MT.

** Includes Yellowstone Trtmnt Ctr, the only Medicaid-approved residential treatment facility operating in MT throughout 1992. (Shodair opened in Nov, 1992; Intermountain Deaconess rec'd C.O.N. approval, but had not sought licensure as of 12/92.)

*** Combined totals: annualized in-patient psychiatric hospital and residential treatment services provided (see previous notes).

**** Includes only those new services proposed under the Model Waiver.

***** Includes new Waiver services AND other community-based services already covered by Medicaid (full complement).

1. From Missoula County only. In-ptnt based on 80% of 49 svd 7/91 - 10/92 per DFS. Residential based on formula: Cost of care, divided by average cost per child, divided by average length of stay. Data supplied by DFS and DCHS. Number of children in Waiver services is equal to combined total in institional care for sake of comparison.
2. In-patient cost based on 80% total cost for Msla children in Rivendells and Shodair as reported by DFS for period 7/91 - 10/92. Residential cost based on pro-rated $52,983 gen'l fund exp for Msla 7/91 - 4/92 per DFS (assume $70,644 total gen'l fund). Waiver costs based on highest estimates per "Services Menu" tables, enclosed. Ratio of 28% General Fund to 72% Medicaid Match applied in each instance.
3. Derrived by dividing total cost by total number of children served.
4. Derrived by dividing cost per child by length of stay. In-ptnt & res'l compare to simple averages of $464 & $158 as per DCHS.
5. Based on data in the Mental Health Management (Medicaid) rpt per DFS. Combined total=(39.2x39.09)+(206.13x7.75)/46.95.
6. Derrived by dividing 365 by average length of stay.
7. Derrived by dividing number of children served by rate of turn-over.

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MODEL WAIVER S.E.D. SERVICES MENU	LEVEL OF INVOLVEMENT			MAX COST PER SVC (90-day period)	AVG COST PER DAY
	1 (30-day period)	2 (30-day period)	3 (30-day period)		
Family Based Intervention $ 49.26 / Unit Hour	$2,956 @ 60 hrs/month	$985 @ 20 hrs/month	$394 @ 8 hrs/month	$4,335	$48.17
Family Training/Education $5.42 / Unit Hour	$54 @ 10 hrs/month	$108 @ 20 hrs/month	$217 @ 40 hrs/month	$379	$4.22
Respite $11.70 / Unit Hour	$936 @ 80 hrs/month	$702 @ 60 hrs/month	$234 @ 20 hrs/month	$1,872	$20.80
Emergency Stabilization $100 / Unit Day	$700 @ 7 days/admission	$700 @ 7 days/admission	$700 @7 days/admission	$700	$7.78
Transportation $0.28 / Unit Mile	$28 @100 miles/month	$28 @100 miles/month	$28 @100 miles/month	$84	$0.93
Environmental Modification $750 / Family Maximum	$750 @ $750/family/year	$750 @ $750/family/year	$750 @ $750/family/year	$750	$8.33
Psychiatric/MH Consultation $100 / Unit Hour	$200 @ 2 hrs/month	$200 @ 2 hrs/month	$200 @ 2 hrs/month	$600	$6.67
Day Activity Program $5.42 / Unit Hour	$390 @ 72 hrs/month	$390 @ 72 hrs/month	$390 @ 72 hrs/month	$1,171	$13.01
Language/Cultural Interpretation $10 / Unit Hour	$20 @ 2 hrs/month	$20 @ 2 hrs/month	$20 @ 2 hrs/month	$60	$0.67
COST PER LEVEL OF SERVICE	$6,034	$3,884	$2,933	$9,951	
Avg Cost/Child/Day	*$201*	*$129*	*$98*		*$110.57*

