

An Analysis of Washington State  
Public Mental Health Funding –  
Pre and Post Implementation of the  
Balanced Budget Act of 1997

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## Table of Contents

<b>I. INTRODUCTION</b>	<b>3</b>
<b>II. PRE-BALANCED BUDGET ACT (BBA) FUNDING</b>	<b>3</b>
<b>III. THE BBA AND FISCAL YEAR 2006 FUNDING</b>	<b>9</b>
<b>IV. SUMMARY OF RECOMMENDATIONS</b>	<b>22</b>
<b>ATTACHMENT A – 1998 STATE MEDICAID DIRECTORS LETTER</b>	<b>24</b>
<b>ATTACHMENT B – OREGON MHOS SAMPLE TRACKING REPORTS</b>	<b>25</b>
<b>END NOTES</b>	<b>28</b>

## I. Introduction

The purpose of this document is to answer the question, “Why have public mental health stakeholders raised concerns about funding levels and funding cuts across the system, when total projected revenues for Fiscal Year 2006 are 4% higher than Fiscal Year 2005?”

This report can also be described as an explanation of the changes in Washington State public mental health funding that were brought about, in part, by the implementation of the Balanced Budget Act of 1997 (BBA).

Section II describes funding by Regional Support Network (RSN) prior to the August 2003 implementation of the BBA, including an explanation of how Medicaid and non-Medicaid funding and services fell out of balance and description of the funding shortfalls in the public mental health system.

Section III reviews the impact of the BBA and resulting funding changes, including the substantial efforts that were made by DSHS and the Legislature to bring the system back into balance, and identifies the unintended consequences that are resulting from the funding formulas.

Section IV provides a set of recommendations for correcting the problems.

## II. Pre-Balanced Budget Act (BBA) Funding

### Move to Medicaid Managed Mental Health Care

In July 1993, Washington State moved the public mental health system into managed care with the implementation of an Integrated Mental Health Services Medicaid 1915 (b) waiver. The waiver included mandated Medicaid enrollment in managed mental health care plans – the Regional Support Networks – and limited the number of service providers.

During the 1980s and 1990s there were two *flavors* of Medicaid managed care organizations. Those that provided full health care coverage including inpatient and outpatient services were called Medicaid Health Maintenance Organizations (HMOs), more recently relabeled Managed Care Organizations (MCOs). These comprehensive health plans were often associated with commercial insurance carriers such as Premera Blue Cross and Group Health Cooperative, or Medicaid focused carriers such as Molina. These carriers obtained accreditation from the National Committee for Quality Assurance (NCQA). The NCQA standards set a high bar for MCOs a decade ago, but now have become expected business practice.

Organizations that provided a more limited array of services, such as behavioral health or dental care, were classified as Prepaid Health Plans (PHPs). The Regional Support Networks in Washington, the Oregon Mental Health Organizations (MHOs) and the California County Mental Health Departments are all examples of PHPs.

Because of the more limited nature of PHPs, including RSNs, the Federal Government chose to *exempt* those entities from many of the administrative and quality requirements in the Medicaid managed care regulations. This, in part, led to a substantial growth in PHP enrollment throughout the country, especially in behavioral health, where many states have created behavioral health PHPs that have operated alongside Medicaid MCOs providing the medical care. In Washington State, the RSN PHPs were specifically exempted from meeting the insurance carrier requirements of the Insurance Commissioner.

**Key Concern:** Because RSNs were exempt from many of the Medicaid managed care administrative and quality regulations, they were never required to develop all of the tracking and reporting systems that have been in place for many years at comprehensive health plans.

## Medicaid Funding Rules

During this period of managed care the Washington State mental health system operated under a set of “working assumptions” related to the State’s Integrated Mental Health Services Medicaid 1915 (b) managed care waiver, including:

- Each Regional Support Network (RSN) became a Medicaid Prepaid Health Plan (PHP), receiving capitated payments for the Medicaid enrollees in their region along with limited state general funds for non-Medicaid enrollees and non-Medicaid services.
- Under managed care, added flexibility was available to help clients “get what they need”, even if it doesn’t fit into a defined service code.
- Recording and tracking every unit of service under managed care was not as important as focusing on service delivery.
- Cost savings from the Medicaid managed care plan could be used to provide additional mental health services to state residents.
- There was a fair amount of latitude in serving indigent, non-Medicaid individuals, as long as the needs of the Medicaid population were being met.

Working within the framework of these assumptions, the Washington State Mental Health Division pursued an assertive set of strategies to leverage Medicaid funding for the entire mental health system, based, in part, on the 1998 State Medicaid Directors letter shown in Attachment A. As long as an RSN met its “*contractual obligations to serve Medicaid beneficiaries... the PHP can use its savings as it wishes. In effect, it is no longer ‘Medicaid money’.*”

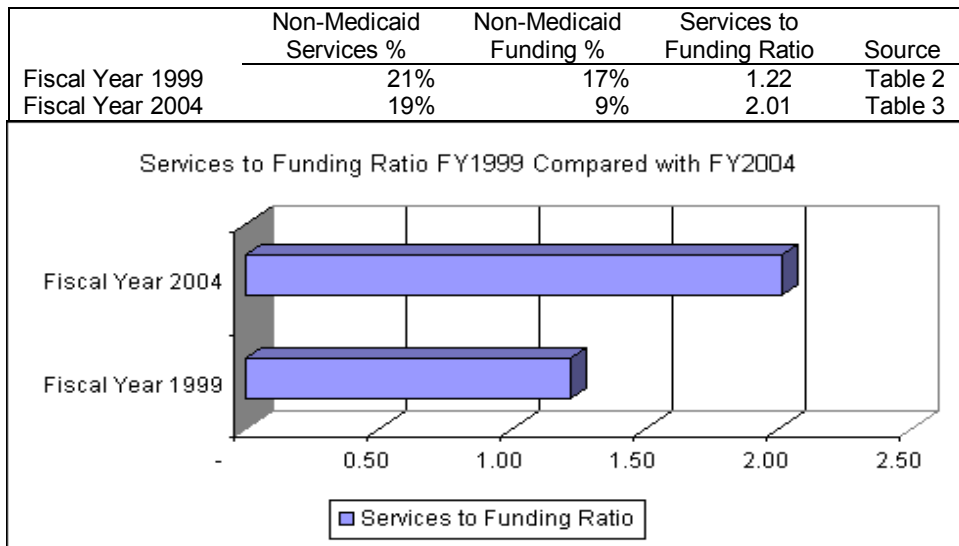
The letter also stated, “*it is not appropriate for the State Medicaid agency to require in its contract with an MCO or PHP that savings from capitated payments be used to provide health services to individuals not otherwise eligible for Medicaid.*” With this letter in hand, the Mental Health Division avoided addressing the problem of under-funded non-Medicaid services and “encouraged” RSNs to use their Medicaid “savings” to fund these services.

## Funding Mismatch

These funding strategies worked! Table 1 illustrates this by comparing how the use of Medicaid funding for non-Medicaid services changed between 1999 and 2004. In Fiscal Year 1999, non-Medicaid funding comprised 17% of total Mental Health Division funding for community-based services, while the services themselves represented 21% of the total community services. This meant that there was approximately 22% more non-Medicaid services provided than would have been supported by the Medicaid/Non-Medicaid funding levels. This is described by the “Services to Funding Ratio” of 1.22 in the table below.

By Fiscal Year 2004, the gap had widened such that only 9% of the funding was non-Medicaid while 19% of the outpatient services were provided to non-Medicaid persons. In other words, *by 2004 there was twice the amount of non-Medicaid service provided than would have been supported by the funding levels.*

**Table 1: FY1999 and FY2004 Comparisons**



Tables 2 and 3 illustrate how the funding mismatch evolved within each RSN. The Fiscal Year 1999 table also shows the profound imbalance of non-Medicaid funding across RSNs that existed at that time - Service to Funding Ratio range of 0.37 to 10.19 – with two RSNs receiving no non-Medicaid funding (Clark and NEWRSN).

**Table 2: FY1999 Medicaid/Non-Medicaid Services and Expenditures**

RSN	FY1999 Outpatient Hours [a]			FY1999 Outpatient Funding [a]			Services to Funding Ratio
	Medicaid Outpatient Hours	Non-Medicaid Outpatient Hours	Non-Medicaid %	Medicaid Funding [b]	Non-Medicaid Funding [b]	Non-Medicaid %	
Chelan Douglas	26,235	17,920	41%	\$2,713,200	\$391,620	13%	<b>3.22</b>
Clark	172,758	74,052	30%	\$16,896,073	\$0	0%	<b>N/A</b>
Grays Harbor	24,066	8,194	25%	\$3,387,656	\$231,620	6%	<b>3.97</b>
Greater Columbia	227,003	40,387	15%	\$25,546,783	\$2,031,208	7%	<b>2.05</b>
King	741,003	84,124	10%	\$50,296,067	\$19,433,057	28%	<b>0.37</b>
NEWRSN	32,715	8,576	21%	\$3,228,350	\$0	0%	<b>N/A</b>
North Central	26,494	13,772	34%	\$6,176,245	\$250,981	4%	<b>8.76</b>
North Sound	167,682	74,958	31%	\$31,304,021	\$978,259	3%	<b>10.19</b>
Peninsula	151,487	32,786	18%	\$10,898,151	\$2,935,586	21%	<b>0.84</b>
Pierce	305,720	110,040	26%	\$29,662,809	\$5,804,860	16%	<b>1.62</b>
Southwest	28,673	19,413	40%	\$2,992,013	\$575,178	16%	<b>2.50</b>
Spokane	177,289	57,270	24%	\$10,916,623	\$7,241,790	40%	<b>0.61</b>
Thurston Mason	75,032	12,608	14%	\$7,638,716	\$538,148	7%	<b>2.19</b>
Timberlands	19,695	9,107	32%	\$2,408,761	\$825,703	26%	<b>1.24</b>
<b>Total</b>	<b>2,175,851</b>	<b>563,208</b>	<b>21%</b>	<b>\$204,065,468</b>	<b>\$41,238,010</b>	<b>17%</b>	<b>1.22</b>

[a]: Source - WA State Mental Health Division.

