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TO: All Interested Parties
FROM: DMH Executive Team
SUBJECT: DMH State Fiscal Year (SFY) 2011 Budget Development Information

This memorandum begins the SFY 2011 budget development cycle for the Department of Mental Health (DMH). Information herein alerts consumers, families, advocates, community providers and DMH facility staff to issues, constraints and opportunities. It is divided into five sections:

1. SFY 2010 Budget Recap
2. SFY 2010-2011 Economic and Political Scan
3. Key Mental Health Budget Development Themes for SFY 2011
4. DMH SFY 2011 Priority Areas
5. Budget Development Timeline

SFY 2010 Budget Recap

Despite the struggling Missouri economy, DMH fared better than expected in the SFY 2010 budget process, guided by Governor Nixon's strong budget recommendations for DMH:

- The Governor limited DMH core cuts to \$19.7 million General Revenue (GR) or about 3.2% of DMH's \$616.5 million GR core. Cuts were taken primarily by closing state acute psychiatric inpatient beds and concurrently expanding inpatient psychiatric beds at community hospitals in Columbia and Kansas City. DMH supported this recommendation to avoid the loss of client services and to maximize Medicaid reimbursements available to community hospitals but not state facilities.
- Despite the necessity of the core cuts, Governor Nixon and his budget office, led by Linda Luebbering and her talented staff, recommended over \$36 million in new GR for DMH programs in SFY 2010, with an additional \$47 million in federal matching reimbursement for Medicaid-eligible individuals. Legislative budget deliberations brought diverse perspectives that ultimately shaped the DMH budget passed by the Legislature. The tables on the following pages reflect the DMH "wins and losses" in the SFY 2010 budget.

Table 1: Key New DMH Decision Items Passed by the Legislature in SFY 2010

Budget Item	GR Increase	Federal Increase	Total-New Items
Medicaid Caseload Growth -- Cost to Continue from FY 2009	\$8,411,556	\$15,072,477	\$23,484,033
FY 2010 Medicaid Caseload Growth Expansion	\$7,000,000	\$12,541,979	\$19,541,979
Replacement of core funding lost through federal regulation changes in billing by DMH for "Organized Health Care Delivery System" (one-time funding from Federal Budget Stabilization Fund)		\$2,679,546	\$2,679,546
Increased medication funding for non-Medicaid CPS and ADA consumers	\$2,863,897		\$2,863,897
Funding for DD children aging out of public schools and into DD Waiver programs	\$2,200,000	\$3,941,820	\$6,141,820
Increased food and medical care funding for DMH facilities	\$935,929		\$935,929
Missouri Sexual Offender Treatment Center (MOSOTC) cost of continuation and expansion funding	\$1,342,495		\$1,342,495
MO HealthNet and DMH Mental Health Partnership Technology (one-time funding from Federal Budget Stabilization Fund)		\$1,250,000	\$1,250,000
Veterans Initiative		\$783,162	\$783,162
Housing -- Federal Grant Expansion		\$615,057	\$615,057
ADA SBIRT Federal Grant		\$2,619,097	\$2,619,097

Table 2: SFY 2010 Governor Recommended Items for DMH Not Funded by the Legislature

Recommended Item	GR Amount	Federal Amount	Combined Total
Medicaid expansion coverage for families below 50% of poverty with mental health problems	\$2,162,751	\$3,875,080	\$6,037,831
State employee general structure increase	\$7,690,207	\$734,013	\$8,424,220
Increased DMH consumer housing costs	\$123,465		\$123,465

As reflected in Table 2, the failure to reach agreement on increasing health care coverage for low income working families has a dramatic impact on DMH, which serves many individuals among this population -- particularly in ADA and CPS. Because these clients are not Medicaid eligible, DMH has to cover the costs of their services with GR dollars only. Had Medicaid coverage been extended, at least 64 cents of every dollar would have been paid by the federal government. This problem is further exacerbated by the additional Legislative core cuts in ADA and CPS non-Medicaid funding (see Table 3). Therefore, DMH has lost the potential of \$6 million to serve low income individuals who come to its community mental health centers and other community providers for mental health and substance abuse treatment services and has simultaneously lost an additional \$1.5 million in Legislative core cuts that will mean more of these individuals will be turned away from services.

