MINUTES

MONTANA HOUSE OF REPRESENTATIVES
54th LEGISLATURE - REGULAR SESSION

JOINT SUBCOMMITTEE ON HUMAN SERVICES & AGING
AND
JOINT SUBCOMMITTEE ON INSTITUTIONS AND CULTURAL EDUCATION

Call to Order: By **CHAIRMAN JOHN COBB** on January 24, 1995, at 7:30 a.m.

ROLL CALL

Joint Subcommittee on Human Services and Aging
Members Present:

Rep. John Cobb, Chairman (R)
Sen. Charles "Chuck" Swysgood, Vice Chairman (R)
Rep. Beverly Barnhart (D)
Sen. James H. "Jim" Burnett (R)
Rep. Betty Lou Kasten (R)
Sen. John "J.D." Lynch (D)

Joint Subcommittee on Institutions and Cultural Education
Members Present:

Rep. Marjorie I. Fisher, Chairman (R)
Rep. Red Menahan (D)
Rep. Steve Vick (R)
Sen. Larry Tveit, Vice Chairman (R)
Sen. Gary Aklestad (R)
Sen. Mignon Waterman (D)

Members Excused: none

Members Absent: none

Staff Present: Lisa Smith, Legislative Fiscal Analyst
Lois Steinbeck, Legislative Fiscal Analyst
Douglas Schmitz, Office of Budget & Program Planning
Mary LaFond, Office of Budget & Program Planning
Ann Boden, Committee Secretary

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

Committee Business Summary:

Hearing: Managing Resources Montana Program
Montana Mental Health Access Program
Executive Action: Montana Diabetes Control Program

{Tape: 1; Side: A; Approx. Counter: 000; Comments: This meeting was recorded on three 60-minute audiocassettes.}

EXECUTIVE ACTION ON MONTANA DIABETES CONTROL PROGRAM

Motion/Vote: **SEN. J. D. LYNCH MOVED TO RECONSIDER THE SUBCOMMITTEE'S ACTION REGARDING THE FEDERAL GRANT FOR THE MONTANA DIABETES CONTROL PROGRAM. The motion carried unanimously.**

Motion/Vote: **SEN. LYNCH MOVED TO ACCEPT THE FEDERAL GRANT IN THE AMOUNT OF $650,000 FOR THE STUDY OF DIABETES. The motion carried with REP. KASTEN and SEN. SWYSGOOD opposed.**

HEARING ON MANAGING RESOURCES OF MONTANA

Ms. Lisa Smith, Legislative Fiscal Analyst (LFA), gave an overview of the Managing Resources Montana (MRM) Program. **EXHIBIT 1** In previous biennia, the Office of Public Instruction (OPI), the Board of Crime Control (MBCC), the Department of Family Services (DFS), the Department of Social and Rehabilitation Services (SRS), and the Department of Health and Environmental Sciences (DHES) have received general fund monies for providing services to emotionally disturbed youth. In the 1997 biennium the executive rolls all MRM Program funding into the Department of Corrections and Human Services (DCHS) and recommends more than $20 million of general fund for the program, a 150% increase over the 1995 biennium.

Ms. Lois Steinbeck, LFA, reviewed the issues regarding residential treatment. The executive budget originally included residential psychiatric benefits in two places. It appears that at least $1.3 million more was "double budgeted" in DCHS for the same function. She added that this issue may be related to including funds that were budgeted in OPI in the 1995 biennium. She said she was going to meet with those agencies to determine exactly where the extra funds come from.

Ms. Steinbeck discussed the growth in inpatient psychiatric costs for youth. The 1993 Legislature eliminated this funding, for a $10 million savings in general fund. She pointed out that the budget for residential psychiatric benefits has grown from $3.6 million total funds in FY92 to $8.3 million in FY94, with a proposed budget of $9.6 million in general fund only. She suggested that the subcommittees ask DCHS how it plans to stabilize these increases and how it will control the number of in-state residential psychiatric beds. Currently, beds are approved through the certificate of need process administered by DHES; during the last biennium there was an increase in the number of beds approved. She also noted that the Human Services Subcommittee has a bill request in to either revise or eliminate the certificate of need process. She suggested that the subcommittees ask some of the providers how this might affect the benefits expenditures.

Questions from Subcommittee Members and Responses:

In response to **REP. BETTY LOU KASTEN, Ms. Smith** explained that the five managing resource specialists for the MRM program are currently employed by the five Community Mental Health Centers (CMHC). There is a state team involved with MRM as well as teams in each region working with the CHMC's, which are involved in hiring these specialists. She pointed out that the managing resources specialist is the one that refers the child to services. This provider could be either a CMHC or another provider in the community.

Informational Testimony:

Mr. Dan Anderson, Administrator, DCHS Mental Health Division, then spoke. MRM was started two years ago to provide community-based services in response to legislative action which eliminated Medicaid reimbursement for in-patient psychiatric services for youth. He reviewed the history of the development of the program, which was a collaborative process and included clarifying the definition of a severely emotionally disturbed (SED) child. He stressed that this program is geared only towards the most severely emotionally disturbed children.

Mr. Anderson reviewed the objectives of the program, which include more cost-effective use of available services in the least restrictive, therapeutically appropriate community-based environment possible. Another objective is to enhance the opportunity for preservation of the family.

Mr. Anderson said they are trying to develop a program which could make use of all of the many service providers in the state rather than just a select few. They are working to make the MRM program as accessible as possible for eligible families. Funds are provided for individual communities to develop their own set of services and to custom-tailor the program to the children in those communities. Another objective of the program is to reduce the number of children with out-of-state placements.

The MRM Program is designed to provide the State MRM Governing Board with the main policy-setting responsibilities. The CMHC's were selected to be the core service agency in this program because of their good connections with the local communities and their expertise in implementing state policies. The regional MRM teams have a good deal of the responsibility for oversight of the program on the local level. He suggested this provided the check and balance to offset possible conflict of interest issues concerning the resource specialists. On a formal basis, the regional teams are the appeal body for parents who take issue with the decisions of the resource specialists.

Mr. Anderson then went over a diagram which describes how a child gets into the program. A key part of the process is case management, a service not available before the program was

initiated. The resource specialist is the one who is key to getting the child into the system.

Mr. Anderson reviewed the accomplishments of the program. As a collaborative effort it has been quite successful, particularly at the local level. In addition this program has been able to direct itself at SED children, which is the first time that group has been specifically focused on. The managed care aspect of the program is a unique and new way of looking at services and is a step in the direction of instituting a public mental health managed care system.

He pointed out that one of the biggest criticisms of the public mental health system for children and adolescents is there has been a very small amount of community-based options available, which has contributed to increased residential and in-patient care. This program has helped increase the options and has focused on providing the local programs with a great deal of flexibility in authorizing services which are geared towards the child's needs. Service options including intensive case management, school-based day treatment and respite care have been made available or improved upon since this program was started. The idea of in-home aides has been reintroduced on a small basis, as part of the broader concept of wrap-around services. Another accomplishment of the program has been enhancing the parent role in the treatment team.

Mr. Anderson added that the program expects financial participation on the part of parents: each CMHC has a sliding fee schedule. Another accomplishment of the program has to do with preventing residential placements. He said the bottom line is that in FY94 they served 1,571 children through the program, with virtually every child receiving intensive case management. About 164 of those children received day treatment, 512 received out-patient therapy, and 165 received group therapy. 103 youth received wrap-around services and respite care was provided for 35 youth. Of the 1,571, 578 have been identified through the schools as emotionally disturbed. In the entire state there are only 1,000 children in the school system who have been found to be emotionally disturbed. 379 of the children served were in DFS custody. 969 of the youth were Medicaid-eligible. Thus far in FY95, 1,700 children have already been served in this program.

He referred the subcommittee members to a graph which illustrated MRM services expenditures from 1991 to the 1997 biennium. He pointed out that the residential in-patient program and the community health portion were not well-coordinated before 1994. In the coming biennium they propose that all funding be consolidated under the MRM Program. He pointed out that the executive budget for 1996-7 is the same as what was spent in 1993. He predicted that critics as well as supporters of the program would agree that there has not been sufficient funding of the community-based part of the program during the current biennium. Therefore the executive budget proposes a funding

increase although this does not result in a net increase in dollar amounts.

Mr. Anderson went over the details of the executive budget request. The regional teams were involved in prioritizing the request and they are most interested in procuring additional funding for home-based treatment, expansion of day treatment, school and clinic-based therapy and more intensive case management and crisis management. When there is an increase in the demand for services but no funding increase, a waiting list for services has to be started and/or the mix of available services becomes smaller. Although they have already administratively moved the review process from DFS to the MRM system, they are requesting that the Legislature approve this. He stressed that they are not asking for additional FTE and are just asking for authorization to continue with the ones currently in the budget. One FTE was moved from DFS and another has previously been paid for with federal funds.

CHAIRMAN JOHN COBB explained that the Human Services and Aging Committee would be setting the budget for Pine Hills and Mountain View, the Institutions Subcommittee would be setting the MRM budget and the subcommittees would jointly vote on the managed care issue.

Informational Testimony:

REP. BRAD MOLNAR, HD 22, Laurel, discussed the MRM Program, the cornerstone of which was HB 632, which he authored. He pointed out the problems with the MRM Program. Although youth under age 18 are supposed to fall under the program, they ended up under Corrections. As a result the expertise of the DFS caseworkers couldn't be used. Corrections placed this responsibility with the CMHCs. He verified that the CMHCs do compete with the other providers in their regions. Some providers won't refer their clients to MRM because they will lose them. He added that the CMHCs charge $90 per hour for services while private psychologists only get $45. He suggested that twice as many children could be served if DFS gave the business to the private sector. He added that the prorating the CMHCs provide to help parents is based on the higher rate. The result is there is no real cost savings to the parent for the child to go under this program.

Another problem is that the request for proposals (RFP) which were called for under HB 632 to bring the 120 out-of-state placements back into Montana were never put out. The idea was to return the children in a group (they are placed in groups of five or six). He submitted that the RFPs were what was supposed to create the savings. The program was supposed to use the $5.5 million being spent annually out-of-state to bring the kids back and fund the program, with the savings to go to the program and not the general fund. Not only did the $5.5 million not make it back but the budget became $4.4 million.

Another problem regards the goal of providing the least restrictive environment as is therapeutically required for the child. This has been redefined in practice. In actuality this has come to mean the home. Under current law a child can refuse medication. When this happens and is combined with insufficient funding to provide for in-patient treatment the result is disastrous. Rather than the original intent, which was to tap into six departments for money, only DFS and SRS have had to provide funds. OPI is sending the kids out-of-state and circumventing the placement committee which is creating havoc. He stressed that without coordination there will be no savings. He submitted that the mental health definition currently under the law is so broad that there is no one who cannot be diagnosed with SED.

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He stressed that kids are not understanding the criminality of their actions. Based on anecdotal reports he concluded that the various referring agencies do not send any children to MRM because the program has no money and is ineffective. He stressed the need for timely help for the children, which often end up back on the street because they do not fall under the provisions of the MRM program. He said he would like to amend **HB 2** to put MRM back under DFS.

Questions from Subcommittee Members and Responses:

REP. LYNCH wanted to know where **REP. MOLNAR** got the $45 figure. **REP. MOLNAR** replied that the CMHCs charge $90 and they had determined to subcontract the work out for $45 per hour.

