

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

[]

The Children's Behavioral Health Oversight Committee and Health and Human Services Committee met at 1:30 p.m. on Monday, December 5, 2011, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a joint public hearing.

Senators present: Kathy Campbell, Chairperson; Bill Avery, Dave Bloomfield; Colby Coash; Tanya Cook; Annette Dubas; Mike Gloor; Gwen Howard; Bob Krist; and Jeremy Nordquist. []

SENATOR CAMPBELL: Good afternoon, and welcome to the joint hearing of the LB603 Committee and the Health and Human Services Committee. As is our practice at the Health and Human Services Committee, we do self-introductions, so I'm going to start as I usually do, to my far right. []

SENATOR BLOOMFIELD: Dave Bloomfield, District 17, Wayne, Thurston, and Dakota Counties in the northeast part of the state. []

SENATOR COASH: Colby Coash, District 27, right here in Lincoln. []

SENATOR NORDQUIST: Jeremy Nordquist, District 7, downtown and south Omaha. []

SENATOR GLOOR: Mike Gloor, District 35, Grand Island. []

SENATOR CAMPBELL: Kathy Campbell, District 25, Lincoln and Lancaster County. []

SENATOR DUBAS: Annette Dubas, District 34, Nance, Merrick, Hamilton, and Hall County--parts of Hall County. []

SENATOR HOWARD: Senator Howard, District 9, and that's right really in the heart of Omaha--think UNO--and then it goes east to 24th Street. []

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

SENATOR AVERY: Bill Avery, District 28. You're in it right now. (Laughter) []

SENATOR CAMPBELL: And Senator Krist. []

SENATOR KRIST: Bob Krist, District 10. []

SENATOR CAMPBELL: Everybody has a little change of place, that's why we're looking for places here. I would like to remind you that if you have a cell phone, to put it on silence or to turn it off. It's very disruptive to testifiers to hear that ringing in the background. We will use the light system after a couple of the first people who have a longer information have already visited to us. But if you're going to testify today, make sure that you have an orange sheet completed and you can give it to Claudia Lindley, who is serving as the clerk today as my legislative aide, and Ayisha is the page. Ayisha, do you want to raise your hand there? And Michelle Chaffee is over there. She is the legal counsel to the Health and Human Services Committee. If you are testifying, as you come forward you can give the orange sheet, as I said, to Claudia, and also identify yourself and spell your name so that the transcriber knows exactly how you usually spell it, and not how we would like to spell it--let's put it that way. I particularly want to thank everyone for coming. This is an issue that we have followed on the Health and Human Services Committee, and I believe the LB603 Committee was with us. We have had two briefings on the IMD-PRTF issue, and one public hearing, and this is our second public hearing on that. So we are particularly glad to see many of you return. I would like to offer good wishes and "get well soon" to Vivianne Chaumont. Director Chaumont fell this morning and is having...they're taking a look at her thoroughly to make sure that she's okay, but she will not be joining us today. But we certainly send her our best wishes to get well quickly. And in her place--and I'm going to let you introduce yourself. []

SUSAN BUETTNER: I'm Susan Buettner. I'm the deputy director for the Division of

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

Medicaid and Long-Term Care, the Department of Health and Human Services. []

SENATOR CAMPBELL: Okay. []

SUSAN BUETTNER: And I will spell my last name. []

SENATOR CAMPBELL: That would be great. []

SUSAN BUETTNER: It's B-u-e-t-t-n-e-r. []

SENATOR CAMPBELL: Okay. And with you today...and Sue, I'm going to let you go ahead and identify yourself. []

SUE MIMICK: I'm Sue Mimick. It's M-i-m-i-c-k, and I'm the general manager at Magellan Health Services here in Lincoln. []

SENATOR CAMPBELL: Okay. And this afternoon's hearing we decided that we would start off with an update from the department and from Magellan. So, Susan, I'm going to let you go ahead and step us through the handout that you have provided. []

SUSAN BUETTNER: (Exhibit 1) Okay. Thank you. I do want to also express my regrets for Director Chaumont. She was planning on being here, and as Senator Campbell indicated, she is unfortunately not able to be here this afternoon. But this PowerPoint or this presentation was prepared on her behalf, so I will do my best to go through it. I'm happy to answer any questions that you may have either during or after the presentation. But as a reminder, before we begin, Medicaid is a health insurance program. It's for eligible clients. All services must be medically necessary in order to receive payment, and Nebraska must administer its Medicaid program in compliance with all federal Medicaid requirements in order to receive federal reimbursement. An Institute for Mental Disease has been defined by both federal regulations and by statute,

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

and what it basically states is that it's a hospital, a nursing facility, or other institution that has more than 16 beds that's primarily engaged in providing diagnosis, treatment or care of persons with mental illness, including medical attention or nursing care or other related services. Whether a facility is deemed to be an IMD is really a fact-specific instance. It's looking at its overall character of that facility to establish and determine why the person is in that facility, is it maintained for the care and treatment of the individuals with mental disease and whether or not it's licensed as such. For the IMD exclusion, federal financial participation is not available for any Medicaid services provided to any individual who is under 65 and who is a patient in an IMD. So if they're in an IMD, there is no federal participation. No Medicaid payment can be made for services provided either inside or outside the institution. And the exclusion was designed to assure that the states, not the federal government, have the principal responsibility for funding inpatient psychiatric services. The only exception to the IMD exclusion is for funding for Medicaid to provide services to children up to 21 years of age, and those were in a facility called a psychiatric residential treatment facility, or a PRTF. A PRTF has to follow specific federal requirements. And by way of a little history of what's happened within the department, I'm sure many of you are aware of this, but back in June 2010, the Centers for Medicare and Medicaid Services contacted the department by way of a letter requesting that we provide assurances that we were in compliance with those rules; the federal requirements regarding the standards and payment methodology for children's behavioral health services; also assuring for payment of...assure that we're not paying for behavioral health services in an institution for IMD--or an institution for mental disease, excuse me. Failure to comply puts funding for Medicaid children's behavioral health services, those benefits, at risk. And in FY 2010, that was just over \$108 million. In August 2010, the Nebraska Department of Health and Human Services submitted a corrective action plan to CMS. We submitted that plan so that we could continue to receive this federal funding. By January 2011, Nebraska...part of that plan was that Nebraska would begin auditing its facilities for compliance with the psychiatric residential treatment requirements. By July 2011, Nebraska would then submit a state plan amendment with all service definitions,

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

provider qualifications, units of service, limitations, and reimbursement methodology for all children's behavioral health services. So basically what we were saying was that by July 2011 the department would be in compliance with all the federal rules and regulations. At that time, we gave an opportunity to the providers to either choose to enroll as a PRTF or a therapeutic group home. By July 2012, Medicaid in our corrective action plan has indicated that Medicaid providers would be in compliance with all federal requirements for residential treatment. State regulations needed to be changed, and as of July 2011, all of the Medicaid children behavioral health services had to be in compliance with the federal regulations. All the prior services that were defined in the previous Chapter 32 were stopped. They ceased to be federally reimbursed on July 1. We are reviewing...stepping back, the current Chapter 32 has gone to public hearing. We have received multiple comments on those regulations and we are currently actively going through those comments to determine what we can utilize, what we can change, and be as flexible as we can in utilizing those comments. Part of the comments, what we received, was that Nebraska Medicaid has been overly strict in its interpretation of two of the issues presented. One is the application of the IMD criteria itself, and the other is the PRTF criteria. We disagree. The Department of Health and Human Services has relied on guidance that we've received from the federal CMS agency, both within the state Medicaid manual that CMS prints as well as the federal regulations found in the CFR. We developed guidance based on both of those documents, and we submitted that documentation to CMS and that was approved. We then utilized that guidance to then go through and individually go facility-to-facility to make a determination of IMD status. A PRTF, as an exception to the IMD rule, is defined as...it's a facility other than a hospital; it provides psychiatric services to individuals under the age of 21; and it's an inpatient setting. It must be accredited; it must meet the requirements set out in the federal regulation as provided in this document; and services must be provided under the direction of a physician. For a child who is a Medicaid client when they're admitted into a PRTF, certification must be made by an independent team. The team must include a physician that has competence in diagnosis and treatment of mental illness, preferably in child psychiatry, and also has

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

knowledge of the individual's situation. The team must also certify that the ambulatory care resources available in the community do not meet and would not meet the treatment needs of this child; the proper treatment of the child's psychiatric condition requires services on an inpatient basis under the direction of a physician; and that those services can reasonably be expected to improve the child's condition or prevent further regression so that the service will no longer be needed. So Nebraska Medicaid can no longer pay for services it had previously paid for. There are no federal funds available for those services. A child's behavioral health facility with more than 16 beds must comply with the PRTF requirements to continue to receive Medicaid funding. The requirements are substantially more stringent than what had previously been in place for other levels of care that are familiar, like RTC. A PRTF, as a reminder, is an inpatient psychiatric level of care. What has not changed, however, is that all Medicaid children who do not qualify for a PRTF level of care are authorized for community services or therapeutic group services. National trend for the last year has been towards fewer residential placements and for services in the community. Children live in the community and they need to learn to successfully stay in the community and to succeed in the community. Now there are challenges involved with this transformation. Residential services continue to be seen as the most desirable services for children. Nebraska Medicaid continues to pay for and encourages community-based treatment services, however, such as intensive outpatient, day treatment, and community treatment aide services. Community providers need more referrals in order to sustain their programs as well. So, in conclusion, our program, our system, is in transition. The Nebraska system needs to change to continue to access federal funds; providers of residential services can choose to change their business model towards community-based services in order to receive additional Medicaid funds; and these changes are good for our children. Thank you. []

SENATOR CAMPBELL: Thank you, Susan. Senator Krist. []

SENATOR KRIST: You were very explicit, and you said we do not agree. Can you

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

define the "we" that do not agree? []

SUSAN BUETTNER: We, as in the Department of Health and Human Services, Division of Medicaid and Long-Term Care. []

SENATOR KRIST: Okay. So there are several, and I'm sure we'll hear from them, and have been hearing from them, that think that the definitions that are being used by other states, which, by the way, don't consider themselves to be at risk, are operating in a more flexible manner that allows some services to continue. And you're aware of that and you still don't agree that the definitions that are being applied by other states could be applied here in Nebraska? []

SUSAN BUETTNER: Based on the information that we have right now for the state of Nebraska, the way that we're set up, I do not believe that this an overly stringent definition. I am aware of other states, however, and we are researching other states. We also are aware that there's other states that believe that they were not in peril of federal funding and have lost federal funding anyway. And so we are being very cautious in moving forward to make sure that that doesn't happen to the state of Nebraska. But based on the research that we have and the information that we've been looking at, absolutely I believe that this is correct. []

SENATOR KRIST: Okay. I will tell you I think this discussion needs to continue and that the flexibility of the definition and services to children are more important to me than whether we disagree or there's a (inaudible) agreement within the community as opposed to within the department. And there's one question I'd like to ask and I'm not sure where it needs to be asked, but it's my big question for the day and I'd like to have somebody get back to me and let me know. I've been aware from both constituents and from my dealings with Health and Human Services that we have children under the age of 5 that are being denied psychiatric help or services, and yet I'm aware of at least four of those that are getting psychotropic drugs to treat a mental situation. How in the world

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

do we expect to get them off of those drugs if they're not getting quality care from a psychiatrist or a psychologist? I think it is a complete diversion from sanity to think we're ever going to get those kids well. I...you don't have to answer now, I wish you wouldn't, but I would like to have you get back to us and make sure that we understand how we're supposed to treat kids. And, oh, by the way, those psychotropic drugs are not even authorized for use in children below the age of X. You're shaking your head so you must know the situation. I'd like it in writing because I need to answer some constituents on the issue. Thank you very much. []

SUSAN BUETTNER: Okay. I can do that. []

SENATOR CAMPBELL: Senator Coash. []

SENATOR COASH: Thank you, Senator Campbell. Thank you both for being here. I want to talk about capacity for a minute. We still...there are a few providers out there providing PRTF services, is that correct? []

SUE MIMICK: Yes. []

SENATOR COASH: How many providers do we have in Nebraska doing that? []

SUE MIMICK: I have slides on that if you want to...? []

SENATOR COASH: Do you? []

SUE MIMICK: Do you want to go through those now or would you want to hold it until I get to my slides? []

SENATOR COASH: Well, let me ask the questions and then you can be sure to answer them as you go through, because my question is, you know, how much capacity do we

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

have to serve children in what is now the PRTF? And we also know that because of these changes, that we lost a few levels of service, and subsequently we've lost and continue to lose providers who were providing a level of service, aren't going to do PRTF; now they're leaving, and that's the most concerning piece to me. So I'm trying to get my head wrapped around capacity that we used to have compared to capacity that we do. And I did understand what you were saying about the movement towards more community-based services, and these are out-of-home placements where...I mean, the levels of service, PRTFs, enhanced treatment group homes, treatment group homes, all those require that kid is not sleeping with Mom and Dad when he's getting that service. But my big concern that I would like to see addressed is the capacity of these children. Because the kids didn't go away even though the services did, and they are somewhere, and where they are is the most concerning to me and if their needs are being met and where they are. So capacity is really my biggest question to be answered today. []

SUE MIMICK: Sure. []

SENATOR COASH: So if can answer it here, great. If not, I would like to... []

SENATOR CAMPBELL: Let's go ahead and have Ms. Mimick go ahead and give her presentation and that might answer some of the questions. And we've all been given a packet. []

SUE MIMICK: I'm hoping that this works--and it doesn't. []

SENATOR CAMPBELL: Okay. []

SUE MIMICK: I'll stand if you don't mind. []

SENATOR CAMPBELL: Not at all. []

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

SUE MIMICK: (Exhibit 2) Okay. Actually I think my first slide, Senator Coash, addresses your issue. Here's the availability: 6/27, we had 442 contracted...well, let me back up. We...Magellan contracts with providers for a specific number of beds, so, and the Boys Town contract--Pat Connell is here--we have that they have X number of beds that are Medicaid set aside beds. They send in to us a weekly census, and in that census it says how many contracted beds that we have. And we generally run a difference between what they tell us they have as beds and what they're contracted for. And, you know, we believe that the difference is some beds that perhaps aren't staffed right now or they're just not prepared at the moment to fill but could if the issues were there. That being said, there were at the time, June 27, 390 beds that they told us on their census that they had, and that included 78 contracted and 71 reported ETGH beds, which are...ETGH is not a level of care that we have any longer. So in that 6/27 census there were 291 beds that they told us were occupied, of the...and that was a 74 percent of the beds that they told us that they had contracted. And at that time there were 196 that were funded by Medicaid; 95 funded by CFS. Okay? Today, I'm going...there are reports for various points in times. As of last Monday--not today, but last Monday--we had 405 contracted beds, 328 reported beds on the census reports. There were 218 occupied beds, and that included nine youth that were funded by commercial insurance or private pay. And for a 66 percent occupancy rate, 107 were Medicaid-funded and 102 were CFS-funded. []

SENATOR CAMPBELL: Senator Coash, did you want to follow up or would you like her to finish the report? []

SENATOR COASH: I'm going to let her go ahead. []

