



EXHIBIT 2
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HB HB 183

Appendix 7: Characteristics of Seriously Emotionally Disturbed Population

The following information on the characteristics of Seriously Emotionally Disturbed (SED) children was derived from a fiscal year 2003 MMIS data extract of Medicaid expenditures for all mental health services provided to individuals meeting the state's criteria of SED. Severely Emotionally Disturbed children are defined in the Administrative Rules of Montana (ARM) as children with a primary diagnosis from a specific group of mental-illness diagnoses and exhibiting certain behavioral characteristics. Because the current MMIS system does not track recipients by major disability (i.e. mentally ill, developmentally disabled, physically disabled, etc.), it is possible that some SED children are not included in the data extract and that some individuals who meet the diagnostic criteria are included but may not meet the behavioral or age (6-17) criteria. However, despite these shortcomings, the data contained in this report are adequate to provide a synopsis of the general characteristics of Montana's Medicaid-eligible SED children.

A total of 8,330 children were identified as meeting the diagnostic criteria of SED. Of that number, 4,706 (57 percent) were male and 3,624 (43 percent) were female. The age distribution of SED children is presented in Figure 1 on page 101. As may be seen from this chart, the age distribution is fairly even from ages 7 to 16, peaking at age 12. Also, it is important to note the number of individuals who meet the diagnostic criteria of SED but fall outside of the ARM-defined age range of 6 to 17. A total of 924 individuals between the ages of 18 and 21 continue to receive Medicaid mental health services and have a primary diagnosis consistent with serious emotional disturbance. Because there is some overlap in the definitions used to determine SED in children and Seriously Disabling Mental Illness (SDMI) in adults, it is possible that at least a portion of these individuals have transitioned from the children's mental health system to the adult mental health system. However, for the majority of SED children, the diagnostic and behavioral criteria in the adult SDMI system are different, and the transition from children's mental health services to adult mental health services is difficult if not impossible.

Figure 2 (see page 101) presents the distribution of the 10 most frequent primary diagnoses of SED. Almost 18 percent of SED children have a primary diagnosis of Attention Deficit Disorder with accompanying Hyperactivity. The second most frequent diagnosis is Oppositional Disorder. Of significance in the distribution of diagnoses is the fact that the three most frequent diagnoses as represented in Figure 2 are not recognized as part of the diagnostic criteria for adult SDMI or for SED without an accompanying more serious secondary diagnosis. Thus, by virtue of the diagnosis of their primary mental illness alone, 46.5 percent of the SED children would not transition to adult SDMI services.

Figure 3 (see page 102) shows Medicaid expenditures by major service categories. Of the total expenditure of \$48,504,729, Residential Treatment Centers, Therapeutic Group Homes, and Therapeutic Foster Care accounted for \$29,444,219 (61 percent). Residential care represents a major portion of the total mental health cost for SED children. Of the total expenditure for



residential care, \$1,771,716 (6 percent) is spent on out-of-state facilities. The vast majority of residential care is provided in Montana.

Figure 4 (see page 102) provides information about the costs of individual recipients. It shows that just 5 percent of the SED recipients account for 51 percent of the total SED mental health expenditures. Ninety percent of SED mental health expenditures were spent on just 25 percent of all children diagnosed as SED. Data included in the analysis showed that 17 children cost in excess of \$100,000 per year per child. Two hundred and twenty children cost between \$50,000 and \$99,000 per year per child. The high cost of services to the relatively small percentage of the population is primarily due to the cost for high-end residential care (residential treatment centers, therapeutic group homes, and inpatient hospital care). However, the above analysis includes only Medicaid costs. Not included in the analysis are the significant costs born by other public and private agencies that also interact with SED children, such as the school and juvenile justice systems.