[b]: Includes Outpatient, Crisis, Residential; does not include Inpatient.

**Table 3: FY2004 Medicaid/Non-Medicaid Services and Expenditures**

RSN	FY2004 Outpatient Hours [c]			FY2004 Outpatient Funding [d]			Services to Funding Ratio
	Medicaid Outpatient Hours	Non-Medicaid Outpatient Hours	Non-Medicaid %	Medicaid Funding	Non-Medicaid Funding	Non-Medicaid %	
Chelan Douglas	33,795	14,293	30%	\$5,423,082	\$697,251	11%	<b>2.61</b>
Clark	334,376	27,331	8%	\$18,324,839	\$735,355	4%	<b>N/A</b>
Grays Harbor	24,171	6,370	21%	\$6,091,957	\$378,561	6%	<b>3.56</b>
Greater Columbia	255,879	66,346	21%	\$40,062,360	\$3,087,852	7%	<b>2.88</b>
King	929,664	230,633	20%	\$78,153,269	\$12,321,973	14%	<b>1.46</b>
NEWRSN	20,250	6,368	24%	\$6,207,706	\$155,094	2%	<b>N/A</b>
North Central	39,184	11,882	23%	\$10,737,008	\$911,794	8%	<b>2.97</b>
North Sound	201,213	35,219	15%	\$46,620,506	\$2,212,705	5%	<b>3.29</b>
Peninsula	162,237	39,814	20%	\$17,478,800	\$1,939,963	10%	<b>1.97</b>
Pierce	255,610	93,264	27%	\$44,748,782	\$4,196,954	9%	<b>3.12</b>
Southwest	51,642	20,859	29%	\$7,012,551	\$690,297	9%	<b>3.21</b>
Spokane	266,731	42,750	14%	\$27,795,196	\$4,411,010	14%	<b>1.01</b>
Thurston Mason	62,428	9,319	13%	\$13,641,775	\$965,894	7%	<b>1.96</b>
Timberlands	68,756	12,534	15%	\$6,627,757	\$704,298	10%	<b>1.61</b>
<b>Total</b>	<b>2,705,936</b>	<b>616,982</b>	<b>19%</b>	<b>\$328,925,589</b>	<b>\$33,409,000</b>	<b>9%</b>	<b>2.01</b>

[c]: Source - DSHS State-Wide Publicly Funded Mental Health Performance Indicators Report, July 2005.

[d]: Source: WA State Mental Health Division. Includes Outpatient, Crisis, Residential and Inpatient.

Tables 2 and 3 also tell us that between 1999 and 2004, non-Medicaid services hours increased 9.5% from 563,208 to 616,982 while non-Medicaid funding decreased 19% from \$41.2 million to \$33.4 million.

**Key Concern:** Prior to the implementation of the Balanced Budget Act, the Washington State mental health system, by design, was relying on a substantial amount of Medicaid funding to support non-Medicaid services.

## Mental Health System Shortfalls

Since 2000, there have been multiple studies that have analyzed funding gaps in the public mental health systems of Washington, California and Oregon.

In September 2000, the Washington Community Mental Health Council and NAMI Washington (National Alliance for the Mentally Ill) released *Blueprints for an Effective Mental Health System in Washington State*, which included utilization and financial analyses prepared by the authors of this report. In this study, a funding gap of approximately \$216,000,000 was identified<sup>i</sup>.

In November 2000, the California Legislature's Little Hoover Commission Report, *Being There: Making a Commitment to Mental Health* noted that, statewide, the public mental health system is able to serve only about half of those individuals who require services (467,000 were served and between 512,083 and 580,926 were estimated to be unserved)<sup>ii</sup>. While the Commission did not place a specific price tag on this gap, the report included anecdotal statements from the California Association of Mental Health Directors that "mental health funding provides sufficient resources to meet approximately half of all mental health needs" and, "Services are rationed as a result."<sup>iii</sup>

In January 2001 the *State of Oregon Report to the Governor from the Mental Health Alignment Workgroup* determined that, "To fully fund needed services for the 11,898 Oregon children and 12,232 adults who need public mental health services, an additional \$139,685,346 for children and \$90,625,665 for adults is needed – for a grand total of \$230,311,011."<sup>iv</sup>

Using Fiscal Year 2001 data from the National Association of State Mental Health Program Directors, the three states are ranked closely in public mental health expense per target client with Oregon ranked 13<sup>th</sup>, Washington 17<sup>th</sup> and California 18<sup>th</sup>. (Note: This analysis uses a standard prevalence method to calculate target clients consistently across all states, in order to better understand the differences in funding levels beyond straight per capita methods of analysis.)

Table 4 lists the top 20 states and compares each with the average funding of the top 10 states (\$5,208 per target client per year), which in the absence of more definitive data, is being considered as a proxy for adequate funding. Washington State's Expense per Target Client was \$3,437, which was \$1,771 below the average of the top 10 states. This translates into an estimated \$270 million shortfall for Fiscal Year 2001.

**Table 4: FY2004 Medicaid/Non-Medicaid Services and Expenditures**

SMHA-Controlled Mental Health Expenses by State, FY 2001 <sup>v</sup>								
STATE	Total Mental Health Expense	Target # of Annual Persons to Serve	Expense per Target Client	Rank	"Top 10" Expense per Target Client without Wash DC	\$ Over (Under) Average	\$ Gap based on Top 10 Avg	% Funding Incr to Match Top 10 Avg
Washington DC	\$226,558,837	15,706	\$14,425	1	\$5,208	\$9,217	\$0	0%
Hawaii	\$213,643,908	31,471	\$6,789	2	\$5,208	\$1,580	\$0	0%
New York	\$3,331,688,218	500,154	\$6,661	3	\$5,208	\$1,453	\$0	0%
Pennsylvania	\$1,859,763,966	311,719	\$5,966	4	\$5,208	\$758	\$0	0%
Vermont	\$79,658,335	15,071	\$5,285	5	\$5,208	\$77	\$0	0%
Connecticut	\$439,519,867	83,499	\$5,264	6	\$5,208	\$56	\$0	0%
Maryland	\$677,806,345	132,372	\$5,120	7	\$5,208	-\$88	-\$11,605,807	2%
Montana	\$111,722,233	23,855	\$4,683	8	\$5,208	-\$525	-\$12,516,802	11%
New Hampshire	\$140,484,321	31,033	\$4,527	9	\$5,208	-\$681	-\$21,140,652	15%
Minnesota	\$517,963,917	121,962	\$4,247	10	\$5,208	-\$961	-\$117,233,933	23%
Massachusetts	\$682,218,519	162,896	\$4,188	11	\$5,208	-\$1,020	-\$166,169,423	24%
Maine	\$137,507,731	34,043	\$4,039	12	\$5,208	-\$1,169	-\$39,792,783	29%
<b>Oregon</b>	<b>\$336,847,640</b>	<b>88,804</b>	<b>\$3,793</b>	<b>13</b>	<b>\$5,208</b>	<b>-\$1,415</b>	<b>-\$125,656,757</b>	<b>37%</b>
Delaware	\$73,505,846	19,775	\$3,717	14	\$5,208	-\$1,491	-\$29,482,702	40%
New Jersey	\$763,057,140	208,504	\$3,660	15	\$5,208	-\$1,548	-\$322,861,393	42%
Michigan	\$895,065,635	252,937	\$3,539	16	\$5,208	-\$1,669	-\$422,266,904	47%
<b>Washington</b>	<b>\$525,564,708</b>	<b>152,894</b>	<b>\$3,437</b>	<b>17</b>	<b>\$5,208</b>	<b>-\$1,771</b>	<b>-\$270,729,245</b>	<b>52%</b>
<b>California</b>	<b>\$3,147,792,993</b>	<b>918,073</b>	<b>\$3,429</b>	<b>18</b>	<b>\$5,208</b>	<b>-\$1,779</b>	<b>-\$1,633,669,311</b>	<b>52%</b>
Rhode Island	\$92,499,566	27,134	\$3,409	19	\$5,208	-\$1,799	-\$48,818,926	53%
Alaska	\$51,444,549	15,402	\$3,340	20	\$5,208	-\$1,868	-\$28,768,930	56%

These studies are relevant because they support a hypothesis that has been quietly talked about in Washington State public mental health circles:

*If the entire mental health system has been systematically under-funded, and there are demonstrated shortfalls in services to both Medicaid enrollees and non-Medicaid persons, and Medicaid money has been used to fund non-Medicaid services, the argument that Medicaid persons have been “adequately served” is not supportable. In addition, the assumption that reduced Medicaid funding and rates are adequate is also not supportable.*

The “adequately served” argument that was the Mental Health Division’s basis for using Medicaid funds to pay for non-Medicaid services becomes even more questionable when Medicaid Penetration Rates and Average Service Hours per Case throughout the State are examined. Table 5 shows Penetration Rates as low as 5.2% in North Central, with a statewide average of 8.6% for Fiscal Year 2004 and Outpatient Hours as low as 13.3 with an average of 29.1 Hours per Client per Year.