SENATOR CAMPBELL: Okay. []

SUE MIMICK: Okay. []

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

SENATOR COASH: Thanks. []

SUE MIMICK: All right. So we continue. Last time I was here I talked about an issue with the applications declining--the next graph. I think it shows it a little bit better on your handout than it does on the slides. Shows that we continue to experience a decline in the number of applications that we're getting. Part of the reason, of course, is that we have ETGH, which was enhanced treatment group home, which was an (inaudible) for children that only had conduct disorders, and that level of care essentially went away with these changes. The RTC and therapeutic group homes converted to PRTF...or excuse me, treatment group homes converted to the therapeutic group homes. And the ETGH homes, as well, converted to either PRTF or therapeutic group homes. So you see that although...that the applications have continued to decline. You continued to ask me about approval rates of the applications that we get. The 12 months, July through June of--last June--the approval rate was 54 percent. In October, we were running 55 percent. So we're back to the approval rates that we had before, after having a little bit of decrease as we were going through transition. Where do we get our applications from? That's the first thing we look for...for, you know, why are the applications going down. The monthly average prior to 7/1, when we made the changes, we got 21 applications from hospitals, a month; we're currently getting 10, so that's a decline of 52 percent. Prior to the change, we got 48 applications from residential facilities themselves, and we are currently getting 28, which is a decline of 42 percent--and referrals from the community. So it's everybody that's not a hospital and not a residential facility. We used to get 20 applications and now we're getting 10. So it's pretty much across the board. Yes, Senator Campbell. []

SENATOR CAMPBELL: Ms. Mimick, why do you think that is happening? []

SUE MIMICK: Well, November data looks like it's coming...for applications, it's coming back up. And that is on the heels of KVC refusing to put in an LOA for a child unless

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

they have a Magellan denial. So we think that people are going directly to the lead agencies, trying to get a letter of agreement directly for a child, into a residential facility, without going through the Magellan process. So there's a possibility of that. I can't prove it but that's one hypothesis. The other hypothesis that some people have told me, and it's one I don't really buy into, is that people just don't want the psychiatrists and psychologists, the teams that have to certify the (inaudible) for the three criteria don't want to put their name on a sheet of paper that certifies that (inaudible). I don't give that a lot of credence, but it's what some people are hypothesizing. []

SENATOR CAMPBELL: So, I mean, it seems to me that the number of kids in the state hasn't drastically dropped in this. []

SUE MIMICK: No, it hasn't. []

SENATOR CAMPBELL: So where are those kids? []

SUE MIMICK: You know...well, I have some information on that. []

SENATOR CAMPBELL: Okay. []

SUE MIMICK: I don't have all of that with me but I do have some. []

SENATOR CAMPBELL: Okay, I'll wait. []

SUE MIMICK: All right. One place that we put the kids is in IOP and day treatment. We have a pretty significant increase in IOP services, but that's accompanied by a decrease in day treatment services, and I do not know (inaudible). We are showing the approval rates down here at the bottom. We run nearly 100 percent approval rates but these include both the initial and the concurrent, so it's a little bit inflated, but it's the best data that I can give to you. Okay? But it's pretty...we don't deny hardly any IOP or day

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

treatment, in essence. []

SENATOR CAMPBELL: In the...I have to say that Ms. Chaffee and I have developed this chart, a moment in time, and I want to thank Magellan for helping to fill that in. Once I learned the acronyms, I was okay. []

SUE MIMICK: Okay. (Laugh) We have a lot of acronyms. It took me about a year. []

SENATOR CAMPBELL: But on that chart...I mean it, the PRTF, was denied, and then it goes across. So you counted that as a denial. []

SUE MIMICK: Yes. []

SENATOR CAMPBELL: And then if it was subsequently appealed and denied, is that another denial? []

SUE MIMICK: No. That would only be one denial. We only count that as one denial. []

SENATOR CAMPBELL: So across the board as I'm reading, if it's appealed and appealed, and then the final disposition. That's all one... []

SUE MIMICK: Yeah. However many steps it goes through, the last step is how we count the times. []

SENATOR CAMPBELL: Right. And we are working with the department. We've gotten some data back but we need to check that. We're trying to figure out exactly then what happened to that youth. []

SUE MIMICK: Yes. []

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

SENATOR CAMPBELL: Because you tell us what was recommended, and we're not always sure that that person is still there. But in looking at that chart, it seems like there was an awfully lot of IOP recommended. []

SUE MIMICK: Yes. []

SENATOR CAMPBELL: Are we ready for that in the communities? []

SUE MIMICK: I think so. As far as I have heard, no IOP services complaining that they're not getting enough referrals. []

TOPHER HANSEN: We just shut ours because we don't have any. []

SENATOR CAMPBELL: I'm sorry. Could you repeat that? []

SUE MIMICK: Topher said he just shut his because he didn't have any...enough. []

SENATOR CAMPBELL: Okay. But I think that's an issue that at least the Health Committee has talked about, is whether we're ready for those services--do we have them available in the community. []

SUE MIMICK: And I know Mary was struggling with day treatment services. I saw her raise her... []

SENATOR CAMPBELL: Yeah. And she's going to testify today and we can ask her that. I'm sorry, and now we're getting to the question, the children under 6, is that right? []

SUE MIMICK: Yep. So I included this time a chart for services under the age of 6, because I know it's a current topic. The Magellan data on this is a little hard to follow. The number of units requested is what we measure. And, unfortunately, I can't measure

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

new requests for children's services because I know that's what you would like me to do, and I don't have those measures. So in order to do those new requests, we have to go one, two, three, four, five, and it's just too many requests to do manually. But we approved 785 requests in October and denied 42, so those are units denied. So, you know, maximum is 42 children in October were denied services under the age of 6. And we have quite a few children that are getting services. They're mostly getting family therapy, but we would generally deny individual therapy because, you know, talk therapy with a child isn't going to be very effective. You have to deal with the family dynamics. []

SENATOR CAMPBELL: Senator Krist, you had that question on that. Was there any follow-up you wanted or should...? []

SUE MIMICK: We'll follow up on his. We have much more specifics than we're prepared to address today, so. []

SENATOR CAMPBELL: Okay. And that would be good. []

SUE MIMICK: Yeah. We will follow up on Senator Krist's (inaudible) services. []

SENATOR KRIST: But to comment: I just spent a good deal of time with a psychiatrist who would give me a different opinion of whether or not talk therapy, quote, unquote, is effective. []

SUE MIMICK: I know. []

SENATOR KRIST: So I still have a concern that that child under six, and this one was four and a half years old, continues to be on a drug, yet is not followed up, so. []

SUE MIMICK: I have those concerns too. []

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

SENATOR KRIST: Okay. Thank you. []

SUE MIMICK: All right. Okay. One of the things we always watch for when we're talking about denial rates and kids moving to different levels of care is what's happening with the inpatient. So this is ages 11-15 and ages 16-17. These are admits, and it's initial admits only, but it is the number of days that they were initially admitted for is the measure. And so if the population was getting much sicker, it's my opinion that you would see a significant increase in the inpatient census for children; it would be pretty dramatic here. The other studies that we have done that show where the kids go after we deny a residential service--I've shown those graphs before; they don't change a whole lot--about I think the latest numbers are 40 percent of the children that we deny go on to the service that was requested on an LOA, a letter of agreement, funded by CFS. []

SENATOR COASH: Could you repeat that? []

SUE MIMICK: Sure. Forty percent of the children that Magellan denies residential services for go on to the requested level of care on a letter of agreement from CFS. []

SENATOR COASH: So they get it but you don't pay for it. []

SUE MIMICK: They get it, but they don't meet medical necessity criteria, so Magellan has denied it, and so they go anyway. []

SENATOR COASH: Would you say that you're denying on average, I mean, 50 percent? Is the main reason for denials, inability to meet medical criteria? Is that...is that...? []

SUE MIMICK: They're nonclinical requests. They're court-ordered or they are...the

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

family doesn't want the child in their home anymore, or there's no place for the child to go that's safe, or there is...a child is, oh, let's say having gang activity or drug activity, and those do not meet medical necessity criteria. []

SENATOR COASH: Any other reason? I mean that's probably the majority of the denials (inaudible). []

SUE MIMICK: Yeah, because I don't...probably there's other reasons. []

SENATOR COASH: Okay. []

SUE MIMICK: Oh, you mean why we deny? []

SENATOR COASH: Yeah. []

SUE MIMICK: Oh yeah. If a child needs to...we deny some and that's included in our numbers because (inaudible) we feel they need a higher level of care. So, you know, higher...we feel like they need to be inpatient; they would apply for residential treatment, and so we're arguing to put them there. Some of the requests are for, say, if a child had a brain injury or an organic brain issue like a brain tumor or something, that would be covered by their physical health plan and not by their behavioral health plan. If they are...let's see, I'm trying to think. There's nine criteria, so they could be denied for any one of the nine. []

SENATOR CAMPBELL: Ms. Mimick, I'm going to go to Senator Krist in a minute, but I want to go back to your second chart, the "Residential Bed Availability." In the very last column, you give to us the number of in-state CFS-funded. []

SUE MIMICK: Right. []

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

SENATOR CAMPBELL: And so... []

SUE MIMICK: To the...as we see them on the census reports that the providers give us.
[]

SENATOR CAMPBELL: Okay. So at this point, in June, before the changeover on July 1, we were at 95 of those census reports, and in November we went to 102. []

SUE MIMICK: That's right. []

SENATOR CAMPBELL: So while it's an increase, it's not a substantial increase... []

SUE MIMICK: That's right. []

SENATOR CAMPBELL: ...although it had gone down. Because some of the information or questions have been posed about that there's a great, far greater number of kids who are being paid for CFS. But your data wouldn't show that. []

SUE MIMICK: It does not. []

SENATOR CAMPBELL: Okay. []

SUE MIMICK: But I have to tell you, this data is not vetted against N-FOCUS data, for example, but CFS people would have access to it that I (inaudible). []

SENATOR CAMPBELL: Okay, that helps. Thank you. []

SUE MIMICK: So, you know, there could be a data issue here. I just have to warn you about that. []

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

SENATOR CAMPBELL: Okay. Senator Krist. []

SENATOR KRIST: I'm not going to qualify myself to ask this question. I'll just say that many of us have spent the last eight or nine months immersed in the whole process. []

SUE MIMICK: As have I. []

SENATOR KRIST: We are talking about your specialty, the court's specialty, CFS's speciality, the department's speciality, our play in this, the legislative process. Something that you said just struck me. Even though a child who is represented by an agency--right now, let's say it's KFC for lack of a better description. They come into the courtroom...I'm sorry, KVC. I'm sorry. They come into KFC...I'm hungry...(laughter)...KVC. They come into the courtroom and they tell the judge, as the CFOMs will concur, this young child needs X. []

SUE MIMICK: To be in a residential treatment center. Yes. []

SENATOR KRIST: The judge takes the recommendation of the Kentucky Fried Chicken guys (laughter) and our own guys, and yet we're saying, no, they don't. So what's the purpose of going to court, to begin with, if the judge is asking for the services? []

SUE MIMICK: Well, I think that NFC and KVC are working very hard on that recommendation that's going to court. They are much more likely to be present in the courtroom than they have in the past, and they tell us that we are on the right track. (Inaudible) most of the time they agree with our medical necessity determination, but they wind up having to place the child in a residential facility anyway if it's going to court. Sometimes the judge doesn't know what else to do. []

SENATOR KRIST: But backtrack. []

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

SUE MIMICK: Okay. []

SENATOR KRIST: But we've got the experts saying they've looked at the child's situation. []

SUE MIMICK: That's right. []

SENATOR KRIST: They've looked at the home. They've looked at the whole picture, and they're recommending to the judge that this is the way it goes. Yet your definition doesn't match something else in the system, so they can't get through that little hole to get the services they need and get paid for within the Medicaid area, and so now this falls back on general funds. It doesn't make sense. []

SUE MIMICK: We can...Magellan can only authorize Medicaid medically necessary services. []

SENATOR KRIST: So do we need to change the definition? []

SUE MIMICK: Well, that would be up to other powers to be. (Laugh) []

SENATOR CAMPBELL: That's a policymaker decision, probably. Okay. []

SENATOR KRIST: Thank you. []

SENATOR CAMPBELL: Senator Cook. []

SENATOR COOK: I'm going to ask it in plainer language so that I can attempt to get my head around it. []

SUE MIMICK: Okay. (Laugh) []

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

SENATOR COOK: If we were to change the definition of medical necessity, would you, Magellan, be able to serve more of those children that you currently turn away? []

SUE MIMICK: Well, the medical necessity criteria that Magellan uses is approved by the state, so it's the HHS Department's wish that we use the medical necessity criteria that we have. If we had medical necessity criteria that didn't have nine elements to it and only had a very vague definition, then, yes, I would imagine we could approve some more--some additional children. []

SENATOR COOK: Okay. Not...if it had three that were specific, is that better than having a broader, what you termed a vague definition? Or are you kicking somebody out because they don't meet one of the nine? []

SUE MIMICK: Yes. []

SENATOR COOK: Okay. []

SUE MIMICK: Like if the child has an organic brain condition and the symptoms that they're exhibiting are due to their organic brain condition, they are not eligible for behavioral health services funding by Medicaid and Magellan. They may be eligible for services through their physical health plans but they are not eligible for behavioral health services. []

SENATOR COOK: Okay. Thank you. []

SUE MIMICK: So that is one criteria that would...yes, would definitely kick them out. []

SENATOR CAMPBELL Any other questions? []

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

SENATOR HOWARD I do. []

SENATOR CAMPBELL Oh, sorry. Sorry, Senator Howard. []

SENATOR HOWARD: Thank you, Senator Campbell. I have a little problem with the statement that the judge will order a placement in a psychiatric facility if there's no other place available. The judge isn't going to just arbitrarily say to KVC: Place this child in your facility in Olathe, Kansas, because I can't think of anything else. As somebody that went into the court for a lot of years, that doesn't happen. So somewhere they're getting that information that... []

SUE MIMICK: But it's not always specific to a place, and if you interpreted what I said to mean that then I'm sorry I miscommunicated. But sometimes it's to a specific place. I would say most of the time it's for specific services. []

SENATOR HOWARD: So then the agency would go back and the agency would find the placement. []

SUE MIMICK: Um-hum. []

SENATOR HOWARD: For example, if it was KVC and they decided they would use their own facility in Olathe, Kansas, then who pays for that? []

SUE MIMICK: The judge didn't order a specific (inaudible). []

SENATOR HOWARD: Who pays for that? []

SUE MIMICK: CFS. Oh, well, KVC in that case. []

SENATOR HOWARD: So there wouldn't be any Medicaid dollars involved in that. []

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

SUE MIMICK: No. []

SENATOR HOWARD: It would strictly come from them. []

SUE MIMICK: Yes. []

SENATOR HOWARD: Does Magellan make placements out of state? []

SUE MIMICK: We do when we cannot find an in-state placement for a child that we're approving. We currently have six children out of state. Three of them are sex-offending females that there is no treatment facility for in the state of Nebraska; the other three are very aggressive males that no in-state facility would accept. []