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WAIVER AND REGULAR S.E.D. SERVICES MENU	LEVEL OF INVOLVEMENT			MAX COST PER SVC (90-day period)	AVG COST PER DAY
	1 (30-day period)	2 (30-day period)	3 (30-day period)		
Family Based Intervention $ 49.26 / Unit Hour	$2,956 @ 60 hrs/month	$985 @ 20 hrs/month	$394 @ 8 hrs/month	$4,335	$48.17
Family Training/Education $5.42 / Unit Hour	$54 @ 10 hrs/month	$108 @ 20 hrs/month	$217 @ 40 hrs/month	$379	$4.22
Respite $11.70 / Unit Hour	$936 @ 80 hrs/month	$702 @ 60 hrs/month	$234 @ 20 hrs/month	$1,872	$20.80
Emergency Stabilization $100 / Unit Day	$700 @ 7 days/admission	$700 @ 7 days/admission	$700 @7 days/admission	$700	$7.78
Transportation $0.28 / Unit Mile	$42 @150 miles/month	$42 @150 miles/month	$42 @150 miles/month	$126	$1.40
Environmental Modification $750 / Family Maximum	$750 @ $750/family/year	$750 @ $750/family/year	$750 @ $750/family/year	$750	$8.33
Therapeutic Day Treatment Group @ $ 16.92 / Unit Hr Ind/Fam @ $ 68.52 / Unit Hr Day Trtmt @ $ 10.92 / Unit Hr	$1,891 group @ 20 hrs / mo; ind/fam @ 8 hrs / mo; day trtmt @ 92 hrs / mo.	$1,891 group @ 20 hrs / mo; ind/fam @ 8 hrs / mo; day trtmt @ 92 hrs / mo.	$1,891 group @ 20 hrs / mo; ind/fam @ 8 hrs / mo; day trtmt @ 92 hrs / mo.	$5,674	$63.04
Outpatient Therapy $68.52/ Unit Hour	$274 @ 4 hrs/month	$411 @ 6 hrs/month	$548 @ 8 hrs/month	$1,233	$13.70
Psychiatric/MH Consultation $100 / Unit Hour	$200 @ 2 hrs/month	$200 @ 2 hrs/month	$200 @ 2 hrs/month	$600	$6.67
Day Activity Program $5.42 / Unit Hour	$390 @ 72 hrs/month	$390 @ 72 hrs/month	$390 @ 72 hrs/month	$1,171	$13.01
Therapeutic Case Management $38.16 / Unit Hour	$954 @ 25 hrs/month	$954 @ 25 hrs/month	$954 @ 25 hrs/month	$2,862	$31.80
Language/Cultural Interpretation $10 / Unit Hour	$20 @ 2 hrs/month	$20 @ 2 hrs/month	$20 @ 2 hrs/month	$60	$0.67
COST PER LEVEL OF SERVICE	$9,167	$7,154	$6,340	$19,762	
Avg Cost/Child/Day	*$306*	*$238*	*$211*		*$219.58*

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FAMILY- and COMMUNITY-BASED WAIVER SERVICES

DRAFT DEFINITIONS 02/05/93

Child & Family Support Services - are interventions that clients assist children and family in achieving and maintaining successful patterns of community living. Services include, but are not limited to: assistance in locating appropriate housing; monitoring of residential settings other than those which are operated by the provider; assuring that clients are able to access non-mental health/mental retardation programs and resources in the community; and, other traditional social casework and counseling activities. Services are limited to those identified in the individualized plan of care.

Day Activity - is primarily social and recreational service with minimal emphasis on structured, professional-rendered programming. Though not primarily treatment oriented in nature, the day activity program would be required to provide or assure provision of a set of core, professionally-monitored services including: periodic evaluation of general health status; monitoring of health problems that can be managed in nonmedical settings; nutrition services; counseling and training in the use of leisure time; structured leisure activities; and assistance with basic activities of daily living as necessary. Day Activity Services may take place weekdays, evenings and weekends.

Family Education and Training Services - are designed to increase the capabilities of families to care for their children with serious emotional disturbance. Training is offered in one or more of the following areas: developmental programming to assist the child with the acquisition of self-care, communication, mobility, and social skills; behavior management techniques; specialized interventions for dealing with unique health and mental health needs of the individual; and, any other training which enables the family to maintain the child at home and contributes to his/her growth and well being. Specific skills to be developed include: identify community resources, seek assistance when needed; increase personal initiative; develop temporal skills; manage personal financial resources; independently use common community resources such as transit services; recognize situations which are dangerous or threatening to health and respond properly; and apply appropriate behavior management techniques.

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Respite Care Services - are short term child care services provided to families on behalf of children who are unable to care for themselves in the absence of those who normally provide such care. These services may be provided in the child's home or in a setting approved in the individualized plan of care. The extent and schedule of respite care will be determined by a family's (or other care giver's) particular needs.

Environmental Modification - If no other means are available, payment for modifications of the physical environment of the child's residence which will enable the child to remain there.

Language/Cultural Interpretation - Interpretive services provided to service providers and non-professional care givers when the child experiences speech or language barriers, or is a member of a minority culture. Examples include, but are not limited to children who are Native American, Hmong, deaf, or blind.

Consultation - Psychiatric Mental Health Professional - Case consultation provided to service providers and/or non-professionals concerning medical and psychiatric problems identified in the plan of care. This consultation would be available to persons such as, but not limited to, "regular education" teachers, scout leaders, coaches, and other persons directly involved with the child, to improve their understanding and management of the child's emotional disturbance.

