“Non-Medicaid” Mental Health Services and Financing

Background and Context

for the

Joint Legislative and Executive

Mental Health Task Force

July 27, 2004

This morning's agenda seeks to establish a foundation for approaching the "non-Medicaid funding" part of the Task Force's charge.

9:00–9:30 Overview of Community Mental Health Funding

9:30–10:00 Why the concern about “Medicaid” vs. “non-Medicaid” funding?

10:00–10:30 Who’s eligible for community mental health services?

10:30-10:45 Break

10:45-11:45 What the new federal restrictions might mean at the local level

- RSN panel
- Consumer Advocate panel

Overview of Community Mental Health Funding

RCW 71.24 provides that Regional Support Networks are to provide a broad array of community mental health services:

- 24-hour crisis intervention
- involuntary commitment
- assessment & diagnosis
- case management
- counseling & treatment
- consultation & education
- day treatment
- employment services
- medication management
- residential services

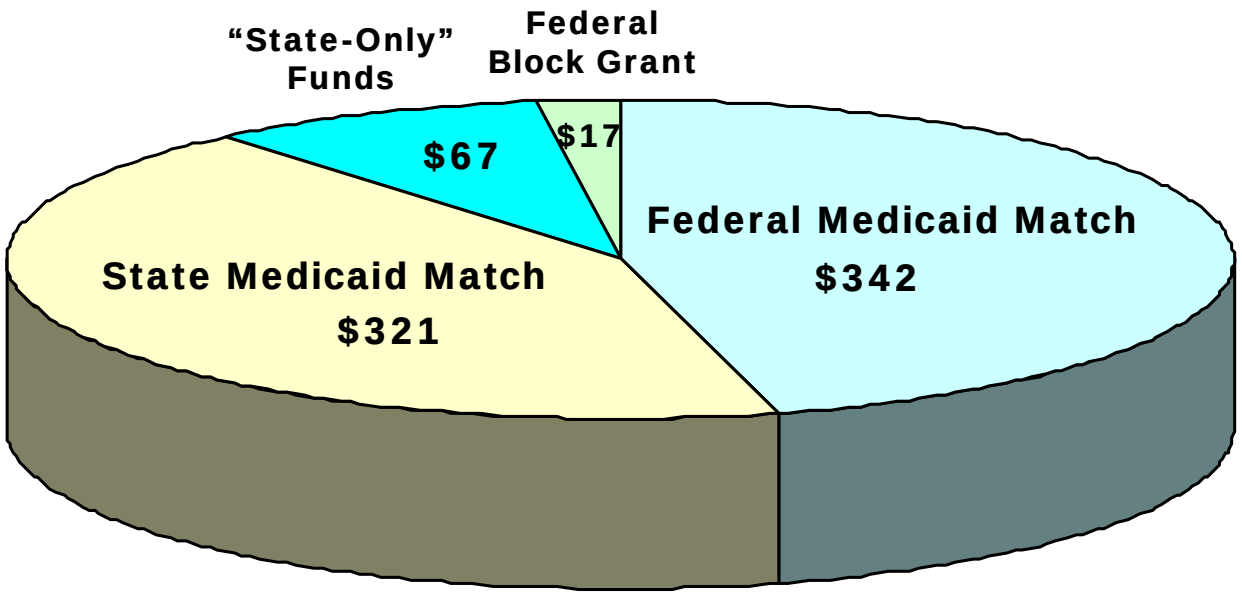
For the following priority groups:

- acutely mentally ill children and adults
- chronically mentally ill adults
- severely emotionally disturbed children
- seriously mentally disturbed children and adults

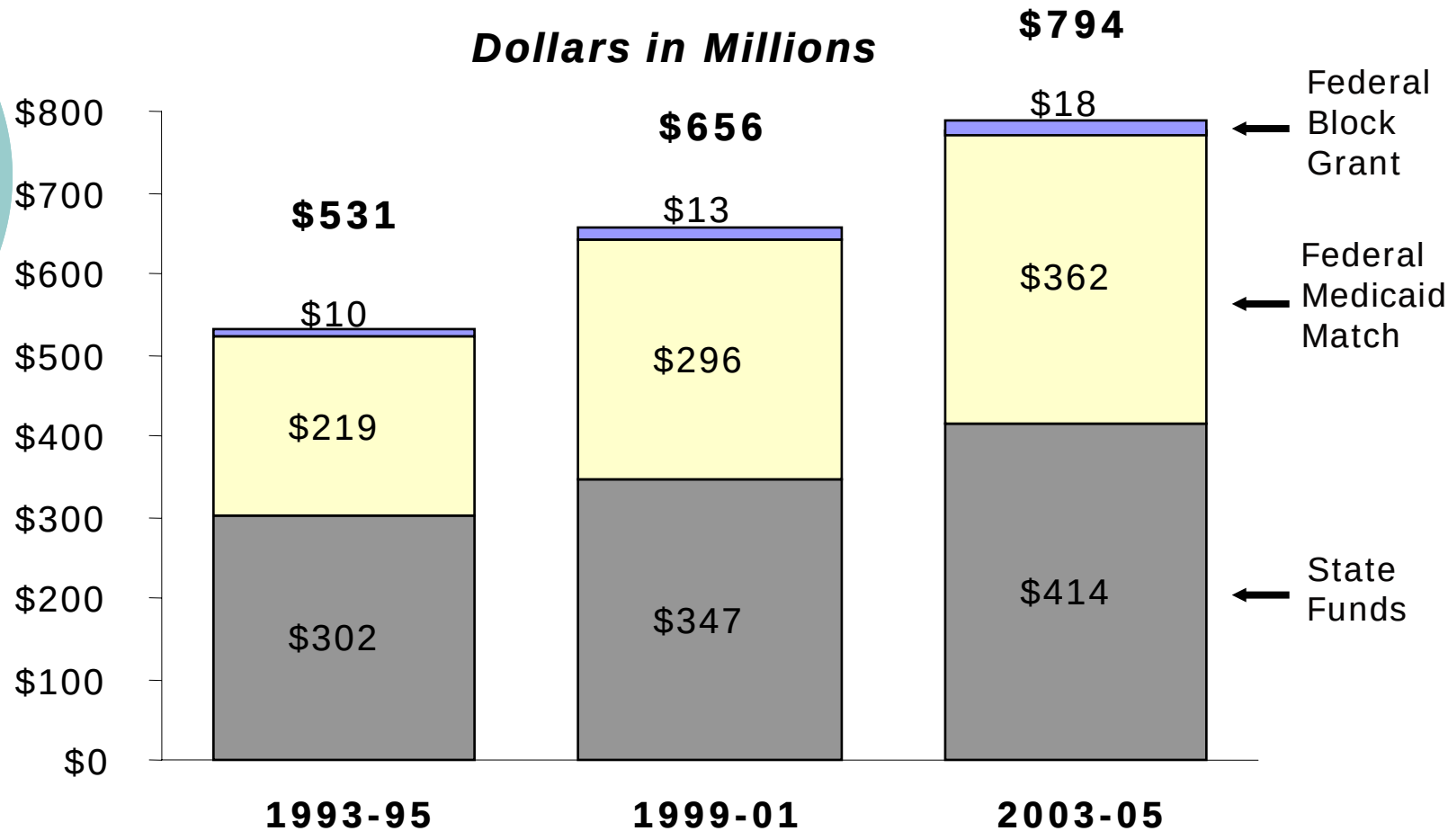
The state is budgeted to spend about $750 million on Regional Support Network services this biennium.

