

Overview of Mental Health Services and Issues

Staff Presentation



Senate Ways and Means Committee

January 26, 2005

<http://www1.leg.wa.gov/Senate/Committees/WM/>

Today's meeting and tomorrow's focus on two issues studied during the interim by the Joint Task Force on Mental Health:

- Loss of \$82 Million of federal funding for “non-Medicaid” people and services.
- Availability of state hospital, community hospital, and residential treatment facilities.

Plans for Today's Meeting

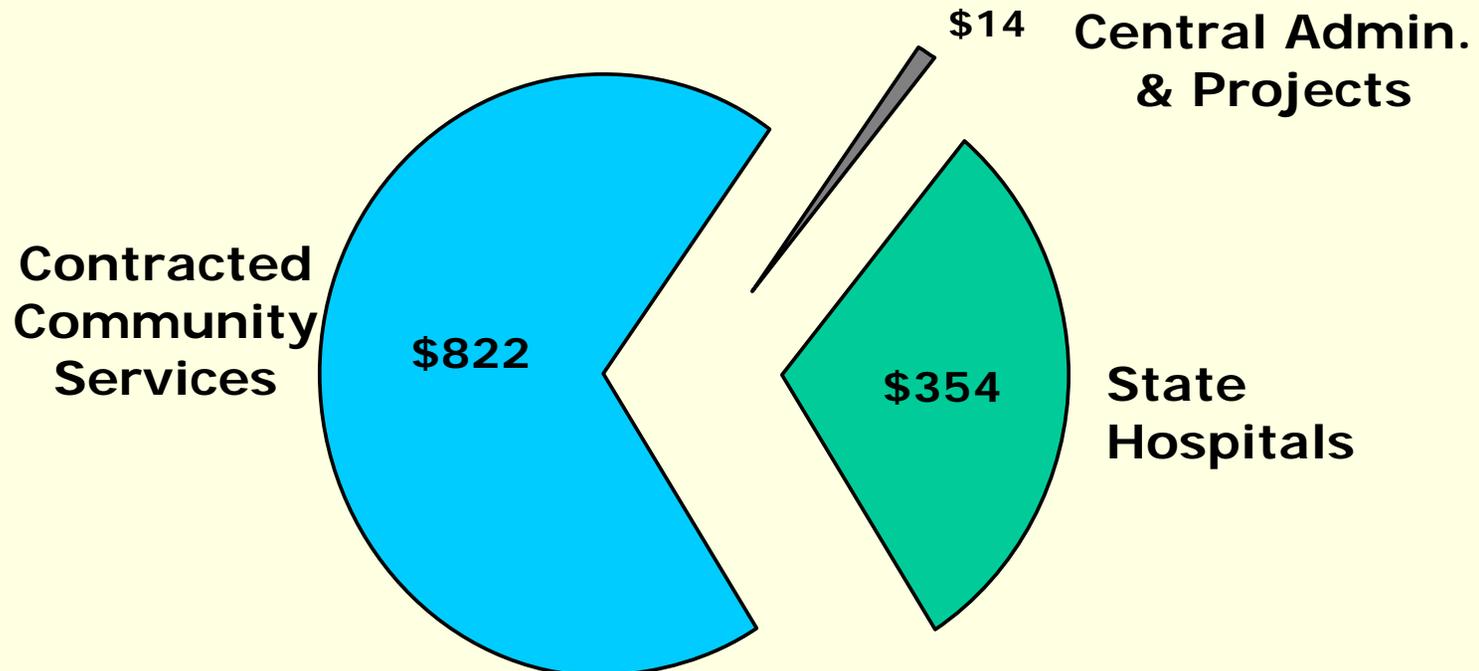
- Overview of Washington's Public Mental Health System.
- Background on "Non-Medicaid Funding."
- Panel Presentations:
 - Who's a "non-Medicaid client," and why?
 - Implications of reduced funding for:
 - RSN service delivery systems.
 - hospitals and jails.
 - housing and treatment services.

Overview of Washington's Public Mental Health System

The state-funded mental health system has two primary components.

2003-05 Operating Budget

(All Funds, In Millions)



Washington operates two state psychiatric hospitals.

Eastern State, in Medical Lake

- 275 average daily patients.
- 700 FTE employees.
- \$47 million annual budget (\$23 million state, balance federal Medicaid, Medicare, and private insurance).

Western State, in Steilacoom

- 900 average daily patients.
- 1,800 FTE employees.
- \$121 million annual budget (\$62 million state).

Adult state hospital patients fall into three broad categories.

315 “Forensic” Patients

- defendants being evaluated for competency to stand trial, & felony defendants judged incompetent or criminally insane.