Table 3: DMH SFY 2010 Core Cuts

Budget Item	GR Loss	Federal Loss	Total Loss
Governor's Recommended Core Cuts (not including one-times and Medicaid match adjustments): <ul style="list-style-type: none"> • Closure of Mid-MO Mental Health Center* • Closure of units at Western MO MHC* • Core cuts to DMH Central Office 	\$16,513,439	\$266,235	\$16,779,674
Legislative core cut in ADA GR Non-Medicaid funding	\$1,000,000		\$1,000,000
Legislative core cut in CPS GR Non-Medicaid funding	\$500,000		\$500,000
Reduction of DD Community Services to be replaced by approval of new DD Autism Waiver	\$1,000,000		\$1,000,000
GR core cuts accruing from the conversion of Marshall and St. Louis DDTC Habilitation Centers funding streams from ICF/MR to DD Waiver funding **	\$7,455,416		\$7,455,416
Total loss through DMH core cuts or funding below Governor's Recommendation	\$26,468,855	\$266,235	\$26,735,090

* *Acute inpatient psychiatric services in these areas will be available through community hospitals after June 30, 2009.*

** *By transitioning the ICF/MR program at Marshall Habilitation Center and St. Louis DDTC to state operated waiver programs, GR savings will be obtained with minimum impact on consumers at Marshall and DDTC. Savings result from eliminating congregate food service and housekeeping (responsibility shifted to direct care staff and consumers), on-site clinical staff (responsibility shifted to community health care providers, some of which may continue to operate on campus), and administrative staff.*

Table 4 overviews the legislatively passed DMH operating budget for SFY 2010. *For comparison, the total DMH FY 2009 operating budget (all funds) was \$1,159,524,427.*

**Table 4: SFY 2010 Legislative Truly Agreed and Finally Passed (TAFP)
DMH Operating Budget Overview:**

Fund	Total Adjusted Core	New Decision Item	Total TAFP Operating Budget
General Revenue	\$563,243,078	\$31,610,836	\$594,853,914
Federal	\$498,992,056	\$75,677,294	\$574,669,350
Other	\$37,954,979	\$4,316,075	\$42,271,054
Total	\$1,100,190,113	\$111,604,205	\$1,211,794,318

Table 5 provides key SFY 2010 Capital Improvement items for DMH, either through GR or Federal Budget Stabilization Funding.

Table 5: Capital Improvements Budget Highlights

Capital Improvements Item	Amount
Construction of new group homes for medically fragile populations and other campus improvements at Bellefontaine Habilitation Center	\$18,000,000
Other Maintenance and Repair projects for DMH facilities	\$8,937,799

DMH's ASSESSMENT OF THE SFY 2010 BUDGET PASSED BY THE LEGISLATURE

In light of the economic environment and the complexity of the state's budget issues, the SFY 2010 DMH budget is highly encouraging. It also represents important "sea changes" in the following program areas:

Medications to fight addictions: For the first time, substantial funding was provided to the Division of Alcohol and Drug Abuse (ADA) for prescription medications that reduce the cravings associated with addictions as part of DMH's overall medication item increase. Evidence-based practices show the effectiveness of prescription drugs such as Vivitrol when combined with counseling in combating alcoholism and other drug addictions.

Funding for DD youth aging out of public schools: Through the leadership of Senators Shields and Nodler, the Division of Developmental Disabilities (DDD) was allocated over \$6 million in new funding for DD youth aging out of public school special education programs and into the adult DDD services system which will:

- Allow continuity of services across systems by immediately enrolling these youth into DD Waiver services instead of being placed for years on the DD Waiver wait list;
- Prevent regression in the skills achieved by the youth during their school years;
- Allow parents to continue working instead of being forced into full-time caretaking; and
- Avoid families and their disabled children from being forced to reach crisis stages to qualify for DDD services that would be far more expensive annually than the home-based services provided through this approach.