Informational Testimony:

Ms. Kathy McGowan then spoke on behalf of the **Montana Council of Mental Health Centers. EXHIBIT 2** In closing, she said their upcoming goal is to focus on outcomes, but their "plate has been pretty full" thus far with just getting the program going.

Ms. Nancy Uhlhorn, a case manager in the MRM Program, then spoke. She testified that the MRM Program has been working well in Region Five. When the program was started they shared the belief that children should be served in their homes or in the most home-like setting possible and with lots of family involvement. They had to "invent" themselves, since it was a brand-new program. Now they believe even more strongly in the principles behind MRM: close collaboration amongst service providers, empowerment and involvement of the family and the child in treatment, and the continued development of new community programs such as day treatment, therapeutic foster care, etc.

She said they get referrals from all over the community. All of the service providers have been pleased to refer their kids to MRM. Part of why this works so well for them is that service

starts immediately: case managers are masters-level therapists or social workers. She stressed the need to pay attention in fundamental and unrelenting ways to the problems of the SED children of the state, so their stories are ones of opportunities taken and not lost and relationships strengthened and not broken and that treatment is coherent and not chaotic. She submitted that MRM case managers can do this job.

Mr. Robert Runkel, Director of Special Education at OPI, then spoke. OPI feels it is a full partner with the other agencies involved in MRM. As a result of MRM there has been significantly improved coordination between the public schools and the mental health community. Schools participate in and are key decision-makers in each of the regional teams, two of which have a public school representative as their chairperson. MRM honors special education diagnosis of emotional disturbance as a qualifier for MRM services. OPI has a representative on the state team as well.

Mr. Runkel pointed out that half of all the children in special education identified as emotionally disturbed receive some form of additional services through MRM. OPI is responsible for making sure that educational services are offered for the child and sufficient intervention is available in order for the child to benefit from his or her education. Through intervention MRM is able to augment and compliment these services. The biggest change that has occurred as a result of MRM is the expansion of day treatment centers, which are now located in nine communities. They feel the executive proposed budget will permit the development of even more school-based services and he asked for the subcommittees' support.

Ms. Kayleen Jones, Billings advocate for families of emotionally disturbed children, then testified. **EXHIBIT 3** She stressed the need for continued funding for this program, which is still in its infancy. She read a letter from **Pat and Carole Lanphear** supporting the work of the Spring Creek Adolescent Day Treatment Center, from a family with a son attending that facility. **EXHIBIT 4** She submitted several other letters in support of the MRM program from **Kenneth Marx, Helena; April Lynn Counts; Billings; Becky Hill; and Leslie Barnes Albright; Billings.** **EXHIBIT 5**

Ms. Tina Brostrom, Children's Case Manager in Hill County, then rose in support of continued funding for the MRM Program. **EXHIBIT 6** She stated that DFS and MRM had been very cooperative in working with them. She read a letter from **Ms. June Kamps,** mother of a boy with Attention Deficit Disorder with Hyperactivity, which outlined the way case management has helped her family. **EXHIBIT 7**

Ms. Elizabeth Cooper, mother of two emotionally disturbed children, then testified about the effectiveness of the MRM Program. **EXHIBIT 8**

Ms. Barbara Hogg, Billings, said that as the mother of a SED child, a teacher and a member of the MRM Board from the Billings Region, she is in support of MRM. **EXHIBIT 9**

Mr. Jeremy Ogemagishig, a seventeen year old who has benefitted from the MRM Program, testified. **EXHIBIT 10**

Mr. Joe Furshong, Assistant Director for Student Services for the Helena Schools and chairman of the Southwest Montana MRM Team, spoke about the impact MRM has had on education. He submitted the program works, but only with adequate funding, which is no longer the case in southwest Montana. The number of services their region provides have gone from sixteen to two: case management and crisis response. He illustrated how this had impacted the life of a Helena eighth grader. He requested that the Legislature provide adequate funding for the MRM Program and suggested that the subcommittee members visit with the school districts about the issues facing them.

Ms. Bonnie Zapata, a Helena Middle School seventh grader, then spoke up in support of the MRM Program. **EXHIBIT 11**

Mr. Mike McIntyre, Great Falls parent of two SED children, spoke. He rose in support of the respite care as well as the in-school help provided through the MRM Program. He was in support of continued, if not increased, funding for the program.

Ms. Connie Leveque, mother of two children who receive services from MRM, then rose in support of the program. **EXHIBIT 12**

Mr. David Hemion read several policy statements from the **Family Committee of the Mental Health Association of Montana** in support of efforts to develop the coordination of continuing care which maximizes the use of a full range of appropriate, safe and adequately funded community and family-based services. They support the utilization of collaborative funding and the continued development of treatment services for children and SED youth, youth in the juvenile corrections system and youth who are sexual offenders or victims. They support the provision of intensive treatment services in Montana for SED children currently being served outside the state. In addition they support joint planning and collaborative programming for all the departments involved in providing the services including prevention and intervention. **Mr. Hemion** said he was also representing the **Montana Association of Churches,** which has adopted a position statement which stresses the importance of the best interests of the child being of paramount consideration.

Ms. Andree Larose, Montana Advocacy Program, then spoke, stressing that she felt this is one of the most important programs for children before the Legislature. She was in support of continued funding, if not an increase in funding, pointing out that ineffective intervention due to insufficient funding would lead to increased costs.

Ms. Marty Onishuk, Montana Alliance for the Mentally Ill, then spoke. Many of the people being served by MRM have neurobiological brain diseases. Many of these diseases can occur at a very early age. She expressed concern about the definitions currently in place under MRM.

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Ms. Onishuk stressed the importance of families receiving respite, support and education, which is now being offered by MRM. She also stressed the importance of early diagnosis.

Mr. Glenn McFarland, employee at the Yellowstone Treatment Center in Billings, then spoke. The Yellowstone Treatment Center is recognized primarily as a residential provider. He rose in support of MRM. He reviewed a recently completed study to identify what the needs are for SED children in Montana. The report analyzes the definitions of "seriously emotionally disturbed" based on federal law and compares this to what has been the historical planning number for the state of Montana. The federal definitions imply there would be 20,103 SED youth in Montana. Historically the state has used a 3-4% range to estimate that there were 7,096 children who would qualify for SED. The number of children that have been served in Montana historically have been well below even the 7,000 level.

Mr. McFarland said there had been problems with the MRM program including administrative and procedural issues, which needed to be worked out. The one thing that has been consistent is a commitment to work cooperatively to fix the problems. He said this is continuing: they are working and meeting regularly to make sure MRM gets better. He stressed the importance of continued funding for the program.

Mr. Dave Bennett, Northcentral Regional Administrator for DFS and Chairman of the Northcentral Regional MRM team, recommended that spending should be increased for the MRM Program. The major problems facing MRM are related to a budget that was cut from $30 million to $5.5 million. This created tremendous gaps in the system. MRM forced the six agencies involved in this area to work cooperatively on how to meet kids' needs. This challenge has been met, in different ways for each region. To continue to meet these needs there needs to be an influx of community services. He stressed the importance of an ongoing partnership to develop the system called the continuum. The continuum is based upon meeting families' needs at an earlier age: MRM Case Management gives that service to children at an early age. Although there will always be a need for residential care, the community-based support system needs to fostered. The cost of one child in residential care for 14 months is $120,000. This same $120,000 could serve 80 families in the community. He submitted that the MRM Program has created a support network for families that meets kids' needs all across the state. **Mr.**

Bennett submitted some statistics which were gathered about Medicaid placements.

Ms. Mary Ellerd, Executive Secretary of the Montana Juvenile Probation Officers Association, requested the subcommittee's support for the MRM Program.

Ms. Dawn Smith, a Children's Case Manager in Region Two, pointed out that many families need a system that can "prop them up." MRM allows for this by providing for such things as emergency medication, food, transportation and gas money, as well as information and moral support.

Ms. Peggy Dicellis, a Region Two children's case manager, spoke. in support of continued funding for MRM as well as expanded services for SED children.

Ms. Pat Gonich, Program Director for the Southwest Adolescent Day Treatment Program, spoke. She worked in a California residential treatment center where Montana kids were being sent, and used to believe that residential care was the best treatment. She now believes very strongly that kids should be served in community settings. She said they are operating on the "skin of their teeth" at present and expressed concern about funding cuts. The 75% of their kids being funded by MRM are not being funded fully even at present. She expressed the firm conviction that the "bad rap" MRM sometimes receives is due to the fact that it is being inadequately funded. The problems in MRM are due to gaps in programs. More transitional services are needed for kids coming out of treatment in order to ensure that the continuum works. In closing she rose in support of increased funding for the MRM Program.

Mr. Rick Day, Director of DCHS, then spoke. The MRM Program has received top priority for funding in DCHS.

Questions from Subcommittee Members and Responses:

In response to **REP. RED MENAHAN, Mr. Anderson** explained that the average caseload for the case management staff was 30 for Region Two, but this depends on the region. Each region has been allowed to establish their own case management model. The caseload in the Missoula region is lower but is more intense and staffing is based more on a therapeutic model. The brokering model is used in another region, which entails bringing all the agency people working in a community together to service a plan they can all agree to.

CHAIRMAN FISHER asked for clarification on the level of funding for the MRM Program and was told that in 1994 there was about $2.3 million "pure" MRM money. In addition, Medicaid spent about $13 million, which includes residential care, which is not part of the MRM budget itself. **Mr. Joe Williams,** Fiscal Bureau Chief, DCHS, said that the total request for MRM for 1996 is

$22,204,735. There is approximately $10.9 million in the 1996 SRS budget for residential treatment.

REP. BEVERLY BARNHART asked **Mr. Bennett** to explain why the CMHC's were charging $90 for $45 worth of service. **Mr. Bennett** explained that $45 is the billable Medicaid rate for psychological services. $90 is basically what a therapist charges for services, although this can be lower. The CMHC's charge a rate with administrative costs included which the non-CMHC's cannot charge. This has been a bone of contention between the private providers and the CMHC's. When MRM started, RFP's were sent out requesting private providers but they could only offer them $45 per hour. The providers felt they should be entitled to the same rate as the CMHC's.

In response to **SEN. LYNCH, Mr. Pete Surdock, Child and Adolescent Service System Project Manager, DCHS,** spoke. He is the statewide coordinator for MRM. In Region Four (Southwest Montana) there is a core regional managing resource team which is comprised of representatives from the child welfare system, the mental health system, the schools, a private provider, a child advocate, a parent advocate and a Native American. They are allowed to expand the team to the size they wish from this core. Each community within the region has smaller teams. Each region is allocated a specific amount of funding. The region identifies its priorities and services are provided based upon the region's individual needs, which are based on the child's needs.

When a plan is done on a child, other funding sources besides MRM are scrutinized. The final budgeting decisions are made by the management resource specialists. In each kid's case there is an individual team that puts together a plan for the child, which the specialist reviews. The amount of funding each region receives is independent of what the other regions receive.

REP. MENAHAN said that in the past the Legislature had been told there were persons who could provide some of the services being provided by the CMHC's for $30 per hour or less. He asked why the private providers couldn't competitively bid to provide this service.