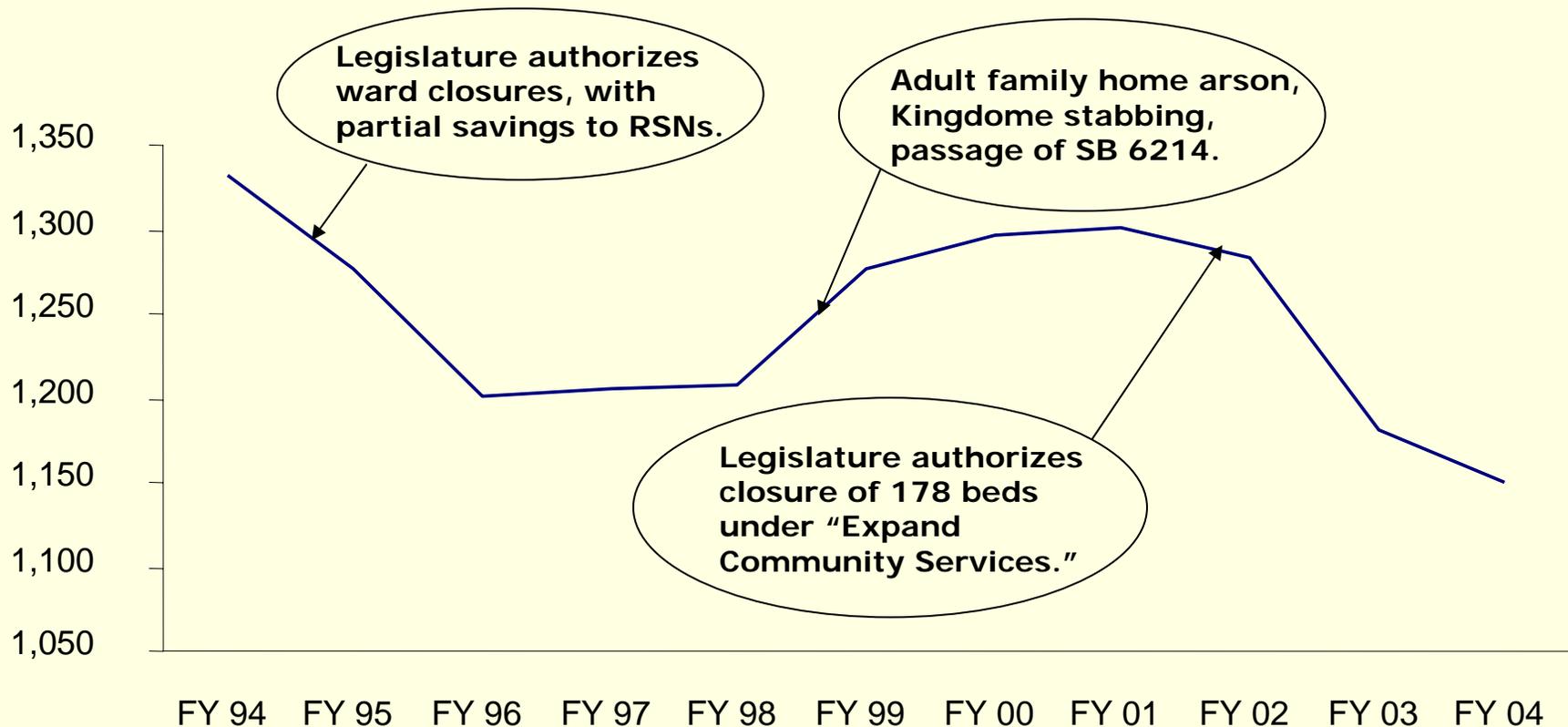
760 Adult & Geriatric Patients

- people civilly-committed to at least 90 days of treatment because judged a danger to themselves or others.

100 “PALS” Residents

- adults no longer needing hospital treatment, but awaiting community placement.