2003-05 Operating Budget Appropriations

($ in Millions)



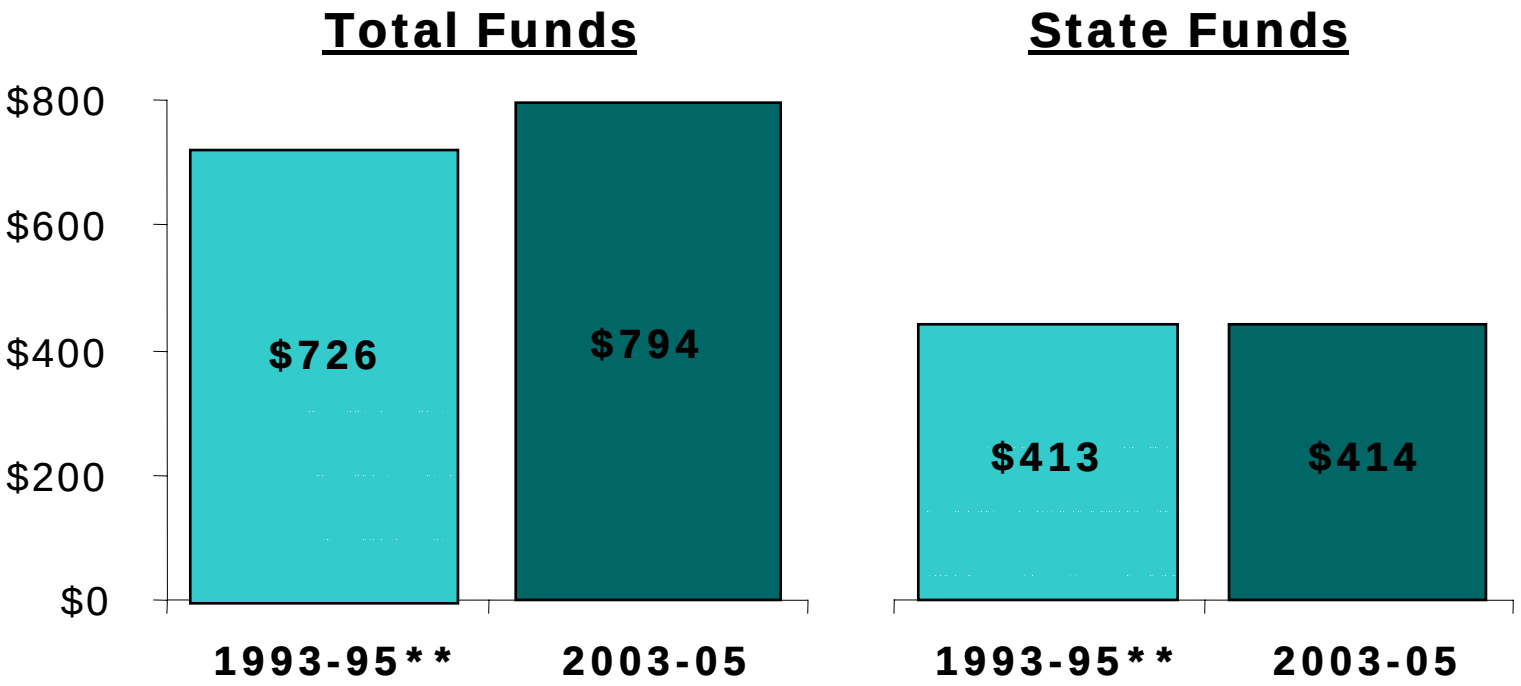
Total funding for community mental health services* has increased by 50% over the past decade.



* Includes children's long-term residential services, and some hospitalization costs not contracted through RSN's; does not include federal funds matched locally, or drugs for Medicaid and GAU clients paid through the Medical Assistance budget. Federal block grant amount estimated for 1993-95.

After adjusting for inflation and population growth, total funding for community mental health* has grown by about 9%. Funding from state tax sources has been unchanged.