Conversion of state-operated acute psychiatric inpatient services to community hospitals: This conversion was crucial for the state because:

- The federal Medicaid program reimburses psychiatric acute inpatient services when provided through community hospitals in which fewer than 50% of their beds are for psychiatric services. In contrast, Medicaid does not fund state psychiatric hospitals, which are designated as "Institutions for Mental Disease" and are prohibited from billing for Medicaid reimbursement for otherwise eligible individuals, ages 22 through 64.
- Many states have already discontinued the operation of large, stand alone state psychiatric acute centers and moved toward better integration of medical and behavioral health.

DMH had hoped to use the GR savings accruing from this change to strengthen its community mental health and addiction services. This is no longer possible in light of the required core cuts. Had the change not occurred, \$15 million in community services core cuts would have been necessary.

A MAJOR DISAPPOINTMENT IN SFY 2010 – NO RELIEF FOR OVERCROWDING AT FULTON STATE HOSPITAL (FSH)

Given federal stabilization and stimulus funding available to the state, it is highly disappointing that action was not taken to address overcrowding at FSH because:

- The intermediate security unit at FSH is operating at 111% capacity, while the minimum security unit is operating at 114%;
- Forty-five of FSH's 86 minimum security patients are from Southwest Missouri and another 28 consumers in intermediate security are from Northwest Missouri, where no space is available to serve them once they are ready to return to that area;
- Operating at substantial over-capacity is causing major problems for FSH, including expense and equipment cost overruns, employee overtime, severe patient overcrowding that is creating patient stress, and high levels of staff and client injuries;

- The one-time capital costs for a new 45 bed minimum security facility at Southwest Missouri is estimated at \$19 million. The net annual operations costs for a Southwest facility, after federal reimbursements, would be less than \$2.5 million and would create 140 new state jobs in Southwest Missouri;
- A new 28-bed wing addition for the Northwest MO Psychiatric Rehabilitation Center in St. Joseph would cost \$7.5 million in one-time capital costs. Ongoing *net* GR operations would be \$900,000, creating 52 new state jobs for the Northwest Missouri area.

This was a major lost opportunity for DMH clients and state jobs. DMH will renew its request in SFY 2011.

SFY 2010-2011 Economic and Political Scan

ECONOMIC PROJECTIONS FOR 2010-2011

- Missouri's SFY 2009 annual revenue growth estimates were dramatically reduced as the fiscal year progressed, requiring additional DMH withholding above normal 3% reserves in the amount of \$10,796,180 in January and a later withhold of \$653,061 in April. In all, DMH took \$21.3 million in total withholding in SFY 2009.
- Originally, state revenues were projected to grow by approximately 3% this year, but as the global economic downturn became more evident, the Governor and Legislature revised SFY 2009-2010 economic forecasts downward and are now estimating that revenues for SFY 2009 will fall 5% below SFY 2008 levels and SFY 2010 will see very weak growth above revised SFY 2009 levels, if at all.

Many national economists believe the recession will end late in calendar year 2009. However, there are complicating factors for the state to consider in projecting positive or negative revenue growth in SFY 2010:

1. The infusion of approximately \$2 billion in federal stabilization funding for Missouri, while vitally important in reducing the shortfall for a nine-quarter period, complicates the state's projections for the SFY 2011. Significant stimulus fund amounts were built into operations budgets for state departments' in SFY 2010 by the Legislature with the understanding that it was "one-time" funding. However, some of the places where this funding was inserted (the school foundation formula, for example) may require GR replacement in SFY 2011-12.
2. While national economic recovery may begin in late calendar year 2009, economists still predict that job losses may continue well beyond that point. Since Missouri's tax revenues are heavily dependent on state individual income tax, the state may not see significant recovery in the second half of SFY 2010.
3. Finally, it is important to understand the dynamics of state revenue collections. States usually experience the full effects of a recession a year later than it begins due to revenue collection cycles, and states come out of a recession a year later than it ends for that same reason.