Figure 1
Age Distribution of SED Children

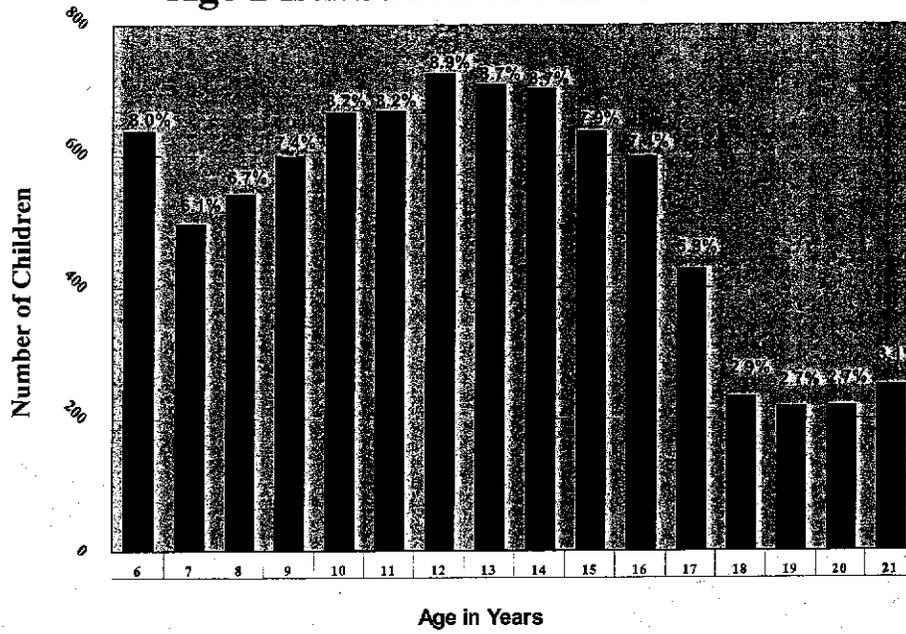
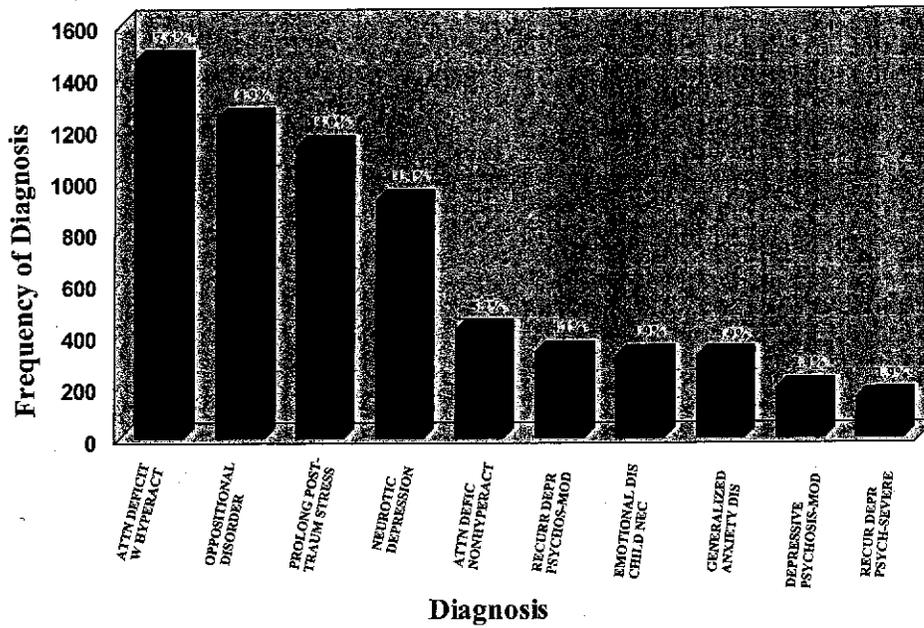


Figure 2
10 Most Frequent Diagnoses



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Figure 3
Expenditures by Major Service Category

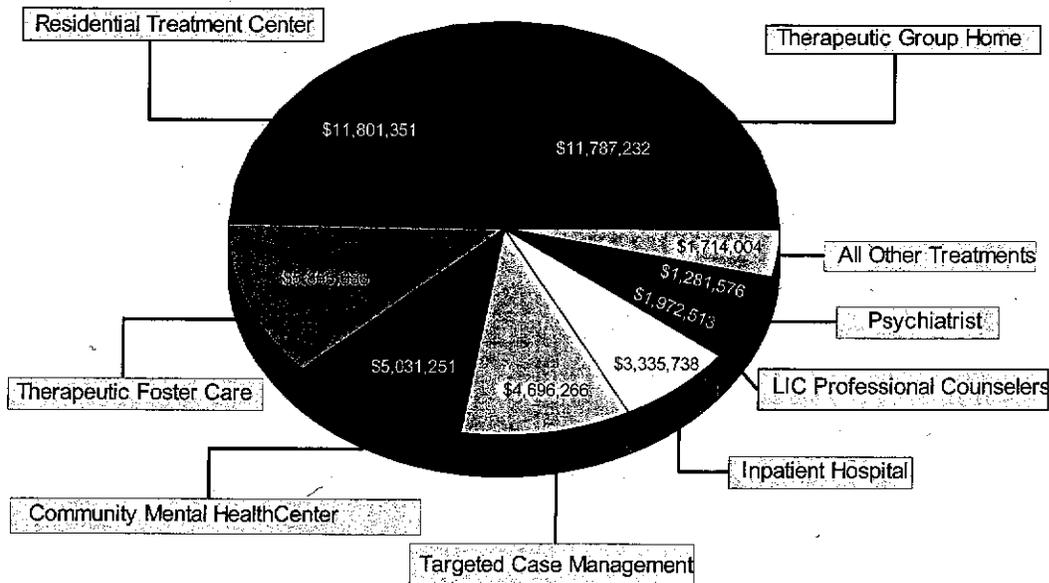


Figure 4
Percent Expenditures by Percent of SED Recipients