**Table 5: FY2004 Medicaid Penetration and Hours per Case**

RSN	Medicaid Served	Medicaid Enrolled	Penetration Rate	Medicaid Outpatient Hours	Average Hours per Case
Chelan Douglas	1,714	22,441	7.6%	33,795	19.7
Clark	5,399	69,358	7.8%	334,376	61.9
Grays Harbor	1,823	17,621	10.3%	24,171	13.3
Greater Columbia	12,022	158,039	7.6%	255,879	21.3
King	26,086	231,539	11.3%	929,664	35.6
NEWRSN	1,202	19,433	6.2%	20,250	16.8
North Central	2,140	41,119	5.2%	39,184	18.3
North Sound	13,148	156,815	8.4%	201,213	15.3
Peninsula	4,735	50,601	9.4%	162,237	34.3
Pierce	9,020	130,213	6.9%	255,610	28.3
Southwest	2,940	22,670	13.0%	51,642	17.6
Spokane	8,096	93,142	8.7%	266,731	32.9
Thurston Mason	3,762	45,292	8.3%	62,428	16.6
Timberlands	2,641	22,477	11.7%	68,756	26.0
Total	92,999	1,080,760	8.6%	2,705,936	29.1

[a]: Source - DSHS State-Wide Publicly Funded Mental Health Performance Indicators Report, July 2005

These Medicaid Penetration Rates can be compared with an early target of 10% penetration in the Medicaid population that was suggested in the early 90s as a national benchmark for appropriate access to Medicaid managed mental health services (at that time, the commercial managed care penetration rates were at 7%). The Report of the Surgeon General<sup>vi</sup> suggests a 20% prevalence rate in the general population, and studies conducted by MAA suggest much higher percentages in the Medicaid population. Recent work, such as the California Mental Health Services Act planning, has brought greater sophistication to penetration target-setting by calculating plan-specific rates based on age, ethnicity, disability and other relevant variables.

The Average Hours per Case per Year in Table 5 including the statewide average of 29.1 can be compared with the 60 Hours per Case per Year benchmark that can be found in Chapter 5 of the aforementioned *Blueprints for an Effective Mental Health System in Washington State*. Indeed, several RSNs have Medicaid Performance Improvement Projects that include increasing Medicaid penetration and Medicaid utilization.

**Key Concern:** Decisions about Medicaid funding for Fiscal Years 2006 and 2007 were likely based on incomplete and potentially misleading assumptions about the adequacy of existing Medicaid service levels and funding. There is ample evidence to suggest that Medicaid service levels have been suppressed by the use of Medicaid funds for non-Medicaid services and persons.

### III. The BBA and Fiscal Year 2006 Funding

#### Change in Medicaid Funding Rules

In June of 2002, the final rules for implementing the Balanced Budget Act of 1997 were issued with an implementation date of August, 2003. This publication, in effect, created

a new “Rule Book” that turned the working assumptions, described earlier, upside down and brought new and important challenges to the Washington mental health system. Specific changes included:

- Rules for the Regional Support Networks (RSNs) that include the same level of administrative and quality management standards as commercial health plans serving the medical care needs of the Medicaid population.
- Implementation of a Medicaid actuarially-based rate setting process that is based on counting historical services, multiplying them by the cost per service, adjusting for inflation, and projecting utilization changes due to system change initiatives to determine the new capitation rates.
- Cost savings from greater efficiencies will result in lower capitation rates in future years. Not recording and tracking every unit of service will result in lower rates. Providing flexible services that are outside the State Plan will result in lower rates.
- Elimination of the ability to count any and all non-Medicaid services in the calculation of future capitation rates.
- Significant increases in the oversight of Medicaid managed care programs by the Federal Government’s Center for Medicare and Medicaid Services (CMS).

From an infrastructure perspective, the bar was substantially raised regarding the authorization, care management, financial management, quality management, information technology and data analysis and reporting systems that needed to be in place.

From a financing perspective, *capitated Medicaid managed care systems have reverted back to a “widget counting”, fee for service type system that must be mirrored at the RSN level. There’s also an added twist that if an RSN spends more money than anticipated, it gets no additional federal funding, but if it spends less than anticipated, it will have its rates cut in the future.*

MCPP Healthcare Consulting prepared a white paper in 2003 that went into detail about the potential impact of these changes. The paper identified the mismatch between the Washington State public mental health system and the “new rules” and highlighted our concern that failure of the Mental Health Division and RSNs to aggressively address the rule changes would result in a downward funding spiral. The paper also provided a set of suggestions for change, including the need to address non-Medicaid funding and adequately prepare for actuarially-based Medicaid rate setting. This document can be downloaded from the National Council for Community Behavioral Healthcare website at: <http://www.nccbh.org/WHO/Industry/ImpactOfTheCMSBBARules.pdf>

**Key Concern:** The Washington State mental health system is out of sync with the new Medicaid managed care rules promulgated by the Balanced Budget Act and without strong leadership and a focused game plan, the system is at risk of continued funding loss.

## Washington State's Response

In late 2003 and early 2004, with limited guidance from the Mental Health Division, the RSNs took a series of steps to bring their budgets into alignment, mostly through the reduction of services to non-Medicaid clients. This was a very difficult period. CMS was suggesting that use of Medicaid funds for non-Medicaid persons after January 1, 2004 could be considered Medicaid fraud; the system knew that calendar year 2004 was the time period Milliman USA, the state's actuarial firm, would use for counting and pricing Medicaid services to Medicaid eligibles for its actuarial study; and the Mental Health Division was counseling RSNs to not drastically cut services to non-Medicaid persons because it was working on a funding solution.

The Mental Health Task Force was established during the 2004 Legislative session to examine these and other related issues impacting the delivery of public mental health services. In the course of its work the task force estimated that \$41 million per year of Medicaid funds were being used to support non-Medicaid persons and non-Medicaid services to Medicaid enrollees. During the 2005 regular legislative session the Task Force's recommendations resulted in the passage of E2SSB 5763 and E2SHB 1290 and a budget proviso passed by the Legislature to backfill the impending Medicaid losses for Fiscal Years 2006 and 2007 and keep the system "whole".

During this same period the CMS-mandated 2005 Medicaid Actuarial Study was completed by Milliman USA, using calendar year 2004 data to project Fiscal Year 2006 and 2007 Medicaid rates. The study set rate ranges based on historical Medicaid services that were provided to Medicaid enrollees and multiplied these rates by projected Medicaid enrollees for Fiscal Years 2006 and 2007.

Weaving the Medicaid and non-Medicaid funding levels together was a complicated task. ***The analysis was based on the assumption that Medicaid persons historically had been adequately served, a substantial portion of Medicaid funding could be de-matched and used to partially close the non-Medicaid gap, and new state general funds would be used to close the remainder of the gap.***

Our understanding is that the final Fiscal Year 2006 RSN budgets are the result of a multi-step process that approximated the following activities.

- Step 1: The Mental Health Task Force calculated the cost of non-Medicaid Inpatient, Residential and Crisis Services for each RSN (\$68.6 million). Although these allocations were not evenly distributed across RSNs due to unevenly distributed resources, agreement for this allocation was reached by the stakeholder community and endorsed by the Mental Health Task Force and Legislature.
- Step 2: The remaining non-Medicaid funds were distributed on a Per-Capita basis (\$35.6 million). These were targeted primarily for Outpatient Services to non-Medicaid Priority Clients.
- Step 3: The Medicaid per member per month rates to be paid to each RSN were set near the bottom of the actuarial ranges based on the assumption that Medicaid

persons historically had been adequately served and less Medicaid funding was needed.

- Step 4: The resulting totals were compared with Fiscal Year 2005 funding levels by RSN and substantial losses were calculated for some RSNs.
- Step 5: A new category of State-Only funding was created called “Infrastructure Stabilization”. \$25 million of the \$35 million Per Capita funds were used to ensure that no RSN would have less total funding in Fiscal Year 2006 than in FY05.
- Step 6: RSN Contracts were set based on the Medicaid rates and the revised State-Only allocations, and included restrictions on the use of non-Medicaid funding directed by budget proviso.

### **Analysis and Unintended Consequences of FY 2006 Medicaid Funding**

The rate ranges set by the actuaries were based on two variables – provider productivity and RSN administration. The *ceiling* of the rate band used *actual* productivity levels from a Unit Cost Study completed by the actuaries, and a 15% rate for RSN overhead. The *floor* of the rate band used *targeted* productivity levels, which were set at the 85<sup>th</sup> percentile of all providers and a 10% rate for RSN overhead (despite the increased administrative and care management responsibilities that were part of the BBA). *In other words, the ceiling was a close approximation of actual 2004 system costs, adjusted slightly for inflation, and the floor was a fairly aggressive cost reduction target for the system.*

When the Milliman actuarial study was released in late May 2005, the actual cost of Medicaid services (the rate band ceiling) was higher than previous Mental Health Division projections. The MHD had assumed a lower Medicaid expenditure level because it was working with 2003 data, which was prior to the implementation of the BBA, and did not have systems in place to collect and analyze what was unfolding in 2004 as some RSNs took steps to sync Medicaid/non-Medicaid funding with service levels.