Ms. Mary Dalton, SRS Primary Care Bureau Chief, replied that Medicaid pays to private social work therapists $34.50 per hour, with a slightly higher rate for psychologists. The CMHC's are paid cost-based reimbursement and each region is different. The cost differences are due in part to the fact that CMHC's have to meet certain clinic requirements, costs a private therapist does not incur. The therapists that are serving Medicaid kids get paid $34.50. When the CMHC's went out to contract for the non-Medicaid eligible kids under MRM, most of them opted to set the rate at what Medicaid had traditionally been paying.
Some CMHC's have tried to contract with outside therapists; in many centers the goal was to offer people a choice in therapists which went beyond those available through the CMHC's.

SEN. CHUCK SWYSGOOD said he had been told that the larger, urban communities were getting the bulk of MRM funding.

Mr. Stuart Kline, Region Four Director, said the determination of who got the funding was influenced by the regional team and the size of the budget. Funding is portioned out according to where the greatest need is.

REP. BARNHART said that when MRM first started, most of the people doing the planning were from Helena. **Mr. Kline** said most of the people are not from Helena. They made a concerted effort to get representation from elsewhere. **SEN. LYNCH** wanted to know if each county was represented on the regional teams. **Mr. Kline** said this was not the case although they have representation from each of their full-time program locations.

REP. STEVE VICK wanted to know if there was prioritization of the people being dealt with. **Mr. Bennett** said "pain drives the system." If the pain is great enough, a child's priority will rise.

Mr. Bob Ross, Director of the Region Three Mental Health Center in Billings, spoke. He verified that the most extreme cases got the highest priority. The administrators of the program do not drive the system, the children do.

REP. MENAHAN pointed out that the Legislature has no idea what the CMHCs do with their money once they get it. He said he would rather see more state control. **Mr. Ross** pointed out that what they did was monitored very closely.

SEN. MIGNON WATERMAN asked what the increase in residential beds the Board of Health authorized in the past was and wanted to know the Department's opinion on whether or not there needs to be an expansion of the number of beds or whether the certificate of need should be removed.

Mr. Day replied that the expansion in beds was 48. DCHS has counseled DHES to go slowly in this area. As additional community resources are developed, he felt the need for expanded beds would be reduced.

SEN. WATERMAN wondered if it would be wise for the Legislature to cap the number of residential beds, in light of the need for more community-based services. **Mr. McFarland** said there were some very clear indications that the number of residential beds in the state is appropriate at present. One issue that is a concern is the geographic location of the present beds. The Yellowstone Treatment Center would like to work with MRM in trying to develop more regionally-based beds. At present all of the beds are located in Billings, Butte and Helena. **SEN. WATERMAN** pointed out that the study **Mr. McFarland** was basing his information on was paid for by the providers and it varies from the study produced by DHES.

Mr. Jim Smith, Montana Association of Homes and Services for Children, then spoke. The above-mentioned study was funded by private providers of psychiatric services. However, it was paid for with the concurrence of and to some degree the collaboration of DHES's Board of Public Health. It arose out of the department's responsibility to develop a state health plan. The state health plan estimated 88 beds were needed in the state. At a hearing in March 1994 there was some criticism of the study that resulted in this recommendation. A better methodology was suggested and became the source of the provider-funded study. At the hearing, DHES suggested that a roadblock was being put up to providers and the State Health Plan was being used to discourage additional residential treatment beds. The new study said that all of the 105 kids in residential treatment and 97% of the in-patient admissions reviewed were appropriate. It also stated that the relative lack of available services at lower levels of care exacerbated the need to utilize higher acuity services: i.e., in-patient and residential.

{Tape: 2; Side: B; Approx. Counter: 000; Comments: n/a.}

Mr. Smith said his association has never been opposed to expanded community-based services, even though it has meant some of the funding has had to come from the higher end of the system. He stressed, however, the inappropriateness of putting a child in a lower level of care when residential treatment is what is needed.

SEN. GARY AKLESTAD asked if it was true that the children whose parents could not afford to help with the cost of treatment had been made wards of the state in the past. He was told that this was not the case under the MRM Program, which uses a sliding scale to charge parents for services. If the family is on Medicaid, the full cost of the services is paid by Medicaid. If the child is a ward of the state, a fee can be assessed on the parents through the child support system.

SEN. AKLESTAD wanted to know if there were cases where the parents wanted help for their child and were willing to help monetarily, but they would be forced to give up custody in order to receive services. **Mr. Hank Hudson, Director of DFS,** said there was a time when getting services required relinquishing custody to DFS. One of the reason MRM was created, and funded with general fund, was to save families. The MRM Program works as long as there is general fund available, but once it runs out waiting lists start for the families not on Medicaid.

Ms. Steinbeck added that when a child is in the custody of DFS, they then become Medicaid-eligible. **Mr. Hudson** said the Partnership Project was established because DFS wanted to provide family support services independent of mental health. In the past DFS could not offer help until abuse of the child was substantiated. Several million dollars of foster care funds were transferred to services, however, and now families have access to general fund money to help them before abuse occurs. DFS's

intention is to open a lot of doors for families without requiring them to give up custody.

SEN. LYNCH wanted information regarding the salaries of regional directors, caseworkers, etc. **REP. MENAHAN** wanted to know how many people were paid from grants, and where the grants originated.

Informational Testimony:

Mr. Shawn Hammond, a Dillon youth, testified that through MRM he was able to return to Dillon and stay out of trouble.

Mr. Robert Tibbets, a single parent from Dillon, spoke about how MRM had affected his family. Participation in the program has helped improve his son's self esteem and made for a better home environment. He expressed that hope that the program would continue and would receive adequate funding.

Ms. Tina St. Claire Fisher, a Dillon MRM case manager, spoke. She expressed the firm conviction that the community is the most therapeutic place for children to heal, in addition to being less costly than residential care. She reviewed a few of the MRM success stories she had worked with, which include **Mr. Hammond.** She stressed that uniting a community to support a child's uniqueness can work wonders. She pointed out that Beaverhead and Madison Counties have no clients presently in residential treatment. She submitted the reason for this success is because the treatment plan is created by the people who know the child and the child's environment the best. This approach provides the parents with emotional support, education and the tools necessary to manage the case themselves. The role of the youth case manager is essential to pull this all together. She added that all the money spent stays in the community, which is another positive aspect of community-based treatment.

One barrier in the MRM Program now is that only the most severe cases are eligible. Without the wrap-around services, half of the success stories she has seen would not have been possible. She submitted that if MRM funding remains at the current level or is cut, it will force an increase in residential treatment.

HEARING ON
MONTANA MENTAL HEALTH ACCESS PROGRAM

Ms. Mary Dalton, Primary Care Bureau Chief, Medicaid Division, Department of SRS, gave an overview of the Montana Mental Health Access Program. **EXHIBITS 13, 14 and 15** She stated that SRS and the executive branch are very dedicated to doing all they can to control Medicaid expenditures. If these expenditures continue to increase, benefits and/or eligibility will have to be reduced and if this occurs, there will be increased costs in the private uninsured sector. Regarding the possible elimination of

residential treatment services, as was done with free-standing in-patient psychiatric services in 1993, she felt it would be very questionable whether the Legislature would be able to continue to get Medicaid funds if this occurred.

She pointed out how the current mental health system is fragmented. Eligibility requirements for MRM are different than those for Medicaid. There are different access points for Medicaid, MRM and DFS eligibility. Often the services a person receives are dependent upon the funding source. Approval of the Mental Health Access Program will integrate both the financing and the delivery of services, and it will be the first program in the nation to provide for a fully integrated mental health system. SRS hopes to finance this program with the "1115 Research and Demonstration Waiver." Since the program will not be in place until FY97, MRM funds need to remain in SRS's budget the first year.

Ms. Dalton stated that the MRM Program was a very important first step and its strongest point is that it has both interagency and community collaboration. The Mental Health Access Program will continue this. This new system will address the weaknesses MRM has, which includes the fact that MRM is a capitated system. MRM was begun with a lack of capital and administrative resources. Another problem is the services available vary from region to region, and many children are excluded from the program. Also, there is a lack of transition from child to adult services in the MRM Program. She stressed the importance of including the state hospital in the continuum, to prevent the managed care company from shifting off the burden of care. She pointed out that when people go to the state hospital, which is entirely general funded, they lose their Medicaid eligibility. Building a larger system will encompass all of the needs of these people and will help solve some of the problems they encounter upon discharge.

Ms. Dalton said there is little expertise in the state in the area of administration of mental health programs. An organization is being sought which will be large enough to take on the financial risk of a capitated system and will have the capital for up-front costs. Providers will for the most part be those who are already providing services in the state. She added that no additional general fund or FTE are being requested in this proposal.

The new program will expand access to care, possibly up to 200% of poverty. At present, about 15% of Montana's residents are uninsured, and when there is insurance, often mental health services are capped.

The new system will do away with the old rules that provide for CMHC's to be paid on a cost-based basis. The managed care company will be negotiating with providers for the rates being paid.

Persons currently Medicaid-eligible, approximately 125,000 in a year, will be covered under the new system. Hopefully, Medicaid will be expanded for mental health services only, so that families with incomes of less than 200% of the federal poverty level will be eligible, about 40% of the population. **SEN. THOMAS KEATING** will be introducing a bill which is integral to this plan. At present if a family earns more than 72% of the poverty level, they are not eligible for Medicaid. The new system will not cover substance abuse and chemical dependency until the funding streams can be "teased out." This has not been a covered benefit under Medicaid for adults, although it is for children in an outpatient setting. In-patient and out-patient residential services will also be expected to be provided by the managed care company, along with the services at both the Center for the Aged and the CMHC's.

Ms. Dalton explained capitation: a capitation plan is when a set amount is paid for all services. All of the funding currently going into mental health will be put into one pot and the Managed Care Organization (MCO) will be directed to provide all mental care for this set amount. Under a capitated system there is the potential to either make money or lose money, depending on how well the system is managed. The MCO will be required to have reinsurance, which will guarantee that there will be dollars left to serve people if the MCO becomes insolvent.

CHAIRMAN JOHN COBB wanted to know when the subcommittee would have the new data regarding capitation rates. **Dr. Peter Blouke,** Director of SRS, said the timeframes have been recalculated and the projected savings have been adjusted in the budget. The new figures will be available when the Medicaid budget hearings occur.

{Tape: 3; Side: A; Approx. Counter: 000; Comments: n/a.}

Ms. Dalton said the regional MRM councils or something similar will provide input regarding the development of community-based stepdown services. She stressed that it is their intention to not lose this important aspect of MRM, which is the regional input as to what services are needed where. The three-year plan that has been done for the MRM Program will be shared with the MCO.

The 1115 Waiver is the same type of waiver that **Dr. Blouke** was successful in obtaining for welfare reform. The department is going to ask the federal government to waive, among other things, IMD (Institute for mental disease) exclusion. If this is successful, Medicaid matching funds will become available to help pay for the first thirty days of care at the Montana State Hospital, which is currently paid entirely from the general fund. This will enable the state to pick up seventy cents on the dollar for those first thirty days. This is the biggest refinancing piece as far as bringing federal dollars into the system.

Ms. Dalton explained that under most Medicaid programs there is minimal cost sharing. Under this program a sliding fee scale is proposed.

ADJOURNMENT

Adjournment: 12:00 p.m.