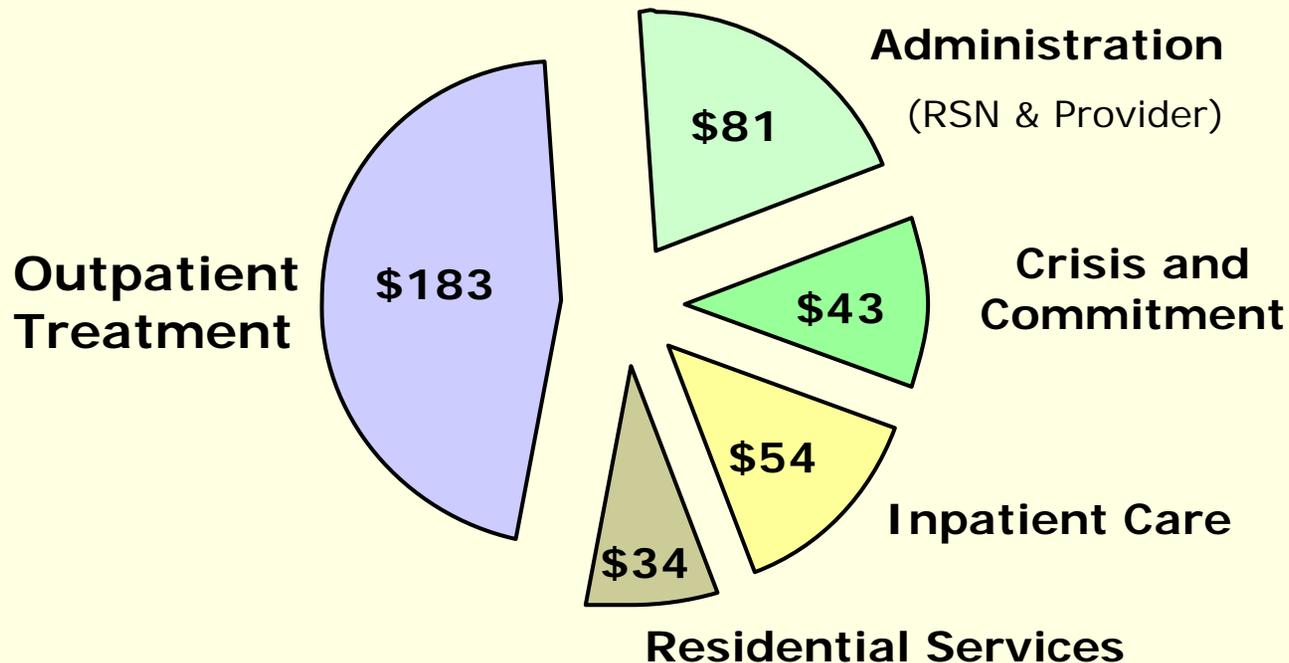
The number of patients in the state hospitals has decreased by about 150 (12%) since 2002. Governor Locke proposes closure of an additional 130 beds in 2005-07.



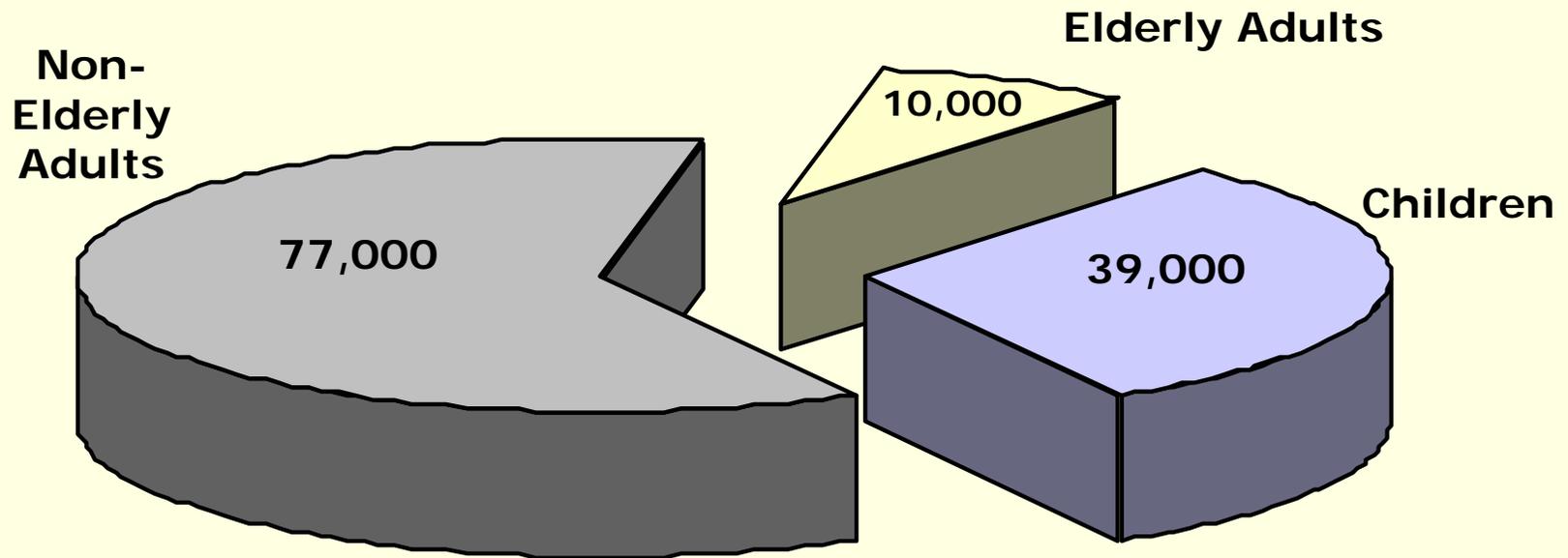
Through the 14 Regional Support Networks, Washington will spend about \$750 million this biennium on a wide array of community mental health services.