In support of the Mental Health Task Force, the MHD did a thorough job of analyzing the cost of non-Medicaid services using 2003 data. It projected a reduction in Medicaid match, the loss of the federal share of these funds, and a reprogramming of the state match for non-Medicaid services.

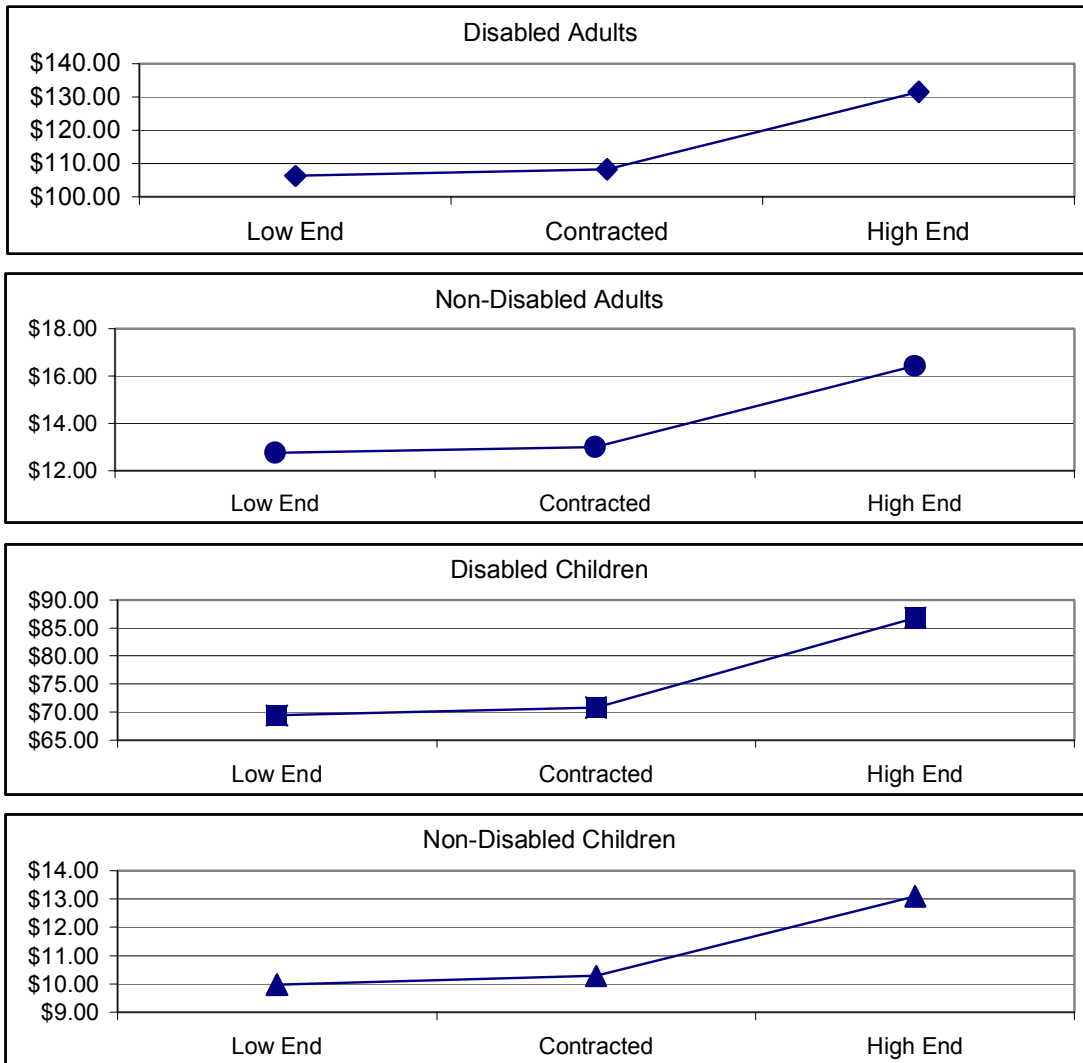
When the 2004 actuarial figures came in at a higher level and demonstrated that the system, in total, had spent most or all of the Medicaid revenue on Medicaid services, the MHD found itself in a difficult position. Aligning the FY2006 Medicaid rates to historical costs would have resulted in “re-commandeering” the state match for Medicaid services and made less money available for non-Medicaid services.

As a result, *the Mental Health Division set the RSN capitation rates near the bottom of Milliman’s actuarial rate bands, apparently assuming that the system would have to achieve the targeted productivity levels and lower RSN overhead costs described above*

(see Table 6). This resulted in substantial reductions in Medicaid funding for Fiscal Years 2006 and 2007 (see Table 7).

**Table 6: Medicaid Rate Ranges FY2006**

	Low End of Rate Band	Contracted Rates State Average	High End of Rate Band	High End % above Low End	Contracted % above Low End
Disabled Adults	\$106.22	<b>\$108.17</b>	\$131.41	23.7%	1.8%
Non-Disabled Adults	\$12.76	<b>\$12.99</b>	\$16.41	28.6%	1.8%
Disabled Children	\$69.40	<b>\$70.80</b>	\$86.83	25.1%	2.0%
Non-Disabled Children	\$9.98	<b>\$10.29</b>	\$13.10	31.3%	3.1%
Combined	\$25.55	<b>\$26.11</b>	\$32.23	26.1%	2.2%



Source: Milliman USA 2005 Actuarial Study.

In order to further understand how the Medicaid Contracted Rates translate into a comparison of FY2005 and FY2006 Medicaid revenue, one has to dig down two layers.

## DSHS/Milliman Medicaid Projections

Table 7 compares the estimated FY2005 Medicaid revenue with three sets of FY2006 figures: the actuarial floor and ceiling of Milliman's Medicaid rate ranges and Medicaid revenue estimates based on the RSN-contracted rates. (Note: As of this writing, finalized FY2005 Medicaid Revenues by RSN were not available and FY2005 estimates were developed based on MHD recent data.)

**Table 7: Medicaid Funding Ranges FY2005 – FY2006**

	FY2005 Medicaid Estimate	FY2006 Medicaid Rate Band Floor	FY2006 Medicaid Contracted Rates	FY2006 Medicaid Rate Band Ceiling	Change: FY2005 to FY2006 Ceiling
Chelan Douglas Clark	\$5,703,402	\$5,070,938	\$5,162,946	\$6,426,256	\$722,854
Grays Harbor	\$18,920,827	\$13,949,606	\$15,058,067	\$17,657,668	-\$1,263,159
Gr. Columbia	\$6,054,824	\$4,080,894	\$4,156,449	\$5,132,453	-\$922,371
King	\$39,317,814	\$29,188,189	\$29,727,614	\$37,039,711	-\$2,278,102
NEWRSN	\$77,585,786	\$76,032,352	\$77,431,372	\$95,710,467	\$18,124,681
North Central	\$6,171,538	\$3,770,397	\$3,840,004	\$4,752,971	-\$1,418,568
North Sound	\$10,789,570	\$7,133,315	\$7,265,150	\$9,038,871	-\$1,750,699
Peninsula	\$47,667,085	\$34,386,951	\$35,018,638	\$43,409,645	-\$4,257,440
Pierce	\$17,538,857	\$15,171,214	\$15,449,744	\$19,086,965	\$1,548,108
Southwest	\$44,578,479	\$32,731,700	\$33,330,174	\$41,232,519	-\$3,345,961
Spokane	\$7,212,946	\$5,958,807	\$6,068,106	\$7,504,522	\$291,576
Thurston Mason	\$27,352,544	\$26,142,789	\$26,627,746	\$32,942,331	\$5,589,786
Timberlands	\$14,578,949	\$9,521,862	\$9,696,516	\$12,001,349	-\$2,577,600
Statewide	\$5,873,093	\$5,160,029	\$5,254,129	\$6,502,174	\$629,080
FY2005 to 2006 Change	\$329,345,714	\$268,299,041	\$274,086,656	\$338,437,901	\$9,092,187
FY2005 to 2006 Change		-\$61,046,673	-\$55,259,058	\$9,092,187	
FY2005 to 2006 Change		-18.5%	-16.8%	2.8%	

Source: Calculation of PMPM Rates multiplied by the projected enrollees in the June 2005 Milliman USA Actuarial Rate Certification Report

As mentioned above, the rate band ceiling of \$338 million approximated the cost of Medicaid services in FY2006 dollars based on actual 2004 productivity and 15% RSN administration. This is \$9 million higher than the FY2005 Medicaid revenue. With the rates set slightly above the floor, the Milliman-projected FY2006 Medicaid revenue was calculated to be \$55 million less than FY2005 and \$64 million less than the ceiling (\$338M minus \$274M). ***In other words, FY2006 Medicaid revenues were set at approximately \$64 million less than FY2006 projected Medicaid costs - the ceiling of the 2004 actuarial study.*** If we assume that FY06 Medicaid service levels should be at least comparable to 2004 levels, the available Medicaid funding is short by \$64 million.