Notes Read 6/95

Marjorie I Fisher

REP. MARJORIE I. FISHER Chairman

John Cobb

REP. JOHN COBB, Chairman

P. Bottneman

for DEBBIE ROSTOCKI, Recording Secretary

Note: These minutes were proofread by Lois Steinbeck, LFA.

MIF/JC/dr

HUMAN SERVICES AND AGING

Joint Appropriations Subcommittee

ROLL CALL DATE 1-24-95

NAME	PRESENT	ABSENT	EXCUSED
Rep. John Cobb, Chairman	X		
Rep. Beverly Barnhart	X		
Rep. Betty Lou Kasten	X		
Sen. Chuck Swysgood, Vice Chairman	X		
Sen. J.D. Lynch	X		
Sen. Jim Burnett	X		

INSTITUTIONS

Joint Appropriations Subcommittee

ROLL CALL DATE 1-24-95

NAME	PRESENT	ABSENT	EXCUSED
Rep. Marj Fisher, Chairman	X		
Rep. Red Menahan	X		
Rep. Steve Vick	X		
Sen. Larry Tveit, Vice Chairman	X		
Sen. Gary Aklestad	X		
Sen. Mignon Waterman	X		

HUMAN SERVICES & AGING

ROLL CALL VOTE

Joint Appropriations Subcommittee

DATE 1-24-95 BILL NO. _____ NUMBER _____

MOTION: #1 Motion to reconsider action the Mont. Diabetes Control Program $33,000 #2 to encumber fed grant

NAME	AYE	NO
Rep. John Cobb, Chairman	X	
Rep. Beverly Barnhart	X	
Rep. Betty Lou Kasten	X	
Sen. Chuck Swysgood, Vice Chairman	X	
Sen. J.D. Lynch	X	
Sen. Jim Burnett	X	

#2 Lynch accpt fed grant

Kasten - Swysgood - no

(1 FTE - fed grant)

EXH I

Lisa Smith LFA

EXHIBIT 1
DATE 1-24-95
HB 2

Chairman Fisher, Chairman Cobb, Members of the Subcommittee

I'm presenting a brief overview to introduce the Managing Resources Montana Program, which we have been referring to during the past few days as MRM. I prepared the diagram that should be in front of you. This is an ***extreme simplification*** *of the program but I hope it will help you to understand the concept. I think MRM is easier to comprehend if you look at it as a concept or process rather than a structured program within itself.*

Most of you are probably aware that MRM was formed in response to the 1993 legislature's mandate that the human services departments work together to coordinate programs for SED youth.

Various departments had funding in past biennia to provide mental health services to youth. (agencies are listed across the top of the diagram) The executive includes funds from these agencies in Department of Corrections and Human Services budget for the 1997 biennium.

If you look at the map below you'll see the state is divided into 5 regions. The department uses MRM funds to contract with a CMHC (a private-non-profit organization) in each region to implement the MRM program.

Each CMHC employs a Managing Resource Specialist, paid with MRM funds, who reviews treatment plans for kids and refers them to services, either within the CMHC or with another provider.

I. The Executive proposal includes over $20 million of general fund in the MRM program. This money will provide community services and residential psychiatric treatment services to youth. Expenditures for these services in the 1995 biennium were approximately $8 million so this proposal represents an expansion of 150%.

The first issue raised by the LFA is that there are no performance indicators or data to evaluate whether or not the program is effective and if it justifies this significant increase in resources.

A. Whether or not the increase is justified, there are issues with the dollar amount, I will talk briefly on 2 of the largest,

1) The MRM present law budget request for the 1997 biennium is overstated by $1 million:

The 1993 legislature authorized a $2 million general fund ***biennial*** *appropriation for DFS in lieu of inpatient hospital psychiatric services. DFS transferred this appropriation to DCHS in fiscal 1994 for MRM services. The department spent approximately $1.5 million of this appropriation in fiscal 1994.*

In calculating its MRM funding request for the 1997 biennium, the department included $1.5 million ***in present law in each year*** *of the biennium, a total of $3 million in its budget. This is $1 million more than was appropriated by the previous legislature.*

2) The next overstatement involves education costs:

The 1993 legislature authorized OPI to provide the general fund match necessary for medicaid reimbursements for education costs of children receiving residential treatment services. The department includes these funds, approximately $700,000 each year, in its budget request. The 1993 legislature included language in House Bill 2 that specifically

excluded these funds from current level (or in todays terms "present-law").

This issue is related to the issues Lois will discuss momentarily regarding residential psychiatric treatment.

B. Another concern noted is that the MRM new proposal provides funding for foster care for children not in the custody of DFS. Since these children are not in the custody of DFS and are not medicaid eligible, these placements are funded with general fund.

C. Mental Health Managed Care - SRS, DCHS, and DFS have been involved in the formation of the mental health managed care proposal. The executive plans to implement the contract for mental health managed care by May 1996.

The proposal will include: 1) medicaid mental health expenditures from SRS; 2) CMHC expenditures from DCHS; 3) certain State Hospital and Center for the Aged expenditures from DCHS; and 4) therapeutic group home and, potentially, therapeutic foster care expenditures from DFS.

The role of MRM within MH managed care is not clear. The departments have indicated that MRM will go away or disappear once MH managed care is in place. The subcommittee may want to ask the departments if the funding requested for the MRM program will be included in the MH managed care budget.

D. Lois will now brief you on the issues regarding residential treatment

E. The final issue raised regarding the MRM program is related to its organizational structure. Specifically, five managing resource specialists are employed by the CMHCs to screen referrals to determine if youth are SED, to refer youth to services and to review and approve billings for payment.

The specialists have a potential conflict of interest because they are employed by CMHCs which are service providers.

No evidence exists that referrals have been inappropriate. However the potential exists for preferential referrals to a CMHC.

This concludes my overview.

Managing Resources Montana (MRM)

Office of Public Instruction (OPI) $

Board of Crime Control (MBCC) $

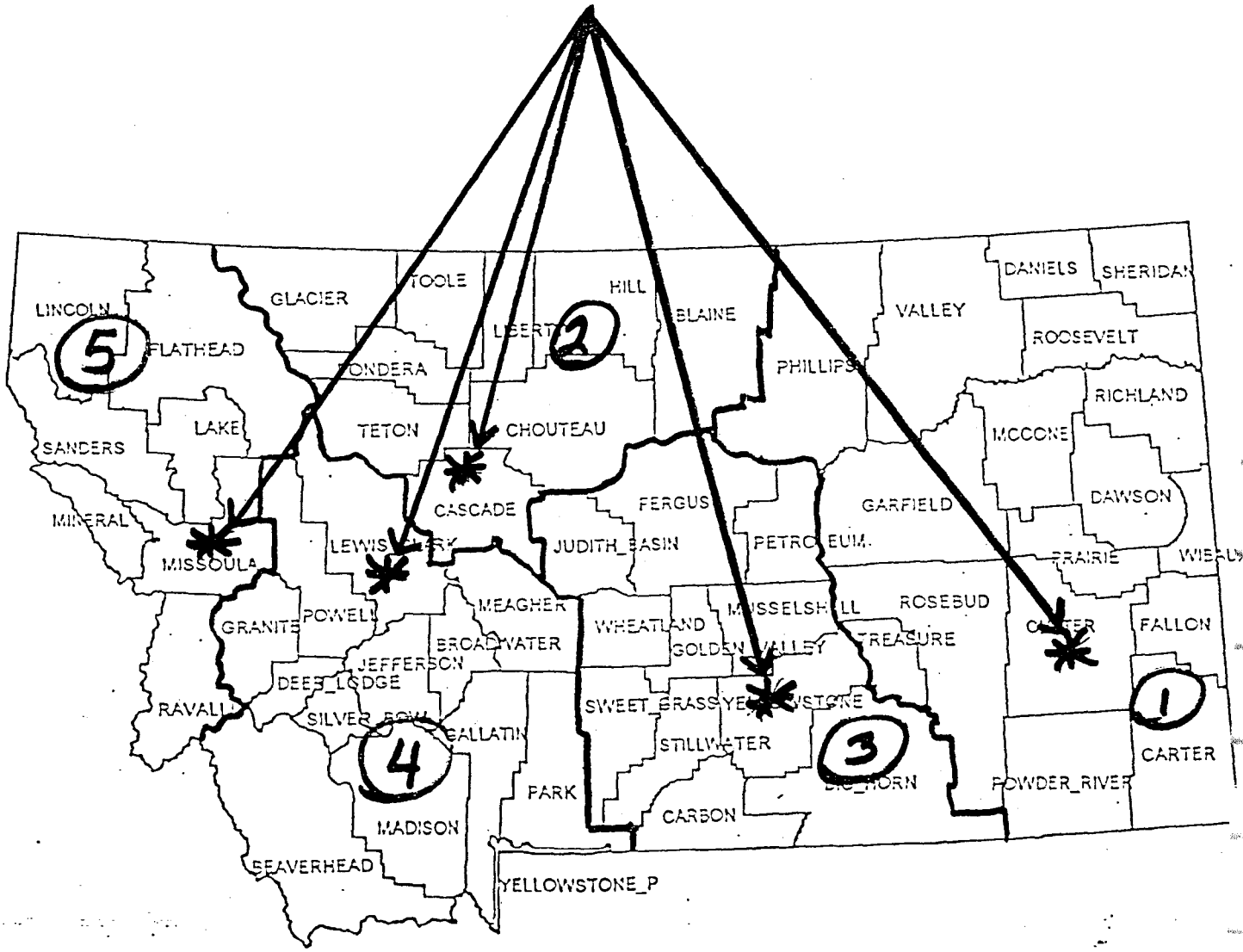
Family Services (DFS) $

Social & Rehabilitation Services (SRS) $

Health & Environmental Sciences (DHES) $

Corrections and Human Services

MRM $



* Community Mental Health Center (Private Organization)

Hires a Managing Resources Specialist (MRS)

EXHIBIT 2
DATE 1-24-95
HB 2

EX # 2

Testimony Regarding Managing Resources Montana (MRM)
Presented by Kathy McGowan
On Behalf of the Montana Council of Mental Health Centers

It was two years ago that the Human Services Joint Subcommittee "crashed the system," thus eliminating Medicaid funding for treatment for youth at free standing psychiatric hospitals, as well as residential treatment for a large number of Montana youth. Approximately $30 million of services were wiped out and the marching orders were to create a new system of community-based services with an appropriation of approximately $3 million. Thus was conceived Managing Resources Montana, better known as MRM.

Immediately the Mental Health Centers were catapulted into the middle of the plans that began to formulate the very next day. The fact that the five Centers already had an administrative and clinical structure in place made them a natural choice for a central role. My advice to them, however, was to think about it very carefully. I warned them that developing a new system would be tumultuous and fraught with innumerable pitfalls --- that they would be damned if they did and damned if they didn't. Their answer was one that I should have expected. They said that they wanted to do it because what was proposed was the very heart of what community mental health centers have stood for and because the funding stream never had been favorable toward them providing the kinds of services to children that they believed in and that they knew they were capable of providing. Thus began an exciting, painful, frustrating, rewarding, and maddening experience.

The order from the Subcommittee was to change the way we did business. The order coupled with the amount of the appropriation meant changing in a very big way the way we did business. It meant serving only the most serious of the Seriously Emotionally Disturbed children. It meant serving them differently. It meant, in many cases, serving them in the most minimal ways. Some people refer to this as bare maintenance, or hanging on by their fingernails.