FY 04 Community Mental Health Expenditures

(All Funds, In Millions)

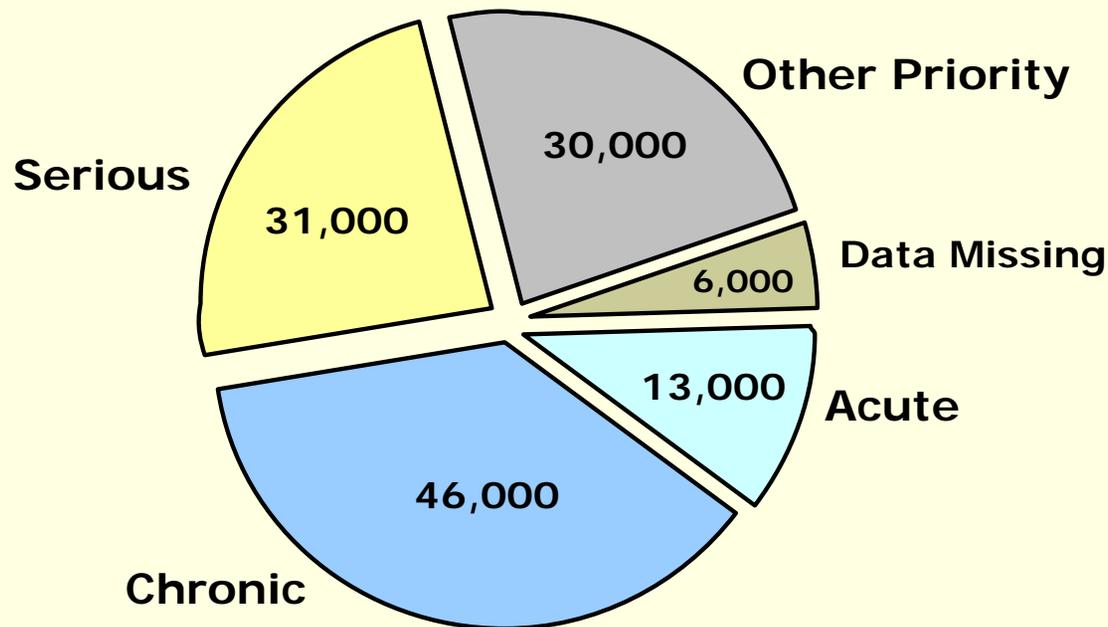


126,000 people – about 2% of the state population – received a publicly-funded community mental health service in FY 03.



About half those who receive community mental health services are acutely or chronically mentally ill; another quarter are classified as seriously disturbed.

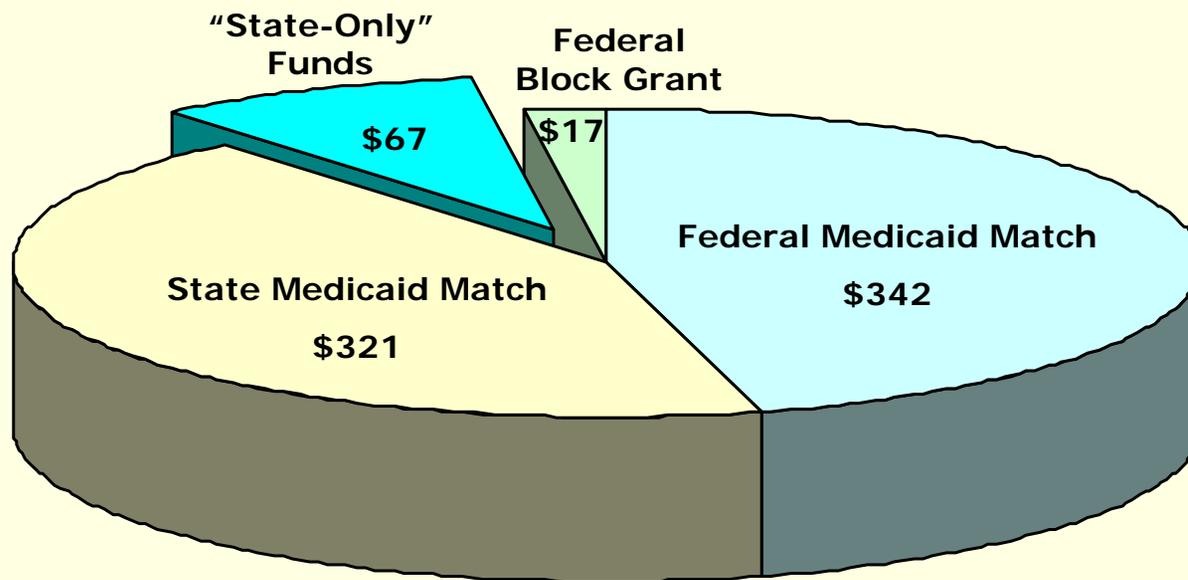
**Impairment Status per RCW 71.24
Persons Served in FY 03**



Overview of “Non-Medicaid” Funding

Almost 90% of the \$750 million Washington will spend on community mental health services this biennium is associated with Medicaid.