SENATOR HOWARD: And those are through the Medicaid dollars. []

SUE MIMICK: Yes, six. Six children. []

SENATOR HOWARD: How long have they been out of state? []

SUE MIMICK: One has been out of state over two years, but that's really extreme. Most of them have been...I think the average is 82 days or something like that. []

SENATOR HOWARD: I would be real curious to see what the permanency goal is for that child that had been away from its family, hers or his family, for two years. []

SENATOR CAMPBELL: Any other questions? Oh, Senator Nordquist. []

SENATOR NORDQUIST: I have one. []

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

SENATOR CAMPBELL: Senator Nordquist. []

SENATOR NORDQUIST: Thank you, Madam Chair. Just a quick follow-up to the department on the Medicaid reform act recommendations from December 1 capping the behavioral health therapy visits at 60 per year. It said 226 clients would be affected. Is that...that would be children's services as well? Behavioral health therapy visits? []

SUSAN BUETTNER: That's correct. []

SENATOR NORDQUIST: Any idea of how many of those...or could you get that to us? []

SUSAN BUETTNER: You know, I knew. I saw it this morning and I didn't bring the data with me. We do know and we can provide that to you. []

SENATOR NORDQUIST: Okay. Could you get that to us? Thank you. []

SENATOR CAMPBELL: That would be very helpful if we could all get that, Susan. []

SUSAN BUETTNER: Yeah. We're working on that. I know there was a request and that was the first thing that we had asked for, for today, and then I didn't bring it. So I apologize. []

SENATOR CAMPBELL: As long as we get it. All right, seeing no other questions, I want to thank both of you for coming, and I'm assuming...I know that Sue will probably stay around, and Ms. Buettner, thank you. Good job pinch-hitting. []

SUSAN BUETTNER: Thank you. []

SENATOR CAMPBELL: And I hope you feel better too. []

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

SUSAN BUETTNER: Thank you. I appreciate it. []

SENATOR CAMPBELL: Seems like the department has only got people who are ill today, according to Mr. Winterer, so we appreciate you coming in specially to pinch-hit. Thank you. []

SUSAN BUETTNER: Thank you. []

SENATOR CAMPBELL: All right. To open the public testimony this afternoon, there are several people that have notified me that they wanted to testify, so I am going to start with them and then we'll go to anyone else. Could I have a show of hands of how many people wish to testify today? Claudia, can you count? []

CLAUDIA LINDLEY: Twelve. []

SENATOR CAMPBELL: Okay. Voices for Children is a maybe. []

CAROLYN ROOKER: No, it's a for real. []

SENATOR CAMPBELL: Okay. All right, we will start with the first testifier: Mr. Connell. []

PAT CONNELL: (Exhibit 3) I have provided a handout plus supporting documentation that would be helpful for the committee to have before I can start. Good. Let me start with the formalities while handouts are being passed out. My name is Pat Connell, C-o-n-n-e-l-l, and I'm here today on behalf of the...serving as the chair of the Nebraska Behavioral Health Coalition, which is a group of associations and advocacy organizations in this state working to assure access for children's mental health services. I also serve as the vice president of behavioral health services and government relations at Boys Town. And in talking to Senator Campbell before the

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

hearing, she asked me if I would sort of frame the discussion today from more of a 10,000-foot view as to what is going on and happening in other states for children (inaudible) services, because Nebraska is not the only state that's going through these types of problems. If you go to the second slide, I think I'm kind of uniquely qualified in this area. I have been spending the last 20 years both at the state level working for various associations and serving in a leadership capacity as well as the national level. At the national level, I serve as the board member representing the Midwest states for the National Council of Community Behavioral Health Care Organizations, which is about 1,900 organizations in all 50 states. I also serve on the board of the National Association of Private Psychiatric Health Systems and I serve as the children's services committee. My presentation today is really kind of focusing on sort of giving you a different overview as to what are the current issues facing Nebraska services and providers; what is going on in other states in this area; the public policy implications; and then proposed solutions. And I will be rather quick. If we could go to the next slide, I'm going to skip through the history of what an IMD is, what a PRTF is, and when, where, why, and how, but actually get back into a little bit of the history. You know, when Medicaid was started back in the '60s, I was a little kid at the time, and it was started after the Medicare program. And it was designed to, as a partnership between the states and the federal government. And the feds pledged that they were going to provide federal matching funds if the state would provide this service for a population between 21 and the age of 64. It had a couple of exclusions, and the exclusions were behind, if you remember back in the '60s, the state hospitals were huge facilities. I mean they had thousands of mental health patients in those facilities, just like...and Nebraska was not unique. Every state had this. So what the federal government had was an exclusion and that's the reason the IMD came to pass, because the federal government...Congress did not want states to use the Medicaid dollars to pay for its residents in the state hospitals. So it wrote this law, and it's been on the books since the '60s. Then in 1972...if you go to the next slide. In 1972, Congress recognized that there was a need for an exclusion in what they called the under-21 benefit, and it was for kids that were under the age of 21. And there's a dispute as far as what was the intent of

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

Congress back then. Well, what it did was it said we will pay for psychiatric benefits in certain types of facilities under certain types of conditions, which we've already belabored more times than you probably want to remember. A new part of this was the establishment of this PRTF. So if you go to the next slide, you know this goes through your standard definition; we've already heard this. We'll go to the next one after this. Okay. So what happened is, back in 2003, the OIG went ahead and did an audit and came up and said: Hey, states were not complying with this 1960 law and the 1970 law. And they came back and they said: We're not going to pay for these services. It started off in a small number of states. To date, there's over 29 states that have had the letter from CMS saying: Get in line with the IMD/PRTF rules. And one of the interesting things is there's a letter that I put in as an attachment to your package about a bipartisan letter that came out from Congress back in 2003, to the OIG and to HHS, disagreeing and saying that the intent of Congress back in the 1960s and the early '70s was not how the OIG was interpreting it. OIG and HHS disagreed. And so I think there's a very growing movement as this happens to occur in more and more states that this will be recognized at a national level, at least for children and adolescents, within the next couple of years, of correcting and modifying the law. Because as you've heard before, you know, you can pay for psychiatric care, but if there's medical care for those children in that PRTF, it won't be covered. So if a child breaks his leg playing basketball under a PRTF, it isn't going to pay the Alegent provider who is fixing the leg. That was never the intent of what Congress and that's what I am working with, both of those national associations, as well as other advocacy groups and even with members of Congress, to fix. Okay, so if we go on to the next slide--and I think this is really an important point here. This is...so if CMS says: States, you can't use federal matching funds to pay for non-PRTF services or that pay for our patient medical services while in an IMD or PRTF. But CMS does not restrict or ban states from using its own funds to pay for non-PRTF services or pay for medical services while in a PRTF. States have a number of ways that they could continue to pay for these needed children and adolescent mental health services. It's just that you can't use the federal matching funds of Medicaid to do that. Now here is kind of the big elephant that's going to be in the room, and this is the Affordable Care Act. So the

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

Affordable Care Act is supposed to come about in another couple of years. It's going to introduce millions of new people onto the Medicaid rolls, and it's got HHS administrators, state governments, probably yourselves, worried about how are we going to fund these new bills. And so what do state administrators do, public administrators do? They try to figure out a way in which they can start minimizing their expenses now to get ready for this big elephant that's going to appear on the horizon in a year or two. If you go to the next slide. So here are the three trends that they're using, and specifically in behavioral health. They're limiting the access to behavioral health services; they're limiting the capacity of behavioral health services; and thereby, limiting states governments and expenditures. And we'll briefly go through how this is occurring. Okay, so the first thing you do...and this is going on around the country, is...and you've seen reports and heard testimony before about the Medicaid enrollment process. It's a 20-some page report...I mean, a 20-some page application. I put you a copy of the application for Nebraska in your file so you could see it. I think it's a little more difficult than doing the Nebraska tax return, and it is a challenge probably for any of us in the room to do this, let alone somebody who is poor or poorly educated or lacking familiarity with this program, to be able to successfully navigate through the application process. The second thing is the barrier to preauthorization for services. And how this is being done around the country is you create onerous and time-consuming pretreatment documentation process by which you wear down providers. The providers get to the point where, you know, it becomes very discouraging to them, because what happens is you put an application in and then you have to go into an appeals process. And if you're talking to child psychiatrists, what they'll say is that appeals process takes them out of their office so they can't see another patient, and they have to get on the phone and they have to go through that process, and then they sometimes get approved. If they don't get approved, then there's a whole other problem and we'll talk about that in a second. So the appeals of denials are time-consuming and costly. And just to give you one example of what those processes are, I put a current Magellan seven-page application process in for a PRTF. Recently, a family stopped in to see me, and they said, you know, if my child had to get open-heart surgery, I could probably get it a lot

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

easier than I can by filling out the PRTF application. That just seems kind of wrong to me. I mean, it shouldn't be that difficult for kids to get mental health services. Go to the next slide. So another way to limit access to behavioral health services is going to a capitated full risk management care...a full risk managed-care contract. There's a typo there. So you rely on an external contractor. And the biggest problem is, is how do you monitor a contractor who's running a public program and whether or not they're representing the best interests from a public policy perspective versus a shareholder's perspective. And that's been a problem all along. Those of you who were around in the 1990s remember when we had a Medicaid managed-care contract with another non-Magellan company. And if you remember, the discussion was the definition of medical necessity changed per month, and we had, at times, difficulty getting hold of what that definition was because it was labeled as proprietary--belonging to the company--and it was a great mystery. And that's why Nebraska went from a fully capitated managed-care contract to the ASO agreement which we're operating under today. We've also put in your packet is a 15-state comparisons of what Nebraska's definition of medical necessity is versus what other states are. And that's for your information and it's for your education. We don't have to be this restrictive. Other states have chosen not to be this restrictive. If you look at the national medical necessity definition for both Magellan and ValueOptions, the two largest managed-care companies in the country, they're not as restrictive as what Nebraska is using today. So the big issue here is going to be balancing public goods against meeting managed-care companies' shareholders' expectations. Go to the next slide. So now you've started...you're going to limit provider service capacity because you're limiting access. That should be pretty...you're reducing the volume of referrals. You're reducing the number of admissions. People are going to reduce the size of their programs. So then you go ahead about and you restrict what services will be covered and paid, and then you add some overly prescriptive regulations. When these regulations first came out for Chapter 32, back in the early 1990s, I was not a young kid at the time. I was a very active member of this process. We saw at that time that our regulations were way beyond what was seen in other states; I would almost say, other countries. But we saw

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

it being more restrictive than in other states. And the thing is, is that whenever you have a regulation, you generate a cost. It's a real cost. So if you say to a provider that you're going to have to X ratio of staff to this number of patients, that generates a cost. If you're going to have twice-a-week requirements for this particular type of session, that generates a cost. We have argued as providers, every year, that we need to reduce the size of these rules and regulations. We are required to have an accreditation body come in and accredit our program. That's how you get your quality assurance. You don't need the size and scope of the regulations, which then also generates who can provide these services--if that's making sense. So you pay provider rates that do not allow providers to recover the full cost of providing their services, and the results are providers close programs and/or facilities or opt out of providing services to a specific payer like Medicaid. Okay. In your packet there is a list and it gives you all the provider programs that have been closed within the last 2-3 years, and what programs that they've closed, and etcetera. One of the common problems, though, with...say, you have enough capacity in the state. Let's use a real-life example. Let's use child psychiatrists in this state. There's less than 30 child psychiatrists in the state. You say, for a state of population of 1.8 million, hey--or is it 2 million now is Nebraska? I don't recall. You would say that's a reasonable amount of doctors. Well, here's what you're not getting in that statistic. What you're getting is what is licensed, who is licensed to practice. What you're not getting is people who have retired, who are working part time, who are doing research, who are just teaching, who may be working in other occupations, working for a managed-care company and not seeing patients. And all of sudden, that pool of available psychiatrists shrinks enormously, and then on top of that, you have patients...I mean, you have docs who don't want to accept the Medicaid patients because of the onerous paperwork and etcetera. So the available psychiatrists is a very small number, and that's the problem when you start looking at these statistics from, you know, whether you've got licensed or operated, etcetera. Because like, for instance, Boys Town: We do have kids coming from other states that takes those beds out of service. Okay. So the net goal: You limit state government expenditures by limiting Medicaid expenditures; limit other general fund expenditures for mental health programs; and

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

then you start having an experience that every state has had that has gone through this: you start cost shifting. And you start cost shifting to child welfare programs, juvenile justice programs, county and our state-funded programs, or if the youth is not meeting the needs for treatment, what happens is that child doesn't get any better; it doesn't go away. The problem almost in all cases gets worse, and when it gets worse then the kid is way behind in his education; he has disrupted the school; he's hurt the family's relationship with each other. It becomes a much bigger problem at that point in time to treat. So...and if you go to the next slide. []

SENATOR CAMPBELL: Pat, if we could kind of go through these and get to your last one so that... []

PAT CONNELL: Okay, and this will be really fast. So the three programs that we have in this state that are interrelated are Medicaid, child welfare, and juvenile justice. They don't sit and exist by themselves. They are...if you make a change in one program, it's bound to affect the other program. Go to the next slide. So what we're experiencing in this state, and some other speakers will talk about this, is we're shifting costs from Medicaid to child welfare and to juvenile justice. And the next slide. And in what you're talking about with KVC and NFC is that you're shifting costs from Medicaid into child welfare. The next slide. Okay, this didn't come out right. The most vulnerable population is the population that's up there in this corner here that's outside of this. This is the population that doesn't have people out there advocating for it, helping them walk through and navigate through the mental health system. These are the ones that if you don't get them access, that some of them will eventually make their kids state wards in order to gain services. So "Public Policy--Next Steps." We would suggest three things...four things actually, but three things are up there. First, is we need to develop a review process before public policies are changed that analyze what are the effects on each of the three systems: Medicaid, child welfare, and juvenile justice. The process needs to be timely, transparent, include consumer advocates, providers, etcetera, from the very beginning of the process through implementation. Second, we need to revamp

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

our rules and regulation process. We need to simplify our regulations and rely more on approved accrediting bodies for quality assurance. We as a state need to understand the cost to providers and the state. We need to require a cost-benefit analysis be completed as part of any new or reviewed regulation. We need to review the last two years of changes and use the above two points to guide any changes in any future legislation. And I think the last thing is, is that we ought to think about making the medical necessity definition part of the rules and regulation process. Right now, it's made by Medicaid and it's interpreted by a third party. We need to...and it needs to be very transparent. We all need to understand when services are covered and when they're not. []

SENATOR CAMPBELL: Questions? Senator Krist. []

SENATOR KRIST: I apologize to my Health and Human Services Committee members, but I'd like to say this again: I don't think it's any accident that we spent the entire day on the anniversary of the Van Maur massacre. It was a terrible travesty to allow a child to age out of the foster care system, take away his psychiatric treatment and his medication, and give him the weapon to do the damage that he did. This...you speak to it. It is...you're talking about shifting costs. I'm talking about shifting human capital. []

PAT CONNELL: Absolutely. []