MISSOURI POLITICAL SCAN

This year's legislative session was particularly complex and difficult given the economy, the infusion of over \$2 billion in federal stabilization funding, and the debate over expanding Medicaid to the working poor. DMH anticipates that the coming legislative session will be at least as conflicted. The topics are likely to be much the same—when will the economy rebound, how should federal stabilization funds be spent, how to prepare for future years when the federal windfall is no longer available, and whether and how health care should be expanded to Missouri's uninsured populations.

Key Mental Health Budget Development Themes for SFY 2011

DMH's Executive Team, with support from the Mental Health Transformation Initiative, has identified the following key themes for SFY 2011:

1. Timely access to mental health services—getting immediate help to those in need;
2. Increasing the mental wellness and productivity of all Missourians—a population based public mental health approach;
3. Preserving the mental health safety net—assuring safe, high quality mental health services and supports;
4. Increasing public support and understanding for people and their families who suffer from addiction disorders, developmental disabilities and mental illnesses; and
5. **Special Issue**—Re-designing services for individuals inappropriately served in Missouri nursing homes.

These themes and issues are described in greater detail below.

1. Timely Access to Services for DMH Consumers

The lack of timely access to treatment for mental illnesses, addiction disorders and developmental disabilities is the preeminent criticism of Missouri's DMH system. By the time people are able to access mental health treatment they are often in serious crisis conditions and their services are very expensive.

DMH must do better—by reducing barriers to access, by assuring that every Medicaid-eligible consumer is immediately enrolled in services, and by restoring the loss of state GR funding that occurred in the SFY 2010 budget for services to low income individuals who are not Medicaid eligible.

DMH programs are currently overwhelmed with high-end client needs. Access to DMH programs is generally conditioned on the applicant being in a serious crisis before being accepted into the system. While the DMH budget has grown over the last ten years by 33% from \$902 million (adjusted for Medicaid match added in FY 2004) to \$1.2 billion, the demand for services has still far outstripped DMH's resources.

DMH's services are often "one size fits all" and this is particularly problematic for special populations, such as persons who are Deaf or hard of hearing with mental health problems. DMH must continue its efforts to specialize services for these populations.

2. Missouri Population-Based Mental Health and Developmental Disabilities Wellness Strategies

Missourians are accustomed to the state and federal government spending public dollars to keep the general population healthy by such activities as assuring clean drinking water, providing immunizations to avoid childhood diseases and widespread epidemics, and inspecting food production and distribution.

Comparable mental health population-based strategies are not as well understood although they do exist. Examples include the elimination of the use of lead-based paints to reduce the risk of disabilities in infants and young children or warning pregnant women of the risks associated with alcohol and drug use (including smoking) to their unborn children to prevent cognitive and behavioral disorders as well as medical conditions.

Other potentially powerful mental health wellness and early intervention strategies could be developed to address the following known threats to mental wellness:

- Repeated trauma in a young child's life or children removed from their homes due to abuse, neglect or family crisis;

- A combination of certain chronic diseases, such as diabetes and cardiovascular problems dramatically increases the risk of depression for patients; and
- The loss of a spouse or developing a serious disease creates high risk of depression, anxiety and withdrawal in elders.

Yet our programs are not focused directly on these issues

Mental health should increasingly move toward the promotion of mental wellness and early intervention strategies for Missourians at risk of developing serious mental health problems. Otherwise, DMH will lose the battle in providing timely mental health services at sustainable costs to those in need.

A social marketing campaign focused across the life span – early childhood, adolescents, teens, transitional youth, adults and the elderly will help the public, including caregivers, educators, medical providers and policy makers, understand that they can take personal action to impact their own mental wellness. This approach can also change their perspectives about mental illness, developmental disabilities and substance abuse disorders in a positive way. A targeted, social marketing strategy, utilizing evidence based messaging, will serve as a foundation to improve the social and emotional health of our citizens and to change the attitudes of the public toward mental health conditions.

Another strategy is to grow and strengthen the current network of citizen coalitions that have proven effective in reducing substance abuse and drunk driving in their communities. With assistance from ADA state and regional support centers along with additional funding, many of these coalitions are well positioned to take on broader efforts to address mental health issues across the lifespan.

