Laying the Groundwork for Budget-Related Recommendations

Staff Presentation to the
Joint Legislative and Executive
Mental Health Task Force

October 28, 2004

The balance of today's agenda lays the groundwork for the Task Force's budget-related recommendations to the next Governor and Legislature.

10:45	Key points from July and August meetings on "non-Medicaid" issue.
11:00	Sizing the non-Medicaid funding gap.
11:15	"Priorities of Government" approach to Task Force budget recommendations.
11:45	Lunch
1:00	Current non-Medicaid service activities.
2:00	Service Improvement options.
3:15	Service Reduction options.
3:45	Public Comment

Summary of Key Points on non-Medicaid Funding From July and August

State and federal Medicaid accounts for 89% of the $750 million Washington is budgeted to spend on community mental health services this biennium.

- Washington has made much more use of Medicaid to finance community mental health services than most states.
  - in 2001, Medicaid comprised more than 80% of total community mental health funding in only 4 other states.
  - the national average and median was 38%.
- Under federal waivers during 1993 – 2004, Washington was able to use Medicaid managed care savings to pay both for:
  - non-Medicaid clients; and
  - non-Medicaid services to Medicaid clients.

Beginning in January, Washington will no longer be able to use Medicaid managed care savings for non-Medicaid people and services.

- Loss will be about $41 million per year:
  - about $39 million per year, $78 million per biennium in Mental Health budget.
  - about $2 million per year, $4 million per biennium in Medical Assistance budget.
- Some RSNs are already eliminating or reducing services to non-Medicaid clients, in order to:
  - phase-down services in an organized manner;
  - safeguard future Medicaid rate levels.
- DSHS, RSNs, and providers hope for early action on 2005 supplemental to avoid additional large cut-backs.

One-third of those who received a community mental health service in FY 2003 – 43,000 people – were not on Medicaid.

- about 20% of the 39,000 children served were not on Medicaid.
- about 40% of the 87,000 adults served were not on Medicaid.

Non-Medicaid clients have low incomes, even though that is not specifically required by state law.

- 73% of those for whom income data are available have incomes below the poverty level.
- 22% have incomes between 100-200% of poverty.
- 17% of those who were “non-Medicaid” at one point in FY 03 were “Medicaid” at some other time the same year.

The reason the large majority aren’t on Medicaid probably isn’t because their incomes are significantly too high, but rather because they:

- are disabled, but not severely or long enough to meet social security standards.
- meet federal disability standards, but receive more social security income than the $565 per month allowed for Medicaid.
- are elderly, but receive more than $565 per month in social security, and don’t need COPES or nursing home care.
- are non-elderly adults who don’t have children.
- have not re-established Medicaid eligibility after time in jail, or failing to follow through on certification paperwork.
- don’t meet U.S. residency requirements.

Non-Medicaid clients are more likely to be in crisis when they are served.

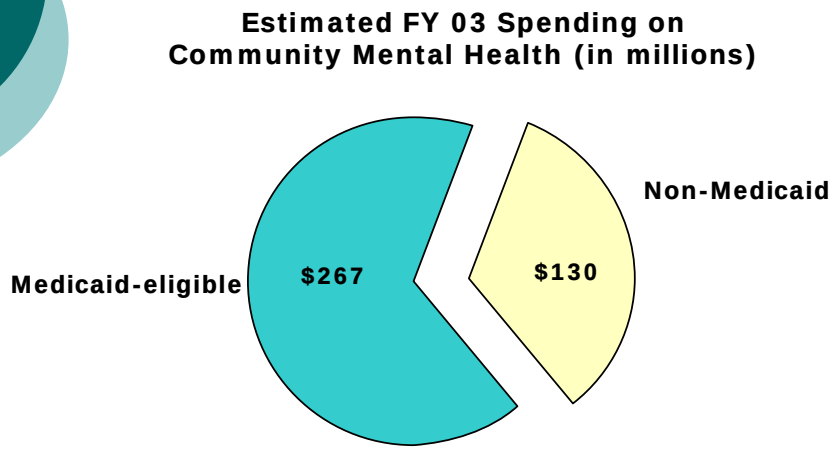
- 55% of all ITA evaluations involve a non-Medicaid client, even though non-Medicaid clients comprise only one-third of the total community mental health caseload.
- Non-Medicaid clients are more than twice as likely to be classified as acutely mentally ill. This may be because:
  - their illness is just beginning to manifest itself, so they have not yet established Medicaid eligibility;
  - their illness interferes with establishing or maintaining Medicaid eligibility.
  - Medicaid clients receive more ongoing treatment, and so are less likely to have a crisis.

The "average" non-Medicaid client is not as severely impaired as the average Medicaid client – though, on an individual basis, many are just as impaired.

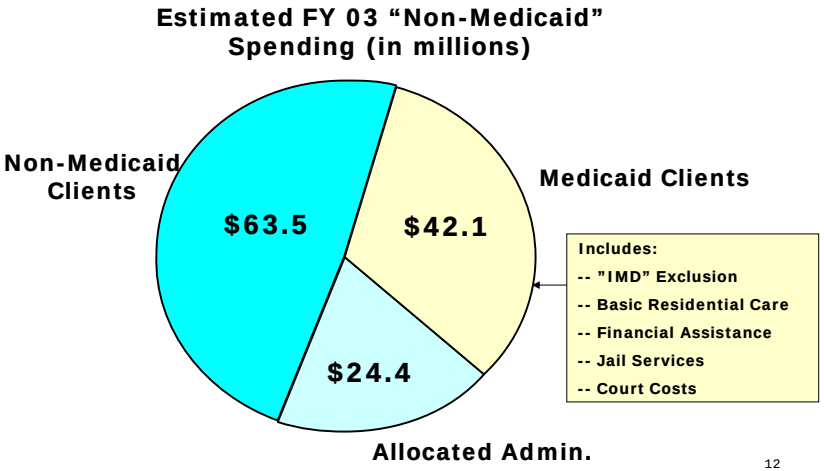
- 62% of non-Medicaid adults have a GAF score of 60 or less, or are classified as acutely mentally ill, compared to 86% of Medicaid adults.
- One-quarter of non-Medicaid children are classified as "severely emotionally disturbed," compared to 36% of Medicaid children.
- 17% of non-Medicaid adults did not meet one of the state priority categories, compared to 6% of Medicaid adults.