SENATOR KRIST: And at some point we're going to have another Van Maur and we're going to have another young man who, if he would have been treated properly, who knows if he would have been in the same situation--but I doubt it. So thank you for your testimony and thank you for your clarity. []

PAT CONNELL: Thank you. []

SENATOR CAMPBELL: Any other questions? Thank you, Mr. Connell. Next is Andy

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

Keller. []

ANDREW KELLER: (Exhibit 4) Topher said you would be able to go through the slides but I have to pull it up first, so I apologize. Good afternoon. Thanks for letting me be here. My name is Andrew Keller, and do you want me to spell that? K-e-l-l-e-r. That was what I was supposed to do, right? Okay. All right, great. []

SENATOR CAMPBELL: Thank you. []

ANDREW KELLER: Well, Senator Krist, actually I want to start with your comments about the anniversary today. My background, I work with TriWest Group. We are a human services consulting firm. We work with states, we work with counties, we work with providers. And we're working under contract right now with the Nebraska Association of Behavioral Health Organizations, so I am representing them today. And my first...one of my first projects I had working on issues of children involved in PRTFs was actually in mid-April in 1998. I was helping the state of Colorado write an application to try to put a collaborative planning process in place between child welfare, juvenile justice, and mental health for Jefferson County and Denver. We were in Jefferson County, which is where the division of behavioral health was headquartered, and that day was actually the day that Columbine happened. And, you know, it was a very vivid and it really kind of stands out in my mind of just, you know, what the implications are. And I think that's exactly the children we're talking about today and I'm really glad you called our attention to that. I'm going to actually begin my comments. Topher, if you want to go forward to "Options in Full Risk Capitated Managed Care," because I think the initial points on IMD have been adequately made and we can certainly come back and talk about those. There has been some discussion about whether NABHO and the providers that provide behavioral health services in Nebraska support moving in a way to kind of work together and have managed care, in the good sense of that term, happen more. And I think the fact that I'm here today is a definitive "yes" answer to that. NABHO has made a very large investment over the last...since

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

July of this year to prepare for this, to help provide guidance to folks in the community, to themselves as providers, and to the state, so that if managed care is done--the next phase of it, rather--is done here in Nebraska, it's done right. And I would say you're looking at moving from your first...from actually your second phase. Your first phase was with ValueOptions and the full risk contract you had back in the late '90s. Your second phase is this ASO arrangement. And now you're looking at whether or not to go into a third phase, which has been precipitated and catalyzed by this IMD issue. The IMD issue, when it applied to adults--even though there was a solution for children, there really wasn't one for adults--and so that was kind of a point of decision where NABHO decided to support the state and going forward in this managed care, this next version of managed care, and to design that. And I really think that if you go...this slide right here. These are, I think really does offer you a path forward if it's done right. I mean, I think Pat did an excellent job showing the risks of managed care. If you basically hand it over to a company and say, "Please figure this out for us," it's important that people figure it out before the contract goes in place. And you're going to hear me talk about that time after time. The contract terms between the state and a managed-care organization really are critical. They define how the money is spent, what the performance indicators are, and who are the providers and how do they participate. Are the providers partners or are the providers folks that have to get through a, you know, 27-page document in order to even have a conversation? And, you know, it's not always...you know, it's not the fault of Magellan. It's not the fault of the managed-care organization. The best managed-care plan I've worked with and the worst one we've worked with in the country are run by the same vendor: ValueOptions. And Massachusetts is the best; North Texas is the worst. And that's because of the lack or presence of policy considerations that were done ahead of time. So that's why this next point about the performance improvement partnership that can be put in place through a well-constructed contract between payers, providers, other agencies, like DBH and DCFS, and the stakeholders, is the key to this, and that takes time and thought, because these are not easy things to do. You can't just go write this contract in a month, and even if CMS is requiring you to do under a tight time frame, you have to figure out

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

how to have a consensus-building process in place. The second thing is that you also have to have some way to reinvest savings. You're not going to build the community-based alternatives that I think everybody in this room would prefer to have children served in, if they can, by just stopping doing PRTF or stopping doing residential care. There has to be a process where that capacity is built up and where you have a systematic transfer over time, and that needs to be thoughtful--and that's a lot of, I think, of what Pat was talking about. So, you know, and this also I need to say before we leave this slide: This is the key to health reform. And I don't know what's going to happen with federal health reform. No one does. No one knows. But we do know that if we're going to get costs under control, we have to quit doing this where we pass costs back and forth between agencies and say, "You take care of them this week; you take care of them this week," and we need to have more of what is...that's the notion of accountable care, health FOMs, healthcare reform. It's all about integration and working more together. So when we go...can you go to the next slide, Topher? Thanks. So full risk, one of NABHO's big points on this, and full risk needs not to mean unbridled risk. We think that there are plenty of opportunities in the federal law, and we cite them up there and I won't bore you by reading them, but there is perfect allowance under the Medicaid rules for a state to design performance incentives, risk sharing, to have more of a partnership rather just say: Here's 80 percent; please spend 80 percent of the funds on care and do what you want with the other 20 percent. That's a bad idea. You can...but it takes a lot of thought to put the parameters in place in order to do more than that. So we go to the next slide, Topher. NABHO agreed; in late August, they had a meeting that was passed by an overwhelming majority of the providers in the organization to work with the state on this. You know, there's been in the past, I mean I think we've not spoken with one voice on that. I think that there's been reason to interpret providers as being opposed to this. But now NABHO is prepared and they've made a major investment in moving forward and they wanted several things done, which I think pretty much anyone would agree in, that they want the state to figure out how to have the risk-sharing structure. They want to maximize the savings to reinvest it in behavioral health systems so we can address some of these issues. They want to

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

make sure that all populations are involved, the regional variations--I mean, sort of motherhood and apple pie-type things. So what NABHO has done--and go to the next slide please, Topher, slide 10--has made a major commitment. They've engaged us which is a significant investment. Usually we work with states and that's why we have the high rates we do is because we charge states around a lot of these risk management things. Because of some of the limitations about what Medicaid is able to do in this state, given your funding environment, they weren't able to get...you know, have a huge investment in consulting. And NABHO saw that and they said, look, we'd like to bring in some expertise, so they brought us in--which is somewhat unusual. I'm not aware of another provider or association that's taken this step to try to make this investment to help guide a contract. They've also engaged us to review and summarize best practices from other states. We've looked at eight other states. NABHO has that document in their position and can share it under the right circumstances with folks about background. And what they're using that to do is to inform their input to the state. And they're poised to do. They've organized themselves. They've offered to...in the process of involving other folks who might be interested, DBH, CFS--so this could be really a community consensus statement--and to contribute that to the contract development process. This state has expressed an interest in that, but right now it's on hold because, understandably, they have to work it out with DAS how you can do that, because the procurement rules are not set up to promote collaboration. They're set up to make sure, you know, we don't steal money or we don't, you know, engage in bad things. And I don't mean to make light about it. I think there's also a very important things around antitrust and other considerations. So right now that's being sorted out to try to determine what the best way is to go forward. And we...I think my job here is to really talk about how it's very important that we do move forward and not just to have Medicaid write this off in isolation but to have a process where we do what Pat talked about, where NABHO and the others who are able to give input really help design this so we take advantage of some of these opportunities. And I'll just note a couple of those opportunities real quick on the next two slides. This is slide 12. Most important, we think there needs to be a commitment to use these savings to reinvest and to fill these gaps

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

in the children's system. You know, IOP and day treatment are nice but they're not enough. You need to really put in more intensive community-based services if you're going to get kids out of residential settings appropriately and not just set them out on their own or cost-shift them to CFS. The performance partnership I talked about is really probably going to take some change in rules and doing things differently so we're not just shifting between agencies; we're actually allowing agencies and the community to work together on this and actually let providers (inaudible) accountable care means allowing providers to be part of that solution alongside everyone else. And tying performance incentives to priority improvements. When you put that managed-care contract in place, put some of the dollars behind actually addressing these issues. A managed-care organization is going to do what you pay them to do. If you pay them to count the things that Sue presented, they're going to do that. If you pay them to make linkages and to get kids into appropriate settings and you give them the resources to do that, they will do that as well. The last slide I would note are some other things. I mean, I don't want to...we could go on and on about this. We have literally hundreds of pages of documents that we've developed for NABHO that they're prepared to share with the state through the appropriate channels. But administrative requirements: When you purchase a medical director from a managed-care organization for children, is that medical director actually serving children in their state, or are they running around developing business in other states in the country? Utilization management should not be focused. If 99 percent of cases are approved, why are we reviewing every case? I mean, maybe we could extrapolate that the vast majority are going to get approved and just look at the outliers. That's contemporary managed-care. Care coordination standards need to move beyond just, you know, did it comply with the Medicaid rules to actually put in place resources so Magellan or whoever the vendor is has the ability to have a transfer and work with CFS, work with judges, work with these other folks so they can put a comprehensive solution in place. And provider networks need to involve key child and family-serving providers. Those are the kinds of things we need to have. Hopefully, we could even get in place some of the intensive coordination like wraparound that really has tremendously positive outcomes, allows kids to be served

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

outside residential placements. But you're only going to do that if a thoughtful design happens. It's not going to happen just by, you know, complying with the CMS rules and shifting to managed care so you can continue to do IMDs for adults. So that's my prepared statement. []

SENATOR CAMPBELL: Questions? Senator Dubas. []

SENATOR DUBAS: Thank you, Senator Campbell. Thank you so much. This was one of the more encouraging presentations I've been able to sit through, and I certainly have not sat through as many as the Health Committee has. But I'm very intrigued by some of the things that you've said. And, historically, it always seems like we have the administration and we have the providers, and we're just always at loggerheads. But yet, basically they're wanting the same things. And so your talk about actually putting specifics into the contract, I mean that doesn't...that seemed like a no-brainer, but apparently we've had troubles doing that. And so you referenced two separate states, one where it apparently is working and one where it's not. Is it basically because of how the contracts are worded that makes it either work or not work, or is it not quite as simple as that? []

ANDREW KELLER: I think it's the biggest thing. I mean, one is Massachusetts and one is Texas. There are some differences in how they approach human services that we could talk about, but...and it's a fact they probably hold down each end of the continuum. But Massachusetts, I think the biggest difference and I think it comes down to staff a lot of times. I mean these are difficult things to sort through to go...I mean, it took my staff hundreds of hours to go and pull this information together. I mean, your departments, given the size state you are, are actually quite small, so the number of folks you have to work on this is not huge. In Texas, which is huge, they have two mid-level people; this is their baby and they are the only people to work it. In Massachusetts, it has the secretary works on it, the folks underneath him or her over the years have worked on it, and they have, you know, many folks who have been able

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

to...and they've also been doing this for 15 years. I mean, you know, the things they put in place in the mid-90s were not that different from what you all put in place in them mid-90s, but they kind of kept working on it and chipping away. And so what they have today has evolved, and I think you have the opportunity as you go back into this to...I mean, that's why we looked at those other states. You know, let's not reinvent the wheel; let's use some of those terms. But let's have folks in Nebraska figure out what's going to work here. That's why this collaborative piece is so important, because, you know, I can come in and say, here, do this, this, and this, but, you know, ultimately I don't live here and I'm not aware and as sensitive to the issues that NABHO and the consumers, family members--NABHO also includes NAMI--I mean, other folks as well, so. []

SENATOR DUBAS: So you're able to, even as administrations change, this is the type of a program in process that could be in place that would provide a sense of continuity. To me, it seems to me that's one of the components that's missing. We're always changing the rules midstream, it seems like, and so this appears to put some of that continuity in place. Would that be a correct assumption? []

ANDREW KELLER: Yeah, I think it's a correct assumption if you have the time to build a consensus. Because, you know, you need to do both Republican-ish and Democratic-ish things. I mean you need to have both, you know, financial accountability and trying to empower families to become independent as well as providing services they absolutely have to have at times. And that takes...that's hard. I mean, that takes some public work to develop that sort of consensus. It's not something that happens in two weeks. You need a couple months. You don't need two years, though. I mean, I think a couple months--two, three months--you can do a lot. []

SENATOR DUBAS: And then the second component that I am very interested in, we're always talking about if we do this we're going to save this much money, but somehow we never see the savings. We just talk about it but it's always just on paper. And so is

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

there a way to actually quantify, okay, we know that if we spend X amount of dollars, like on immunization, we're going to save money, you know, down the road with childhood diseases. But how can we quantify the types of savings we're talking about here where we can actually put them back into more community-based care? I see that as one of our hugest stumbling blocks is we know we need community-based care but how do we build that financial support for it so we can grow that care? []

ANDREW KELLER: Well, every managed-care arrangement I'm aware of where you've done a carve-out and you've given the money to a managed-care vendor has achieved savings, and they achieve savings in the first year usually by reducing the amount of time that people spend in hospitals and PRTFs. And, you know, you've already done a lot to reduce that so I don't want to say that, you know, there's going to be some limitations to what you all can do. But I guess I would be optimistic that if that organization was put in place, especially with where they weren't, like, reviewing every case. I mean, it costs money to review every case. And if you're going to say "yes," 99 percent of the time, let's not do that, you know. And so that type of more sort of data-driven contemporary managed-care approach. And I think, you know, Magellan does this in other states. Would allow you to have incremental savings that then could be reinvested in these types of community alternatives, and then you build it over time. It's not a silver bullet. It's something that requires a multiyear investment to do. But, I mean, other states have done it. And so in terms of quantifying it, it's not so much an algorithm that you do X, you get so much dollars. It's put a performance improvement process in place; incentivize the kinds of things you want to get built and it will get built, as opposed to those going to shareholders, who--I like shareholders; I mean, I'm a shareholder. But you don't want it all to go to shareholders. One or 2 percent of \$100 million-plus contract is fine. They'll do that, especially now, because they're trying to position for healthcare reform. You'll get a great deal right now. []

SENATOR DUBAS: Thank you very much. []

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

SENATOR CAMPBELL: Thank you, Mr. Keller, very much. []

ANDREW KELLER: Thank you. []

SENATOR CAMPBELL: The next person is Jonah Deppe. And I really appreciate Mr. Keller. He was speaking as quickly as he could, I know, because he was trying to stay within a time frame. So I encourage all of you to be as tight as you can in your testimony because we have 12 people who want to speak to us today, so. Mr. Connell was speaking for a lot and I had asked him for some of that information, so. []

JONAH DEPPE: Good afternoon. []

SENATOR CAMPBELL: Good afternoon. []

JONAH DEPPE: (Exhibit 5) My name is Jonah Deppe, J-o-n-a-h D-e-p-p-e, and I'm representing NAMI Nebraska, the National Alliance on Mental Illness. I am also vice president for consumers with NABHO. And you will be receiving the written statement, so if I miss something you'll have it in writing, right? NAMI Nebraska is recommending that the LB603 Committee request the Department of Health and Human Services develop and implement a systems of care services for children and youth. And I know that sounds like a pretty big thing, but, you know, in the '80s I was working for another state. My job was under the direction of the governor to work with seven human services agencies in that state and develop and implement a systems of care for children age 5 and under, and their families. So I know that it's something that can be possibly done. Over the past 30 years, actually plus, since 1970--and I've attached to you the piece that came out of one of the documents. It came out of the behavioral health LB542 document, the whole listing of different activities that this state has done looking at children's behavioral health. And it's really interesting that since 1970 until today, and we still don't have a system of care in place for children. None of these activities have done anything but make recommendations, and nothing is done to