2003-05 Operating Budget Appropriations
(\$ in Millions)

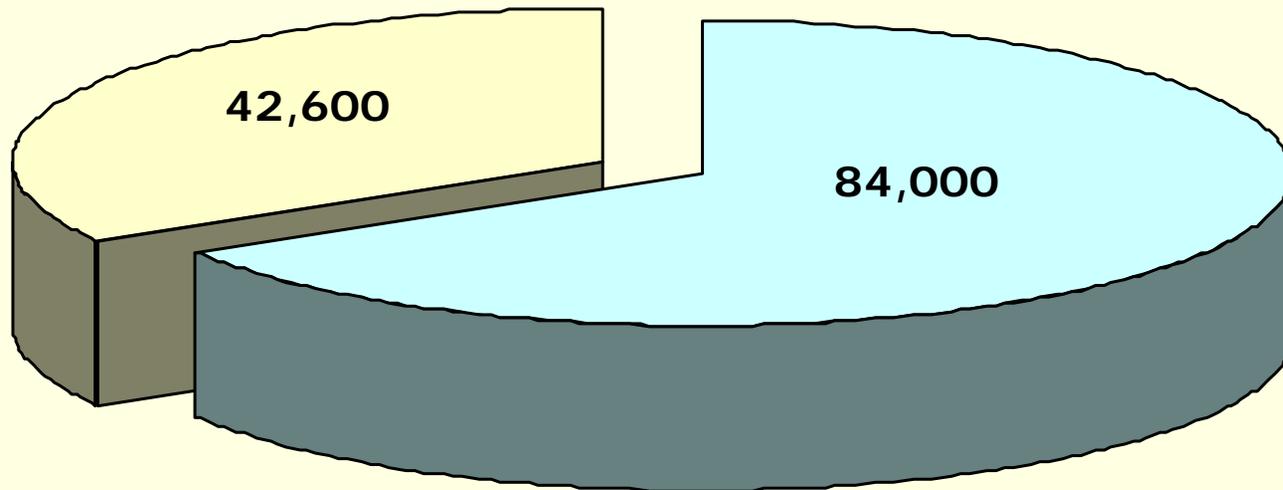


But last year, about one-third of the people who received a state-subsidized community mental health service were not on Medicaid...

Unduplicated Persons Served in FY 03

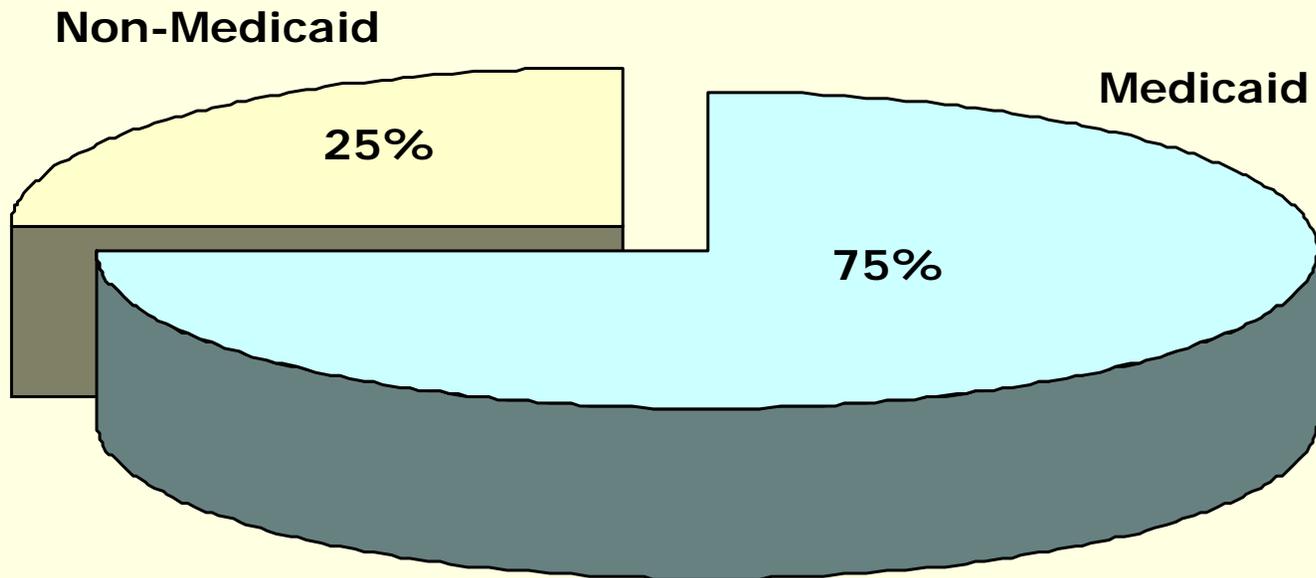
Non-Medicaid

Medicaid



...and they received about 25% of the total hours of service* that were delivered during the year.

