BEHAVIORAL HEALTH
ALLIANCE OF MONTANA

DATE: June 10, 2021
TO: Adam Meier, Director Montana DPHHS; Mike Foster, Chair ARPA Health Commission
CC: Charlie Brereton, Governor's Health Policy Advisor; Kristen Juras, Lt. Governor; Marie Matthews, Director, Montana Medicaid
RE: Request for Relief of Montana Behavioral Health Crisis Post-COVID 19

The behavioral health system in Montana is in danger of imminent collapse unless it receives immediate relief.

Montana has an enormous opportunity over the next 3.5 years to transform the broken behavioral health system into one that serves all our one million Montanans. With the influx of $2.7B of American Recovery Program Act (ARPA) funding over the next four years, we have a once in a lifetime opportunity to not only fix the system but, transform it into a model for behavioral health in the United States. Under Governor Gianforte's leadership, we can finally develop sustainable solutions to mental health and substance abuse problems that have plagued the state for decades. The Behavioral Health Alliance of Montana submits these solutions with the full support of our members, and we stand ready to partner with DPHHS and the administration to enact the Governor's vision.

I. IMPACT OF COVID 19 ON BEHAVIORAL HEALTH IN MONTANA.

The impact the pandemic has had on Montana mental health and substance abuse treatment agencies cannot be understated:

- Shodair has 74 beds for children and adolescents; only 30 beds can currently be staffed due to worker shortages. Shodair currently has a waiting list of 66 kids.
- Yellowstone Boys & Girls Ranch receives 110 referrals a month; they can only accept up to 10 kids per month at most.
- AWARE, due to staff shortages, has closed three children's homes, and has consolidated day services for an additional two therapeutic group homes and four developmental disability residences.
- Intermountain has closed one children's home due to an inability to staff the home.
- Youth Dynamics has 80 beds in 10 group homes and are at a full census and there is a current waiting list of 46 children. They have referrals for over 130 community children in need of services that are awaiting assessments to be performed.
- Rimrock has an adult substance use residential home closed due to staff shortages, with a waiting list of 6-8 weeks for residential homes that are in operation.
- Youth Homes is at capacity and is seeing dramatic increases in referrals from State agencies to accept children who are denied admission to higher levels of care due

to lack of capacity. It is also important to note that the safety net that shelters provide are not reimbursed though Medicaid, and therefore only receive a rate that covers about 50% of the actual cost. They are not reimbursed by Medicaid as they are not considered therapeutic even though a majority of the children have a Serious Emotional Disturbance (SED) diagnosis.

- Providence inpatient adolescent unit's 12-beds are full and there is nowhere to discharge to for step-down. The length of stay is typically 7-10 days; they now have kids for 30-40+ days.
- A survey of behavioral health providers across all four Behavioral Health Alliance sectors (children's, adult, Tribal and SUD) found employee vacancy rates from 20-50% in April 2021).
- Many outpatient SUD clients could not be served in the SUD Intensive Outpatient Program due to a lack of therapists available to work in that program.
- Home Support Services are unavailable in most areas due to the low rate of reimbursement and the inability to find therapists and care coordinators who will work for below-market salaries.
- CSCT programs across the state - providing accessible therapy and behavioral health treatment for children in schools - have had to close or reduce supports due to inability to staff teams with qualified direct care or licensed staff and due to the funding crisis at DPHHS for this program.
- Montana kids have been sent out-of-state due to the workforce shortage in Montana at a huge cost to the state of 133% of in-state Psychiatric Residential Treatment Facility (PRTF) plus full payment for education costs to out-of-state providers with no quality assurance.
- Room and Board for children in therapeutic group homes and PRTFs is no longer paid by Montana Medicaid. If a family cannot pay the room and board or if the agency cannot fund this cost through donations, the agency cannot afford to care for that child. CFSD does pay room and board for children in their care admitted to the facilities.

II. HISTORIC FAILURE OF CARING FOR MONTANANS.

- ✓ Montana is consistently in the top four states in the nation for suicides.[i]
- ✓ Montana is near the top in the nation per capita for children placed in foster care.[ii]
- ✓ Native Americans in Montana die one full generation ahead of the rest of the population.[iii]
- ✓ Sixty-four percent of Montana children removed from the home were for reasons related to parental substance use.[iv]
- ✓ Substance use treatment is reimbursed by Medicaid at the lowest rate in the four contiguous states to Montana, and those rates have been stagnant for a decade.[v]
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- ✓ Among Medicaid patients, the percentage of infants with perinatal drug exposure increased from 3.7 percent (2010) to 12.3 percent (2016) and has continued to increase since 2016.[vi]
- ✓ Opioids were involved in 46,802 (a rate of 14.6) overdose deaths in 2018—nearly 70% of all overdose deaths.[vii]