Emergency Stabilization - Emergency stabilization is a method of care provided for children experiencing acute mental health crisis which does not require inpatient psychiatric hospitalization. Acute mental health crisis is evidenced by: (1) sudden change in behavior with negative consequences for well-being; (2) a loss of usual coping mechanisms; or (3) presenting a danger to self or others. Emergency stabilization may include diagnostic, psychotherapeutic services, and psychiatric evaluations provided in a secure residential facility. Emergency stabilization services are intensive, time-limited, and intended to resolve or stabilize the immediate crisis through direct treatment and support services to primary care givers.

Family Based Intervention - Intensive home-based psychotherapeutic treatment provided by certified professionals to children and families on issues or problems identified in the child's individualized plan of care. Intervention includes the development of appropriate interpersonal

skills, affective and behavior management skills, coping skills, parent training in behavior management and identification of community resources, and basic life skills acquisition. Specific skills to be developed include: increase span of attention; ask questions or seek assistance when needed; increase personal initiative; develop temporal skills; manage personal financial resources; independently use common community resources such as transit services; recognize situations which are dangerous or threatening to health and respond properly; and behave in a manner that is appropriate to the situation; and application of appropriate behavior management techniques.

Transportation - If no other transportation is available, payment for transportation of family members to and from services to benefit the child with severe emotional disturbance. Services are limited to those described in the individualized plan of care.

EXHIBIT 11
DATE 2-5-92
SB

HOME- and COMMUNITY-BASED SERVICES FOR CHILDREN WITH SEVERE EMOTIONAL DISTURBANCE (SED)

February 5, 1993

I. THE CHALLENGE

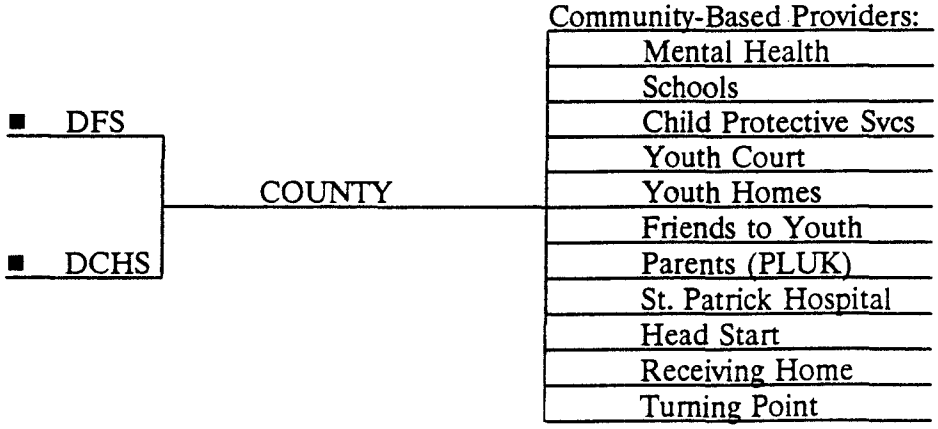
- **Intensity of Need** -- SED children have profound needs; their cases are among the most complicated and time-consuming to serve, and the nature of their disability predicts crises, family stresses, and the need for intervention over the long-term.
  How can the service delivery system be strong enough, comprehensive, and flexible enough to respond effectively to the changing needs presented by these children and their families?

- **Multiplicity of Problem** -- By definition, SED children need specialized services from two or more providers. Because they cross usual organizational and programmatic boundaries, no single part of the "system" can adequately meet the needs of SED children and their families.
  How can care be delivered and managed with continuity for a single SED child across jurisdictional lines of different programs, organizations, and governments?

- **Quality of Crisis**-- An SED condition is not self-correcting. Without appropriate intervention problems tend to escalate and result in more intensive, more costly, and more disruptive responses by the service delivery system.
  How can interventions occur timely, appropriately, and with minimal disruption to the lives of children and to the working of the delivery system?

- **Costliness of Services** -- Financially and programmatically, SED children are heavy consumers of service resources.
  How can services be delivered more efficiently so that resources are maximized, and costs are contained?

II. THE PARTNERSHIP



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III. THE PROJECT DESIGN

- **Planning Process** -- Analyzing needs and resources, and developing a planned response to what was found, required the involvement of virtually 100% of the local provider community. Resources, target populations, model program approaches, and the service delivery system all were studied.