Reported Hours of Service in FY 03



* Excludes residential and 24-hour crisis hours, because of inconsistent reporting.

Washington, like 34 other states, replaced Medicaid fee-for-service with managed care during the 1990's.

Under Managed Care:

- single prime contractor, responsible for all medically necessary services, for all eligible clients, for a fixed monthly “capitation” payment per client.

Mental health managed care provided opportunities for both savings, and service improvements, through:

- Case and utilization management.
- Selective contracting.
- Service substitution.

Under 1993-2004 federal waivers, state-level capitation rates were set at the *projected* amount that *would have* been spent under fee-for-service.

If all medically necessary services were provided for less than this “upper payment limit,” part of the Medicaid rate could be used for:

- services that wouldn't otherwise be eligible for Medicaid;
- people who weren't otherwise eligible for Medicaid;
- budgetary savings through cost-avoidance.

In July, new federal policies will require dramatic changes in the financing of Washington's public mental health system.

Under the new rules, rates must reflect the cost of only:

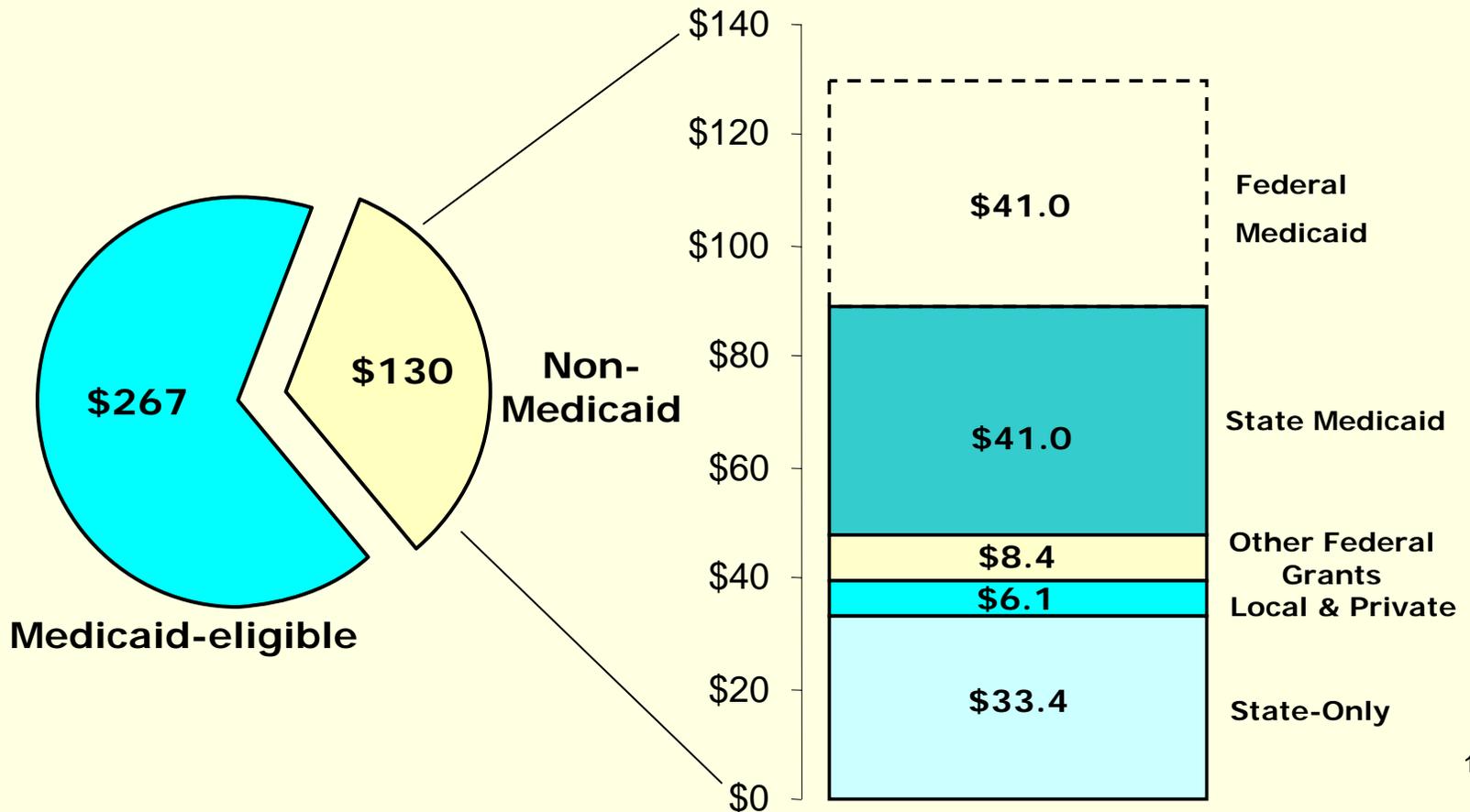
- Medicaid-eligible services to Medicaid eligible people.