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

coordinate behavioral health services for children and youth. And this includes a federal State Infrastructure Grant that the state received in 2004, and for five years, where the state Division of Medicaid received \$750,000 a year for each of five years to develop an infrastructure grant for children's services. And I remember sitting at one meeting and having one of their consultants say to them: Look, you got a grant from the federal government to develop an infrastructure, and there was not directions to this; and what's happening here, folks, is you're going off on little side trips and you're losing the sight of where you're supposed to be in the end. And that's exactly what we saw. We saw \$750,000 for each of five years just really misused, in my estimation, because we did not end up with an infrastructure for children's services. And then in 2004, the state passed the behavioral health reform LB1083. That language included services for children, but somehow children were lost along the way. And they decided or they all be...the LB1083 Committee decided to put all their efforts towards closing state hospitals and developing community-based services for adults, and left the children and their families to fend for themselves. Thus, we then had the safe haven issue, which I'm sure you all remember, putting Nebraska in the national news, and bringing us up to LB603 and today. There was the Nebraska Family Helpline was developed out of that, and the only way families are able to access the Family Navigator to have assistance in receiving services or accessing services is they have to call the Helpline for most of that. There has been a slight difference put in that, and more recently, but still it is very difficult for families to discover how to access services and when they discover how to actually do that. It's time that the Department of Health and Human Services require the divisions to collaborate and develop a plan which can be implemented and provide needed services to children and their families. One of the summaries for the LB542 report states the following deficiencies in the current system, although it did remark that we have excellent services for children--which I'm not sure how that fits. But we have a lack of coordination and integration across agencies and systems. There's no single point of accountability for the system. There's no uniform and portable needs assessment tool. Funding is inconsistent, fragmented, and inefficiently allocated. A lack of adequate community-based services capacity--and I think we've heard that before

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

too. A shortage of behavioral health providers, and they are getting less and less of them now. A lack of transformational vision, planning, and implementation. It's really time to address these deficiencies and develop a system of care for our most vulnerable children's population. And I also attached for your review a couple other pieces that I'm not sure you know about. In 1982, a federal act called the TEFRA Act or the Katie Beckett Act was passed, which provided a state option for serving children with developmental disabilities and mental illness. And Nebraska, along with nine other states, opted out of putting behavioral health services in that. The rest of the states have included that piece, the children with behavioral health need for services. I am really not...I wasn't in Nebraska at that time so I'm not really quite sure why that happened that way. And also I included some data that's recently come out indicating that children in foster care have behavioral health issues which are not being identified and services provided as required by EPSDT. An EPSDT is early periodic screening, diagnostic, and treatment, which every child in Medicaid should be receiving. So recognizing that Nebraska, like many other states, are addressing the issues of funding, we would request that Nebraska put the health of its children as a priority, and providing behavioral health services to children can reduce the need for more intensive services as adults, if we just put our minds to it. Thank you very much. []

SENATOR CAMPBELL: Any questions from the senators? Ms. Deppe, you might want to take a look at the state of Louisiana. Some members of the Health and Human Services Committee have been paying quite a bit of attention to it, because they have put into play a systems of care services in the mental health for children and youth, and they've worked on it for, like, five years. But we've been reading, and a lot of research was done by Ms. Chaffee. So we'd be glad to share some of that with you. []

JONAH DEPPE: Thank you. []

SENATOR CAMPBELL: Um-hum. []

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

JONAH DEPPE: Thank you for your letting me talk to you about this. []

SENATOR CAMPBELL: Mary Fraser Meints. While Ms. Fraser Meints is making her way to the front, this will be the last person who identified that they wanted to talk, and so from there we'll go to testifiers. And you can just kind of make your way to the front and take a chair. []

MARY FRASER MEINTS: Hello. []

SENATOR CAMPBELL: Good afternoon. []

MARY FRASER MEINTS: (Exhibit 6) I travel with paper. Hello. I'm Mary Fraser Meints, M-a-r-y F-r-a-s-e-r, no hyphen, Meints, M-e-i-n-t-s. I'm the president of Uta Halee Girls Village. I'm here today with a heavy heart because Uta Halee has provided services to young people and families in Omaha for our kids in our state for 60 years. We are closing our doors for our public service population, December 16 of this year. We have become one more program designed to help kids that cannot live its mission because of state-imposed roadblocks that restrict access to appropriate care and services. Our hope is now that the system will pay attention and take action to ensure the kids and families of Nebraska receive the services they need to be strong and healthy. We will continue to provide services to young women whose families are able to pay for the services. I'm going to talk a little bit about our journey and I have some solutions. In September 2010, Medicaid met with providers across the state and said there were upcoming changes because of the CMS--Centers for Medicare and Medicaid Services--and that Nebraska would need to do our services differently. So we listened carefully and we provided the information request for cost of reports, and we looked at what other states have done and we looked at what the proposal was for Nebraska. Keep in mind, the regulations just went to public hearing November 3; we received draft regulations in May. But Uta Halee looked at our position, and we had provided this residential treatment center for 16 years, ever since it came into existence. And so we

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

said it looks like we could provide this level of care. We have a psychiatrist, full-time employed. We had an advanced practice nurse to meet the medical needs of our kids; nurses, 24-hour coverage; and dually-licensed therapists, as well as highly trained staff. The first draft of Chapter 32 of the Medicaid regulations asked for trauma-informed services. Uta Halee is the only certified trauma-informed program in the state of Nebraska, and I think we're 1 of 12 in the world. That is a pretty significant designation. Trauma-informed care looks at what's happened to the child, not what's wrong with the child. So we look at the traumas that have impacted the child and figure out ways to get those traumas under control and help the child be in control of their own behaviors and their own issues. We have a very strong family (inaudible), family-centered program. We employed a family partner and had a family/professional partner committee with staff and family members of kids that we served. And we learned a lot from the families about how to work differently, how to involve families, how to include their voices in our decision making, and how to go along with the family in terms of what they need for their child. We also provided training to families so that they have the same language and skill set that our staff did, so that when the child goes home, they would know how to deal with their child and how to help the child before they escalate and also have the same language and some of the same tools. And that worked very well; we had 100 percent satisfaction of our family training. We also have reduced and eliminated restraints. We had less than three restraints since July of this year, and we have not had a seclusion--I always have to knock on wood, because, you know, when you say stuff out loud--we haven't had a seclusion for over two years. So it's significant work that we did to reduce that and have a safe environment for our kids. So we said we'll provide PRTF for 36 kids, and we decided to close our child welfare group home, which was a wraparound group home--we heard someone talk about wraparound. We put the child welfare program plus the treatment plus the school all in one service. We closed that in mid-August. We thought we would get referrals for PRTF, and we did not, so we closed a cottage and came down to 24. We received our first referral from Magellan in August of--August 24, 2011. From July 1 till October 13, we received a total of six referrals for PRTF from Magellan. We heard--you heard testimony about providers not getting

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

Magellan approval. Our staff actually is very good about getting approval, and we only had a few kids paid for by letters of agreement from the lead agencies. And most of our kids were paid for by Magellan. We just didn't have very many of them. But our--some of the children were court-ordered to our program, and then after the month, our staff got them authorized for Magellan, which was very helpful to lead agencies, because then they didn't have to have that cost. So providers have been trying to have a collaborative discussion; you heard from Andy about the need to collaborate and work together. And I have a time line in this documentation. This is my...I made this based on what we've done, to try to be proactive about what's happening. We said there needs to be a transition plan. And on June 1 we had an emergency meeting with Voices for Children and several other providers to talk about our concerns, because if Medicaid is changing, it affects children and family services. So we asked that there be a plan, a transition, a discussion, about how do you move from PRTF to other services. And we asked for an immediate work group to be established. That was not done. So you've got the time line; I'm not going to go through that. In...so we closed our 36 beds, went down to 24. The most we had was 22 kids. And when we didn't get more referrals and the kids were starting to discharge, in October, we decided in October--now it started July, August, September--we decided in October, three months later, that we are not able to do PRTF because of referrals. Now, community-based services--(laugh) a transition would be nice for community-based services, because we also tried to do community-based services. Our day-treatment referrals went down. And we tried to switch to IOP; that was a couple months' process. And IOP is a good service, but so is day treatment. So to switch from that kind of service, from a residential service to community-based services, is pretty difficult to do. And, I mean, we did it; we just didn't have enough finances at that time, and it was challenging. I did bring up that issue of, how do we do this better? I brought this up to HHS and Magellan, asked for a work group on that issue. And that was not allowed--or provided. So there were four of us who provided that day treatment and IOP services who said: We'll help have a discussion about how to get the system so you can say this kid can live at home and we'll provide these services in the treatment and they'll be okay. That didn't happen. I do believe that

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

there's a place for residential care. I do believe kids grow best in families, but when they need treatment, they need to get it. And when they need residential treatment, they need to get it and access it and then be done and go home with their families. I've included a document from Building Bridges Initiative from SAMHSA, the Substance Abuse and Mental Health Services Administration, and it talks about residential care needs to be a component in your array of services. And then there's an article from Child Welfare League of America. We must look at this as a system: child welfare, juvenile justice, Medicaid, the courts, everybody. We all have to work together, and it has to be done in collaboration, not in isolation. My possible solutions are major changes in the system--such as case management services, payment methods must be discussed in partnership with HHS and key stakeholders including providers, advocates, youth representatives, judges, people from the community, everything. All the brains together get a better solution. This will lead to a smooth transition and more knowledge. As Andy said, some of us have the opportunity to participate in national groups, so we get information that people at the State Office Building might not get. I worked there; you don't have a lot of time for research: there's a lot of work to do. So we have resources and research that HHS won't have access to. And here's an important thing: people support what they help create. My second recommendation is to fund services appropriately. There's a clear expectation from the state of Nebraska for not-for-profits to cover the cost of mandated services. When we bring up services and there is no guarantee that they will be used and we don't get the people, we lose money; we close the services; and then we fund-raise (laugh) them again. The state and now the lead contract agencies need to bear the burden and ensure the services are there. There must be a better way to ensure the needed services are present and available for the kids and families. I'd suggested that we have a work group immediately to talk about what the needs of the kids and families are and to get those services figured out and to have a transition plan. I've talked to people from other states; when they saw this coming, they spent six months as a group and figured out what services to put in place if they weren't going to support PRTF. My last is require HHS to follow the regulation process. I heard testimony about policy development. When I worked at the central

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

office--I was a foster care manager--and we went around the state. First we developed the values of the policy, and then we developed the policy and we had meetings. I think every summer for three years we had meetings across the state. We went to every service area, talked to lots and lots of people to get their buy-in, to get the agreement, to figure out what the policy should be. And I suggest that that be another way to go. That's all I have for prepared testimony. I know I didn't read my letter, but I was kind of close. And I'd be glad to answer any questions you might have. []

SENATOR CAMPBELL: I appreciate the time-saving effort. []

MARY FRASER MEINTS: (Laugh) []

SENATOR CAMPBELL: Senator Krist. []

SENATOR KRIST: At least four times during your testimony you talked about reaching out to the Health and Human Services and Magellan, trying to initiate meetings and trying to coordinate, going back almost a year to the first time we all met here in Lincoln. Is that about right, Chair? Was it about a year ago? []

SENATOR CAMPBELL: I think this committee met in March of 2010. []

SENATOR KRIST: '10? []

SENATOR CAMPBELL: No... []

SENATOR KRIST: Okay. []

SENATOR CAMPBELL: March 20... []

SENATOR KRIST: 11? []

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

SENATOR CAMPBELL: ...11. []

SENATOR KRIST: We heard the same thing from you and others there. For the record, is it true that a little less than three months ago you tried to meet with leadership in Health and Human Services and never heard back from them about issues that you had wanted to bring to their attention? []

MARY FRASER MEINTS: Yes. []

SENATOR KRIST: And can you tell me...and I know it's--when you've invested that much in a structure--and I know it's painful. But can you tell me, just in terms of painful, where are those girls--or where are those kids now? []

MARY FRASER MEINTS: Okay, I did really well not crying so far. []

SENATOR KRIST: I'm not trying to... []

MARY FRASER MEINTS: Some of the girls...I believe that residential care is a transition, and there are kids...and if you listen to Leslie Byers, who was one of our partners, she will talk to you about why her daughter needed residential care. Then they need to go home. So, yay, some of the kids that we have had in PRTF then went to wraparound psychiatric residential treatment center, went to wraparound group home. And some of them are going home now. So that's very good; they'll go home with some services. Some of the girls are going to other PRTFs. We'd tried them in this lower level of care, and it did not work, so we're making applications for two or three girls right now. We have three girls that we don't have places for. And Friday is our last day of residential care. Our intensive outpatient services--it is a challenge to even do that service; it needs to be paid for. Somebody...if you want community-based services, you have to pay for those too, and so we're having some challenges with getting IOP

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

programs. So we have eight girls right now, and so some of them are going to go home or foster care. Some of them aren't ready to go to foster care, so one is going to a shelter until she can get introduced to her foster family and then go there. []

SENATOR KRIST: Well, I've said this in other hearings--and I think that the state has done a great job of breaking the back of the nonprofits that are out there trying to do a great job. And thank you for what you've done so far. []

MARY FRASER MEINTS: Thank you. []

SENATOR KRIST: We'll see if we can't try to clean up this mess. []

MARY FRASER MEINTS: Thank you. []

SENATOR CAMPBELL: Any other questions? Senator Howard. []

SENATOR HOWARD: Well, again, this is not so much a question, but I think the services that you provided, in terms of the family working with the girl, were so critical. And we see the list of the kids that are placed in out-of-state placement, and a couple of them were there for over 150 days. And Magellan mentioned the girl that had been in out-of-state placement for two years. There's not the opportunity for family participation on a regular, ongoing basis so that that child has a place in the family to return to. And I just think it's such a loss when we lose an agency that's committed to working with the families, to working with the court system, to being there to provide information for us. I second what Senator Krist says--breaking the backs of our providers in this state. And it's going to cost everybody more, no two ways about it. []

MARY FRASER MEINTS: Thank you, Senator Howard. Thank you, Senator Krist. []

SENATOR CAMPBELL: Any other questions? Thank you for being in the state and the

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

community for 60 years. Goodness. []

MARY FRASER MEINTS: Thank you, Senator Campbell. []

SENATOR CAMPBELL: And for all your effort. And I particularly want to thank you for the time line, because I know that took a lot of... []

MARY FRASER MEINTS: (Laugh) []

SENATOR CAMPBELL: ...extra effort, and I wanted it for the record. So thank you... []

MARY FRASER MEINTS: Thank you. []

SENATOR CAMPBELL: ...so much. Next testifier. Go ahead. []