- **Target Population** -- After reviewing all available data, we narrowed the target to middle-school aged children (11-14 years) and their families. Considerations included: a) **success in identification**--of the 296 children identified, 114 were middle-school age; b) **presenting needs**--at the time of the study, this age group experienced a disproportionately high number of "out-placements" to intensive services; c) **critical gaps in service**--the community lacked services for this age group that were available to SED children of other ages; and d) **impact**--appropriate intervention at a young age increases likelihood of preventive success.

- **Services to be Provided** -- The project is designed to: a) incorporate the best aspects of models proven effective in other parts of the country; b) meet the needs identified in the community study; c) build on the resources and programs currently existing in community; d) complete the continuum of care by adding critical new services--therapeutic case management, intensive family-based services, school-based day treatment, and emergency stabilization services.

IV. THE DEMONSTRATION PROJECT COST

$ 40,000	DFS	Family-Based Svcs	
$ 96,000	DCHS:		
	$ 10,000 (CASSP)	Planning	County contracts
	$ 46,000 (CASSP)	Case Management	with Community
	$ 40,000 Block Grant	Day Treatment	Providers
$ 40,000	Missoula County	Day Trt & Case Mgt	
$176,000	Total cash investment (first year)		

V. THE CONTINUING NEED

- **Test the Demonstration** -- Problems and resources have been identified. Program approaches have been designed carefully to maximize available resources and ensure positive results. Base-line data is established against which success can be measured, and program implementation has begun--let's test the model!

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- **Keep the Partnership Intact** -- Unique partnerships have been forged among units of state and local government, public and private service providers, parents, and professionals in fields of education, juvenile justice, social work, and mental health. Challenges presented by SED conditions can be met successfully only through such partnerships--let's see what this partnership can accomplish!

- **Continue Necessary Funding** -- The Demonstration project cannot go on without continued funding from its partners. The Project is equally reliant upon the $40,000 it received from DFS as it is on the funds recieved from DCHS and from the County. We understand that continued funding is not currently in the DFS budget, and we do not want to put additional stress on the Foster Care budget. However, financial support withheld from this project will result in costs to the service delivery system (not to mention to children and families) which far exceed short-term monetary savings--let's take an educated long view and risk a little to achieve a lot!

- **Refine Systems of Service Delivery and Resource Allocation** -- A working demonstration project can provide the foundation upon which to build additional improvements in the service delivery system for SED children and families. Continued work and refinement should occur in at least two areas--

  Financing: Are we making the best use of general fund dollars? Are resources following children's needs? Are some placement decisions being forced by funding mechanisms? A model Medicaid waiver can help correct these imbalances. We need sanction to pursue a waiver and approval to utilize Medicaid funding if the waiver is approved.

  Gate-keeping: Do parents and providers have equal ability to access services most appropriate to their needs and resources? Can we improve our ability to introduce children and families to services along the continuum which best address their level of need? Can mechanisms be put in place which improve the "system's" ability to manage its finite resources? Can this Demonstration's public/private partnership make maximum use of public *and* private resources? Let's keep working!

EXHIBIT 13
DATE 2-5-93
SB

MEDICAID WAIVER FOR

SEVERELY EMOTIONALLY DISTURBED (S E D) CHILDREN

PURPOSE:	**CREATE ELIGIBILITY/FUNDING FOR HOME AND COMMUNITY BASED SERVICES**

HOW:	**EXTENDING THE RULE OF ONE TO SED CHILDREN ON THE THRESHOLD OF PSYCHIATRIC HOSPITAL / RESIDENTIAL TREATMENT ADMISSION**

EXHIBIT 12
DATE 2-5-93
SB

CURRENT SYSTEM :

FREE TICKET TO PSYCH HOSPITAL

FREE TICKET TO PSYCH HOSPITAL

FREE TICKET TO PSYCH HOSPITAL

FREE TICKET TO PSYCH HOSPITAL

LOTS OF THESE AVAILABLE

HOWEVER, TICKETS FOR THESE ARE NOT GENERALLY AVAILABLE:

HOME AND COMMUNITY BASED SERVICES

SERVICE NOT AVAILABLE

NO $

NO SERVICE

THERAPUTIC CASE MANAGEMENT

THERAPUTIC DAY TREATMENT

RESPITE CARE

EMERGENCY SERVICES

PSYCHIATRIC / M. H. CONSULTATION

SHORT TERM OUT OF HOME STABILIZATION

EXHIBIT 13
DATE 2-5-93
SB

BACKGROUND:

1. SIMILIAR IN CONCEPT TO THE DD AND ELDERLY WAIVERS;
   " KATIE BECKETT" MODEL

2. PROPOSAL DEVELOPED COOPERATIVELY BY:
   SRS
   DC & HS
   DFS
   MISSOULA CO YOUTH CONSORTIUM

3. PROJECT MUST COST LESS THAN CURRENT COST OF
   PSYCHIATRIC INPATIENT/ RESIDENTIAL TREATMENT

4. PROJECT IS INIATIALLY LIMITED TO A SINGLE COUNTY
   EVENTUALLY, WHEN SUCESSFUL, TO BE REPLICATED STATEWIDE

5. DOES NOT INVOLVE NEW $;
   RATHER REDEPLOYS EXISTING INSTITUTIONAL $ NOW PAYING
   FOR HOSPITALIZATIONS/RESIDENTIAL TREATMENT

LEGISLATIVE ACTION NEEDED:

1. AUTHORIZATION TO PROCEED WITH FINAL DEVELOPMENT/SUBMITTAL
   OF WAIVER

2. AUTHORIZATION FOR DFS TO PROVIDE MATCH FOR WAIVER FROM
   EXISTING INSTITUTIONAL CARE BUDGET.

for the record

EXHIBIT 13
DATE 2/5/93
SB

ATTACHMENT

MODIFICATION SUMMARY: MEDICAID CLAIMS PROCESSING

The MMIS contractor (Consultec) is responsible for the processing of all Medicaid benefits claims. The contract which began in 1987 and terminates on June 30, 1993 can be renewed for 1994 and 1995 for a small inflationary increase in monthly charges related to the change in the CPI from 1992 to 1993. The base cost of this contract has not increased over the term of the current contract, since its inception in 1987. Renewal of this contract for the two year extension is by far the most cost effective approach for continuing the claims processing function for Medicaid. The original contract requires that we provide this inflationary increase pursuant to the extension the cost and is budgeted at $30,000 per year. Procurement of a new contract would be much more expensive than a simple extension of the current contract.

In addition, the monthly charges have increased based on volume for special program processing related to the Qualified Medicare Beneficiaries (QMB) Program, the prior authorization program, the drug utilization review program, the EPSDT subsystem, and the provider outreach and information program. These additional costs are related to increased volume in the programs or special processing required for new programs such as automated prior authorization. To reduce the overall cost of the modification the Department has determined that it will adjust to cover the TPL portion of the original modification in other areas of the existing budget.

MODIFICATION TOTAL COST:

Description	Total	General Fund	Federal Fund
FY 1994 Total Cost	$ 193,200	$ 48,300	$ 144,900
FY 1995 Total Cost	$ 193,200	$ 48,300	$ 144,900

MODIFICATION ANNUAL COST IN DETAIL:

Description	Total	General Fund	Federal Fund
Contract Extension	$ 30,000	$ 7,500	$ 22,500
Outreach & Information	$ 14,400	$ 3,600	$ 10,800
Prior Authorization	$ 45,600	$ 11,400	$ 34,200
QMB	$ 24,000	$ 6,000	$ 18,000
Drug U/R	$ 48,000	$ 12,000	$ 36,000
EPSDT Subsystem	$ 31,200	$ 7,800	$ 23,400
Grand Total Per Year	$ 193,200	$ 48,300	$ 144,900

HOUSE OF REPRESENTATIVES
VISITOR'S REGISTER

_____ COMMITTEE BILL NO. _____

DATE 2-5-93 SPONSOR(S) HUMAN SERVICES

PLEASE PRINT **PLEASE PRINT** **PLEASE PRINT**

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
John Harwood R-1 Box 96 St. Ignatius, MT	Families		
Joe McGrath	Mental Health Assn		
AL DAVIS	DFS		
Jack Casey	Shodair		
LARRY BURGE	GLACIER VIEW		
Pete Surdock	DCHS - MHD		
Peg Shea	MHC - Missoula Co.		
Cindy Klette	Mdla County (SED)		
CINDY BARTLING	Friends To Youth (Mdla.)		
Mary A. Akers	DFS		
CHUCK CERNY	MT. DEACONESS GREAT FALLS		
Dan-Hall Mayfield	DFS St. Council		
J.D. Rich MD	Billings Deaconess Hospital		

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

HOUSE OF REPRESENTATIVES
VISITOR'S REGISTER

HUMAN SERV. COMMITTEE BILL NO. _____

DATE 2-5-93 SPONSOR(S) Human Serv.

PLEASE PRINT **PLEASE PRINT** **PLEASE PRINT**

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Jane Bernard	SRS		
Susan W. Duffy	Parents Let's Unite for Kids	✓ Statecty demo.	

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