Prospects for additional federal flexibility:

- Extensions already granted in March 2004 until January, and in late December 2004 until July 2005.
- Washington has made much more use of Medicaid to finance community mental health than most states.
 - Medicaid was over 80% of total community mental health spending in only 4 other states in 2001.
 - National average and median was 38%.

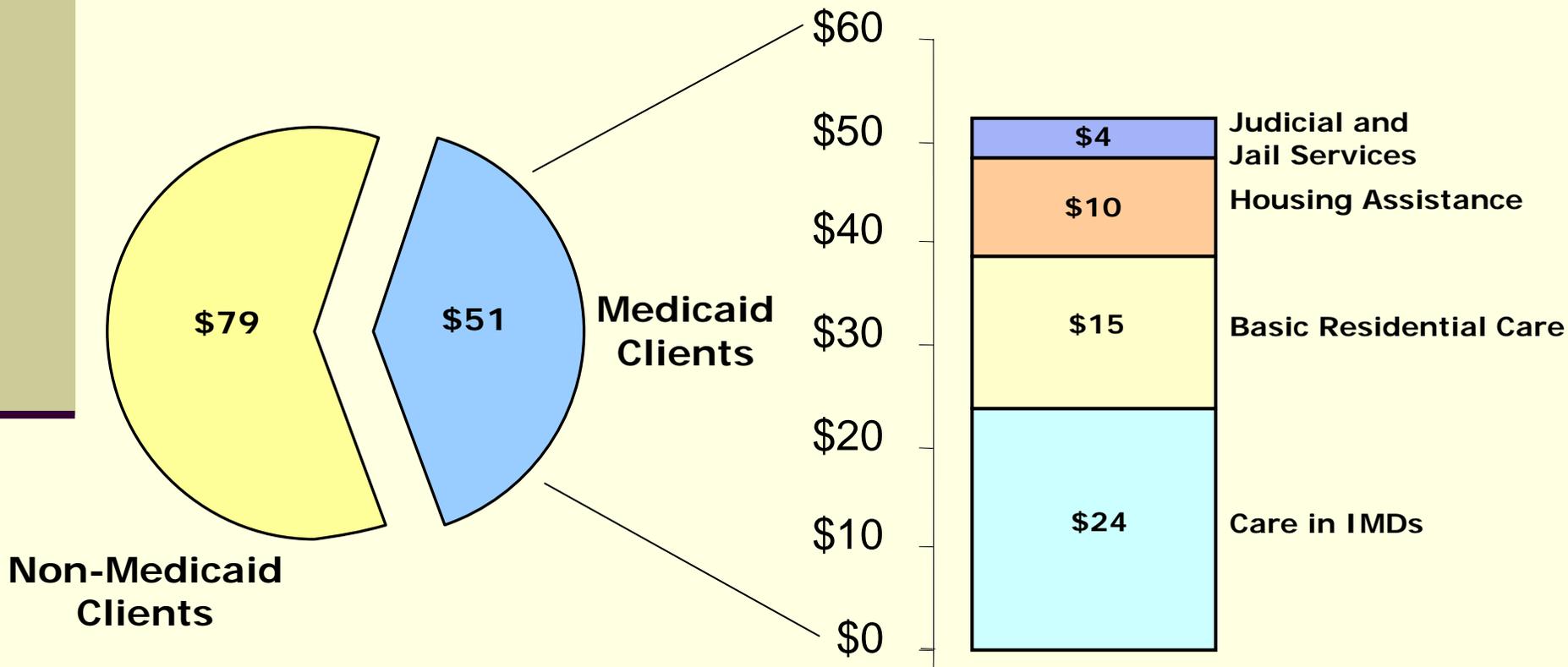
Due to the new rules, Washington will lose an estimated \$41 million per year of federal funding that was previously used for non-Medicaid people and services.

