Legislative Priorities for 2011
Service Area Authorities

Priority #1:

<u>Maintain Funding for existing programs at the current level.</u> The SAAs want to ensure that the 2011 Legislature doesn't reduce or eliminate funding for any mental health programs. This is in order to reduce risks to mental health consumers and reduce impacts on higher levels of care, such as emergency responders.

Priority #2:

<u>Fund Peer Services</u> such as Drop-In Centers, Wellness Recovery Action Planning (WRAP), and Illness Management & Recovery (IMR) training.

Priority #3:

<u>Fund Necessities of Life</u> such as accessible Housing and Employment Opportunities.

Please read below for comprehensive justifications.

1. Clients need the stability of being able to count on access to programs that serve them and providers need to be reimbursed at a reasonable wage, which will serve to encourage longevity in the job positions. (Unlike currently, where the job turnover of MH professionals is another source of anxiety and instability for clients.) Many cuts were made last session and we believe further cuts will have mental health consumers relying on higher levels of care and using services such as emergency rooms, local/regional hospitals, and the State Hospital. Cutting mental health services also impacts other systems such as emergency responders, the legal system, and local hospitals.

2. The most proven approaches to successful MH recovery are generally peer-provided services and those actions that are empowering because they are self-generated by the consumer. These practices are proven and based upon much evidence and research. There are many peer services to be considered including programs that have been funded by AMDD and other grants in the past, but should not be limited to those programs funded in the past. Drop-in centers are based on a peer-driven model; there are many mental health training programs that help mental health consumers to take hold of their own health and to help those of others such as WRAP, IMR, and Recovery International. These programs should be built into the base budget where available. Peer services are a part of the ten components.

3. With recovery, comes the desire to hold a recognized place in one's own home community. Very few options are as important as an individual having decent, affordable housing and a job wherein they can feel competent and be self-supporting. Employment programs should be asked to evaluate their methods and results to find out the program(s) that have the best results for Montanans with mental illness and those programs should be fully funded. Housing is a HUGE issue for many mental health consumers and being able to afford housing is the first obstacle. We recommend having a variety of "levels" of housing available for consumers. There is a huge gap between group level living arrangements and being in their own apartment. Many studies need to be conducted to find where the State is on these issues and what the solutions may be.

SAA Legislative Priorities for 2011

As developed at the SAA Summit, Helena, October 28th, 2009

At the SAA Summit, representatives of the three SAA's compared and combined their individual legislative priority lists. The list below reflects their consensus. To help the SAA's better understand and further refine these priorities, additional information about funding and related issues appears below each priority. This basic funding & program information is intended to be the basis for further investigation and discussion by the SAA's.

AMDD's annual budget during this biennium is $117 million during 2010 and $124 million in 2011. In 2008, the AMDD budget was $103 million.

- Most of the money amounts in this summary are rounded up or down. Almost all money amounts are annual rather than biennial; almost all are for 2011, the second year of the 2011 biennial funding cycle.
- Mental health services spending is 84% of the total (about $104 million), addiction services 14% and administrative costs 2%.
- Federal dollars totaling $44 million per year make up about 36% of the AMDD budget; most of that is Medicaid, and it pays for both addiction services and mental health. The rest, about $79 million, comes from general fund or other state revenue.
- Non-institutional mental health and addiction services are about 51% of the total budget; institutional services are 38% of the total budget (MSH alone is 26% of the total AMDD budget); and the balance is various grant programs (including the crisis bills and 72-hour presumptive eligibility, and drop in centers.)
- Funding for most existing programs was cut 2% by the 2009 Legislature. For instance, MHSP, which is an $11 million/year program, was cut by about $200,000 per year. Because Medicaid is an entitlement program, it was not subject to the 2% cut.
- All mental health programs listed below are provided by AMDD for adults only.

Joint SAA Legislative Priority #1: Maintain funding for existing programs. The SAA's want to be sure that the 2011 Legislature does not reduce or eliminate funding for any mental health services programs. All three SAA's made this their top priority. Below is a list of most AMDD-funded adult mental health services.