All these statistics were true prior to the pandemic. The situation is now much more dire, and the already-decimated behavioral health system is about to collapse:

> During the COVID-19 pandemic, concerns about mental health and substance use have grown, including concerns about suicidal ideation. ... In a survey from June 2020, 13% of adults reported new or increased substance use due to coronavirus-related stress, and 11% of adults reported thoughts of suicide in the past 30 days.
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> …Child abuse-related emergency department (ED) visits dropped during the COVID-19 outbreak; however, the severity of injuries among child abuse-related ED visits has increased and resulted in more hospitalizations. Child abuse can lead to immediate emotional and psychological problems and is also an adverse childhood experience (ACE) linked to possible mental illness and substance misuse later in life….[viii]

With the increased demand for services, Montana is also facing a crisis in behavioral health workforce. Montana remains one of the last fee-for-service states that reimburses Medicaid providers in "units" and only for direct services. This archaic system does not reimburse for the full cost of providing care. Unlike hospitals and Federally Qualified Health Centers (FQHCs) that are reimbursed on a Prospective Payment System (PPS) rate that includes the full cost of delivering the care, the majority of community providers serving the most challenging consumers are unable to pay market wages because of the low reimbursement. These providers have experienced a steady decline in the ability to recruit and retain licensed and unlicensed workers for several years. Due to the low reimbursement rates, behavioral health providers are competing on wages with the retail and food service industries in most of the state for direct care staff while requiring more training, education, and emotionally difficult work environments.

We cannot survive until the legislature-ordered $2.7M Medicaid rate study is even partially completed.

III. IMMEDIATE RELIEF FROM ARPA REQUIRED TO SAVE THE SYSTEM.

1. Use the 10% FMAP increase to pay all state-approved mental health, substance use disorder treatment (SUD), Tribal behavioral health, and developmentally delayed (DD) Medicaid providers 15% over FY2020 annual revenue to be used for immediate relief for retention or recruitment of staff at the agency's discretion and reopening costs of centers after COVID. All providers will sign an attestation that these funds go to immediate relief of workforce issues or reopening costs. (Provider Types 32, 59, 38, 64, 61, 82, and children's shelters.)

2. Increase all state-approved Medicaid mental health, SUD, and DD provider rates by 10% for the duration of the ARPA funding so that agencies can stabilize and work toward sustainable solutions with DPHHS. This could also be used to fund the room and board costs for children in therapeutic or shelter residential facilities. (Provider Types 32, 59, 38, 64, 61, 82, and children's shelters.)
3. Pay all Montana Psychiatric Residential Treatment Facility (PRTF) and Therapeutic Group Home (TGH) providers 133% of in-state reimbursement and full education costs so that Montana kids can be treated in-state and Montana providers can afford to recruit and retain a Montana workforce instead of sending our kids as far away as Georgia. The current state compact required to send Montana kids far away from their families requires several weeks for approval and the kids and families are suffering unnecessarily when they could be treated close to home.
4. Workforce housing and daycare affordability are two main barriers to attracting a workforce to the low-reimbursed and low-paid behavioral health field. An enormous amount of money is available in Montana for both housing and daycare assistance, but the eligibility requirements are so stringent that most workers do not qualify until they are at least one month in arrears on payments. We ask that the housing assistance and daycare assistance through ARPA be made available to behavioral health workers for Mental Health Centers, Chemical Dependency Clinics, Therapeutic Group Homes, Psychiatric Residential Treatment Facilities, children's shelter homes, and Psychiatric Acute Units if they have a household income at 80% of median county income and work at a state-approved Medicaid agency that has at least a 50% Medicaid payor mix. If Montana is not able to reduce eligibility requirements for this funding due to federal requirements, we would ask that you increase the lump sum payment in #1 from 15% to 20% per agency to allow the agencies to increase stipends to the behavioral health workforce for housing and daycare. Again, providers would sign attestations that the money would only be used for these purposes.

IV. RELIEF FROM ARPA NEEDED WITHIN THE NEXT 12 MONTHS.

1. Use ARPA funds to provide 100% student loan repayment for any current employee or recruited employee for BA, MA, MSW, LCSW, LCPC, LMFT, LAC, psychologists, psychiatrists, and psychiatric nurse practitioners working in state-approved Medicaid Mental Health Centers, Chemical Dependency Clinics, Therapeutic Group Homes, Psychiatric Residential Treatment Facilities, and Psychiatric Acute Units, with at least a two-year commitment that includes a loan repayment forfeiture if two-year commitment is not met very much like the current NHSC- HRSA program. This can be used as a recruitment tool to get providers into the Medicaid behavioral health workforce. (Provider Types 32, 59, 38, 64, 61, 82, and children's shelters.)