3. Preserving and Strengthening the Mental Health Safety Net of Services

Historic Failure of Community Provider Reimbursement Rates to Keep Pace with Inflationary Costs: Ninety-five percent of all DMH consumers are served by contracted community providers. Yet Senate hearings have highlighted the problem that DMH community provider reimbursement rates have fallen far below inflationary costs over a multi-year period. Some providers may be reaching a “tipping point” that could cause them to go out of business and create a crisis for the clients they serve.

Housing and employment are the twin pillars of recovery: People with disabilities have the same needs for decent housing and for a working life as do the rest of our citizens. Unfortunately, in Missouri, in excess of 85% of adults with serious mental illness in publicly funded programs are unemployed. The consequences of long term unemployment include increased substance abuse, physical illness, and psychiatric disorders, as well as reduced self esteem, loss of social contacts, alienation, and apathy. DMH clients have repeatedly reported dissatisfaction with their service outcomes around employment.

Department of Mental Health consumers are at particular risk for becoming homeless given their low rate of employment, inadequate income, and complex needs. Despite DMH efforts to pursue federal housing funding and other funding sources, our efforts have fallen short. Over 5,000 homeless consumers received treatment services from DMH last year. The Division of CPS experienced a 21.6% increase in the number of homeless served in 2008. The statistics are particularly frustrating as it has been repeatedly demonstrated that housing works for mental health consumers, resulting in higher rates of employment, reduced costs to the correctional system and lower health care costs. Additional treatment funding cannot be utilized to its fullest benefit for DMH consumers if they continue to live on the streets or in adequate housing that costs more than 50% of their income.

Over Census in DMH State Psychiatric Facilities: DMH long-term care forensic facilities have been struggling with severe and ever-increasing census pressures over the past three years. In FY 2008, these facilities, in combination, operated at over 101% of capacity. The over-census is driven, in part, by significant increases in consumers committed to DMH for restoration of competency after a finding in a criminal court that they are Incompetent to Stand Trial (IST).

With the increased census comes a whole host of operational challenges, including: (a) increased rates of injuries to both consumers and staff; (b) deteriorating physical environments; and (c) difficulties recruiting and retaining both professional and direct care staff. In addition, state psychiatric facility operation budgets have not covered the actual costs of operations. To date this problem has been offset by releasing Governor’s reserves and by “flexing” funding between personal services and expense and equipment lines within the facilities’ budgets. With the core cuts and extraordinary withholdings required by Missouri’s economic downturn, these alternatives are no longer possible.

Hospitals cannot effectively operate at 100% census or higher over long periods of time without significant negative impacts on clients and staff. Yet this has been the case for state psychiatric facilities since FY 2006. The following chart highlights the chronic problems faced by state psychiatric facilities.

	FY06	FY07	FY08	3 Year Average
Fulton State Hospital	100%	103%	105%	103%
Northwest MO Psychiatric Rehabilitation Center	104%	102%	101%	102%
Southeast MO Mental Health Center	91%	92%	101%	95%
St. Louis Psychiatric Rehabilitation Center	103%	97%	92%	97%
MO Sexual Offender Treatment Center	91%	105%	100%	99%
All Long Term Facilities	99%	100%	101%	100%

4. Increasing Public Understanding and Support for People with Addictions, Developmental Disabilities and Mental Illnesses

Improving public understanding of mental illness, developmental disabilities, substance abuse, and reducing stigma for DMH consumers is a statutory mission of the Department. The recent creation of the Missouri Mental Health Foundation has helped further that mission. As more information becomes available about how to prevent and treat mental health conditions, the need also increases to disseminate the information as part of a promotion/prevention/early intervention strategy.

DMH has recently increased its efforts by highlighting the lives of exemplary consumers who have overcome the challenges associated with their conditions and have made major contributions to other DMH consumers or their communities. DMH has also highlighted mental health professionals who have left lasting legacies in treatment and stigma reduction. DMH needs modest funding to continue these efforts in coming years and to identify new ways to highlight the achievements of mental health consumers, to increase public understanding about them, and to reduce the stigma associated with their conditions and the services they receive.