PAM BOCKMAN: My name is Pam Bockman; that's B-o-c-k-m-a-n. Good afternoon. I would--before I begin, I would like to thank Senator Campbell and the esteemed committee here for affording us and myself the opportunity to speak on behalf of Uta Halee Girls Village. Just to offer a brief history, in 1950 Omaha Council of Church Women established Uta Halee Girls Village, then named Uta Halee Protestant Home for Girls. This facility was dedicated to caring for troubled women regardless of race or religion. It consisted of a single house, half a dozen staff, and ten girls. Of course, as you know from the brief history, by 1994 the Village had multiple buildings on a 30-acre campus, over 130 staff, and 150 girls. Currently the Uta Halee Girls Village residential continuum of care is unique to the state of Nebraska and includes three programs exclusively for adolescent girls and their families: residential psychiatric care, residential crisis stabilization, and a treatment group home. The fourth program within the continuum, day program, is the Village's only nonresidential co-ed service. Uta Halee is accredited and certified by Joint Commission on Accreditation of Healthcare Organizations, Nebraska Department of Education, and Nebraska Department of Health

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

and Human Services. On April 5 of 1983, I arrived at Uta Halee Girls Village with my parents. Judge Staley from Sarpy County had just ordered me there after running the gamut of placements--various foster homes and group homes, Douglas County Youth Center, and a 30-day emergency placement at Midlands Hospital. I remember feeling like this was the end of the world for me. I was a teenager in trouble. Judge Staley made it very clear that if I failed here, Geneva would be the end of the line. I was headstrong and manipulative. I didn't do drugs, I didn't really drink, but I certainly didn't get along at home. School was somewhere I had to go, and I hated it. I had been diagnosed with attention deficit at a young age, which made learning and paying attention in school almost impossible. I provided many challenges, and my parents didn't understand, nor did they have the resources to cope and help me. This is still true for many parents today. But the staff at Uta Halee were resilient. I resisted, and they stood firm. After six months, I finally gave in and realized that unless I started working the program, I was going to remain on level one forever. So I settled in, and I grew up. I got along with my peers and started to care about others than myself. It was truly a homelike atmosphere, even down to having a dog, a German shepherd named Jeff, who had one day adopted us and protected us until the day he died. I enjoyed all the privileges and opportunities afforded to us. I attended the Omaha Playhouse and Opera Omaha for a variety of performances, played softball and basketball. I soon earned a level three status, the last stage of privileges, and moved over to the cottage that at that time was way over on the other side of the campus, so it gave you a feeling of independence. We had a garden and horses, all of which required hard work and dedication. We were also responsible for baking the birthday cakes for the girls over in the dorms. We always enjoyed the visits from the Church Women United, who never forgot birthdays or holidays. For some girls, this was their only family. My story is not really all that different from my peers', and yet we all came from different backgrounds, cultural status, and socioeconomic status. We learned many of life's valuable lessons, from the basics of how to manage our finances, obtain housing, to just getting along with others. Many of the other basic lessons would take many hours to explain. There was a song that ran through my head as I visited the Village on Monday's open house.

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

And it's a song by Miranda Lambert: "I thought if I could touch this place or feel it, this brokenness inside me might start healing. Out here it's like I'm someone else. I thought that maybe I could find myself...you leave home, you move on, and you do the best you can. I got lost in this whole world and forgot who I am...if I could just walk around, I swear I'll leave, won't take nothing but a memory from the house that built me." I thought to myself, this place was such a huge part of my childhood. Those words have summed up what all of us alumni have felt at one time or another after we have left. I was allowed to visit the old dormitories and take a trip down Memory Lane and take pictures of where I grew up. Although they have been converted to offices and computer rooms for the girls, I can remember a feeling of such horrible sadness that all this was ending. This is such a legacy, not just for me but for all the others who have the potential to be helped in their life's journey by the current programs that Uta Halee Girls Village has to offer. Several dedicated staff members are still there fulfilling the mission of caring and compassion. The tragic news of the closing has reached many alumni from all over the country. We are a sisterhood of girls who found comfort in the relationships that we have formed. We have all been following this with great interest and hope. For many of us, it has also reconnected old friendships and formed new ones. But the common thread of the conversation always: What can we do? If I do nothing else for the Village today, I hope that I have provided a small introspect in the life of an alumni. Since Uta Halee, I have done many things with my life. I've joined the Army; I have been a foster parent to both children and animals; I walk dogs for the elderly in my small town and provide grooming assistance for them as well. I represent Uta Halee in my everyday life. I am constantly looking for ways to help others in need. Many people have asked me why am I bothering, didn't I hate it there? I did hate it there at first. I hated my parents for giving up on me and leaving me in that place. But it was only years later that I realized they did the best thing for me; placing me there was not giving up on me but helping me along in the only way they could. Now when people ask me what was the hardest part about Uta Halee, I tell them that leaving was the hardest part. People were different on the outs. They didn't care. And you had to learn to deal with that all on your own. And you soon realized that even though you had changed, the world had not; you

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

had to find your way. Thankfully, many of us still had access to our staff that was willing to go the extra mile and still be there for us. They didn't have to do that, but many of them are still a huge part of our lives. Even now, 20-plus years later, one of the girls still calls her old staff on her birthday every year. These are the types of things that these girls need to know: the life after Uta Halee may be rough, but it is what you make of it with the tools you have been given. While the parents and the family of these girls are unfortunately busy with arranging other placements, I am here on their behalf. I speak for those who do not yet have a voice. Thanks to Uta Halee, I have found my inner voice and the ability to help them, as it helped a girl named Wendy find her voice during a level meeting by jumping on the coffee table one night to make her point. While this may have seemed inappropriate at the time, this was her way of finally breaking through her wall to be heard; she was a rather small girl and always talked over. I am now going to take her lead and I'm going to jump on the coffee table to be heard. Please consider helping these girls to grow and mature, by clarifying the language necessary to continue the funding for this great program. It sounds like it's such a simple thing when you say it out loud, and we are aware that, unfortunately, government action can take time. But I implore you, each and every one of you, to think of what is happening as we are down here today discussing this issue. Girls are trying to cope with the huge changes taking place in their lives due to no fault of their own; the staff members are packing up 60 years of memories to put in storage; everyone is feeling such a huge sense of loss. But after visiting with the staff last week, all I can hear is their continued concern for the girls--not for themselves, but what will happen to them. So many people today are focused on the big picture. Uta Halee is just a small piece in life's puzzle. We're not rocket scientists or rock stars; we are, however, wives, mothers, sisters, and daughters. We are a sisterhood, almost a sorority of sorts. We are housewives, biomedical engineers, small-business owners, models, and contributing members of society. Not only is it about the stories you hear, but it's also about the stories that you don't hear. We aren't breaking laws; we aren't going to prison. Every girl that stays out of prison, grows up, has children, goes to school, volunteers at school, hospitals or a hospice program is a success story just like me, and they do not end up being a drain on

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

society. I know many of the alumni wanted to be here today, and many more will be e-mailing their stories to Senator Campbell very soon, all because these girls need to know someone still cares for them. And we want to keep them on the sunny side, which is Uta Halee's mantra. Thank you. []

SENATOR CAMPBELL: Thank you for giving...I'm sorry, in a hearing as this, we do not allow applause... []

PAM BOCKMAN: Understood. []

SENATOR CAMPBELL: ...even though we all do applaud you for coming forward and giving a face and voice to a story. Sometimes it's...we hear a lot about numbers, but it's great to see a face to that story. So thank you very much for coming today. []

PAM BOCKMAN: Yes, ma'am. Thank you all. []

SENATOR CAMPBELL: Thank you. Next testifier, please. I would have called you out if you had booed, so just know that. (Laughter) Good afternoon. []

CONNIE KROKSH: (Exhibit 7) Good afternoon. Thank you for allowing me to testify today. I was going to start out my story just a little... []

SENATOR CAMPBELL: And we need your name. And just spell... []

CONNIE KROKSH: Oh, I'm sorry. My name is Connie, C-o-n-n-i-e, Kroksh, K-r-o-k-s-h. I was going to start out my story a little differently, but I think my daughter came up in discussions earlier today, during Magellan's discussion about a child who's been in residential treatment care for over two years; I believe she's referring to my daughter, my adopted daughter. I am a parent and a grandparent. By way of history, my husband and I began fostering children of Nebraska in 2001. We took in several youth over an

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

approximate eight-year period. Two of those we fostered, whom I will call L and J, we adopted in 2005. L and J are biological sisters, aged 14 and 16, respectively. Both were considered special-needs children, and thus we adopted them under a subsidized adoption agreement. Identified in that adoption agreement were their diagnoses and at-risk behaviors. In that adoption agreement, DHHS made a contractual promise to provide mental health services as recommended by the girls' mental health professionals. Life has been challenging for both girls. Because of the sexual abuse they were subjected to as young children, they have consistently been in need of mental health services. They require very close supervision, due to their struggle with boundaries and other issues. Approximately two and a half years ago it came to our attention that daughter L was in need of a high level of care, residential treatment services. What should have been a simple process to get her the care she needed instead was an intense battle. We were finally able to find an out-of-state facility which could treat her and one that Magellan would approve. Daughter L continues to struggle with the issues for which she was placed in residential treatment care. Because of this, her treating mental health therapist strongly feels she needs to remain under 24-hour supervision, the least of which should be in a therapeutic group home setting, until such time as she makes improvements. Magellan has ended authorization for payment of her care as of November 24, which was Thanksgiving Day. The Department of Health and Human Services, through a letter of agreement with the facility that my daughter is at, made an arrangement for further treatment only until December 24, Christmas Eve. After that date, I was informed, there would be no funding for further residential care or therapeutic group home but only for outpatient services. Magellan and DHHS, in direct contradiction of what my daughter's treating mental health therapist is recommending, thinks that she can come home. If she were to come home, she would be a threat of harm not only to herself but to her sister, who lives in our home, and to the community. Though we dearly love our daughter L and her sister, raising daughter L has been extremely stressful for our family. That on top of having to fight for services has been a literal nightmare. In the last month alone, I have spent over 40 hours researching options for care for her. That has involved numerous conversations with Magellan,

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

DHHS, the folks at Nebraska Family Support Network, Right Turn, Senator Campbell's office, attorneys with Appleseed, and my own private attorney. All the while I'm doing that I have continued responsibilities of raising our other daughter, who also requires a lot of supervision. I am also trying to hold a full-time job. If I were not as fortunate as I am to have a very understanding employer, I would have long ago lost my job. The stress of this has taken a toll on me physically and on me and my family emotionally. This is the kind of stress that can cause marriages to falter and fail and, consequently, families to fall apart. I cannot stress enough the gap in care my daughter is facing. If she is thrown out into the community without that stepped-down level of care that her therapist is strongly recommending, to a therapeutic group home, there is no doubt in my mind that she will end up back in the juvenile court system and/or the criminal system. We owe her more than that. And the state of Nebraska promised our family more than that. We have an obligation to do all we can to help ensure her success. We have upheld our end of the adoption agreement, but the state, DHHS, and Magellan and Medicaid is failing to uphold their end. I plead with you to make changes to the current Medicaid system. It is failing the children of this state. It is failing the parents of this state who are trying to help these children become successful adults. We cannot and we did not agree to do this on our own. We all read and hear in the media of the need for foster and adoptive families. How can we expect others to step forward and make the commitment of providing forever families to these children in need if we don't give them the care that they need. Changes need to be made to the present system, or the future of Nebraska's children will be forever jeopardized. And what a shame that would be. []

SENATOR CAMPBELL: Miss Kroksh, isn't part of the issue here--and I'm not saying I agree with it--but part of the issue, that your daughter can't get better... []

CONNIE KROKSH: She can't... []

SENATOR CAMPBELL: ...in this facility? Because we've been reading about--that if

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

they cannot make progress, then they may be out of a service. And I'm just trying to identify if that fits your daughter. []

CONNIE KROKSH: There is mention that she is maybe getting--she has gotten as much as she can get out of the program. []

SENATOR CAMPBELL: Hmm. []

CONNIE KROKSH: But she still requires supervision. And that's why her therapist is recommending... []

SENATOR CAMPBELL: Right. []

CONNIE KROKSH: ...a step-down level of care. []

SENATOR CAMPBELL: And you articulated that far better... []

CONNIE KROKSH: Okay. []

SENATOR CAMPBELL: ...than I did. Thank you. []

CONNIE KROKSH: Um-hum. []

SENATOR CAMPBELL: I needed that for the record. Senator Dubas. []

SENATOR DUBAS: Thank you, Senator Campbell. And I'd kind of like to pick up where Senator Campbell left off, as far as--I'm...first of all, thank you for coming forward and sharing your very personal story. But I would assume that there's some type of a treatment plan, either to try to integrate your daughter back into your family's life or help her so that she can cope out in the real world. And so as a part of that treatment plan

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

you reference a step-down program. I mean, for her to just automatically be out of the program that she's in, where does that leave her as far as her treatment plan for the future? []

CONNIE KROKSH: Well, the treatment plan right now is--the recommendation by the therapist is the step-down to a therapeutic or enhanced therapeutic group home. The recommendation of Magellan, who has never seen my daughter, is to send her home. Going from a very restrictive setting to a home environment would be disastrous. She's still exhibiting the behaviors that she is in treatment for now. If she is allowed to go from that highest level of care to home, she will fail, I can almost guarantee it. That is too big of a step; that's what her therapists are saying. She needs medical care--or continued mental health treatment and supervision. I cannot give her that 24-hour supervision safely. []

SENATOR DUBAS: Thank you very much. []

SENATOR CAMPBELL: Any other questions? Thank you for coming today and... []

CONNIE KROKSH: Thank you. []

SENATOR CAMPBELL: ...telling your story. Next testifier. Good afternoon. []

SARAH HELVEY: (Exhibit 8) Good afternoon. My name is Sarah Helvey: that's Sarah with an "h," last name H-e-l-v-e-y. And thank you for the opportunity to testify. And I want to extend my appreciation to both committees for the hard work that you've done on these issues over the past several years. As you well know, the LB603 Oversight Committee was created to address a crisis exposed by the safe haven law regarding gaps in access to behavioral health services for children. Unfortunately, in the past year that crisis has gotten worse instead of better, and those gaps have widened instead of narrowed. The federal Medicaid program and specifically Medicaid's EPSDT provisions

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

were intended by Congress to provide preventive screening and diagnosis as well as broad coverage for treatment for children's physical as well as mental health conditions. Unfortunately, the department's policy choices, and in particular some of the recent changes that have been the focus of today's hearings, deny and exclude too many children from receiving these critical preventive services and treatment. And many have heard previous testifiers talk about the cost shift that is created by that scenario, in addition to the immeasurable harm that that causes to children and families. That cost shift is undermining the state's child welfare reform effort and poses potential liability for the state. Although some of the Chapter 32 regulatory changes are, in fact, required by federal law, such as the PRTF issue, others appear to be contrary to it. Under the federal Medicaid act, the department must provide medically necessary services. Any limitation on providing services must be reasonable, however, and the department cannot arbitrarily discriminate on the basis of diagnosis or condition. Yet the pending regulatory changes unreasonably limit services and discriminate on the basis of diagnosis. According to several provisions, services for developmental disabilities, for example, are not covered at any level of care, regardless of whether the treatment is deemed medically necessary by the child's treating provider. Moreover, the department and Magellan in particular operate under clinical guidelines that are even more restrictive. Such limitations are not reasonable, because children with these diagnoses can, in fact, benefit from treatment. Moreover, federal law has special rules for children, which require case-by-case determination of whether a given treatment corrects or ameliorates a condition that the child is experiencing. And these special rules do not allow for broad exclusions based on a child's diagnosis. Furthermore, the process by which the department has made these policy changes has been confusing at best. As you know, the Administrative Procedure Act establishes the minimum procedure for state agencies to follow in making rules or regulations. The purpose of the APA is to allow the public to have notice and an opportunity to be heard before a regulation goes into effect. In other words, the APA requires transparency, clarity, and communication. Unfortunately, the process that has been followed with these recent Chapter 32 regulation changes has been anything but clear. For several months, as you've heard,