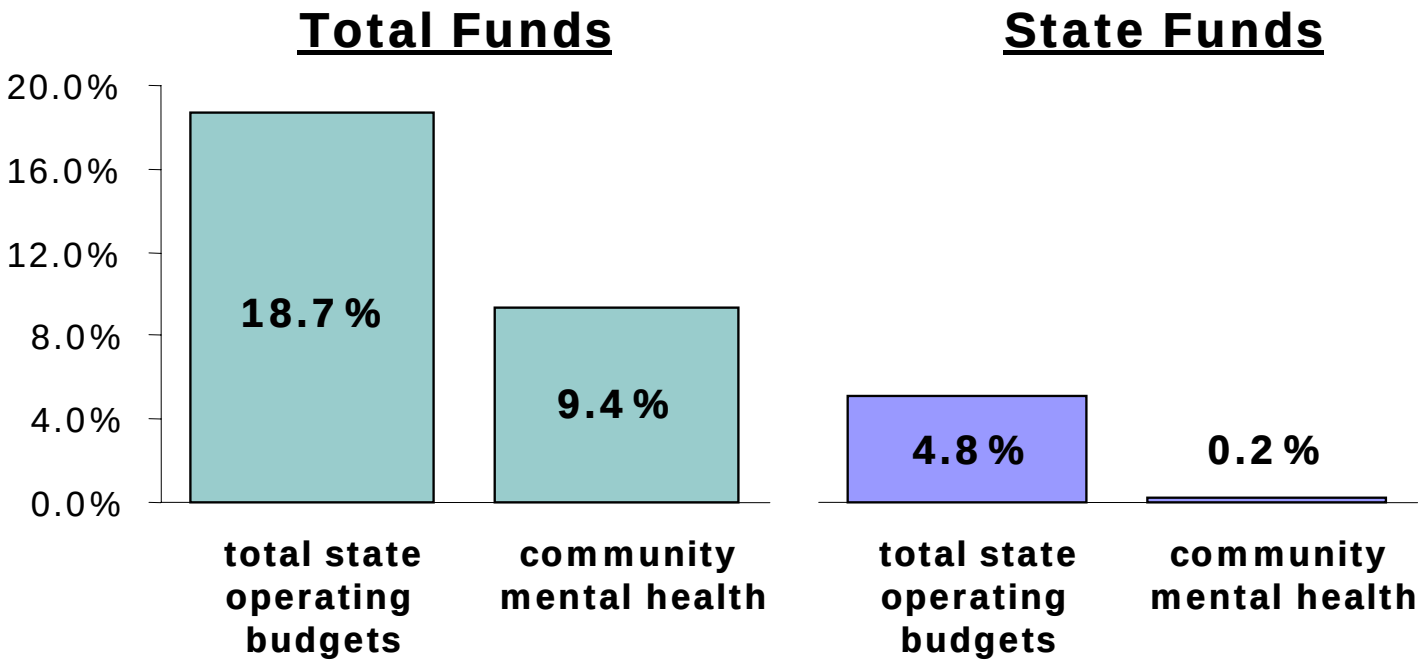
Biennial State Appropriations, in Millions
*****Adjusted for Population Growth and IPD Inflation***



*Community mental health appropriation only. Does not include drug or other physical health expenditures on behalf of Medicaid and GA-U recipients.

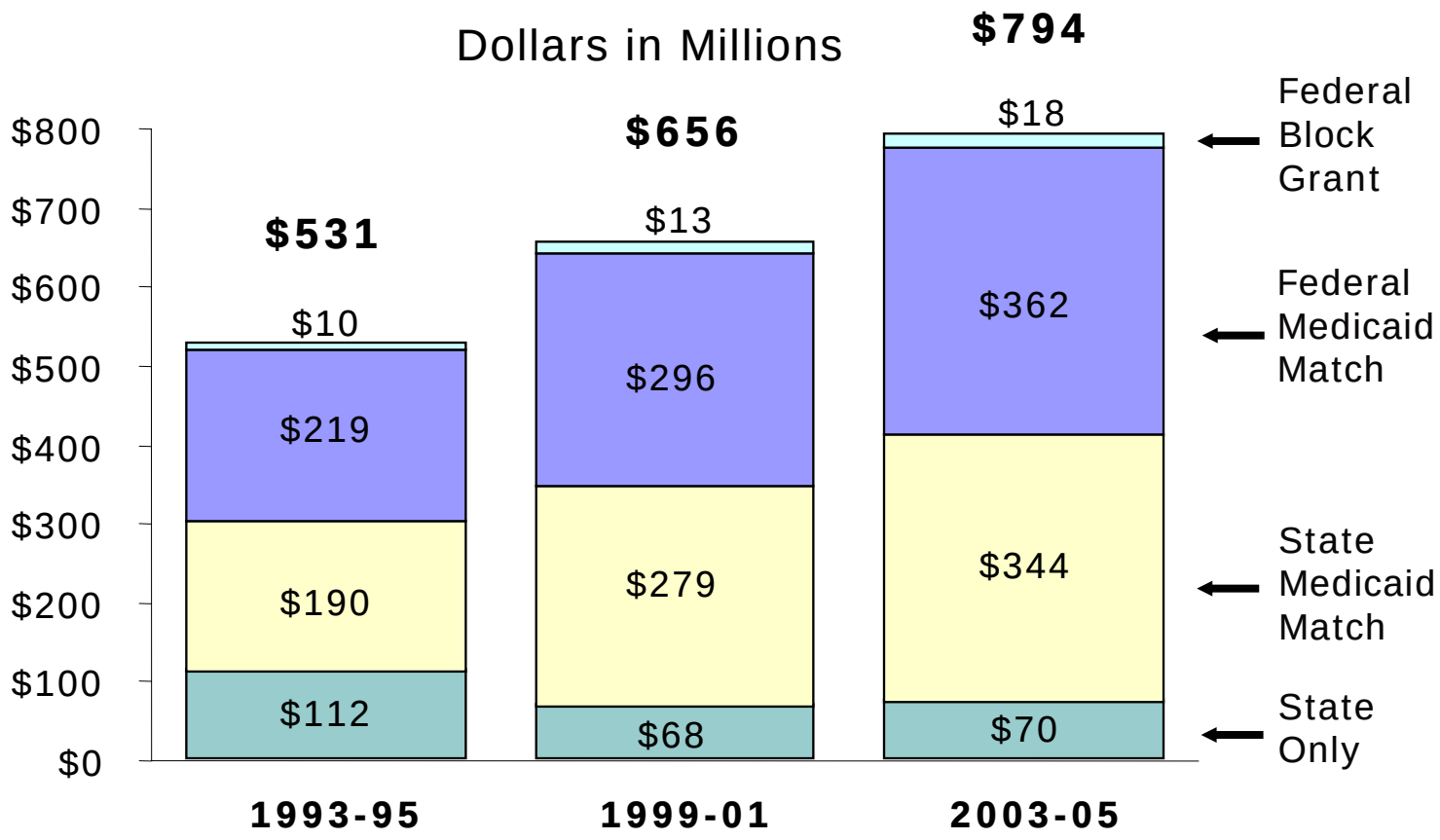
Community mental health* spending has grown more slowly than total state spending over the past decade.