Total FY 03 Expenditures (in millions)



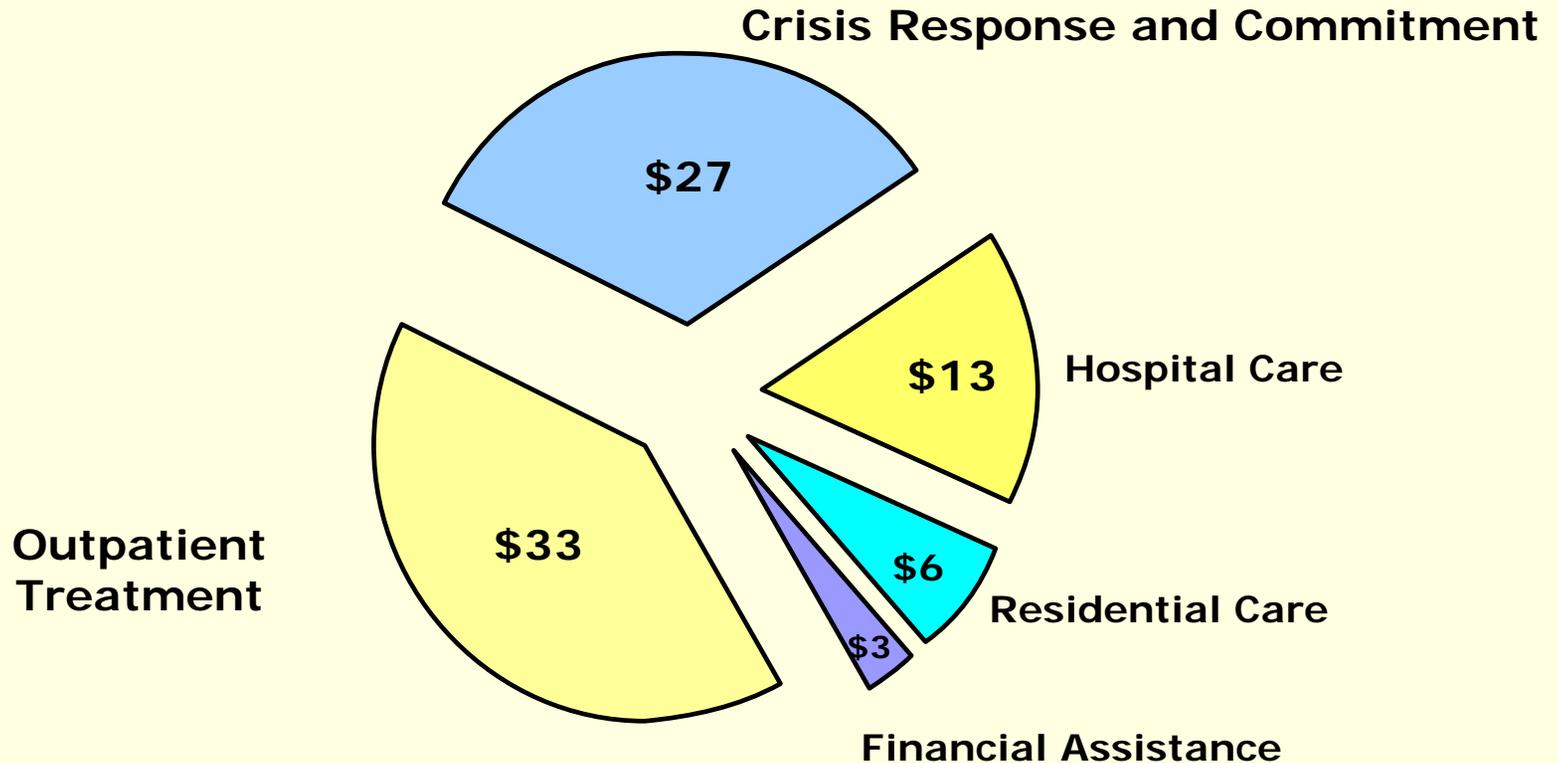
About 40% of “non-Medicaid” spending is on behalf of Medicaid clients, but is for services the federal Medicaid program won’t cover.

Estimated FY 03 “Non-Medicaid” Spending (in millions)



Mental health services for non-Medicaid clients cost about \$80 million in FY 03. About half was for crisis and acute care; 40% was for outpatient treatment.

(Dollars in Millions)



**Joint Legislative & Executive
Task Force Findings on
“Non-Medicaid” Clients’
Income and Impairment Levels**

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 get more social security than the \$565 per month allowed for Medicaid.
- ▶ are elderly, but have more than \$565 in income, 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.

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 moderate or severe level of impairment, 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.

However, non-Medicaid clients are more likely to be in crisis when they are served.

- ▶ 55% of all involuntary commitment evaluations involve a non-Medicaid client, 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.

Recommendations to the Legislature:

- ▶ **Joint Legislative & Executive Task Force on Mental Health recommends:**
 - ▶ replacement of the \$82 million with state-only funding, to the extent possible, and
 - ▶ subject to conditions to be determined by the Legislature.
- ▶ **Governor Locke did not include funding, either in “current revenue” or in “new revenue” budget.**

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