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

draft regulations were distributed and publicly posted, leaving the public questioning whether it must follow the current regulations or the draft ones. And, indeed, we are concerned that these draft regulations were applied to Medicaid recipients despite the fact that they were not yet legally in effect. Furthermore, when the regulations were formally proposed last month, they were different from the draft regulations made available months ago, forcing the public to parse through hundreds of pages for a second time to compare the regulations. The APA exists so that the process for changes that affect people's rights and responsibilities, and in this case their health and well-being, are not muddled and confusing. Regulations should not be applied in draft form; the public should not have to divine the law; this situation should not happen again. In conclusion, the crisis that led to the creation of the oversight committee has been exacerbated by Medicaid policy choices that are causing harm to children and the unnecessary breakup of families and that we believe are contrary to federal law. In addition, the department's ongoing failure to coordinate the divisions of Medicaid and Children and Family Services and to maximize federal funding to meet the needs of children has created unprecedented instability in the state system of care. For these reasons we urge the Legislature to set forth clear policy that ensures children receive services as required by federal law that correct or ameliorate the child's identified condition as recommended by the child's treating provider but forbids discrimination in Medicaid coverage based on the child's diagnosis or age and requires that criteria used to determine medical necessity for children be properly promulgated under the APA. We look forward to working with the Legislature, our partners, and other stakeholders in the coming weeks and months to further develop solutions to address these critical issues so that we can truly reform the system and achieve the outcomes that we all want for children and families. []

SENATOR CAMPBELL: Thank you, Ms. Helvey. Questions? Thank you very much for your testimony today. []

SARAH HELVEY: Thank you. []

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

SENATOR CAMPBELL: Good afternoon. []

CAROLYN ROOKER: (Exhibit 9) Good afternoon. My name is Carolyn Rooker; that's C-a-r-o-l-y-n Rooker, R-o-o-k-e-r. I'm the executive director of Voices for Children in Nebraska. Many of you know that Voices for Children in Nebraska has been, is, and always will be an independent voice of our state's children. We are passionate and committed to fairness and justice for all of our state's kids. And today I'm here to talk to you about our commitment to ensuring that all children have access to behavioral health services at the time they need them--the right access at the right time. I want to thank all of you for your time and energy in this very complicated and confusing and overwhelming system and time of change that's going on for our state right now. I know that you've had to hear a lot of testimony and a lot of details and a lot of facts, so today I want to really kind of simplify our testimony and just play out a couple of things for you. In our testimony on the last page, the written testimony, you will see an info-graphic. One of the rules of info-graphics is they need to be very quick and easy, not very cluttered. This one does not qualify as that. What we've discovered is that these kinds of issues are very, very difficult and they're hard to put in a format, but this is our first draft at trying to help you understand some of the challenges and concerns that we have for the behavioral health issues that are going on right now. In our info-graphic--behavioral health shouldn't be a game of chance. Interestingly enough, I have a good friend who's a child therapist, and he said: You know, I think it's really interesting that you chose this game, because I play this game with a lot of kids that I work with, and it gives them a chance to kind of focus and play a game while they're talking about whatever issues might be going on. But, for today, behavioral health shouldn't be a game of chance. There are three chutes that push kids further away from successful treatment and healthy lives. I want you to imagine with me a kid falling down each of these three chutes. So in this imaginary situation, the first kid is a 4-year-old with aggression, anger, and disruptive behavioral problems. As responsible and caring parents, his mom and dad try to get services for him, but Kids Connection denies their claim, citing that the

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

child just simply does not meet medical necessity. So as the years go by, the problems get worse and worse, and at age 14, this child's condition is so severe that he finally gets access to some treatment, but it's too little and it's way too late. Due to his untreated aggression and compulsive behavior, he is caught stealing and is now involved in the juvenile justice system. He becomes a state ward under the Office of Juvenile Services. One month of detention costs the state about \$5,100, compared to an average course of treatment for preschool-age children which costs about \$640. That is calculated by the typical course of treatment for these types of kids if handled earlier--lasts six to eight sessions at \$90 per session. Now imagine a different 4-year-old, but in this scenario the child sustains a physical injury from falling off a couch. Her parents rush him or her to the E.R., and a doctor immediately treats the problem. Not only does the doctor treat the wound right then but also teaches the parents how to care for the injury once the child goes home, suggests ways to prevent future injuries like this, and helps the parents and teaches them how to keep the child safe at home. If this same child had a behavioral health problem, Medicaid treats the problem quite differently. Unlike physical injuries that we can see, it is very likely that the child would not have received immediate medical attention. And even worse, Medicaid prohibits training the parents as a part of the covered treatment plan. Just as a 4-year-old cannot be expected to care and treat her own broken arm without a trained parent, it is unrealistic to expect that same child to be able to care for their behavioral health problems without parents properly trained as well. And, as you can see through the written testimony, these are all examples of excluded services. Our last child falling down a chute is a child diagnosed with autism. While Medicaid refuses to pay for services based on this diagnosis, critical windows of opportunity to receive treatment come and go, leaving the child without the chance to reach his full potential in life. Lastly, I want to just quickly talk about how this is affecting our state budget due to cost shifting. You've heard much about that today, so I will keep this simple. In our info-graphic, kids falling down the chutes have to get treatment somehow, some way. Many of them end up in the child welfare juvenile services system to access this care. We have learned from the two lead agencies that they have spent collectively over \$11

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

million--child welfare dollars--on services for children excluded or denied by Medicaid. I want to make it very clear that this \$11 million isn't and hasn't been solely and completely to the medical necessity criteria but represents Medicaid denials in general. When Medicaid pays for services, 70 percent of the costs are paid for by a federal match. This match is lost when the costs are shifted to the child welfare system, costing our state more money and stretching our limited child welfare dollars even thinner. Nebraska simply cannot afford to lose the federal match through Medicaid. Our resources for children in both the Medicaid and child welfare systems are already way too limited. Going forward, I would ask that this committee continue to examine and work to improve children's access to Medicaid services, perhaps through statutory changes. The negative impact that service denials are having on children and our state system as a whole must be addressed--and quickly. So in summary, our concerns are in four main areas: cost shifting from Medicaid to child welfare and juvenile services, exclusion of behavioral modification as a billable service, refusal to allow behavioral treatment for autism spectrum disorders, and ambiguity around the definition of medical need and young children. Senator Krist mentioned that today is the four-year anniversary of the travesty of the Von Maur shooting. And I first must say that my heart goes out to the victims and the families today that are reliving that, as I'm sure it will be highlighted in the news stories and so forth. But I can't help but pause and wonder, when I think about the history of this young man and the challenges that he experienced, at age 6 being placed on psychotropic medications, what might his life have been like had he had access earlier on, when there were perhaps some early warning signs that there were some challenges and issues. And Senator Krist also alluded--although this is an extreme case, I just wonder how things could have been different for those families. Thank you again for your attention to this matter, and we look forward to continuing to work with this committee to identify solutions and do whatever we can to help bring solutions to the table. []

SENATOR CAMPBELL: Thank you, Ms. Rooker. Any questions? Thank you for your testimony today. []

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

CAROLYN ROOKER: Thank you. []

SENATOR CAMPBELL: Our next testifier? []

BARBARA JESSING: (Exhibit 10) Good afternoon. And thank you. My name is Barbara Jessing; it's J-e-s-s-i-n-g. I am clinical director with Heartland Family Service in Omaha, Nebraska, and I am testifying on behalf of the Coalition for Children's Mental Health, which is an organization of providers and family advocates serving children birth to 5. And that is the specific focus of our testimony today: services for children 5 years of age or younger. And I would add to Carolyn's comment that Robbie Hawkins' first contact with the mental health system was at age 4. So here's hoping that we are ready for the next child for whom early intervention does change the course of their lives and ours. We want to call your attention to the things we know about early childhood mental health intervention. These services can reduce the future need for the higher levels of care that you've been hearing about today and are comparably less expensive. We need that system of care that you heard Jonah talk about that has room for children at every stage for the services they need. The Chapter 32 definition outlines requirements of DSM diagnosis, standards of medical necessity, and the expectation that services be developmentally appropriate and research based. We agree that all of these standards can and should be applied to children younger than 5. We have validation for the prevalence of early childhood mental health conditions, and we have a body of research about the effectiveness of evidence-based programs for young children. However, in practice, Nebraska mental health providers routinely experience denials when requesting medically necessary treatment and utilizing evidence-based treatments. Most commonly, we are told that parent training is the exclusion--it is not a service that Medicaid covers. However, it stands to reason that no young child can effectively be treated for a mental health condition without active involvement of parents and caregivers. The most effective evidence-based practices for young children include but are not limited to parent training. In the absence of effective treatments, young children

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

are given strong psychotropic medications often untested for this age group. Many of these are children being medicated, for example, for attention deficit disorder. In October 2011 the American Academy of Pediatrics revised its clinical practice guidelines for children diagnosed with ADHD and stated that the first line of treatment for 4- and 5-year-olds should be evidence-based parent- or teacher-administered behavior therapy. Very recently, just last Thursday, the U.S. Government Accountability Office published a study on the use of psychotropic medications for kids in the foster care system, including very young children, and urges increased oversight of such use. We contend that the other question of oversight is: Are these children also getting effective therapeutic intervention and not just medication? We have three points we'd like to see addressed as these regulations go forward and are implemented. The first is we can use better tools for diagnosis of young children, developmentally appropriate diagnostic tools such as the DC 0-3 classification system. Post-traumatic stress disorder looks different in an abused toddler than it does in an adult combat veteran. Research on both DSM-IV and DC 0-3 shows reliable identification of psychopathology in children as young as 18 months, when intervention can most effectively be delivered. Our second point--you've heard mention of EPSDT, the early periodic screening, diagnosis, and treatment services, which is part of Medicaid. This should be the gateway to identifying social and emotional difficulties in young children. Yet a study in the Journal of Pediatrics in July of this year revealed that in Nebraska less than 19 percent of physicians had asked a parent to complete a standardized developmental screening instrument in the past 12 months. Particularly for very young children, physicians need to be consistently using appropriate, valid developmental screenings including social and emotional development. Our third point is that once children are screened and need access, that they be able to find evidence-based mental health interventions. It's extremely difficult for parents or providers to find and authorize these treatments. One example is parent-child interaction therapy. It's an evidence-based practice recognized by SAMHSA for children 2-7 with behavioral problems. It includes parent training, but it's not limited to parent training; it's relatively short term and modest in cost. Yet it's not considered, currently, an acceptable practice by Nebraska Medicaid. Child-parent

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

psychotherapy is another example. Even the effectiveness of traditional play therapy has been found to be increased when parent training is incorporated. This is our conclusion: Young children with mental health conditions are underserved. These conditions worsen and become more difficult and expensive to treat over time. The limited resources of Nebraska Medicaid are being used to provide psychotropic medication and therapeutic treatment of some but not all identified children, without consideration of whether effective practices are being used. It seems ironic that providers have to argue with state officials to get them to recognize and authorize effective, efficient, evidence-based practices. The right words exist in these regulations. Let's just make sure they're implemented accordingly. []

SENATOR CAMPBELL: Thank you very much for your testimony. Any questions? This is very helpful, because the question of the child under 5 has surfaced again and again in discussion among senators, so thank you very much. []

BARBARA JESSING: Yeah. Thank you. []

SENATOR CAMPBELL: Next testifier. While we are getting...are we--is there anyone else...I know the two people came forward, so I have you. Is there anyone else who's going to testify? Okay. Good afternoon. []

MELANIE WILLIAMS-SMOTHERMAN: Good afternoon. My name is Melanie Williams-Smotherman, M-e-l-a-n-i-e Williams-S-m-o-t-h-e-r-m-a-n. I'm the executive director of the Family Advocacy Movement, a collaboration of birth families, professionals, advocates who continue to stress the importance of child welfare reform that pays better attention to the rights, responsibilities, and invaluable roles that birth families play in the lives of their children. I don't have a formalized statement today. I wanted to touch on a few things which I've been very happy to hear others touch on already. When this committee was formed, the LB603 committee, it was on the heels of the safe haven stories that were coming for us nationally and locally. And FAM was

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

born out of that, officially. We were a family ourselves who came together with many other families in Nebraska at the exposure of the problems that were occurring with families desperately seeking help but not exclusion from the care of their children. And Senator Campbell was leading the Children in Crisis Task Force. There were several senators who stepped forward. And we decided that--as families who came together, told our stories together, learned that we weren't actually in isolation but that we were sharing the same experiences, the same stories, of a very broken system that was not serving children, not serving families appropriately--that we could not allow our voices to continue to be silenced. And we continue to hear how many different agencies and public officials have the best interests of our children in mind, but very rarely--it does happen, but it's rare for birth families to be put in that same level of respect with regard to our desire for the health and well-being of our own children. And within the year after safe haven--the revelations occurred--the Family Advocacy Movement kind of cut its teeth on developing a conference, where we called several state senators as speakers and national and local advocates. Senator Dubas was one of the speakers at our conference--Senator Campbell, Senator White. And we had the definitive voices nationally who wanted to speak to not only the issues of foster care that I continue to speak about whenever I'm given the opportunity but also about the solutions to what we saw with safe haven and what all of the speakers today are speaking on. What continues to get missed is, I think, the most relevant piece, which is focusing on the point of origin for all of these issues. And that is children's lives within their families. And we've seen very little--and I would like to see more, with the resources of those who can provide them--cost comparisons between providing a family, a parent, who comes forward and asks for help, with a better knowledge, most vested interest, the best ability to provide love, nurture, and care for their child--with proper resources, the cost of that in comparison to the cost of foster care, the cost of juvenile justice. It doesn't compare. I've seen...and I--we provided Senator Dubas at one point, two and a half years ago, with those statistics that were already old, but they showed a stark comparison. And we need to focus on that, because without that we will not be able to compel our lawmakers and the public to support the most common-sense approaches to children in need,

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

children in crisis, families in crisis, and prevent more harm to children, which is what we're seeing by families being pushed aside when they identify issues that they need resources and help with--and the Department of Health and Human Services and all these other agencies and officials flooding in to take over, pushing families away, basically, you know, stigmatizing parents who reached out for help to begin with. And, you know, the wraparound piece is, really, the most essential, and it's yet going to be the most difficult to convince the public and our lawmakers to work with. Because it's more difficult than taking a child, putting them already in a system that is created, and plugging them with psychotropic medications, which make them behaviorally compliant but do nothing to truly address them as human beings and their futures and the care of their families and the need for family. And so, again, I come forward at these hearings to continue to represent the absolute necessity to value birth families in all of these processes and these thoughts, not to undermine that family parents are the most important components for making decisions, for providing information, and for loving and caring for their own children, even when there are challenges, even when there are problems, and even when there are a lack of resources. []