State Expenditure Growth, 1993-95 to 2003-05
Adjusted for Population Growth and IPD Inflation



*Community mental health appropriation only. Does not include drug or other physical health expenditures on behalf of Medicaid and GA-U recipients.

All of the growth in community mental health funding over the past decade has been in Medicaid. "State-only" funding has actually decreased.



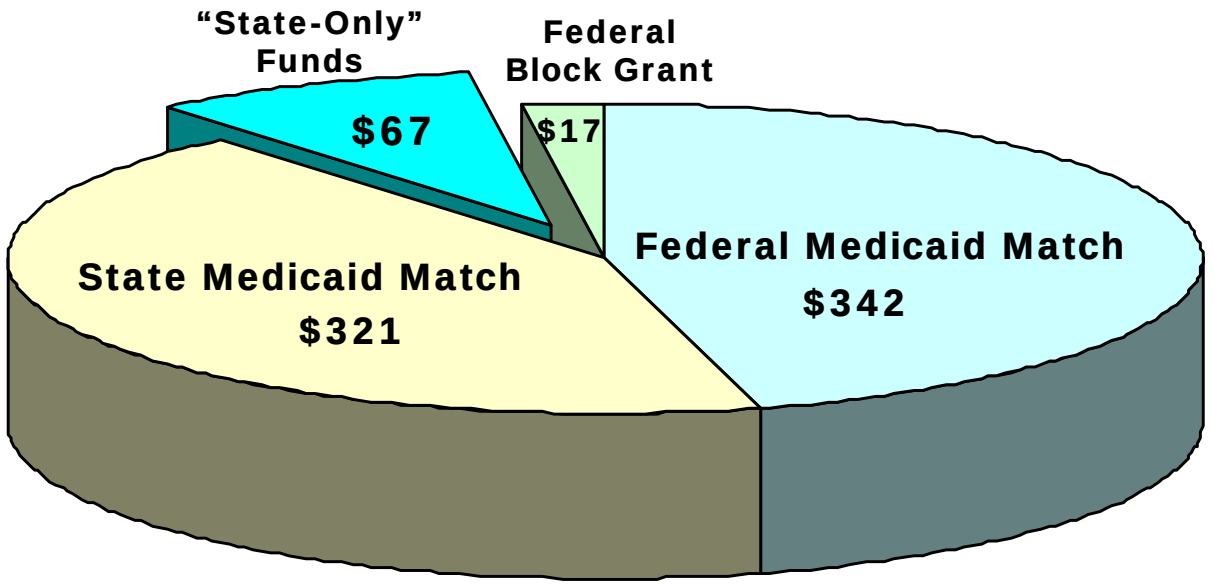
** Includes children's long-term residential services, and some hospitalization costs not contracted through RSN's; does not include federal funds matched locally, or drugs for Medicaid and GAU clients paid through the Medical Assistance budget. Federal block grant amount estimated for 1993-95.

Why the Concern about "Medicaid" vs. "Non-Medicaid" Funding?

Non-Medicaid funding comprises just 11% of the $750 million the state is budgeted to spend on Regional Support Network services this biennium.

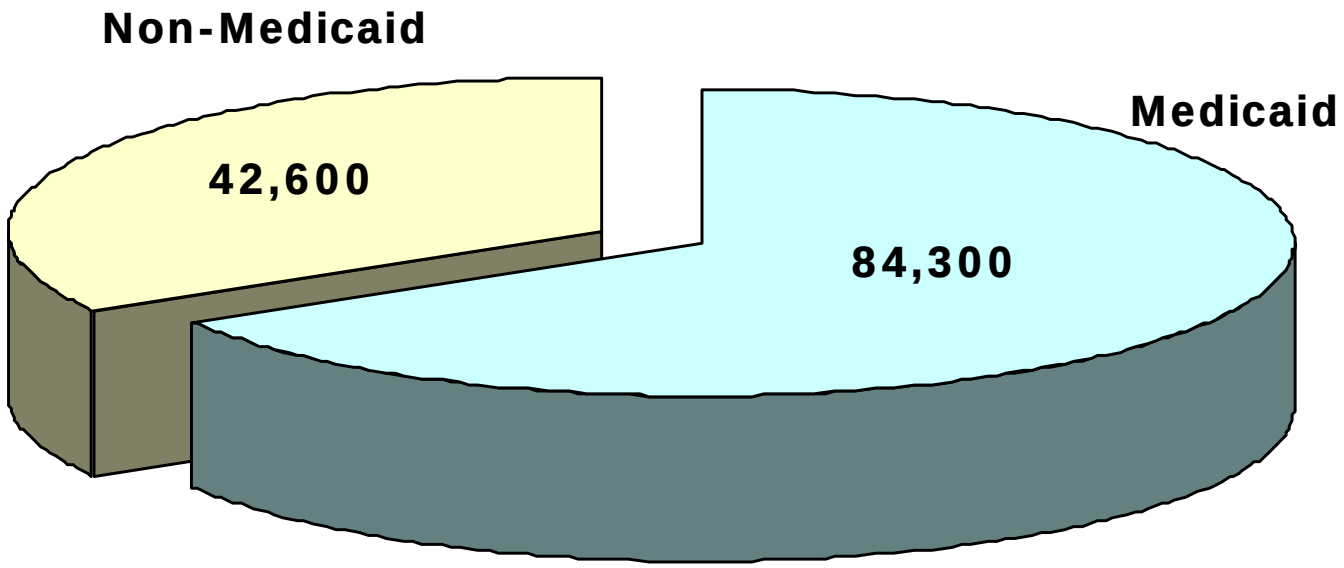
2003-05 Operating Budget Appropriations

($ in Millions)