Inevitably, the question arises: Does MRM work? The answer, in my opinion, is both "yes" and "no." It depends a lot upon one's criteria for success. Yes, we have provided services for less money. Yes, we have expanded community-based services. Yes, the level of community cooperation and involvement has been elevated. Yes, we have a greater degree of parental involvement. Yes, we have fewer kids being sent out-of-state for treatment. But, no, we are not serving a great many of these kids to the level we should be serving them. There still are gaps in our communities, with inadequate crisis services, insufficient respite and other parental support, inadequate school supports, and insufficient flexibility to address the needs of kids and families. Hanging on by our fingernails is not acceptable to us and it should not be acceptable to this Legislature.

The changes we all have experienced over the past two years have not always

brought out the best in us. By "us" I mean all of us who have been involved either as parents, state agencies, providers, advocates, and so on. Change as immense as what we have experienced is not easy or pretty. Parents had come to expect a certain level of treatment for their children and suddenly the door was slammed shut. Their lives already were difficult and the state of Montana made them more difficult. Somebody called MRM suddenly told them that those services no longer were available. Social workers and juvenile probation officers, who had long enjoyed the privilege of making referrals, were told that SED kids must now be screened by this intruder known as MRM. Other providers were resentful, as were judges. Schools especially were up in arms. The kids who heretofore had been referred to programs away from the school setting all of a sudden were disrupting the classroom. Schools, too, were referred to MRM. Who was this MRM anyway, and who were they to be telling everyone else how to conduct their business?

It has not been easy for all the folks I have mentioned to come to grips with the fact that the resources to which they had become accustomed are no longer available. But they are good, caring, capable people and those attributes have pulled us through some very difficult times. I am very proud of the efforts that have brought together social workers, juvenile probation officers, mental health center folks, private therapists, school personnel, residential providers, and many other community representatives. They have planned around the needs of their communities and around the needs of individual kids. MRM is far from perfect, and more funding alone will not answer all its problems, but the commitment of the many players will go a long way in addressing many of those problems. Your commitment for additional funding to bolster the weak spots in the system will help us get the rest of the way.

Testimony from case managers, parents and some of the other folks who are out there on the firing line day after day will give you a better idea of what MRM really is about. They can describe better than anyone what really is meant when we mouth the words, "SED kid," or "priority," or "no."

In closing, I ask you to remember three things:

1) MRM was created by the Legislature to serve the highest risk SED kids in community-based settings. These were the kids who previously had been treated in free standing psychiatric and residential treatment settings. This has meant prioritizing services to kids who have very serious mental health conditions.
2) Yes, MRM works, and no, MRM does not work, depending upon who you are and what your expectations are.
3) Yes, MRM could work better if we were able to fill in some service gaps. Others who testify can better describe what those gaps are and where they exist.

Thank you for the opportunity to testify.

EXH 3
1/24/95

I work as an advocate for families of emotionally disturbed children. Many of my referrals are from the case managers at MRM. As I work with the families assisting them in their daily lives, there is a tremendous reliance on the case managers of their children. The families trust them and are always grateful that they have been fortunate enough to find MRM. MRM is still an infant. Many professionals are only now becoming aware of what MRM does. A part of that lack of awareness is because MRM has been finding its way.

EXHIBIT 3
DATE 1/24/95
HB 2

The funding for MRM must continue. Families need to have a constancy for themselves. Mental illness affects the lives of all of the family members. They have had so many disruptions because of the illness. Their involvement with MRM has provided them services and a personal feeling that there is a team working with them to keep them healthy by providing services.

I encourage this committee to continue funding MRM. There are many families who still need services which can be provided by MRM. And to pull the rug out from under these fragile families would continue their feelings of isolation and reinforce their feelings that mental illness

Kathleen M. Chisholm
538 Chisholm Place
Billings, Mt. 59102

EXH 4

EXHIBIT 4
DATE 1/24/95
HB

January 19, 1995

To Whom It May Concern,

We have a son who is thirteen and has been labeled ED (Emotionally Diabled). Until he was 10 years old, we had never had a label for his behavior. We just went from school to school listening to teachers and principals, telling us how misbehaved our son was and taking the punishments that came. At one time we were even told he makes demonistic noises in class and they seperated him from the other students by putting him in the principals office for 2 months to do his work by hisself.

After being labeled, ED, he was placed in special education classes for 2 years, those didn't work either. We were at witts end with doctors, medications that didn't work, and therapists. We were without Medical Insurance, so this has put tremendous mental and financial difficulties on the whole family. We have tried and tried to find some kind of outside activities for him to keep busy with, but there are not many out there for ED children. We tried baseball, basketball, etc., but we were lucky if he made it through half the season before being kicked out and the entry fee was lost. We think it is because not many people know how to understand children with ED.

When we were ready to give up, the last school he attended recommended The Spring Creek Treatment Center. This is the first time we have felt that there may be a little hope after all. At Spring Creek, their family therapy has not only helped our son, but it has helped the rest of the family too. The burden our other two children have gone through by attending the same schools as our son, has been great. It seems if anybody knows who their brother is then they are automatically labeled and watched very carefully. In family therapy we are beginning to learn how to deal with this and they are also starting to do a lot better.

Everyone that we have worked with at Spring Creek, treat our son as an individual, and if one method isn't working with him, they are always trying other options, instead of giving up on him. We especially like how they individualize each child's talents. This has given our son a chance to feel that he is special in his own way.

This is our first year with Spring Creek, and although our son is doing so much better we know that we still have a long way to go before we are all healed. We don't know if our son will be attending Spring Creek next year or not, either way we owe the staff at Spring Creek a large Thank You for all the options and all the moral support they have given us.

Sincerely,

Pat and Carole Ranphear

Pat and Carole Ranphear

EXHIBIT 5
DATE 1/24/95
HB

24 Jan. 1995

Kenneth Marx
1450 Prospect Ave. #262
Helena, Montana 59601

Chairperson
John Cobb
Montana State Capitol
Helena, Montana 59620

Re: Managing Resources Montana Services

I am the father of a 17 year old daughter who has been helped tremendously by Managing Resources Montana. With the help of the Managing Resources Montana caseworker, my daughter was accepted into Southwest Adolescent Treatment (SWAT). There she receives not only an education, but therapy that she most definately needs.

Before being accepted by Managing Resources Montana and Southwest Adolescent Treatment, my daughter was a very depressed, suicidal teen. Now, after being in Southwest Adolescent Treatment for 5 months, she is an honor roll senior who is eagerly anticipating graduation. Recently she took her ACT test for college admission.

Please do not cut the funding for Managing Resources Montana. If anything, increase it's budget, so Managing Resources Montana can provide more services to an even greater number of Montana Severely Emotionally Disturbed youth.

Thank You for your time and consideration.

Sincerely,

Kenneth Marx

Representative John Cobb, Chairman
Human Services Committee
House of Representatives
Montana State Legislature
P.O. Box 201701
Helena, MT 59620-1701

Dear Representative Cobb:

Please, please, please continue the funding for MRM. My family has had an involvement with one of the intensive case managers at MRM. When we have needed services our case manager has been able to point us in the right direction. I hate to think what would have happened without their assistance.

I know that these are hard times for all of the social programs in our state. One of the things I hope you realize is that when the children of this state have emotional disabilities, as mine does, we often have a great deal of difficulty finding services for them. We often do not know how to find services, how to pay for services, and even where to ask for help. As a parent, I am concerned for my own child but also know that there must be other parents and children who need help in getting services. I hope that you will continue funding MRM so that the children can continue to be served in their homes. It seems like good economics to be able to keep them in our homes rather than have to look for more expensive institutional care. Please keep the funding for MRM.

Thank you for sharing my concerns with the other members of your committee.

Sincerely,

Becky Hill

Leslie Barnes Albright
2933 Stinson Avenue
Billings, Montana 59102

Representative John Cobb, Chairman
Human Services Committee
House of Representatives
Montana State Legislature
P.O. Box 201701
Helena, Montana 59620-1701

Dear Representative Cobb:

I am writing you in regards to the continue funding for MRM. My family became involved with MRM while my child was being hospitalized for his mental illness. Unless you have been there, I feel you will never understand the hardship a family goes through. Our MRM intensive case manager help to point us in the right direction so that we could make positive decisions.

I know that money is tight for all programs, but I hope that this state will see the need for MRM. If not for my child's doctor telling me where to turn, I would have never found MRM. These services need to be out there, and also need to be heard about for families like ours that have emotional disabled members. We need the availability of these services. Without them, there would be a lot of families in crisis.

Please share my concerns with other members of your committee.

Sincerely

Leslie Barnes Albright

Leslie Barnes Albright

EXHIBIT 6
DATE 1/24/95
HB

As a Childrens Case Manager in Region 2, Hill County, MRM is a funding source that I use to maintain severely emotionally disturbed children and adolescents in their community.

The funding that MRM provides to case managers creates community resources to address a child or adolescents therapeutic needs.

Without funding for MRM to provide these community resources, a severely emotionally disturbed child or adolescent will have to leave the community which will result in more difficulty for the family and a much higher cost to the state.

Thank You,

Tina Brostrom
Childrens Case Manager
Hill County

EXHIBIT 7
DATE 1/24/95
HB

January 20, 1995

To whom it may concern:

I am writing this message in behalf of the organization who has helped me immensely, Case Management.

I understand it's a new organization, although a very valuable one.

I am a single parent with an eight year old son. It's been a year now that I've accepted help from Case Management, and my situation has changed considerably.

I am now in my last month of pregnancy, about to be reunited with my ex-husband, our son's father, and have struggled for a year to get myself back on track in my own life and, get my eight year old back in my home.

He has Attention Deficit Disorder with Hyperactivity. I've had some trouble with this, as well as my personal problems, one being chemical dependency.

Last year, I went to a 28 day treatment center and my son went to foster care. This was only the beginning of events. I completed my treatment and still had troubles with my son and his condition. Because of DFS involvement beginning at the time of my treatment, there were other things in the works I wasn't clear on. Things escalated way out of hand when after a month in a half, I relapsed and went drinking.

Just prior to my relapse I was introduced to Case Management. My son was given an advocate and I was given someone for me.

The events afterwards could get quite lengthy. Just briefly though, after the relapse, it seemed the only people who actually would listen to me, really hear me, was Case Management.

I don't want to appear negative towards anyone or any agency, but things weren't looking good for our situation through the eyes of DFS. Things were said and done that I felt unwarranted my family, and they were the only one's really being heard. If it wasn't for Case Management being for the family, my son would have stayed in foster care, and I would have lost him to the system. He'd been placed several times by now, resulting in misplacement in an inappropriate institution, resulting in months of hard work, struggling to get him back to the community with the appropriate help he needed and reunification plans back home.

Case Management stood by me throughout the year, we got my son placed back in the community and he's now back home. It was a very close call, he was swept away in the system. Without the empowerment and voice of Case Management beside me, we wouldn't be anywhere near the family we've been able to become.

To often these type of cases come before the courts and DFS, and due to lack of recourses or services in the community, the lives and people involved are merely labeled, shipped and handled according to procedure. The whole base of "the family" is lost in red tape. Passed around often to only loose sight of what it's really all about, the family. We have plenty of other organizations to help prevent child abuse, domestic abuse, other family related problems. Not enough help to work with the family in their own community, to reunite them, help them become stronger, have a voice in the system. Case Management helps families in their own community without nearly the cost of expensive facilities, unreasonable expenses to the family like travel, housing, other numerous costs.