SENATOR CAMPBELL: Hmm. []

MELANIE WILLIAMS-SMOTHERMAN: So... []

SENATOR CAMPBELL: Thank you for coming forward. []

MELANIE WILLIAMS-SMOTHERMAN: Thank you. []

SENATOR CAMPBELL: Our next testifier. []

SENATOR BLOOMFIELD: Senator Campbell. []

SENATOR CAMPBELL: Oh, I'm sorry. []

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

SENATOR BLOOMFIELD: I have an appointment at 4:00. I have to leave. []

SENATOR CAMPBELL: Okay. Thank you, Senator Bloomfield. []

SENATOR BLOOMFIELD: I apologize to the ladies that are testifying yet. []

SENATOR CAMPBELL: I'm sure they...there are handouts, or whatever, we can get you. []

SENATOR BLOOMFIELD: Okay, thank you. []

CAROL CRUMPACKER: (Exhibit 11) Good afternoon. []

SENATOR CAMPBELL: Good afternoon. []

CAROL CRUMPACKER: My name is Carol Crumpacker; that's C-r-u-m-p-a-c-k-e-r. Thank you for the opportunity this afternoon to talk about some of the issues that we've seen with the recent changes. I'm the executive director of the Child Guidance Center, a nonprofit children's mental health center in Lincoln, Nebraska. We provide an array of children's services including outpatient, intensive outpatient, day treatment, and a therapeutic group home. We have operated a residential treatment program for male adolescent sex offenders since 1992. When Medicaid first announced the changes related to the IMD issue, we planned to pursue becoming a psychiatric residential treatment facility, because we provide intensive treatment. We were not required to do this, as others were, because we have only ten beds. As we moved in this direction, we quickly became discouraged with the requirement to provide all medical care in the facility and the rate and made the decision to go the therapeutic group home route. At this time we have a waiting list and will not have an opening until March in our facility. Currently we are aware of only one additional residential facility, a PRTF, for this

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

population, and that is with the Lincoln Regional Center, on the Whitehall campus. Only two years ago there were two additional ASO, adolescent sex offender, providers of residential services; they were Cooper Village and Boys and Girls Home. They both have closed their programs. While we have maintained capacity and have a waiting list, we're still concerned about recent denials of residential placements for this population. We conduct many adolescent sex offender risk assessments and have experienced denials when we recommend residential placements for these youth. Our staff have consistently appealed these denials through every level, with considerable time and effort, to have the denial overturned at the final appeal stage. However, the number of beds has been significantly reduced, and one wonders where these youth are living, as a number of you have raised. Those waiting for our residential treatment are in detention facilities and in shelters. One example is a young man who was placed in Boys and Girls Home. He was removed from placement after nine days, when the program closed, and went to the Madison detention center, where he remained until November. Because we were full when he was referred in June, the Child Guidance Center developed a plan to provide IOP services--we have a program specific to adolescent sex offenders--for 12 hours per day, if he could be moved from Madison to a foster home or shelter in Lincoln. This took four months to happen. He's currently in a shelter and attending IOP with us, only because we aggressively pursued treatment for this youth. The new Medicaid regulations also require changes in the day treatment level of care for youth, specifically that the treatment be directed by a psychiatrist rather than a psychologist. We were fortunate to have a psychiatrist work with us--after a lot of pleading and begging, I might add--as the program demands a significant time requirement from the psychiatrist. We operate this day treatment program for severely disturbed children ages 5 to 11. Recently we have accepted children with much greater acuity and severity than in the previous 17 years of the program's operation. Many of the children have had multiple hospitalizations, have been in residential treatment or in one of many foster homes. They can be extremely aggressive in our program, at home, and at school. Several clearly need residential treatment. However, we are unaware of any providers of residential treatment for this age group, other than Epworth Village,

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

which has only the PRTF level of care available. These scenarios raise concerns regarding the lack of accessibility to residential treatment for identified children in specific age groups or with specific diagnostic labels as providers of residential treatment close their doors. These children are being denied and will be denied residential treatment simply because we no longer have that level of care. As a children's mental health treatment provider, I have serious concerns regarding the move to at-risk managed care for the mendicant population. While providers--and that includes me--are cautiously supporting this direction because it may address the IMD issue for adults, the benefit or detriment to children's services is unknown. As restriction of residential treatment continues, it would be logical that lower levels of care are expanded and become less restrictive. And I would say at this point our experience is that that is true and reflects the data that Sue indicated. But it's unknown if that will continue with the move to at-risk managed care. Thank you for your advocacy and assessment of the impact of these changes on the system of care. And I implore you to remain vigilant and continue your oversight as Medicaid moves to at-risk managed care. Thank you. []

SENATOR CAMPBELL: Thank you, Ms. Crumpacker. Is there any questions? I have one question for you. When we were in Norfolk for the series of hearings on LR37, Speaker Flood had a interest in the services that are provided for sex offenders, and I think probably because of several constituents, and it may be one of them as you mentioned in your testimony. Have you had an opportunity to visit with him? []

CAROL CRUMPACKER: No, I haven't. But I have a board member who has indicated that he's very interested... []

SENATOR CAMPBELL: Right. []

CAROL CRUMPACKER: ...in it, so I do need to... []

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

SENATOR CAMPBELL: And I... []

CAROL CRUMPACKER: ...to meet with him. []

SENATOR CAMPBELL: ...I sat down and visited, I think, with the same board member you're probably... []

CAROL CRUMPACKER: Okay. []

SENATOR CAMPBELL: ...talking about... []

CAROL CRUMPACKER: (Laugh) []

SENATOR CAMPBELL: ...and encouraged that appointment and would be glad to facilitate... []

CAROL CRUMPACKER: Okay. []

SENATOR CAMPBELL: ...that if you need anything--because the Speaker has a real interest here--and would be glad to set it up, knowing of your program. []

CAROL CRUMPACKER: Yes, and we're concerned about the availability... []

SENATOR CAMPBELL: Okay. []

CAROL CRUMPACKER: ...of those services. []

SENATOR CAMPBELL: We'll make a note of that. []

CAROL CRUMPACKER: Okay. []

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

SENATOR CAMPBELL: And... []

CAROL CRUMPACKER: I'd appreciate... []

SENATOR CAMPBELL: ...I'm not even going to look at Ms. Chaffee and say, "in our free time." But (laughter) we will try to ensure that happens, because of his interest and... []

CAROL CRUMPACKER: Okay. []

SENATOR CAMPBELL: ...questioning when we were at that hearing. []

CAROL CRUMPACKER: Okay, thank you. []

SENATOR CAMPBELL: Thank you. Our next testifier--who I think has the distinction of being our final...good afternoon. []

JUDY DOMINA: (Exhibit 12) Good afternoon, how are you today? Getting ready to go home? Good afternoon. My name is Judy Domina, J-u-d-y D-o-m-i-n-a, and I want to thank the committee today for giving me the opportunity to testify. I'm the executive director of Nebraska Family Support Network, and I'm also a grandmother and an adoptive mother of Zachary Domina. The testimony I give today reflects the trend that Nebraska Family Support Network is witnessing. During the last two weeks, the Family Navigators, who receive referrals from the Helpline, at Nebraska Family Support Network have been working with five families that are experiencing difficulty getting authorization to maintain or place their children that are in need of a higher level of care--in two weeks, five that have been identified. To illustrate this, I'll give you information from my own personal experience, because at the present time I'm also going through this--this experience. Our family and many other families with children

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

suffering from mental illness work on a 30-day time frame, so I've brought 30 dominoes to show you how that works for us--the time frame that covers the authorized treatment by Magellan for most of these children. Every 30 days a review is done, with Magellan deciding whether the child is responding to treatment and/or meets the medical necessity criteria. Zachary Domina is a 12-year-old child that lived in a war zone, the home of his biological mother and stepfather, for over five years. He experienced both sexual and physical abuse that created trauma to the brain and brain damage. I became his foster mother October 1, 2005, when he was six and a half years old. Over the last six years Zachary has been in my home for four and a half years. The first four years he was there he had the same therapist, Nancy Puckett. Three months after he came to live with me, he was hospitalized for the first time, at Richard Young in Kearney. The next time that Zachary was hospitalized was, actually, four years later. And that happened after we'd moved to Elkhorn, so--because his needs were becoming increased and we did not have the resources out in central Nebraska to handle those needs. He was hospitalized at Immanuel in Omaha. He was hospitalized three times between September and December of 2009. Twice he was sent home with in-home services put in place. The third time he was hospitalized, he was placed at Epworth Village. That was on December 3, 2009. And he remained there until he made a lateral move to Boys Town Community One on November 10, 2010. And I made that move so that he could come home more frequently for visits, we could participate in more family therapy. And he was doing very well. And I would visit him after work as I was coming home and driving past Boys Town. Well, he remained there until July 26, 2011. That morning we had a treatment meeting at Boys Town, and Zachary told us that he was feeling sad and confused. That afternoon he attempted suicide, and he was taken to Immanuel. He stayed at Immanuel until July 26, 2011, when he was sent home, against the recommendations of the Boys Town professionals that had worked with him and the doctors at the hospital. He was sent home because the higher level of care that they had recommended, residential treatment, which he had never had before, had been denied by Magellan. I was told that in-home services would be provided. On our way home from the hospital we stopped at the pharmacy to get the prescriptions that the

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

hospital had ordered. Two of them were not available and were not made available until six days later. In-home services were not made available until a week later. So he was at home for a week with no services and short two of the medications that he had been prescribed. Two weeks after he came home, he was having therapy at Beneficial Behavioral Health, became very agitated, and the therapist had to call and have the police come and remove Zachary in handcuffs and take him to Immanuel. So his at-home stay, for two weeks--lasted two weeks with in-home services. Zachary remained at Immanuel from August 9 until September 1. During that time Magellan again denied higher level of care. And with the assistance of 18 agencies and government officials, Magellan reversed and authorized higher level of care on August 31, with the stipulation that he go to Epworth Village in York or to Boys and Girls Home in Sioux City, which required extensive driving--with Boys Town less than 15 minutes from my home. With assistance again from multiple sources, Magellan did then authorize Boys Town to do the treatment for him. And he remains at Boys Town to this day. I give you this history to illustrate three failures that I see in the system. The discrimination of care, based on mental illness not being considered the same as physical illness--because if Zachary had brain cancer, he would not be sent home from the hospital without proper medication or in-home services; he would not be denied care because he was not responding to treatment. And then the appeal process. When treatment is denied, the parents receive a letter that has a listing of numbers of why the child's treatment was denied; the numbers are referring to the state of Nebraska Medicaid criteria. The parent has to take that and print it off and then decipher why the child's treatment is being denied. If the parent decides that they want to appeal the denial, there is some small print on the appeal that tells you that if your appeal is denied, you will be responsible for the payment of your child's care while they're in care. After all the denials are made and the parent has to make a choice, many times the choice--if they do not have the funds and the care is not available--is to make their child a state ward. Again, the cost shifting of dollars, from Medicaid dollars to child welfare dollars. Zachary's case went through peer review in November. December 18 is the end of his treatment authorization. Will he receive the treatment that is recommended by the

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

professionals that are working with him day by day? Or will Magellan decide to deny it without ever meeting or seeing or spending time with Zachary? December 18 Zachary's treatment is balanced on a scale. If Magellan denies treatment, against the recommendations of the professionals working with Zachary, there is a domino effect. Magellan's decision will have an impact on Zachary, his family, his community, his school, Child Welfare, and the taxpayers. Will Zachary Domina, a two-time former state ward, become a state ward again? Will Zachary Domina's family be told to move to Iowa to get the adequate treatment he needs? Will Zachary Domina be sent home again without services in place, to fail and return to the hospital? These are questions that families raising children with mental illness face every 30 days, usually, in Nebraska. And you heard one of the families that we were working with before. Five families, six counting my family, are now facing these decisions in the next three weeks. Please, help make some changes so that our families are not held hostage to these regulations. Thank you. []

SENATOR CAMPBELL: Questions? Senator Gloor. []

SENATOR GLOOR: Thank you, Senator Campbell. Thank you for sharing your story with us, Mrs. Domina. You made mention that not all the prescriptions given could be filled and remained unavailable for six days. Was that...what was the reason behind that? Did the pharmacy not have authorization for those? Is that--is that the connection...? []

JUDY DOMINA: They called the hospital...and this had happened before, and I asked to make sure that that did not happen again, because, you know, he had had several hospitalizations, and I wanted to make sure. []

SENATOR GLOOR: But was that a...did the hospital drop the ball on that? Or was that a Magellan issue of authorizing those scripts? Do you know? []

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

JUDY DOMINA: Could not get an answer. []

SENATOR GLOOR: Okay. Thank you. []

JUDY DOMINA: I don't know. []

SENATOR CAMPBELL: Any other questions? Ms. Domina, before we finish out, you've provided a lot of attachments... []

JUDY DOMINA: Yes. []

SENATOR CAMPBELL: ...to your testimony. And I thought--I don't need you to go through every one, but if you could just give us a brief overview... []

JUDY DOMINA: Sure. []

SENATOR CAMPBELL: ...of what we have... []

JUDY DOMINA: Sure. []

SENATOR CAMPBELL: ...in your packet... []

JUDY DOMINA: Yes. []

SENATOR CAMPBELL: ...so we don't miss anything. []

JUDY DOMINA: Okay. The first item is the first psychological evaluation that was done on Zachary, when he was six and a half years old, because I thought it was important that you see that--and also that it is an assisted adoption; so the adoption agreement is in there. I think I put that in there; I'm not sure. Also, the last evaluation that was done

Transcript Prepared By the Clerk of the Legislature
Transcriber's Office
Rough Draft

Children's Behavioral Health Oversight Committee and Health and Human Services
Committee
December 05, 2011

by Boys Town. And you can see that they haven't changed. The evaluations have not changed much. Also the denial letter from Magellan denying services that was later changed, after many, many people became involved in the case. My concern is what happens to the children and families that do not have a grandmother-slash-mom that will advocate for them and that do not find their way to Nebraska Family Support Network to get help, to advocate--or other agencies like Right Turn. []

SENATOR CAMPBELL: Thank you for describing what's in the packet and for coming today. []

JUDY DOMINA: Thank you. []

SENATOR CAMPBELL: I believe that concludes the testimony of everyone who wanted to testify today. We very much appreciate it. I do want to indicate that the committee had an opportunity this morning to meet with representatives from the department and the Governor, with regard to some of the concerns that had been expressed to us, and we will follow up that meeting. But one of the things that we indicated is that any of the suggestions or information that came today we would make sure to share with the department and discuss with them. So we will have a follow-up meeting, and we will continue to work on this issue. With that, we'll conclude the hearing for the day. Thank you, one and all, for coming. Walk and drive safely. []