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1. **Medicaid** pays for mental health services for people with serious and disabling mental illness, as determined by the Social Security Administration, who earn less than the federal poverty level. Annual expenditure on Medicaid mental health services is $46 million, about two thirds of which is federal funds. Medicaid pays for a range of services, including an in-patient benefit. Medicaid pays for MSH patients who are under 21 years old or over 65 but makes up less than 2% of MSH funding. Medicaid makes up 37% of total AMDD spending every year.
2. **Medicaid Home and Community Based Services Waiver** is funded with $3.8 million this year and $5.1 million next year, which is enough to pay for services to 125 consumers at an average cost of $36,000 per year. To qualify, consumers need to be eligible for Medicaid and need the broader range of community services provided under the waiver. This waiver money, unlike regular Medicaid, can be used to pay for housing. The HCBS waiver is about 4% of the AMDD budget.
3. **Mental Health Services Plan** (MHSP), including the MHSP pharmacy benefit of $425 per month, provides a limited, fee-for-service community mental health services insurance benefit for uninsured people with serious and disabling mental illness whose income is below 150% of poverty. The total MHSP budget is $11 million per year, of which $9.8 million per year is state tax dollars (a.k.a. "general fund") and an additional $1.2 million is federal block grant. Of this total, $872,000 per year funds PACT slots. Because enrollment has increased so much recently, AMDD projects a $1.5 million shortfall in 2009 and has begun prioritizing enrollment and creating a waiting list. About 3.5 % ($800,000) of MHSP funding is set to fund Recovery Grants every biennium. MHSP funding is about 9% of the AMDD budget.

a. **HIFA Medicaid waiver.** *Caution: This new Medicaid waiver appears to be approved by Washington but isn't final yet.* This waiver uses part of the $11 million MHSP budget to fund a new Medicaid benefit for up to 800 people currently enrolled in MHSP. Every dollar of MHSP funding applied to the HIFA waiver will be matched by two federal Medicaid dollars. The Department is planning to move MHSP enrollees with diagnoses of schizophrenia or bipolar disorder into the HIFA waiver at the rate of about 50 people per month beginning in January. The HIFA waiver *may* increase the per-enrollee MHSP dollars for the people who continue to get services through the MHSP; those enrolled in the waiver will receive an array of Medicaid healthcare benefits as well as mental health care.

4. **State-funded diversion programs.** Community crisis services, Plan 189 and 72-hour presumptive eligibility all have a different history but basically the same goal: to divert people from the State Hospital.
   a. The three **crisis services bills** passed in 2009 were funded with almost $3 million dollars, $500,000 of which is one-time federal stimulus money, the rest general fund. The money is being distributed to counties or groups of counties that submit proposals for developing crisis services. This is 1% of the AMDD budget.
   b. **Plan 189** is named after the licensed patient capacity of Montana State Hospital. This program was developed to reduce the State Hospital census by funding community services for people who were ready to leave the Hospital. In 2009 (the fiscal year which ended last June), AMDD spent $1.2 million in general fund to achieve this goal; $1 million was spent on group home beds and the balance on prescription medications. Plan 189 has been funded with $619,000 per year, which is a 50% less than the Department spent in 2009. This is .5% of the agency budget.
   c. **72-hour presumptive eligibility** provides $1.4 million per year to fund voluntary crisis intervention services, including evaluations and if necessary, crisis beds, including secure hospital beds. About $250,000 is being used to create a video psychiatric consultation service to rural communities. This is just over 1% of the AMDD budget.
5. **PACT**, the Program of Assertive Community Treatment, has a certain number of service slots in several communities. PACT is mostly Medicaid-funded, but MHSP money pays for some of the service slots. Total PACT expenditures funding is $5 million per year, including $2.7 million federal dollars, $1.4 million state match, and $872,000 MHSP. PACT funding is 4% of the agency budget.
6. **Drop in centers**. In 2009, the Legislature approved $360,000 per year to support five existing drop-in centers and help start some new ones. This is actually slightly less than AMDD spent to support existing drop-in centers in 2009, but the SAA's and AMDD awarded $175,000 in Recovery Grants to start four new drop-in centers in this biennium and expand an existing one, bringing total state funding for drop-in centers to almost $900,000 for the whole biennium. Drop in centers are about .3% of the AMDD budget.
7. **Montana State Hospital** is funded at $33 million per year, which is about 26% of AMDD's total budget. The per patient cost per day is about $516, or $188,000 per patient per year, up from $143,000 per patient per year in the previous biennium.
8. **Montana Mental Health Nursing Care Center** is funded with about $9.7 million per year during the 2011 biennium, up from $7.7 million during the previous biennium. The patient census has remained stable at 83 patients were day, but per patient costs have risen from $93,000 per year to $116,000 per year since the last biennium. MHNCC is almost 8% of the AMDD budget.
9. **Suicide prevention** is funded with $200,000 per year, which pays for both the Bozeman and Great Falls call center operations and the state's full-time suicide prevention coordinator. Suicide prevention is .2% of the AMDD budget.
10. **SAA's** get $55,000 per year.
11. **AMDD Recovery Grants.** In collaboration with the SAA's, AMDD provided start-up funding of $800,000 for a variety of new community mental health initiatives. Recovery grants are funded with MHSP dollars.
    a. $365,000 was awarded for creation and expansion of consumer employment programs;
    b. $175,000 to create four new drop-in centers and expand an existing one;
    c. $153,000 to fully implement a psychiatric pharmacy program that was started with an ESAA grant;

d. $85,000 to WRAP and Recovery International.