## Problems with Medicaid Eligibility Projections

To calculate projected monthly eligibles for Fiscal Years 2006 and 2007, Milliman used figures supplied by the Mental Health Division, which they stated were consistent with the State's budget forecasting process. Table 8 Summarizes five tables from pages 14 – 18 of the Actuarial Study.

**Table 8: Medicaid Eligibles, Actual, Estimated, Projected**

Part A	Average Monthly Eligibles	Change from 7/03 - 6/04	Source
July 2003 - June 2004 (Actual)	849,145		Table 2b
January - December 2004 (Actual)	839,771	-1.1%	Table 2a
July 2004 - June 2005 (Estimate)	829,606	-2.3%	Table 2c
Part B	Average Monthly Eligibles	Change from 7/04 - 6/05	Source
July 2004 - June 2005 (Estimate)	829,606		Table 2c
July 2005 - June 2006 (Projected)	874,924	5.5%	Table 2d
July 2006 - June 2007 (Projected)	914,431	10.2%	Table 2e

Part A of the table shows a clear decline in eligibles, even in light of the overlapping time periods. These declines are even less than the trend lines reported by various RSNs, who have been closely monitoring monthly eligibles and have reported annual declines averaging 6% to 8%.

Part B shows substantial growth in Medicaid eligibles as described in the Actuarial Study. In essence, DSHS and Milliman were predicting a reversal of the trend line that, in reality, is not occurring. Discussions with several RSNs have confirmed that the number of eligibles in Fiscal Year 2006 is not coming close to the Milliman projections.

Table 9 provides an updated projection of Medicaid revenue for Fiscal Year 2006, comparing the projections in the Milliman USA Actuarial Study with a scenario where 6% fewer Medicaid persons were enrolled during the fiscal year.

**Table 9: FY2006 Medicaid Funding if 6% Fewer Eligibles**

RSN	FY2005 Medicaid	FY2006 Total Medicaid	Total Impact of 6% fewer Eligibles	Revised FY2006 Medicaid Estimate	Unused State Match	Revised FY2005 - FY2006 Change	% Change
Chelan Douglas	\$5,703,402	\$5,162,946	<b>-\$309,777</b>	\$4,853,170	-\$154,888	<b>-\$850,233</b>	-14.9%
Clark	\$18,920,827	\$15,058,067	<b>-\$903,484</b>	\$14,154,583	-\$451,742	<b>-\$4,766,244</b>	-25.2%
Grays Harbor	\$6,054,824	\$4,156,449	<b>-\$249,387</b>	\$3,907,062	-\$124,693	<b>-\$2,147,761</b>	-35.5%
Greater Columbia	\$39,317,814	\$29,727,614	<b>-\$1,783,657</b>	\$27,943,957	-\$891,828	<b>-\$11,373,857</b>	-28.9%
King	\$77,585,786	\$77,431,372	<b>-\$4,645,882</b>	\$72,785,490	-\$2,322,941	<b>-\$4,800,296</b>	-6.2%
NEWRSN	\$6,171,538	\$3,840,004	<b>-\$230,400</b>	\$3,609,604	-\$115,200	<b>-\$2,561,934</b>	-41.5%
North Central	\$10,789,570	\$7,265,150	<b>-\$435,909</b>	\$6,829,241	-\$217,955	<b>-\$3,960,329</b>	-36.7%
North Sound	\$47,667,085	\$35,018,638	<b>-\$2,101,118</b>	\$32,917,520	-\$1,050,559	<b>-\$14,749,565</b>	-30.9%
Peninsula	\$17,538,857	\$15,449,744	<b>-\$926,985</b>	\$14,522,759	-\$463,492	<b>-\$3,016,098</b>	-17.2%
Pierce	\$44,578,479	\$33,330,174	<b>-\$1,999,810</b>	\$31,330,363	-\$999,905	<b>-\$13,248,116</b>	-29.7%
Southwest	\$7,212,946	\$6,068,106	<b>-\$364,086</b>	\$5,704,019	-\$182,043	<b>-\$1,508,926</b>	-20.9%
Spokane	\$27,352,544	\$26,627,746	<b>-\$1,597,665</b>	\$25,030,082	-\$798,832	<b>-\$2,322,463</b>	-8.5%
Thurston Mason	\$14,578,949	\$9,696,516	<b>-\$581,791</b>	\$9,114,725	-\$290,895	<b>-\$5,464,224</b>	-37.5%
Timberlands	\$5,873,093	\$5,254,129	<b>-\$315,248</b>	\$4,938,881	-\$157,624	<b>-\$934,212</b>	-15.9%
Total	\$329,345,714	\$274,086,656	<b>-\$16,445,199</b>	\$257,641,457	-\$8,222,600	<b>-\$71,704,258</b>	-21.8%

If the number of Medicaid eligibles stays relatively flat, this will yield Fiscal Year 2006 Medicaid revenues that are \$72 million less than Fiscal Year 2005. This is an additional \$16.4 million of Medicaid funding that will likely be eliminated from the system; \$8+ million of Federal Match and \$8+ million of State General Fund that will be “left on the table”.

**Key Concern:** Medicaid rates were based on potentially erroneous assumptions about the level of funding needed to support the Medicaid population. Medicaid revenue is likely to be further reduced by a mis-trending of Medicaid eligibles. This will likely result in a reduction of services to Medicaid persons and layoffs of clinical staff due to the Medicaid funding cuts.

### Flattening of Medicaid Rates Across RSNs

During the actuarial study, Milliman examined the utilization for each RSN and then projected service costs for Fiscal Years 2006 and 2007. Based on utilization, this called for *regional rates per CMS requirements*. Milliman then worked with the Mental Health Division to implement a “Smoothing Adjustment”, thereby raising the projected costs and rates for RSNs that reported less Medicaid service per 1,000 enrollees and lowering the projected costs and rates for RSNs that reported greater service levels.

Milliman and the Mental Health Division used a formula that cut in half the amount each RSN’s costs could be over or under the statewide average. For example, King County’s composite, pre-adjusted rate band floor for FY2006 was \$36.75 per eligible per month, 44% higher than the statewide average of \$25.55. This 44% figure was halved and the King County composite rate was re-set at 22% above the statewide average. In Grays Harbor RSN the opposite occurred, where the pre-adjusted floor for FY2006 of \$15.18 per eligible per month (41% lower than the statewide average) was increased 20%. The figures for each RSN are listed below.

**Table 10: Impact of Smoothing Adjustment on FY2006 Medicaid Rates**

RSN	Original Floor	Above (Below) Average	Smoothing Factor	Revised Average	New Floor	PMPM Change	PMPM Change
Chelan Douglas	\$29.14	14%	50%	7%	\$27.35	-\$1.80	-6%
Clark	\$23.11	-10%	50%	-5%	\$24.33	\$1.22	5%
Grays Harbor	\$15.18	-41%	50%	-20%	\$20.37	\$5.19	34%
Greater Columbia	\$20.42	-20%	50%	-10%	\$22.99	\$2.57	13%
King	\$36.75	44%	50%	22%	\$31.15	-\$5.60	-15%
NEWRSN	\$12.72	-50%	50%	-25%	\$19.14	\$6.42	50%
North Central	\$15.45	-40%	50%	-20%	\$20.50	\$5.05	33%
North Sound	\$22.01	-14%	50%	-7%	\$23.78	\$1.77	8%
Peninsula	\$29.39	15%	50%	8%	\$27.47	-\$1.92	-7%
Pierce	\$22.43	-12%	50%	-6%	\$23.99	\$1.56	7%
Southwest	\$22.28	-13%	50%	-6%	\$23.92	\$1.64	7%
Spokane	\$27.97	9%	50%	5%	\$26.76	-\$1.21	-4%
Thurston Mason	\$16.51	-35%	50%	-18%	\$21.03	\$4.52	27%
Timberlands	\$19.92	-22%	50%	-11%	\$22.74	\$2.82	14%
Statewide Average	\$25.55						

Ten RSNs benefited from the smoothing adjustment and four received reductions (Chelan Douglas, King, Peninsula, and Spokane), even though the latter four RSNs' actual utilization was higher than the figures represented by the rates. Although the reason given for this smoothing is credible - the State didn't want to set rates for any RSNs that would "lock" them into permanent under-funding of their Medicaid system - the potential for an Oregon-like downward spiral has been created.

Oregon has the distinction of being the first public mental health system in the country that has undergone two rounds of Medicaid rate cuts. After a 16.5% cut following its actuarial study a few years ago, the State set new rates that were nearly identical across the regions ("extreme smoothing"). In this environment the Medicaid mental health plans with high utilization had to cut staffing, with a resulting reduction in services. Other plans with low utilization were still receiving more Medicaid funds than they had expended in the previous year and did not bring their services and costs up to offset the plans that had to cut. The result was a second cut of 9.1% that will go into effect in January 2006.

**Key Concern:** Unless the Mental Health Division sets appropriate penetration and utilization standards and the low performing RSNs meet those standards, the FY2006 and FY2007 smoothing process could result in a statewide net reduction in Medicaid services and future rate cuts.

## **Analysis of Fiscal Year 2006 Non-Medicaid (State-Only) Funding**

### **Agreed-Upon Formula**

As mentioned above, the original game plan was to allocate non-Medicaid in two ways: Priority Services including non-Medicaid Inpatient, Residential and Crisis Services for each RSN (\$68.6 million) would be allocated based on the location of existing capacity. The remaining non-Medicaid funds were to be distributed on a Per-Capita basis (\$35.6 million). Table 11 shows how these funds were to have been distributed across the RSNs.