With the supportive services of Case Management in the community, there are volumes of families which can be helped at much less the cost of the involvement of less reunification organizations.

Through my own personal experience, I can only say how thankful I am to Case Management for everything they've done and are still doing with and for my family. They've allowed our family to have a second chance at life. We can only pray that there are more people and organizations implemented into rural communities. They serve as a vital source of help to the family itself, less to the system and red tape we so often give too much control and power to.

Please help to keep Case Management in the community. You'd be loosing an invaluable service to the community who needs them.

Thank you,

June Kamps
Havre, MT 59501

EXHIBIT 8
DATE 1/24/95
HB
Elizabeth Cooper

Dear Members of the Legislature,

MRM has done a great deal for my family. If not for the services funded by them and implemented by Childrens Case Management, both of my children would probably be institutionalized.

I live in a small community with limited resources for mental health treatment. In spite of this, Childrens Case Management has managed to develop a plan which has allowed my children to stay at home.

They paid for a therapeutic aide for my children. Without funding from MRM, I would not have been able to pay for this great of an expense. This person actually attended school with my younger son. When the aide started, my son was on the verge of being expelled from the 4th grade. With the support and guidance of his therapeutic aide, my boy had no more school related discipline problems that year. This year he is able to function very well on his own. This is due, in part, to the positive influence of the aide.

My older son was able to come out of residential treatment because of a comprehensive plan developed by his treatment team. Children Case Management is a crucial part of this team. He has a therapeutic aide and it is working out very well. The aide not only helps keep him out of trouble, he is a friend and positive male role model. I cannot express how important of a service the therapeutic aide provides.

With MRM helping out, I am not so overwhelmed. As a single mother, I don't have a partner to help in decision making or to give me a break. MRM has provided the services that fill that role. Not having to shoulder the entire burden allows me to be a better parent.

I believe that MRM is one of the few truly useful programs available to severely emotionally disturbed children. I hope you will continue to give them the support they deserve.

EXHIBIT 10
DATE 1/24/95
HB

January 23,1995

Hi, my name is Jeremy Ogemagishig. I am seventeen. I'd like to thank all of you for the opportunity to share my life having the state as a parent. Its been more difficult to get where I am today than I could ever tell you. I've been in foster care since I was five years old, and in and out of eight foster homes and five different group homes. I have suffered a lot of abuse physically and emotionally from foster parents and family members. In a couple of the homes I've lived in I would do things so that I would not have to live there, In other placements I would get removed for what I thought was no good reason at all, and not my fault. I became very confused and looking back now I knew that no one would keep me for more than a few months. I was always angry and upset, and didn't want to live. I tried to escape any way I could by doing drugs, commiting crimes and running away. I did these things because it made me feel like I had a purpose and made me feel good. I also joined a gang so I could belong to somebody or something that would not push me away. As you can imagine These activitys got me sent to a dentention center for juvinile criminals.

It was during one of my stays in detention that I met my case manager through MRM. At first I thought it was just another person that was going to run my life and tell me how to live it, but then I started to do better at getting away from the drugs and all of the criminal activities that I had been involved in. I have had a team of profesional caretakers that made decisions about my life. This team worked independentally of each other this made it hard for me to trust them. It was confusing, I felt like I was being lied to due to thier lack of communication and responsibility. Now that I have someone who's main role in my life is to help organize and make sure the communication part is taken care of and there is no confusion. And since then I have become a part of the team and I help make decisions for myself. There are a lot more kids out there, I just hope to help some more that are in the same position. Thank you for creating this program, I hope it will be suported in the future. Thanks again.

Jeremy Lynn Ogemageshig

EXHIBIT 9
DATE 1/24/95
HB

Jorgenson's
Holiday Motel

I speak to you today from 3 perspectives. ① I am the mother of a 13 year old SED child, ② a fourth grade teacher, ③ and member of the MRM board from the Billings Region.

I became acquainted with MRM when my daughter was released from Warm Springs Psychiatric Unit. She was not well, not ready for the world but not needing hospital care any longer. MRM provided her a case manager - someone who cared - to oversee her recovery.

As a teacher I have several students who are being served by MRM. Again someone to coordinate their care - no duplication of services, a logical plan that ensures that these children and their parents receive the services available and appropriate for them.

As a MRM board member I have concerns about funding. We need more dollars to help kids. To help the kids identified at this point as kids. To help the kids identified at this point as well as # to include the other children in need of services.

I am concerned, and ask your concern, for those who are being de-criminalized for one reason or another. We cannot dump sexual offenders back into the system because of lack of funds, because their

1714 Eleventh Avenue • P.O. Box 857 • Helena, Montana 59624
406-442-1770 1-800-272-1770 Fax 406-449-0155

time need sent. This becomes a much larger more expensive problem we must find the $ now. Treat these children now, and protect their potential victims.

I have concerns about the Pre-authorization system we need to decide, in Montana, how to spend Montana money. to best serve Montana Children.

MRM boards in each of their function differently. In Yellowstone County we are short beds for our own children because these beds are being taken by children from other regions. We must find a way for each region to be functional and able to serve their own population. We must also develop more facilities to serve mentally ill children.

The bottom line is we need money and time to develop what is potentially the only right way to serve our youth.

As a board member I am constantly amazed at the number and diversity of agencies that serve children + families. It only makes sense to have a group such as MRM to coordinate these groups. These people can + do work together to carefully manage care as well as money. The right hand can know what the left hand is doing.

Barbara Hogg
1185 Trenton St.
Bzltmn, Mt 59715

EXHIBIT 11
DATE 1/24/95
HB

Hi, my name is Bonnie Zapata. I'm 13 years old, 7th grade at Helena Middle school. I have worked with Managing Resoures Montana for 1½ years. My older sister worked with MRM for about 2 years and has graduated from that program. And is now doing very well. I'm still in the MRM program. The services that MRM coordinated for me were very helpful to both me and my family. My caseworker Betsy March and relief caseworker Enid Meeker helped me and my family very much also. Some of the things they do to help me is show me, what I need help on and see the things I do well. Though, MRM I have tutoring classes, after school program activies, and 1 on 1 mentoring. Without Betsy and Enid in my life right now, I would rather be in residential treatment, on run or dead. Thank you for providing the MRM program and please keep it

alot of my family and friends. It could help alot of other kids too.

Thanks
Bonnie
Zepeda

EXHIBIT 12
DATE 1/24/95
HB

Good Morning!

My name is Connie Leveque.

I am the parent of 7 children, 2 of whom receive services from Managing Resources Montana.

I am happy to say that my older daughter has "graduated" from the MRM program. Because of the services she received, she is still in school trying to be on the honor roll. She missed it only by Shundreths of a point

My younger daughter is still with MRM. Thru dilligent effort on the part of our caseworker, Bonnie is in school; she has had 3 schedule changes to do. But she is here today to offer her testimony, so I will let her tell you why we are avid supporters of Managing Resources Montana.

What I would like to share with this committee is the deep commitment I feel I have seen in the members of the

the parents of SED youth, and as a taxpayer in this state, I am continually amazed at the level of concern the members of the governing board have for our kids. These are not people who are just going thru the motions of "doing their jobs", but they are caring members of their communities who only want to see these targeted kids grow up healthy & happy. And I am grateful to say that w/ MKMS help, my kids are doing just that.

EXHIBIT 13
DATE 1/24/95
HB

1-24-95

MONTANA MENTAL HEALTH ACCESS PROGRAM

GOAL

To integrate the financing and delivery of managed mental health services to low income Montanans

1

If Managed Care is not expanded, there will be:

- Need for increased revenue or reduced benefits and/or provider rates to fund program
- Increased long term cost of program
- Increased number of uninsured
- Cost shift to private sector

2

Collaborative Effort on the Part of 3 State Agencies Incorporates the Following Existing Services:

- **SRS** - All inpatient and outpatient mental health services
- **DFS** - Residential treatment centers, therapeutic group homes and therapeutic foster care
- **DCHS** - Community Mental Health Centers, Managing Resources Montana (MRM), Montana State Hospital, and Center for the Aged

3

New program is to be run by a managed care organization under contract with the state.

- A Managed Care Organization (MCO) is a company with expertise in administering large mental health programs such as Medicaid programs in other states, CHAMPUS benefits, or private insurance using managed care principles. The MCO must have proven experience in provider credentialing, efficient (but not onerous) database systems and reporting requirements; and establishing quality assurance program.

4

ADVANTAGES-RECIPIENTS

- Individualized, coordinated care
- Benefits not limited to traditional services
- Limits and caps eliminated
- Quality of care continually monitored
- Clients cannot be "dumped" because they are too expensive
- Waiting lists for services reduced or eliminated
- Access to care expanded
- Emphasis on community based care

5

ADVANTAGES-HEALTH CARE PROVIDERS & THE STATE

- **HEALTH CARE PROVIDERS**
  - Negotiated reimbursement
  - Limits and caps disappear
  - Can provide better continuity of care
  - Potential for stable funding base
- **THE STATE**
  - Cost known up front
  - Reduced budget growth
  - Overutilization incentives eliminated
  - Enhanced provider accountability

6

COVERED GROUPS

- Current Medicaid eligibles
- Expand Medicaid for mental health services only to those with income below 200% FPL
- Income determination only eligibility determination for expansion group
- Cost sharing 100 to 200% FPL
- Persons aged 21 - 64 in State hospital (IMD)
- Medicare dual eligibles
- Native Americans by choice

7

EXCLUDED GROUPS

- Forensic patients at State hospital
- Children placed through Juvenile Justice in a corrections facility
- Substance abuse/chemical dependency (to be phased in)