12. **Crisis Intervention Training:** This is the powerful "Memphis model" for law enforcement training. CIT got started in Montana with funding from NAMI and a small AMDD grant. It was not included in the Governor's budget and not funded by the 2009 Legislature, but AMDD has just been awarded a $212,000 SAMHSA grant that will pay for statewide CIT trainings in the next 12 months, plus several two-day Mental Illness Intervention trainings, plus training for County Attorneys and Judges, plus some data collection. Congratulations and thank you to AMDD and Ms. Matteucci.
13. **Department of Corrections community mental health services funding**
    a. **Medications:** The 2007 Legislature appropriated $950,000 to pay for psychiatric medications for prisoners re-entering the community. The program got off to a slow start and spent only $108,000 during the biennium.
    b. **Community mental health services:** The 2007 Legislature appropriated $370,000 per year for community mental health services for prisoners re-entering the community. During the 2009 biennium, the DOC spent $454,000.
    c. **Total funding for both program in this biennium** The 2009 Legislature appropriated $734,000.

Joint SAA Legislative Priority #2: Restore mental health services funding that was cut in 2009 and fully fund programs that were funded at reduced levels.

SAA representatives discussed whether this funding should either be returned to the programs that lost it, i.e. the state hospital, or whether institutional dollars should be reallocated to fund community programs. Community mental health services initiatives created by the 2009 legislative session but not fully funded include the three community crisis bills, especially HB 132, the diversion bill, which received no funding, and the State Hospital transportation bill.

Joint SAA Legislative Priority #3: Fund provider rates at realistic levels.

The Governor's original proposed budget included a 1% provider rate increased; after the economic situation worsened, the Governor revised his budget recommendation and eliminated the provider rate increase completely. The budget finally passed by the Legislature gives community services providers a 2% rate increase for each year of the biennium, but the increases are funded with one-time money. When this money runs out on July 1, 2011, provider rates will revert to 2008 levels unless the 2011 Legislature takes action to prevent this.

Some rates are worse than others. For instance, out-patient services rates have especially lost ground. One hour of psychotherapy is reimbursed at $57, which is far below the actual cost of providing the service, providers say.

For consumers, inadequate reimbursement for community mental health services reduces access to services. If providers can't pay staff competitive salary and benefits packages, they lose staff. If a service is a money loser, the provider will provide fewer hours of that service and waiting lists will grow.

Joint SAA Legislative Priority #4: Create more drop-in centers.

There are currently five drop-in centers that receive some state funding. Four proposed centers have just received Recovery Grants to get started and one has received a grant for expansion.

Joint SAA Legislative Priority #5: Housing

This priority includes a variety of housing development needs: money for land, buildings, and infrastructure; matching funds for community housing projects; seed money for capital projects; funding for transitional housing and staffing; more subsidized housing for section 8 program.

Virtually no state dollars support the development and operation of low-income and supported housing programs. All subsidized low income housing in Montana is funded entirely with federally dollars.

Projects for Assistance In Transition from Homelessness (PATH) is funded with $377,000 per year, of which 75% is federal dollars. AMDD awards PATH funds competitively to licensed mental health centers to fund outreach to people with serious mental illness who are homeless or at imminent risk of homelessness. In the last reporting period (2007), 833 people in 5 communities were provided with PATH-funded services, which presumably helped at least some of them find housing.

Joint SAA Legislative Priority #6: Employment

This topic was not discussed at the November SAA Summit because time ran out.

Past Legislative Priority: Peer Services

Peer services development has made it onto past legislative priorities lists and one Board member suggested that it be included in this summary for more discussion.
According to AMDD, peer services are included in the MHSP and Medicaid plan of benefits, but they are billed as "community-based psychiatric rehabilitation and support," so there is no way to separately track how much peer service is being provided.

In 2007, the Legislature approved creation of five half-time peer positions in AMDD. These folks provide a liaison between the State Hospital and home communities for patients being discharged.

PACT teams are required by Administrative Rule to include a peer support specialist, but most—if not all—of Montana's PACT teams do not.

Georgia and Phoenix, Arizona, have successfully implemented peer training and certification programs and begun to increase peer services capacity. A potential legislative initiative is to ask for funding for training, testing and supporting peer service providers along the lines of the Georgia or Arizona models.