**Table 11: FY2006 Non-Medicaid Funding – Original Formula**

RSN	FY2006 Priority Services	Total Population	FY2006 Per Capita Method	FY2006 Total State Only
Chelan Douglas	\$660,812	102,600	\$593,096	\$1,253,908
Clark	\$2,351,061	383,300	\$2,215,728	\$4,566,789
Grays Harbor	\$1,048,367	69,200	\$400,022	\$1,448,389
Greater Columbia	\$6,187,858	630,400	\$3,644,130	\$9,831,987
King	\$21,774,775	1,788,300	\$10,337,559	\$32,112,334
NEWRSN	\$341,856	70,100	\$405,224	\$747,080
North Central	\$1,234,869	134,600	\$778,077	\$2,012,947
North Sound	\$10,291,809	1,020,800	\$5,900,900	\$16,192,710
Peninsula	\$2,143,012	332,400	\$1,921,492	\$4,064,504
Pierce	\$14,784,218	744,000	\$4,300,813	\$19,085,031
Southwest	\$774,576	95,300	\$550,897	\$1,325,474
Spokane	\$4,835,258	432,000	\$2,497,246	\$7,332,504
Thurston Mason	\$1,563,628	269,300	\$1,556,732	\$3,120,360
Timberlands	\$647,930	95,500	\$552,053	\$1,199,983
Total	\$68,640,029	6,167,800	\$35,653,971	\$104,294,000

Source: Mental Health Division and Calculation of Population and Stabilization figures.

When the calculated Medicaid funds (based on higher eligibles) were added to this non-Medicaid allocation, decision-makers were surprised to discover that, although total revenues would be slightly greater than Fiscal Year 2005, *eight of the fourteen RSNs would receive less total funding in Fiscal Year 2006.* Table 12 compares funding between the two years and lists in the last two columns the dollar and percentage changes for each RSN if the original, agreed-upon formulas had been used. (RSNs with losses are shown in *bold italics*.)

**Table 12: Comparison of Fiscal Years 2005 and 2006 Funding, Original Formulas**

RSN	FY2005 Total Revenue	FY2006 State Only, Original Formula	FY2006 Medicaid (per Milliman)	FY2006 Total, Original Formula	Difference	% Difference
Chelan Douglas	\$6,197,071	\$1,253,908	\$5,163,220	\$6,417,128	\$220,058	3.6%
<b>Clark</b>	\$19,663,355	\$4,566,789	\$14,070,366	\$18,637,155	<b>-\$1,026,200</b>	<b>-5.2%</b>
<b>Grays Harbor</b>	\$6,502,059	\$1,448,389	\$4,160,102	\$5,608,491	<b>-\$893,568</b>	<b>-13.7%</b>
<b>Greater Columbia</b>	\$42,051,714	\$9,831,987	\$29,730,067	\$39,562,054	<b>-\$2,489,660</b>	<b>-5.9%</b>
King	\$90,309,570	\$32,112,334	\$77,468,496	\$109,580,830	\$19,271,261	21.3%
<b>NEWRSN</b>	\$6,431,093	\$747,080	\$3,840,032	\$4,587,112	<b>-\$1,843,981</b>	<b>-28.7%</b>
<b>North Central</b>	\$11,430,661	\$2,012,947	\$7,266,408	\$9,279,354	<b>-\$2,151,307</b>	<b>-18.8%</b>
North Sound	\$50,047,726	\$16,192,710	\$35,083,039	\$51,275,749	\$1,228,023	2.5%
<b>Peninsula</b>	\$19,624,705	\$4,064,504	\$15,455,901	\$19,520,405	<b>-\$104,300</b>	<b>-0.5%</b>
Pierce	\$48,572,280	\$19,085,031	\$33,334,387	\$52,419,418	\$3,847,138	7.9%
<b>Southwest</b>	\$8,012,342	\$1,325,474	\$6,070,746	\$7,396,219	<b>-\$616,123</b>	<b>-7.7%</b>
Spokane	\$31,644,406	\$7,332,504	\$26,627,755	\$33,960,260	\$2,315,854	7.3%
<b>Thurston Mason</b>	\$15,181,749	\$3,120,360	\$9,701,048	\$12,821,408	<b>-\$2,360,341</b>	<b>-15.5%</b>
<b>Timberlands</b>	\$7,085,984	\$1,199,983	\$5,254,981	\$6,454,964	<b>-\$631,020</b>	<b>-8.9%</b>
Total	\$362,754,714	\$104,294,000	\$273,226,549	\$377,520,549	\$14,765,834	4.1%

Upon examination of the data, it becomes clear why the losses would occur. Table 13, which combines portions of Tables 9 and 12, shows that *seven of eight RSNs that would have experienced funding reductions had Medicaid cuts of 20% or more due to lower actual Medicaid service levels. In each case, the Medicaid reduction was greater than the amount of new non-Medicaid (State-Only) dollars.* This was true, even though the actuaries “flattened” the rate differences between RSNs with high utilization and those with low utilization.

**Table 13: Analysis of Projected FY05-06 Funding Reductions**

RSN	Revised FY05-06 Medicaid Change	% Change	Greater than 20% Medicaid reduction?	FY05-06 Total Revenue Change	% Change	Loss in Total Funding?
Chelan Douglas	-\$849,975	-14.9%	No	\$220,058	3.6%	No
<b>Clark</b>	<b>-\$5,694,683</b>	<b>-30.1%</b>	<b>Yes</b>	<b>-\$1,026,200</b>	<b>-5.2%</b>	<b>Yes</b>
<b>Grays Harbor</b>	<b>-\$2,144,328</b>	<b>-35.4%</b>	<b>Yes</b>	<b>-\$893,568</b>	<b>-13.7%</b>	<b>Yes</b>
<b>Greater Columbia</b>	<b>-\$11,371,551</b>	<b>-28.9%</b>	<b>Yes</b>	<b>-\$2,489,660</b>	<b>-5.9%</b>	<b>Yes</b>
King	-\$4,765,399	-6.1%	No	\$19,271,261	21.3%	No
<b>NEWRSN</b>	<b>-\$2,561,908</b>	<b>-41.5%</b>	<b>Yes</b>	<b>-\$1,843,981</b>	<b>-28.7%</b>	<b>Yes</b>
<b>North Central</b>	<b>-\$3,959,147</b>	<b>-36.7%</b>	<b>Yes</b>	<b>-\$2,151,307</b>	<b>-18.8%</b>	<b>Yes</b>
North Sound	-\$14,689,028	-30.8%	Yes	\$1,228,023	2.5%	No
<b>Peninsula</b>	<b>-\$3,010,310</b>	<b>-17.2%</b>	<b>No</b>	<b>-\$104,300</b>	<b>-0.5%</b>	<b>Yes</b>
Pierce	-\$13,244,156	-29.7%	Yes	\$3,847,138	7.9%	No
<b>Southwest</b>	<b>-\$1,506,445</b>	<b>-20.9%</b>	<b>Yes</b>	<b>-\$616,123</b>	<b>-7.7%</b>	<b>Yes</b>
Spokane	-\$2,322,454	-8.5%	No	\$2,315,854	7.3%	No
<b>Thurston Mason</b>	<b>-\$5,459,964</b>	<b>-37.5%</b>	<b>Yes</b>	<b>-\$2,360,341</b>	<b>-15.5%</b>	<b>Yes</b>
Timberlands	-\$933,411	-15.9%	No	-\$631,020	-8.9%	No
Total	-\$72,512,759	-22.0%	N/A	\$14,765,834	4.1%	N/A

### **Late Course Correction: Infrastructure Stabilization**

In late May/early June after all the figures were compiled and the shortfalls were identified, the decision was made to adjust the non-Medicaid funding formula to balance FY2006 funding with FY2005 funding. This was done by creating a new category of State-Only (non-Medicaid) funding called “Infrastructure Stabilization”, which used \$25 million of the \$35 million Per Capita funds to ensure that no RSN would have less total funding in Fiscal Year 2006 than in FY05. Table 14 shows the impact of these changes within each RSN, substantially increasing State-Only funds to RSNs with lower Medicaid services and the reducing State-Only to RSNs with higher Medicaid service levels.