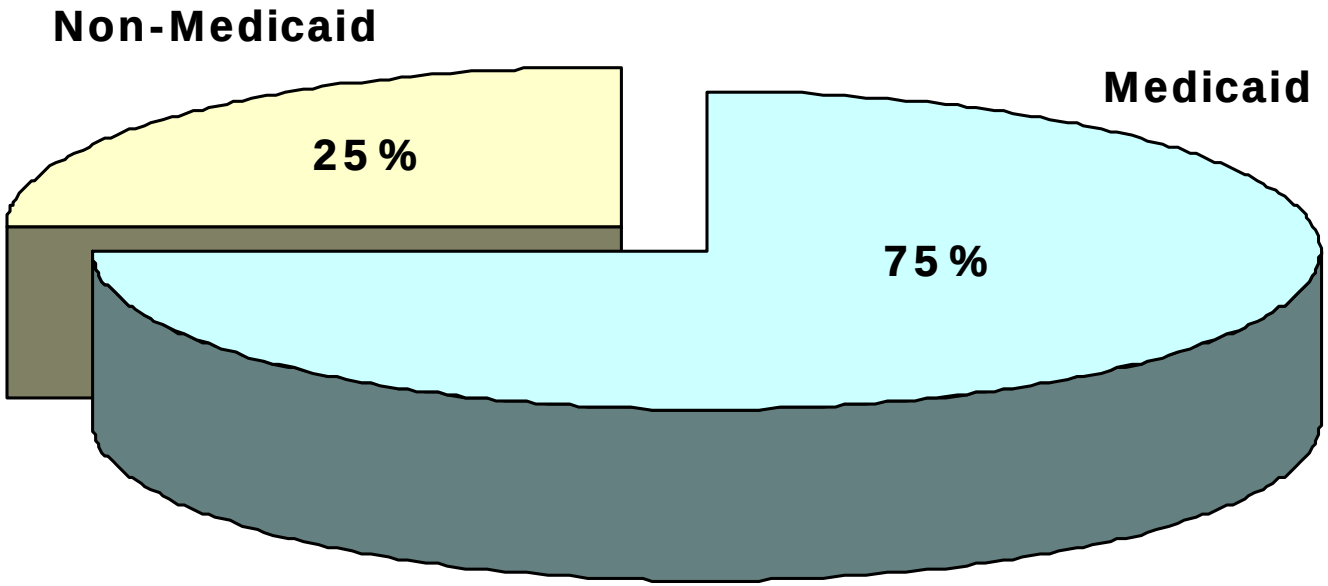
But last year, people who were not enrolled in Medicaid accounted for one-third of the 127,000 individuals who received a state-subsidized community mental health service at some point during the year…

Unduplicated Persons Served in FY 03



…and for 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.

Under the federal waivers that were in effect during 1993-2004, Washington was able to use the federal share of Medicaid managed care savings to pay for:

- services for people who weren't otherwise eligible for Medicaid; and
- services that wouldn't otherwise be eligible for Medicaid reimbursement, including:
  - residential care for persons aged 21-64 in mental health facilities with more than 16 beds (the "IMD exclusion").
  - court costs related to involuntary detention.
  - RSN capital investments.

Prior to 1993, all Medicaid mental health services were paid on a “fee-for-service” basis.

Under fee-for-service:

- any eligible client may obtain
- any covered service from
- any licensed provider, who is paid
- a per-unit rate for the service.

Washington converted from fee-for-service to managed care for outpatient mental health services in 1993, and for community hospital services in 1996.

Under managed care:

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

Like 37 other states, Washington concluded during the 1990's that Medicaid managed care offered a number of benefits for its community mental health system.

- single responsible local manager, consistent with 1989 reform legislation (SB 5400).
- "right service for the right person at the right time" through:
  - case management.
  - selective contracting.
  - rewarding recovery, rather than billable units.
  - substituting more effective services not normally covered by Medicaid, for less effective ones that were.
- budgetary control and savings.

During the 1990's, mental health managed care waivers replaced open-ended fee-for-service spending with a negotiated "Upper Payment Limit".

- upper payment limit set at projected amount that what would have been spent if fee-for-service had continued.
- if managed care succeeded in providing all medically necessary services for less than the upper limit, the difference could be used for:
  - budget savings (cost avoidance).
  - services & people not otherwise eligible for Medicaid.

The federal Balanced Budget Act replaced the upper payment limit concept with the requirement that Medicaid managed care rates be "actuarially sound".