5. Special Issue—Diverting and Providing Alternatives to Nursing Home Placement for Individuals with Mental Illness

In March 2009, two Associated Press articles called attention to the fact that the number of younger individuals with mental illness living in nursing homes has grown at significant rates both nationally and in Missouri, and that Missouri’s nursing home population of adults with mental illness between the ages of 22 and 64 is the 8th highest in the country, having increased by 76% since 2002. Federal data prepared by the Centers for Medicare and Medicaid Services show that more than 4,400 people with

mental illness resided in Missouri nursing homes last year. Such statistics place Missouri at risk for both regulatory and legal challenges. States such as Connecticut, Colorado, and Montana have been successful in obtaining Medicaid home and community based waivers to provide more appropriate community based care for people with mental illness, thus avoiding and diverting them from more costly nursing home care. It is critical that Missouri review its screening processes to avoid future inappropriate placements in its nursing homes, and develop appropriate treatment alternatives for individuals currently in nursing homes who should be treated elsewhere.

SFY 2011 DMH Operating Budget Priorities

1. Mandatory infrastructure support items (food, motor fuel, medication, etc.).
2. Medicaid caseload growth.
3. Community provider rate increases.
4. Strategies to reduce patient census at Fulton State Hospital.
5. Modest funding for stigma reduction and wellness-focused social marketing strategies.
6. Services for special populations such as persons who are Deaf with mental health problems.
7. New treatment options for individuals with mental health problems inappropriately placed in nursing homes.
8. Telehealth psychiatric consultation for general practitioners and nurses of nursing home patients.
9. Prevention and early intervention strategies designed to avoid or minimize mental illness developmental disabilities, and addiction disorders.
10. Housing and employment initiatives for DMH consumers.
11. Strategies to replace the SFY 2010 loss of funding for non-Medicaid consumers.
12. Any DMH core redirection item that allows DMH to move forward with the above themes and that strengthens local community mental health service systems, including:
 - Psychiatric acute care transformation;
 - Transition of patients in state hospital long term care facilities and residents in DD habilitation centers to community living and support settings as individually appropriate.
 - Creating recovery oriented systems of care for people with addictions.
13. Budget proposals that create or strengthen cross-division, inter-departmental, or local and state government services focused on mental health, developmental disabilities, or addictions prevention and early intervention.

Capital Improvements Priorities

The highest DMH capital improvements priority in SFY 2011 will be the downsizing and modernization of Fulton State Hospital (FSH). FSH is the last of Missouri's state hospitals to be modernized, and the change is desperately needed to improve treatment conditions for approximately 500 forensic consumers receiving long term care services and the staff who serve them. Building new campuses at Farmington, St. Louis and St. Joseph has dramatically improved the treatment climate and reduced client and staff injuries. FSH accounts for nearly 50% of all injuries to clients and staff across all facilities in the Division of CPS.

Budget Development Timelines

June 1	Distribute FY 2011 Budget Letter
June 11	Mental Health Commission Meeting – Redirects, Mandatories and Policy Questions
July 9	Mental Health Commission Meeting – New Decision Items
July 17	Distribute FY 2011 DMH Budget Guidelines
August 7	Divisions Submit Completed Core and Program Forms to DMH Budget Office
August 7	Divisions Submit Initial Report of CO and Facility Core Adjustments to DMH Budget Office
August 13	Mental Health Commission Meeting – FY 2011 Budget Presentation (review of changed or refocused items)
August 18	Budget Meeting with Facilities
August 21	Core Decisions Finalized by Divisions
August 28	New Decision Item Forms to DMH Budget Office
September 1-3	Executive Team Ranks New Decision Items
September 4	E-mail FY 2011 Budget Reports/Documents to Mental Health Commission
September 10	Mental Health Commission Meeting – Final review and approval of FY 2011 “Draft” Budget Request, including review and approval of decision item rankings
September 14	Final Changes to Budget Book Due to DMH Budget Office
October 1	Budget Submitted to Office of Administration, Division of Budget & Planning