**Table 14: Impact of Infrastructure Stabilization Adjustment**

RSN	Total Population	FY06 Original Per Capita Allocation	FY06 Population & Stabilization: Adjusted	Difference	% Difference
Chelan Douglas	102,600	\$593,096	\$385,079	-\$208,017	-35.1%
Clark	383,300	\$2,215,728	\$3,497,137	\$1,281,409	57.8%
Grays Harbor	69,200	\$400,022	\$1,299,862	\$899,840	224.9%
Greater Columbia	630,400	\$3,644,130	\$6,425,069	\$2,780,940	76.3%
King	1,788,300	\$10,337,559	\$2,924,791	-\$7,412,769	-71.7%
NEWRSN	70,100	\$405,224	\$2,256,780	\$1,851,555	456.9%
North Central	134,600	\$778,077	\$2,959,445	\$2,181,368	280.4%
North Sound	1,020,800	\$5,900,900	\$5,484,723	-\$416,177	-7.1%
Peninsula	332,400	\$1,921,492	\$2,053,722	\$132,230	6.9%
Pierce	744,000	\$4,300,813	\$1,216,823	-\$3,083,990	-71.7%
Southwest	95,300	\$550,897	\$1,274,529	\$723,631	131.4%
Spokane	432,000	\$2,497,246	\$706,542	-\$1,790,704	-71.7%
Thurston Mason	269,300	\$1,556,732	\$3,959,987	\$2,403,255	154.4%
Timberlands	95,500	\$552,053	\$1,209,484	\$657,430	119.1%
Total	6,167,800	\$35,653,971	\$35,653,971	\$0	0.0%

*The infrastructure stabilization adjustment, while on the right track in intent, created the unintended consequence of throwing out of balance the original purpose of the per capita non-Medicaid funding – to provide adequate funding in each RSN to ensure that priority non-Medicaid persons would receive community-based outpatient services.*

Table 15 illustrates this unintended consequence by calculating the original per capita funding amount for each RSN and the same figures after the infrastructure adjustment was made. As noted in the table, the \$35 million originally provided \$5.78 per capita in each RSN; after the adjustment, this figure varied from a low to \$1.64 to a high of \$32.19.

**Key Concern:** The infrastructure stabilization adjustment resulted in significant under-funding of outpatient services to priority non-Medicaid persons in some RSNs and dramatic over-funding of these services in other RSNs.

**Table 15: Per Capita Funding for Priority Outpatient Services**

RSN	Total Population	FY06 Per Capita Original	Per Capita Funding: Original	Population & Stabilization: Adjusted	Per Capita Funding: Adjusted	% Above (Below) Statewide Average
Chelan Douglas	102,600	\$593,096	\$5.78	\$385,079	<b>\$3.75</b>	-35%
Clark	383,300	\$2,215,728	\$5.78	\$3,497,137	<b>\$9.12</b>	58%
Grays Harbor	69,200	\$400,022	\$5.78	\$1,299,862	<b>\$18.78</b>	225%
Greater Columbia	630,400	\$3,644,130	\$5.78	\$6,425,069	<b>\$10.19</b>	76%
King	1,788,300	\$10,337,559	\$5.78	\$2,924,791	<b>\$1.64</b>	-72%
NEWRSN	70,100	\$405,224	\$5.78	\$2,256,780	<b>\$32.19</b>	457%
North Central	134,600	\$778,077	\$5.78	\$2,959,445	<b>\$21.99</b>	280%
North Sound	1,020,800	\$5,900,900	\$5.78	\$5,484,723	<b>\$5.37</b>	-7%
Peninsula	332,400	\$1,921,492	\$5.78	\$2,053,722	<b>\$6.18</b>	7%
Pierce	744,000	\$4,300,813	\$5.78	\$1,216,823	<b>\$1.64</b>	-72%
Southwest	95,300	\$550,897	\$5.78	\$1,274,529	<b>\$13.37</b>	131%
Spokane	432,000	\$2,497,246	\$5.78	\$706,542	<b>\$1.64</b>	-72%
Thurston Mason	269,300	\$1,556,732	\$5.78	\$3,959,987	<b>\$14.70</b>	154%
Timberlands	95,500	\$552,053	\$5.78	\$1,209,484	<b>\$12.66</b>	119%
Total	6,167,800	\$35,653,971	\$5.78	\$35,653,971	<b>\$5.78</b>	0%

Furthermore, because the infrastructure adjustment conflicts with language in the RSN contracts regarding how non-Medicaid funds can and cannot be used, RSNs are in a Catch-22 regarding their ability to stabilize the system. This unintended consequence can be described by the following bullets:

- The RSN Contracts require that State-Only funds are restricted to specific non-Medicaid services. This includes non-Medicaid Inpatient, Residential, Crisis and Outpatient Services to Priority Populations. The \$35 million Stabilization/ Population-Based portion of the \$104 million State-Only funds should be used primarily to fund Outpatient Services.
- The Infrastructure Stabilization adjustment was intended to keep the RSNs whole; e.g. support a FY2006 transition year, maintain staffing levels and prevent reduction in clients and services.
- The conflict is that some RSNs have received so much State-Only funding that they cannot possibly spend it on the items in the first bullet above. Those RSNs are faced with the choices of:
  - Use the State-Only funds to keep staff hired and dramatically increase services to non-Medicaid persons beyond the Priority Population definition for one year, thus violating the RSN contract funding restrictions, and then after the stabilization formula sunsets, exit these additional clients from service.

- Use the State-Only funds to keep staff hired, meet the needs of the priority non-Medicaid population; use the remaining State-Only funds to serve the Medicaid population that would otherwise be underserved because the Medicaid rates are too low, thereby violating the RSN contract funding restriction.
- Adhere to the RSN Contract restrictions, only spending the State-Only funds on the designated services, put the excess funds in a bank account, and lay off staff to stay in sync with the funding restrictions.

**Key Concern:** Unless immediate changes are made to FY2006 allocations, some RSNs will be faced with either using State-Only dollars to provide services that violate their contracts with the State, or follow the State-Only funding restrictions, lay off staff, and have substantial unspent dollars at the end of the Fiscal Year. At the same time other RSNs will be unable to provide anything other than crisis services to non-Medicaid persons and a substantial number of non-Medicaid persons will be unable to obtain access to care.

## IV. Summary of Recommendations

The following “short list” of recommendations for change should be considered for correcting the problems identified in this paper.

### **Recommendation 1: Revise the Medicaid Rates within the Rate Band**

The Mental Health Division should revise the Medicaid rates to reflect a more reasonable number of Medicaid eligibles for Fiscal Years 2006 and 2007, and thus drawing down the intended federal dollars and funds allocated in the state budget.

The Mental Health Division should also work with the Mental Health Task Force to evaluate whether a FY2007 supplemental budget request is necessary to address the Medicaid funding shortfall that has unfolded.

### **Recommendation 2: Infrastructure Stabilization Correction**

The Mental Health Division should work with key decision makers to revise the infrastructure stabilization formula so a balance is achieved between maintaining FY2005 funding levels *and* funding services for non-Medicaid priority clients. In addition, the formula should also ensure that FY2006 funding supports FY2005 expenditure levels, versus FY2005 funding levels. Under the current formula, if an RSN or provider agency had large surpluses, those surpluses became part of the equation; this should be corrected.

### **Recommendation 3: System Change Tracking Model**

The Mental Health Division should develop a reporting system that uses current data to track actual and projected utilization, cost and PMPM by month, funding source, age group, and service category for each RSN. The tracking system should include actual data for months that have passed, combined with revised projections based on the actual data, to present a set of full-year projections.

These reports should become the basis for system performance monitoring and corrective action planning. The authors are working with the eleven Oregon MHOs (RSN-equivalents) to develop this type of reporting system and Attachment B contains portions of a sample report that is under development.

### **Recommendation 4: Temporary RSN Contract Modifications**

If Recommendations 1 and 2 do not adequately address the non-Medicaid mismatch for FY2006, the Mental Health Division should consider amending the RSN contracts for Fiscal Year 2006 to allow non-Medicaid funds to be used for Medicaid outpatient services. This should be a temporary, transition strategy only! This will have the effect of ensuring that Medicaid persons are not underserved because the Medicaid rates are too low and help enhance Medicaid utilization for future actuarial studies.

### **Recommendation 5: Transition Plan for Fiscal Year 2007**

The Mental Health Division should develop a transition plan for FY2007 that creates a stabilizing trajectory from the revised infrastructure stabilization formula to a full per capita formula.

# Attachment A – 1998 State Medicaid Directors Letter

67 June 24, 1998

Dear State Medicaid Director:

A policy concern relating to certain contract requirements on managed care organizations (MCOs) or prepaid health plans (PHPs) has been undergoing Administration review. This is to inform you how we have considered this issue and what decision we have reached.

Some States have required in their contracts with MCOs or PHPs that any savings within their capitated payment, minus an allowed profit, if any, be used to provide health services to persons who are not eligible for Medicaid.

We view this practice as an inappropriate subsidy for services for the uninsured. (See section 1903(m) (2)(A)(iii) of the Social Security Act, which states that capitated programs are intended for Medicaid recipients.)

However, we recognize that when a capitated payment is made to an MCO or a PHP, the entity is required to meet its contractual obligations to serve Medicaid beneficiaries within the money provided, and that except for limits that may be set on allowed profits (in for-profit entities), the MCO or PHP can use its savings as it wishes. In effect, it is no longer "Medicaid money." In fact, should an MCO or PHP voluntarily choose to serve people who are not Medicaid eligible, it is free to do so. However, we believe it is not appropriate for the State Medicaid agency to require in its contract with an MCO or PHP that savings from capitated payments be used to provide health services to individuals not otherwise eligible for Medicaid.

Therefore, for any new or pending section 1915(b) or 1115 waivers (including applications for renewals) or any other Medicaid managed care situation (e.g., State plan option under the Balanced Budget Act), as a matter of policy, we will not approve any State Medicaid agency waiver application that contains a requirement for MCOs or PHPs to use savings under the capitation rate for non-Medicaid eligibles. Furthermore, in our normal review of waivers, Requests for Proposals, and contracts, we will also ascertain whether or not States are in compliance with this policy directive.

If you have any questions about this policy, please contact Wayne Smith at (410) 786-6762.