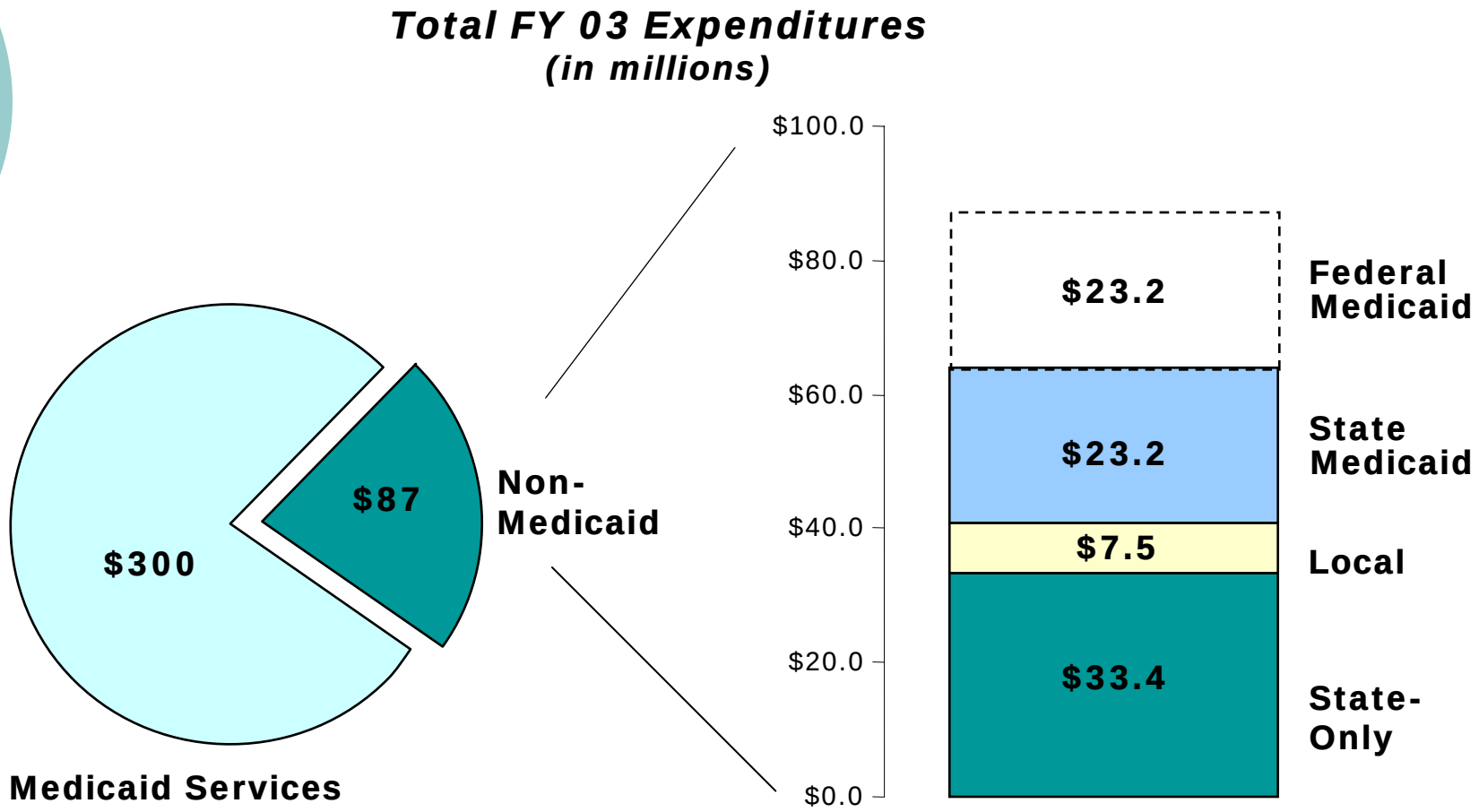
Under 2002 regulations, such rates are to include only:

- Medicaid-eligible services, to
- Medicaid-eligible people.

Implications for Washington:

- rates to be based upon a cost study, because commercial plans don't provide comparable services to comparable population.
- cost of non-Medicaid people and services can no longer be included in Medicaid capitation rates.
- providers have an incentive to increase spending on Medicaid eligibles during the cost-report year, to assure higher future rates.
- any RSN-level profit/savings must be used within one year, for Medicaid clients only.

Due to the new rules, Washington will lose at least $23 million per year that was previously used for non-Medicaid people and services.



$23 Million is an under-estimate of the projected loss:

- does not yet include all non-Medicaid costs for Medicaid clients:
  - services in “IMD” facilities with more than 16 beds.
  - court costs related to involuntary detention
  - some 24-hour crisis services
- cost study may result in higher Medicaid rates, in which case
- some of the $57 million of state funds used for non-Medicaid people and services last year would have to be used for Medicaid instead.

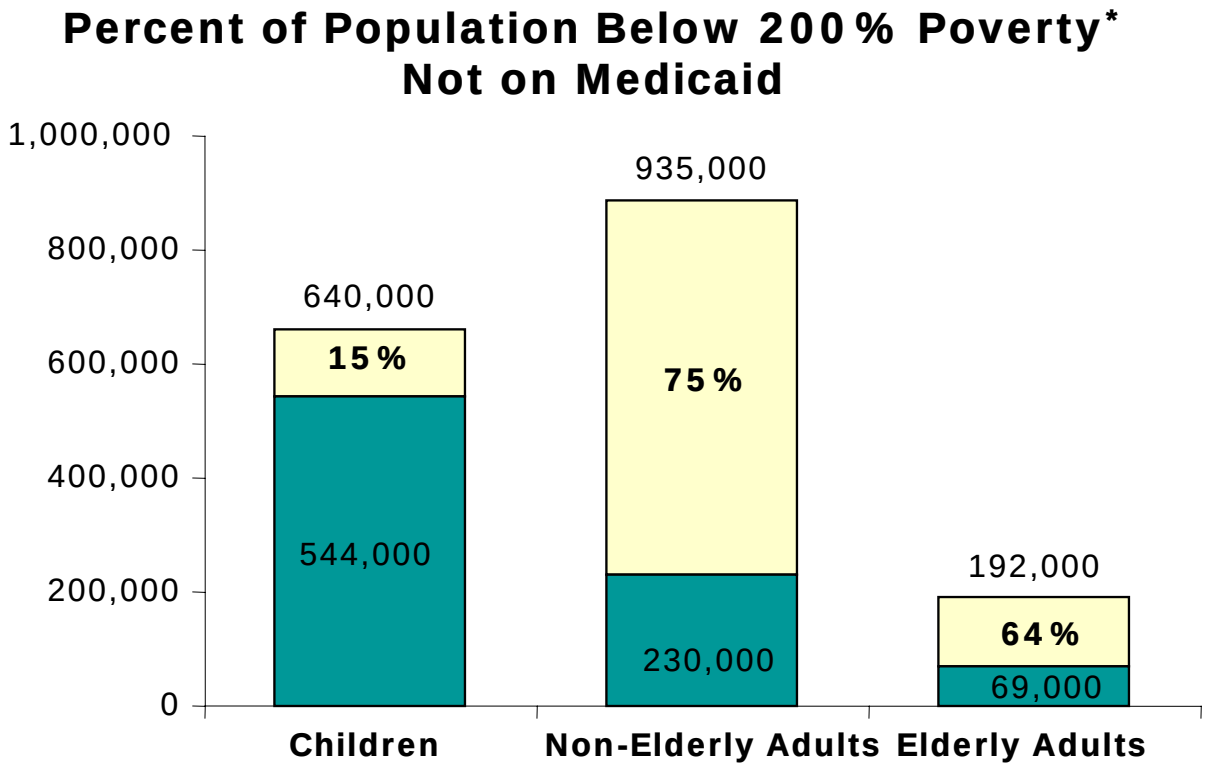
The Governor and Legislature will have to decide how to respond to this funding reduction:

- provide an additional $46 - ??? Million of state funding to replace the lost federal?
- use the funding that's left more effectively?
- drop all services to some people?
- drop some services to all people?
- drop some services to some people?