How Large Is the Impending "Non-Medicaid" Funding Shortfall?

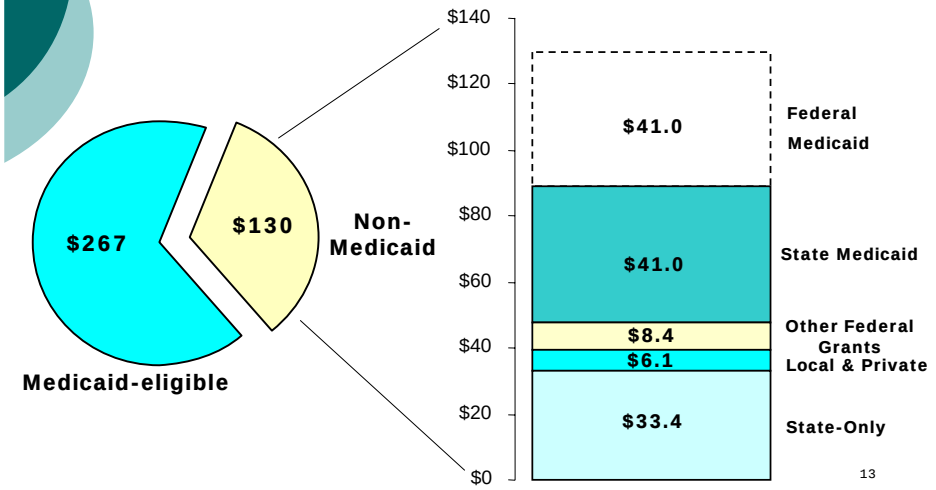
Last year, the RSNs and DSHS Medical Assistance spent an estimated $130 million that will no longer be eligible for Medicaid funding beginning in January.



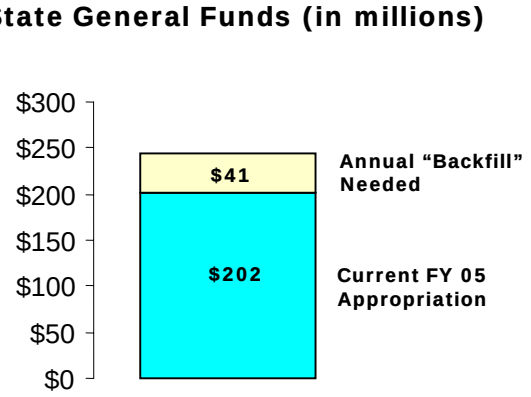
Of the $130 million, half was for direct services to non-Medicaid clients; one-third was for "non-Medicaid" services to Medicaid clients; and 17% was for RSN and provider administration.



Due to the new rules, Washington will lose $41 million per year of federal funding that was previously used for non-Medicaid people and services.



Replacing the $41 million per year, of lost federal Medicaid funding would require a 20% increase in the current level of state funding for community mental health services.



"Priorities of Government" Approach To Task Force's Budget-Related Recommendations

The Task Force prioritized work on the Non-Medicaid and Residential parts of its charge because:

- **both have substantial budget implications.**
- **2005 is a biennial budget-building year.**

In developing budget-related recommendations, the Task Force confronts two constraints

- **state faces a $1.7 billion "current services" deficit.**
- **good ideas about how to address important needs likely exceed funding capacity.**

The Task Force's recommendations are likely to be most useful to the Governor and Legislature if they:

- **include not just spending increases, but also offsetting reductions and efficiencies.**
- **are prioritized.**
- **identify probable outcomes.**

Technical Work Groups have developed three sets of budget-related options for the Task Force's consideration.

Current Non-Medicaid Services

- $130 million per year of current services, subject to the $41 million loss in federal revenue.
- broken into 14 distinct service packages for prioritization.

Service Improvement Options

11 options, that would either:

- reduce future costs, through investments likely to result in increased efficiency and effectiveness, or
- increase service availability and/or quality.

Service Reduction Options

- 5 options for cutting current Medicaid or administrative costs, for reinvestment in higher priority activities.

In its budget-related recommendations, the Task Force will assign the options one of four priorities.

Priority 1: Fund first, within the $89 million/year of state and local funding currently available for "non-Medicaid" services.

Priority 2: Fund next, if half of the $41 million/year loss in federal revenue can be replaced with increased state appropriations.

Priority 3: Fund third, if all of the $41 million/year can be replaced with increased state funding.

Priority 4: Fund next, if $61 million per year of increased state funding is available.

Participation by mental health consumers, professionals, and advocates is important to the prioritization process.

- prioritization materials will be available by Monday evening, November 1, at: http://www.leg.wa.gov/house/opr/MHTF/default.htm
- groups representing state- and system-wide perspectives particularly encouraged to complete the priorities of government exercise.
- statewide groups submitting completed and balanced scorecard by November 12 invited to present morning of November 16.
- other interested individuals and groups also encouraged to present balanced scorecards during November 16 public testimony.

Task Force will:

- also hear a report from DSHS on November 16 regarding its budget neutral proposals to close state hospital wards.
- adopt initial findings and recommendations at its December 8 meeting.