2. Increase Home Support Services reimbursement from the low 15-minute unit rate to the higher day rate like the proposed rate for CSCT to allow for therapists and case coordinators to work with kids in their homes and reduce the need for higher cost, higher acuity residential care.
3. Continue the emergency moratorium on prior authorizations, continued stay requirements, and suspend Quality Assurance and Surveillance and Utilization Review (SURs) audits for the next year at least. Specialty behavioral health providers have been disproportionately targeted for audits by the Quality Assurance Division.[ix] In order for providers to work through this crisis, QAD and licensing need to be available to support, not penalize, agencies for innovations. This punitive atmosphere has undermined the ability of Medicaid provider agencies to conduct business in an efficient manner, and has, in fact, penalized agencies for working in the behavioral health system. For example, one PRTF closed a unit because they could not staff it due to the workforce shortage. When they reopened it, they were required to relicense it and were no longer eligible for the previous grandfathered-in license exceptions. The licensure reverted to the highest level in the country, which was the same as an acute care hospital even though the Medicaid reimbursement is much lower for a PRTF than an acute care hospital. The state needs to work as a partner in remedying this crisis, not exacerbate it.
4. Expand the Behavioral Health Alliance workforce recruitment and retention campaign[x] and establish a state-led behavioral health workforce taskforce with the university system, two-year colleges, BHAM and AHEC to recruit and retain a long-term behavioral health workforce.

V. LONGER TERM BEHAVIORAL HEALTH SYSTEM REFORM.

1. Establish a Medicaid Prospective Provider System (PPS) reimbursement for specialty behavioral health providers to level the reimbursement playing field with hospitals and FQHCs.[xi]
2. Submit an 1115 waiver or State Plan Amendment (SPA) requesting the implementation of Certified Community Behavioral Health Centers (CCBHCs) in the next 2-3 years. CCBHCs come with enhanced federal reimbursement that would provide a PPS Medicaid rate for specialty behavioral health and would allow for expansion of care sites into the rural areas of Montana.[xii]
3. Fund broadband infrastructure to expand telehealth into the rural areas of Montana. We will never have enough behavioral health boots on the ground to serve the one million Montanans living across 143,000 square miles and need to increase proficiency in technology solutions like telepsychiatry and telehealth. As you know, Montana's current broadband coverage is one of the last in the nation and leaves our rural communities without support.
4. Develop behavioral health quality outcome metrics like quality metrics for hospitals and FQHCs that can prove the efficacy of the treatment provided by specialty

5. behavioral health providers. It is time for behavioral health specialty providers in Montana to become full-fledged partners in the healthcare continuum.

We reiterate that the behavioral health system is in a crisis such has never been seen in Montana. Now is the time with the available ARPA funding to transform the system and establish quality outcomes that make us proud to serve our fellow Montanans.

Respectfully submitted by the Pandemic Behavioral Health Crisis Taskforce of the Behavioral Health Alliance of Montana:

Mary Windecker, Behavioral Health Alliance of Montana
Lenette Kosovich, Rimrock
Jim FitzGerald, Intermountain
Mike Chavers, Yellowstone Boys & Girls Ranch
Barb Cowan, Partnership for Children
Matt Bugni, AWARE
Dennis Sulser, Youth Dynamics
Skip Rosenthal, Youth Homes
Craig Aasved, Shodair
Eric Arzubi, MD, Frontier Psychiatry

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[i] https://www.cdc.gov/nchs/pressroom/sosmap/suicide-mortality/suicide.htm

[ii] https://cwoutcomes.acf.hhs.gov/cwodatasite/pdf/montana.html

[iii] http://ibis.mt.gov/indicator/view/PopDemoRaceAIAN.Cnty.html

[iv] https://mthcf.org/grantee/providence-montana-health-foundation-2/

[v] Rimrock Comparison Spreadsheet 2019 – unpublished. Available upon request.

[vi] https://mthcf.org/grantee/providence-montana-health-foundation-2/

[vii] https://www.drugabuse.gov/drug-topics/opioids/opioid-summaries-by-state/montana-opioid-involved-deaths-related-harms

[viii] The Implications of COVID-19 for Mental Health and Substance Use | KFF

[ix] https://dphhs.mt.gov/Portals/85/qad/documents/ProgramCompliance/SURS/SURSSTATSSFY20.pdf

[x] https://montanabehavioralhealth.org/news-resources/

[xi] https://medicaidprovider.mt.gov/Portals/68/docs/manuals/RHCFQHC/RHCFQHCmanual03202020.pdf

[xii] https://www.thenationalcouncil.org/wp-content/uploads/2020/03/2020-CCBHC-Impact-Report.pdf?daf=375ateTbd56