Who's eligible for Medicaid? And who's not?

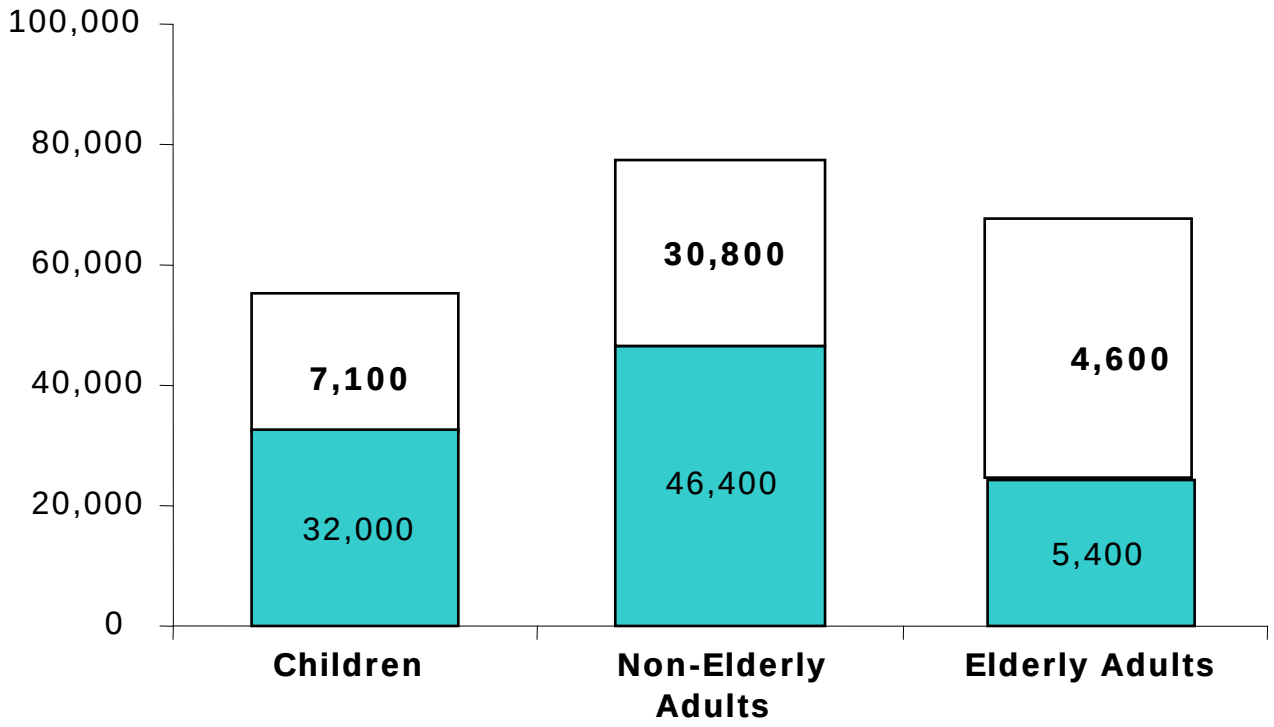
*** See Appendix B for a more complete summary of Medicaid and GAU eligibility requirements.**

Although Medicaid covered about 840,000 people each month in Fiscal 2004, about half of all lower income Washingtonians were not on Medicaid.



	*200% of Poverty, by Family Size			
Income	**1**	**2**	**3**	**4**
Monthly	$1,552	$2,082	2,612	$3,142
Annual	$18,620	$24,980	$31,340	$37,700

About one-third of the people who received community mental health services in Fiscal 2003 were not on Medicaid.



There are no specific financial eligibility requirements for community mental health services in state law or rule.

For the August 26 meeting, we'll know more about non-Medicaid clients' income from:

- Mental Health Division databases.
- GAU and ADATSA eligibility.
- financial eligibility criteria individual RSNs have established.

For today's meeting, we can describe who the non-Medicaid clients <u>may</u> be, in terms of income, based upon:

- medicaid eligibility restrictions.
- the experience of professionals in the field.

Why might someone who is using community mental health services have low income, but still not be on Medicaid?

Any Age Group

- not a U.S. citizen, or legal resident for at least 5 years.
- incarcerated.
- eligible, but hasn't completed application when initial services are provided.
- eligible and enrolled, but fails to fulfill reporting requirements.
- has private health insurance or Medicare, but it doesn't provide sufficient mental health coverage.

Why might someone who is using community mental health services have low income, but still not be eligible for Medicaid?

Children

- family income over 250% of poverty ($39,000 for a family of 3).

Non-Elderly, Non-Disabled Adult

- no children[1].
- children, but family income above about 40% of poverty, if not working; or about 80% of poverty, if working longer than 1 year[2].

[1] if pregnant, income up to about 220% of poverty.
[2] earned income up to 185% of poverty during year after leaving cash assistance.

Why might someone who is using community mental health services have low income, but still not be eligible for Medicaid?

Elderly or Disabled Adult

- monthly income over $565 if single, or $847 if married[1,2,3]
- savings of more than $2-3,000[1,2].
- eligible for Medicaid, but mental illness prevents follow through with application or reporting requirements.
- disabled, but not severely or long enough to qualify for SSI.

[1] income and assets may be substantially higher if in nursing home or community long-term care (COPES).
[2] if working but continue to have substantial chronic disability, income up to 220% of poverty, and no limit on savings.
[3] any income level, if less than $571 per month remaining after medical bills.

How seriously impaired must a person be to receive community mental health services?

State and federal Medicaid rules define clinical eligibility for mental health services differently than state law.

Under Medicaid rules, all Medicaid enrollees are:

- entitled to
- "medically necessary" mental health care.