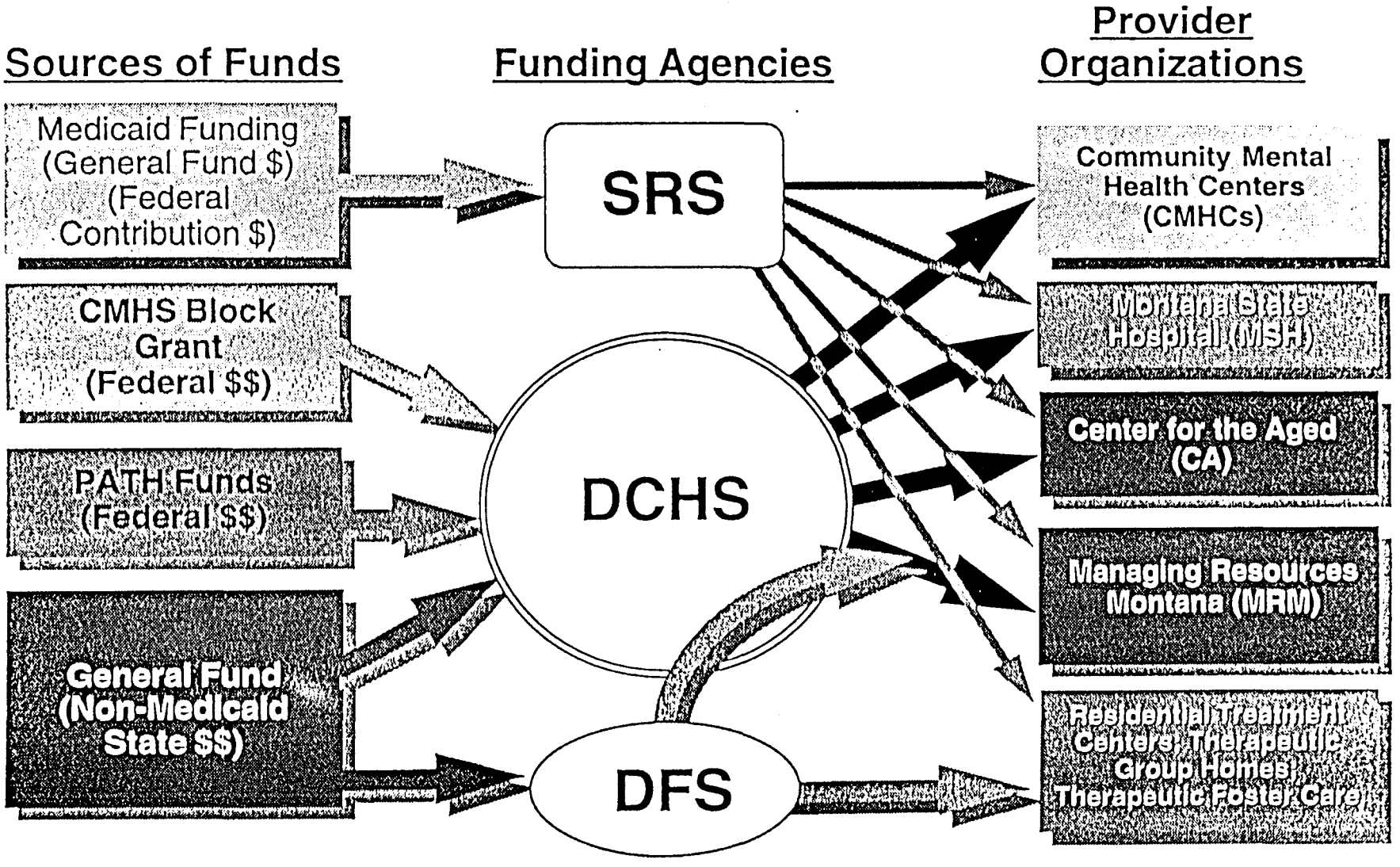
8

MANAGED SERVICES

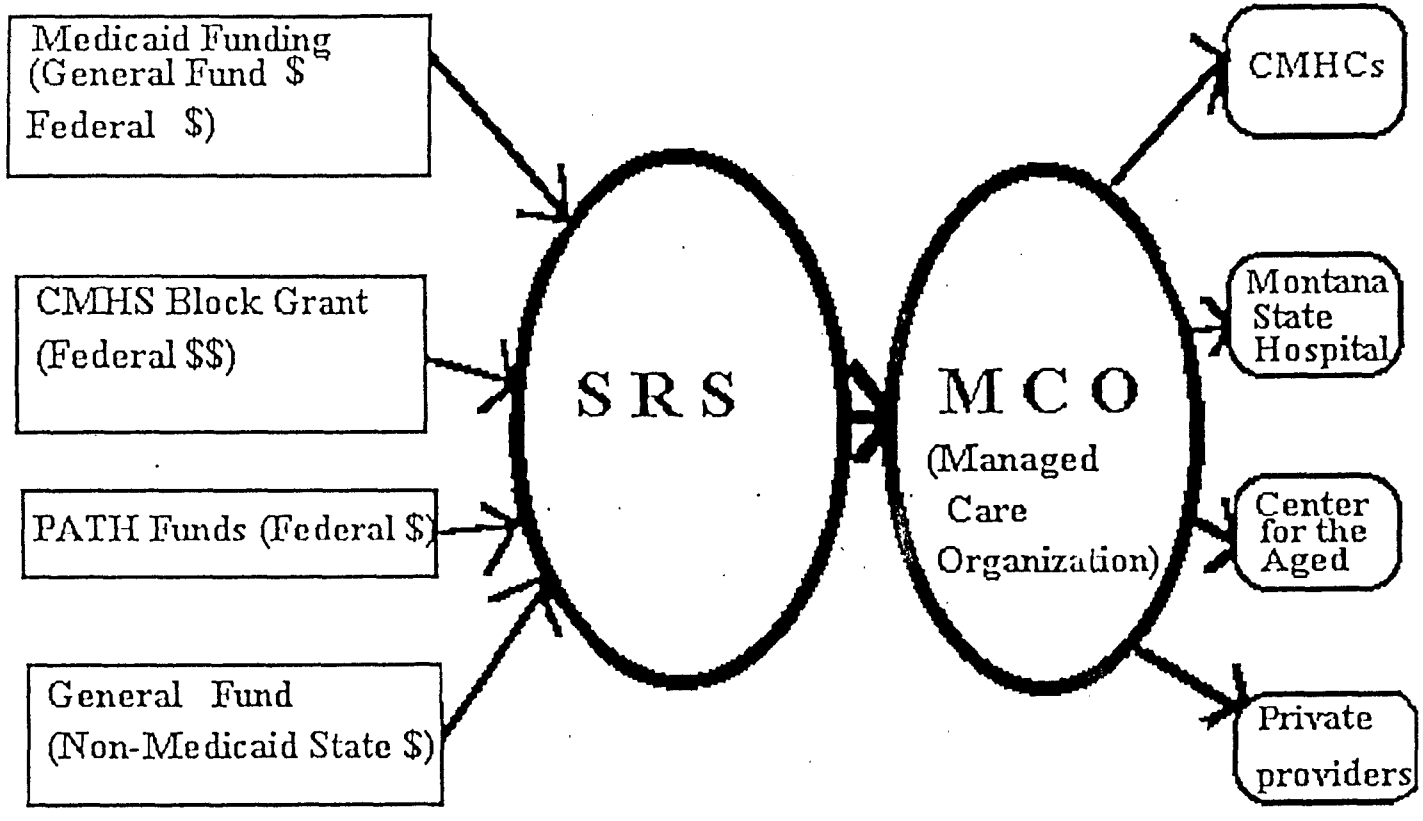
- Evaluation and Assessment
- Individual/Group/Family Therapy
- Day Treatment
- Case Management
- Consultation
- Inpatient Psych Services
- Emergency Stabilization
- Community Living Skills
- *Psychotropic Drugs

CURRENT

Flow of Funding for Mental Health Services (Medicaid and Non-Medicaid)



PROPOSED
Flow of Funding for Mental Health Services
Mental Health Access Plan



Development of Medicaid Capitation Rates

- Calculate FY94 Medicaid Member Months
- Calculate FY94 Base Period FFS Costs for Covered Diagnoses, Beneficiaries, Providers, and Services
- Analyze FY94 FFS and Non-Claims Costs by Beneficiary Class, Age/Sex, and Region
- Trend FY94 Medicaid Costs to FY96 (First Year of Capitation)
  - Trend reflects inflation, underlying utilization, and benefit changes

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Development (cont.)

- Estimate Non-Claims Costs which will shift to Contractor; include in FY96 Medicaid costs to derive Upper Payment Limit
- Capitation Rates Must Be Less Than Upper Payment Limits to Reflect:
  - Costs for program administration and evaluation
  - Funding opportunity for Medicaid eligibility expansion up to 200 percent of poverty
  - Any additional managed care savings

13

Non-Medicaid Capitation Rates

- Calculate FY94 Based Period Costs for Covered Beneficiaries, Providers, and Services
- Trend FY94 Costs to FY96
  - Trend reflects inflation, underlying utilization, and benefit changes
- Establish Monthly Flat Aggregate Payment Rates (Note: This payment methodology is not the same one used for Medicaid)

Significant Activities To Date

- During Special Session Legislature approved legislation authorizing Department to proceed with mental health managed care project, December 1993
- Governor appointed Mental Health Advisory Group, February, 1994 (membership list attached)
- Advisory Group held four meetings to provide preliminary direction, helped write RFP for the system design consultant and participated in the selection of the eventual contractor, February, April, June, September, 1994

15

Significant Activities To Date (Continued)

- Issued contract to Health Management Associates, who will design the actual structure of the system, assist in writing the necessary Medicaid waivers and develop the actuarial analysis of costs and capitation rates, June, 1994
- Held a series of town meetings in 9 locations across the state with 550 participants to solicit input into system design, September-October, 1994

16

Significant Activities To Date (Continued)

- Met with Health Care Financing Administration in Washington DC to present initial concept paper, November 3, 1994
- Statewide METNET Video Conference which focused on children's issues with over 100 participants to solicit input into system design, December 1994
- More than 30 individual presentations to organizations interested in mental health services to solicit input, January 1994 and January 1995

Key Dates For Further Program Development

- **February 1995** - Submission of 1115 waiver application to HCFA; Distribute internal draft of Request for Proposal (RFP) for managed care organization
- **March 1995** - Distribute external draft of RFP for public comment
- **August 1995** - HCFA approval of 1115 waiver application; Release RFP for managed care organization

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Key Dates (cont.)

- **October 1995** - Proposal due from managed care organizations
- **November & December 1995** - Evaluate RFP proposals; Presentation to Advisory Council by top bidder(s); Negotiate a contract; Obtain HCFA approval to award contract
- **January 1996** - Award contract
- **March & April 1996** - HCFA on-site evaluation/approval of system readiness; Begin program implementation
- **July 1996** - Full operation

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Role Of The Managed Care Organization

- Provide or arrange for all necessary mental health services
- Eligibility determination for people up to 200% of FPL
- Assemble, credential, educate, oversee, and pay a statewide panel of providers
- Develop and implement cost-effective, community-based stepdown services
- Utilization Review and Inspection of Care
- Extensive data collection and reporting of State and to HCFA
- Maintain a continuous quality improvement system

Role Of The State

- Cooperative program governance by SRS, DCHS, DFS
- Program Monitoring: *service provided, access to services, enrollment, grievance resolution for client and provider, quality of care, cost effectiveness, and treatment outcome*
- Liaison with Advisory Groups
- Reporting to HCFA (every 6 to 12 months to demonstrate continued access and waiver compliance) - SRS
- Contract management by SRS

21

Role Of The State (cont.)

- Maintenance and revision of 1115 waiver - SRS
- Monitoring and annual reporting for Federal Block Grant - ~~DFS~~ DCHS
- Quality assurance at Montana State Hospital - DCHS
- Exploration to include drug and alcohol treatment services - DCHS & SRS
- License therapeutic group and foster care homes - DFS

22

Role of Advocates and Advisory Council(s)

- Assist state in monitoring quality assurance
  - consumer and provider satisfaction
  - quality of service
- Advise MCO of need for new services or changes to existing services on a regional and state-wide basis

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Quality Assurance

- The **Managed Care Organization** will be required to have a rigorous, well-defined program for continuous quality improvement.
- The **State** will continuously monitor MCO performance including: *access to services, response to grievances, recipient enrollment and education, program standards, client outcome, and consumer and provider satisfaction.*
- The State will contract for an **Independent Evaluation** of the entire program.