Sincerely,

/s/

Sally K. Richardson  
Director

cc: All HCFA Regional Administrators  
All HCFA Associate Regional Administrators for Medicaid and State Operations  
Lee Partridge American Public Welfare Association  
National Conference of State Legislatures

# Attachment B – Oregon MHOs Sample Tracking Reports

## Oregon MHO Tracking Model Report Taxonomy

### Detail Report: Completed by each MHO

Month 1	Month 2	>>>>	Total/Avg	Statewide Total/Avg	Above (Below) Avg
(Actual for Most Recent 12 Months)					
11 Sections (see Sample)					

### Statewide Report: Detail View 1

12 Mo Ttl/Avg MHO 1	12 Mo Ttl/Avg MHO 2	12 Mo Ttl/Avg MHO 3	>>>>	Statewide Total/Avg	Above (Below) Avg
Same rows as Detail Report Column for each MHO					

### Statewide Report: Summary View 1

12 Mo Ttl/Avg MHO 1	12 Mo Ttl/Avg MHO 2	12 Mo Ttl/Avg MHO 3	>>>>	Statewide Total/Avg	Above (Below) Avg
Many fewer rows than Detail Report 1 to 3 graphs per page for most important comparisons Column for each MHO					

### Statewide Report: Summary View 3

Month 1	Month 2	>>>>	Total/Avg	Statewide Total/Avg	Above (Below) Avg
11 Sections with row for each Key Measure (Detail Report) Row for each MHO within each section (Graphs as needed to visually display information)					

### Projections Model: Completed by each MHO

Month 1 Actual	Month 2 Actual	Month 3 Projection	Total/Avg Act/Proj	Statewide Total/Avg	Above (Below) Avg
Same design as Detail Report					
Based on Fiscal Year; includes Actuals and Projections Projections are based on extrapolation of Actuals to arrive at Actual/Estimate for Fiscal Year; this allows the MHO to know at any point in time where they are headed for the year.					

### Statewide Report: Detail View 2

12 Mo Ttl/Avg MHO 1	12 Mo Ttl/Avg MHO 2	12 Mo Ttl/Avg MHO 3	>>>>	Statewide Total/Avg	Above (Below) Avg
Same structure as Projection Model Column for each MHO					

### Statewide Report: Summary View 2

12 Mo Ttl/Avg MHO 1	12 Mo Ttl/Avg MHO 2	12 Mo Ttl/Avg MHO 3	>>>>	Statewide Total/Avg	Above (Below) Avg
Many fewer rows than Projection Model 1 to 3 graphs per page for most important comparisons Column for each MHO					

### Statewide Report: Summary View 4

12 Mo Ttl/Avg MHO 1	12 Mo Ttl/Avg MHO 2	12 Mo Ttl/Avg MHO 3	>>>>	Statewide Total/Avg	Above (Below) Avg
11 Sections with row for each Key Measure (Projection Model) Row for each MHO within each section (Graphs as needed to visually display information)					

## Oregon MHO Tracking Model Sample Summary View 1 Report

### Year to Date Total/Average

	Accountable Behavioral Health		Clackamas County Mental Health		Family Care Inc		Greater Oregon Behavioral Health		Jefferson Behavioral Health		Lane Care MHO		Mid-Valley Behavioral Health		Multnomah County Verity		Tuinity Health		Washington County		Totals	
	Sample Data	Sample Data	Sample Data	Sample Data	Sample Data	Sample Data	Sample Data	Sample Data	Sample Data	Sample Data	Sample Data	Sample Data	Sample Data	Sample Data	Sample Data	Sample Data	Sample Data	Sample Data	Sample Data	Sample Data	Sample Data	Sample Data
12,190	12,720	3,710	14,310	29,150	16,960	28,090	33,390	2,120	7,420	160,060												
10,810	11,280	3,290	12,690	25,850	15,040	24,910	29,610	1,880	6,580	141,940												
23,000	24,000	7,000	27,000	55,000	32,000	53,000	63,000	4,000	14,000	302,000												
248	259	75	291	593	345	571	679	43	151	3,256												
1,843	1,924	561	2,164	4,408	2,565	4,248	5,049	321	1,122	24,205												
3,605	3,761	1,097	4,231	8,619	5,015	8,306	9,873	627	2,194	47,329												
231	241	70	271	552	321	532	632	40	140	3,030												
3,327	3,471	1,012	3,905	7,955	4,628	7,666	9,112	579	2,025	43,680												
26	27	8	31	63	36	60	72	5	16	344												
1,874	1,955	570	2,200	4,481	2,607	4,318	5,132	326	1,141	24,603												
11,090	11,573	3,375	13,019	26,520	15,430	25,556	30,378	1,929	6,751	145,621												
757	789	230	888	1,809	1,053	1,743	2,072	132	461	9,934												
23,000	24,000	7,000	27,000	55,000	32,000	53,000	63,000	4,000	14,000	302,000												

### Section 1: Member Months

Child/Youth (0-17)	
Adult/Older Adults (18+)	
Total	
<b>By Culture/Ethnicity</b>	
American Indian or Alaskan Native	
Asian or Pacific Islander	
Black	
Black, African Immigrant	
Hispanic	
Native Hawaiian/Other Pacific Is	
White, East Euro Lang-Speaking	
White, English-Speaking	
Other/Undetermined	
Total	

### Section 2: Capitation Rates

Average PMPM	
Child/Youth (0-17)	
Adult/Older Adults (18+)	
Total	
Above (Below) Average	

### Section 3: Capitation Payments

Child/Youth (0-17)	
Adult/Older Adults (18+)	
Total	

**Oregon MHO Tracking Model  
Sample Summary View 1 Report**

**Year to Date Total/Average**

	Accountable Behavioral Health		Clackamas County Mental Health		Family Care Inc		Greater Oregon Behavioral Health		Jefferson Behavioral Health		Lane Care MHO		Mid-Valley Behavioral Health		Multnomah Verity		Tuinity Health		Washington County		Totals	
	Sample Data	Sample Data	Sample Data	Sample Data	Sample Data	Sample Data	Sample Data	Sample Data	Sample Data	Sample Data	Sample Data	Sample Data	Sample Data	Sample Data	Sample Data	Sample Data	Sample Data	Sample Data	Sample Data	Sample Data	Sample Data	Sample Data
554	578	169	651	1,325	771	1,277	1,518	96	337	7,277												
1,189	1,241	362	1,396	2,844	1,655	2,741	3,258	207	724	15,618												
1,744	1,819	531	2,047	4,170	2,426	4,018	4,776	303	1,061	22,894												
5	6	2	6	13	8	13	15	1	3	72												
27	28	8	32	65	38	62	74	5	16	355												
32	34	10	38	78	45	75	89	6	20	427												
555	579	169	651	1,327	772	1,279	1,520	97	338	7,286												
1,192	1,244	363	1,399	2,850	1,658	2,747	3,265	207	726	15,651												
1,747	1,823	532	2,051	4,177	2,430	4,025	4,785	304	1,063	22,938												
4.6%	4.6%	4.6%	4.6%	4.6%	4.6%	4.6%	4.6%	4.6%	4.6%	4.6%												
11.0%	11.0%	11.0%	11.0%	11.0%	11.0%	11.0%	11.0%	11.0%	11.0%	11.0%												
7.6%	7.6%	7.6%	7.6%	7.6%	7.6%	7.6%	7.6%	7.6%	7.6%	7.6%												

**Section 4: Members Served by Age**

**Outpatient**

Child/Youth (0-17)  
Adult/Older Adults (18+)  
Total

**Inpatient**

Child/Youth (0-17)  
Adult/Older Adults (18+)  
Total

**Total, Unduplicated**

Child/Youth (0-17)  
Adult/Older Adults (18+)  
Total

**Penetration Rates - Total Served**

Child/Youth (0-17)  
Adult/Older Adults (18+)  
Total

etc..

Dale Jarvis and Barbara Mauer are Managing Consultants at MCPP Healthcare Consulting, a Seattle-based consulting firm, and members of the National Council for Community Behavioral Healthcare's Consulting Service.

Mr. Jarvis has in-depth experience helping managers and providers of health care redesign their administrative, fiscal and information systems. He has been a certified public accountant in the State of Washington and a member of the American Institute of Certified Public Accountants since 1982.

Ms. Mauer has worked extensively with providers and communities to redesign their service delivery systems and support quality and utilization management processes. She was trained as a social worker, has managed large county human service systems and was a senior administrator at Group Health Cooperative, is a Certified Management Consultant and has been consulting for over 15 years.

Both authors have contributed articles to books and publications and are co-authors of two books, The Primary Care Performance Management System and How to Thrive in Managed Behavioral Healthcare.

## End Notes

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<sup>i</sup> Blueprints for an Effective Mental Health System in Washington State, September 2000, page 97.

<sup>ii</sup> Being There: Making a Commitment to Mental Health, November 2000, Page 8.

<sup>iii</sup> Being There: Making a Commitment to Mental Health, November 2000, Page 39.

<sup>iv</sup> State of Oregon Report to the Governor from the Mental Health Alignment Workgroup, January 2001, page 44.

<sup>v</sup> National Association of State Mental Health Program Directors, <http://nri.rdmc.org/>.

<sup>vi</sup> Mental Health: A Report of the Surgeon General, US Department of Health and Human Services, 1999