***Medically necessary* is broadly defined:**

- prevents, diagnoses, corrects, or alleviates a condition.
- no more conservative or substantially less costly suitable treatment.

Diagnostic and level-of-functioning standards used to operationalize this definition will be discussed August 26.

Under state law (RCW 71.24.035), community mental health services are not an entitlement.

- Within appropriated state funds,
- people are to be served in the following priority order:

1. Acutely mentally ill children and adults.
2. Chronically mentally ill adults, and severely emotionally disturbed children.
3. Seriously disturbed children and adults.

Priority population definitions* indicate that people need to be substantially impaired in order to receive community mental health services.

Acutely Mentally Ill

- danger to self or others;
- unable to meet basic needs; or
- Severe crisis episode with substantial adverse effect on functioning.

Chronically Mentally Ill

- 6 months residential treatment in past 12;
- 2 hospitalizations in past 2 years; or
- unable to work because of mental disorder lasting at least 12 months.

* **See Appendix C for more complete summary of definitions.**

Priority population definitions* indicate that people need to be substantially impaired in order to receive community mental health services.

Severely Emotionally Disturbed Child

- hospitalization, involuntary, or residential treatment in past 2 years;
- receiving JR, CPS, special ed, or DD services; or
- At risk of escalating maladjustment, for specified reasons.

Seriously Disturbed

- conditional release or ordered treatment in past 2 years;
- suicide attempt or preoccupation;
- major impairment in several areas of daily living;
- unable to meet basic needs; or
- child with disorder limiting functioning or development.

* **See Appendix C for more complete summary of definitions.**

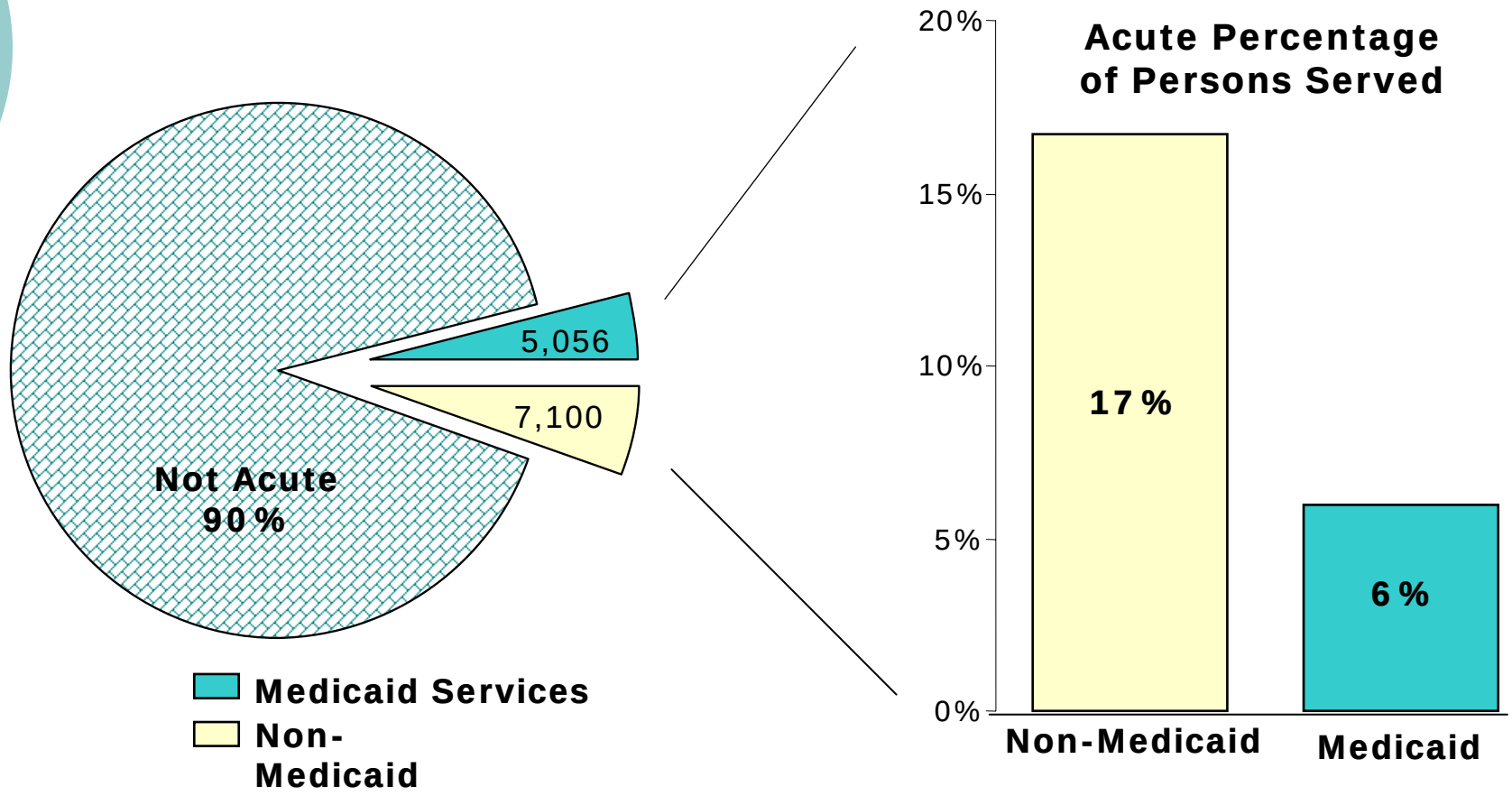
Unfortunately, the priority population data have some serious limitations.

- broad range of conditions/interpretations possible within the “or’s”.
- unclear definition in data system at one point.
- priority status not regularly updated in data system.

Diagnostic, level-of-functioning, other impairment indicators for August 26 meeting.

Based on the available data, in Fiscal 2003:

- Almost 60% of all persons classified as acutely mentally ill were not on Medicaid.
- A non-Medicaid client was almost three times more likely to be classified as acutely mentally ill.



More research is needed on non-Medicaid clients' impairment levels, since 40% of those served in 2003 were not reported as meeting one of the priority definitions.