24

Grievance Processes

- **The MCO's grievance process must include:** *an uncomplicated prompt process, easy access and consumer education, a named responsible individual with authority, provision for appeals, and reporting to the State.*
- **The State will:** *provide an appeals panel for grievances not resolved by the MCO, provide access to Medicaid fair hearings process, Monitor number and outcome of grievances.*

25

WAIVERS REQUESTED

- Expand eligibility to 200% FPL (mental health services and limited drug formulary)
- Contract for eligibility of expanded group
- Eliminate IMD exclusion
- Freedom of choice
- Cost sharing

26

1115 WAIVER LIMITATIONS

- Must be cost neutral to the federal government over the 5 year life of the waiver
- Must have a legitimate research and demonstration component that will be of interest to the rest of the nation - cannot simply be a re-financing measure
- These waivers are granted at HCFA's discretion - they do not have to grant them

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Alternatives to Planned "1115" Research and Demonstration Waiver

- **LIMITED "1115" PROGRAM:** *no expanded eligibility, medicaid reimbursement for Montana State Hospital, coordination with state-funded programs, same waiver review process, same implementation schedule*
- **MEDICAID-ONLY MANAGED CARE PROGRAM:** *No expanded eligibility, no Medicaid reimbursement for Montana State Hospital, limited coordination with state-funded program, simpler "1915B" freedom-of-choice waiver, quicker implementation*

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Mental Health Managed Care Advisory Group

Chair: Dr. Peter Blouke, Director, Department of Social and Rehabilitation Services

Category	Organization	Representative
Legislators	Senate	Sen. Mignon Waterman 530 Hazelgreen Place Helena 442-8648
	House	Rep. Mike Foster 414 N. Cedar St. Townsend 443-4540
Consumers	Meriwether Lewis Institute	Kathy Standard, President 562 Fifth Ave. Helena 442-7416
		Pat Pope, Exec. Director 562 Fifth Ave. Helena 442-7416
Family Members	Montana Alliance for the Mentally Ill	Sandra Mihelish 554 Toole Rd. Helena 458-9738
	Mental Health Advisory Committee on Youth	Tony Jensen* 422 Holter Helena, MT 59601 442-6556
Psychologists	Montana Psychological Association	Dr. Debra Sanchez 535 Saddle Dr. Helena 449-8813
Social Workers	Montana Chapter, NASW	Donna Hale 535 Saddle Dr. Helena 449-8813
Licensed Professional Counselors	MT Clinical Mental Health Counselors Assn.	Ray Venzke 3117 Cooney Dr. Helena 449-3013

Mental Health Managed Care Advisory Group

Category	Organization	Representative
Community Mental Health Centers	MT Council of Mental Health Centers	Kathy McGowan, Exec. Dir 34 West Sixth Ave. Helena 443-1570
	Golden Triangle Mental Health Center	Linda Hatch, Exec. Director PO Box 3089 Great Falls 761-2100
Dept. of Corrections and Human Services	Mental Health Division	Dan Anderson, Administrator Helena 444-3969
Dept. of Family Services	Treatment Services Division	Mary Ann Akers* PO Box 8005 Helena, MT 59604-8005 444-5920
State Hospital	Montana State Hosptial	Carl Keener, M.D. Medical Director Warm Springs 693-7000
County Governments	MT Association of Counties	Howard Gipe Flathead Co. Commissione 800 South Main Kalispell 758-5503
Hospitals	MT Hospital Association	Bill Diers, President Kalispell Regional Hospital 310 Sunnyview Lane Kalispell 752-5111
Physicians	MT Medical Association	Nathan Munn, M.D. 1803 Jerome Pl. Helena 447-2760
Advocates	Mental Health Association of Montana	Candace Butler 1750 Highway 93 South Kalispell, MT 59901 257-1336
		Joan-Nell Macfadden* 2620 4th Avenue South Great Falls, MT 59405 452-4185
	Board of Visitors	Kelly Moorse, Exec. Dir. PO Box 200804 Helena 444-3955

Mental Health Managed Care Advisory Group

Category	Organization	Representative
'vocates (cont.)	Family Support Network	Barbara Sample* 1236 No. 28th St., Ste 101 Billings, MT 59101 256-7783

* New representatives for children's services appointed December, 1994

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24-Feb-94

EXHIBIT 14
DATE 1-24-95
HB

17

ANNUAL POVERTY INCOME GUIDELINES FOR ALL STATES

FAMILY SIZE	1994 POVERTY LEVEL	40.5% OF POVERTY	110% OF POVERTY	133% OF POVERTY	185% OF POVERTY
1	$7,360	$2,981	$8,096	$9,789	$13,616
2	$9,840	$3,985	$10,824	$13,087	$18,204
3	$12,320	$4,990	$13,552	$16,386	$22,792
4	$14,800	$5,994	$16,280	$19,684	$27,380
5	$17,280	$6,998	$19,008	$22,982	$31,968
6	$19,760	$8,003	$21,736	$26,281	$36,556
7	$22,240	$9,007	$24,464	$29,579	$41,144
8	$24,720	$10,012	$27,192	$32,878	$45,732
9	$27,200	$11,016	$29,920	$36,176	$50,320
10	$29,680	$12,020	$32,648	$39,474	$54,908
11	$32,160	$13,025	$35,376	$42,773	$59,496
12	$34,640	$14,029	$38,104	$46,071	$64,084
13	$37,120	$15,034	$40,832	$49,370	$68,672
14	$39,600	$16,038	$43,560	$52,668	$73,260
15	$42,080	$17,042	$46,288	$55,966	$77,848
16	$44,560	$18,047	$49,016	$59,265	$82,436

MONTHLY POVERTY INCOME GUIDELINES FOR ALL STATES

FAMILY SIZE	1994 POVERTY LEVEL	40.5% OF POVERTY	110% OF POVERTY	133% OF POVERTY	185% OF POVERTY
1	$613	$248	$674	$815	$1,134
2	$820	$332	$902	$1,091	$1,517
3	$1,027	$416	$1,130	$1,366	$1,900
4	$1,233	$499	$1,356	$1,640	$2,281
5	$1,440	$583	$1,584	$1,915	$2,664
6	$1,647	$667	$1,812	$2,191	$3,047
7	$1,853	$750	$2,038	$2,464	$3,428
8	$2,060	$834	$2,266	$2,740	$3,811
9	$2,267	$918	$2,494	$3,015	$4,194
10	$2,473	$1,002	$2,720	$3,289	$4,575
11	$2,680	$1,085	$2,948	$3,564	$4,958
12	$2,887	$1,169	$3,176	$3,840	$5,341
13	$3,093	$1,253	$3,402	$4,114	$5,722
14	$3,300	$1,337	$3,630	$4,389	$6,105
15	$3,507	$1,420	$3,858	$4,664	$6,488
16	$3,713	$1,504	$4,084	$4,938	$6,869

* The percentage of poverty amounts per month are computed by first dividing the annual poverty rate by 12, rounding the answer to zero decimal places, and then multiplying by the appropriate percentage of poverty.

Demographic Information for Montana
1990 Census Data
Ratio of Income to Poverty Level

	Number of Persons in Category	Percent of Total Population	Cumulative Population	Cumulative Percent of Population
under .50 ratio income/ poverty level	52,014	6.7%	52,014	6.7%
.50-.74 ratio income/ poverty level	33,200	4.3%	85,214	11.0%
.75-.99 ratio income/ poverty level	39,639	5.1%	124,853	16.1%
1.00-1.24 ratio income/ poverty level	45,384	5.8%	170,237	21.9%
1.25-1.49 ratio income/ poverty level	43,155	5.6%	213,392	27.5%
1.50-1.74 ratio income/ poverty level	48,804	6.3%	262,196	33.8%
1.75-1.84 ratio income/ poverty level	18,579	2.4%	280,775	36.1%
1.85-1.99 ratio income/ poverty level	28,881	3.7%	309,656	39.9%
2.00 and over ratio income/ poverty level	467,137	60.1%	776,793	100.0%
Total	776,793	100.0%		

Note: Actual 1990 US Census Population figure is 799,065. Assume not all households reported income.

EXHIBIT 15
DATE 1/24/95
HB

January 20, 1995, Friday —

Representative John Cobb, Chairman
Human Services Committee
House of Representatives
Montana State Legislature
P.O. Box 201701
Helena, MT 59620-1701

Dear Representative Cobb:

Not only do I feel you should continue funding for MRM, I find it necessary to request that you cut funding from other state programs (at your discretion, or, in your realm of service), to transfer to mental health treatment of individuals in the State of Montana who are currently receiving any of the following aid: AFDC, SSI, Food Stamps, etc.

One agency you may look into for fund reduction is the Department of

Family Services. I think you also need to review the possibility of cutting the number of jobs in these facilities as opposed to the need factor.

A Social Service Conference needs to be held, in which all agencies, private & public are present so that they can all become familiar with each other & their resources so that the client is taken from a stage of helplessness and eventually funnelled into a state of self-reliance.

I realize in some cases, this may be impossible, but, not necessarily.

I worked in welfare for four years & paid the bills for the grants given by the Government.

If you would like further views and suggestions, I have listed my address and phone number.

However, Representative, keep in mind, we must strive in all areas of Human Services to maintain healthy families as the ultimate goal, regardless of income level.

This includes mental, as well as physical health.

The children of today are the adults of tomorrow, so therefore, I would suggest you + all of your staff take all of my words to heart.

If I can be of further assistance, do not hesitate to contact this disabled, ex-AFDC recipient, federally trained, Montana licensed, Certified Nursing Assistant, mother of one.

Also, be advised, I shall begin college in May, and furthermore, your Jobs program is working for me with Day Care, along with Block Grant.

We have the ability, and the resources, we live in the

most profitable country in the world. Let's not give the others an upper hand by short changing ourselves.

As always,

Sincerely,

April Lynn Counts, CNT
P.O. Box 50304
Billings, MT 59105
(406) 256-3564 (my client, Mr. Hutch 100% DAV)
or
(406) 254-1153 message phone
24 hours a day.

I see a lot of potential in welfare recipients. I want the attitudes at the agencies ceased. Even though there is potential, however, there is still a need for the system.

Good Day.

HOUSE OF REPRESENTATIVES
VISITORS REGISTER

Human Services & Aging SUB-COMMITTEE DATE 1/24/95

BILL NO. _____ SPONSOR(S) _____

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	Support	Oppose
Pat Bentley	MRM	X	
MARY ELLERD	MT Pork	X	
Marty Onishuk	Mon HMI	X	
Pat Melby	Rivendell of MT	✓	
[illegible]	MDMC - GF		
Robert Runkel	OPI	✓	
Jan-Nell Mayfield	DFS/State Council	✓	

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

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HOUSE OF REPRESENTATIVES
VISITORS REGISTER

Human Services & Aging SUB-COMMITTEE DATE 1-24-95

BILL NO. HB 2 SPONSOR(S)

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NAME AND ADDRESS	REPRESENTING	Support	Oppos
Donna Gulluse	DHES		
KATHY McGOWAN	MCMHC		
Kent Schof	CMC		
Kaylen Jones Bldg	FSN	✓	
Barbara Hagg	MRM	✓	
Elaine Peterson	WMMHC	✓	
NANCY UHLHORN	WMMHC	✓	
Tevony Ogemagishig			
Bonnie Zapata		✓	
Julie L Zapata		✓	
Connie Leveque	FSN	✓	
Patty Lavin	Mental Health	✓	
Allison Campbell	Mental Health	✓	

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