



Mental Health and Developmental Services

BUDGET PRESENTATION 2009-2011 BIENNIUM

Jim Gibbons, Governor

**Michael J. Willden, Director,
Department of Health and Human Services**

Harold Cook, Ph.D., Administrator

Jeff Mohlenkamp, Administrative Services Officer IV

September 2008

DIVISION OF MENTAL HEALTH AND DEVELOPMENTAL SERVICES

KEY ISSUES 2010 – 2011 BIENNIUM

Several issues must be addressed regarding the budget needs for the Division of Mental Health and Developmental Services (MHDS). This biennium has been dominated by the Division’s efforts to manage funds within the target limit, which is the majority of discussion.

BUDGET REDUCTIONS NECESSARY TO MEET GENERAL FUND TARGET

MHDS created numerous E-600 and M-160 decision units to reduce the General Fund portion of the budget to meet the target set by the Budget Division. These decision units resulted in significant reductions of staff positions, elimination of growth in most FY2009 client services, redesign of service delivery models to increase efficiencies, and an increase in the Division’s collection of other revenue sources.

In total, MHDS submitted general fund reductions of \$43.6 million in FY2010 and \$43.8 million in FY2010 and eliminated 222 staff positions. When offset by the necessary increases in operating costs to meet ongoing business needs, this allowed the Division to meet the general fund target.

Developmental Services Cuts

Developmental Services (DS) agencies have submitted budgets that significantly reduce services available to clients. The Division intends to provide basic case management services to all qualified clients, but will have fewer resources for providing the necessary services which will help clients live more independently. This includes significant cuts in residential supports, jobs and day training, Autism services and other ancillary services to assist mentally disabled clients and their families.

Below (the chart), is an overview of the most significant reductions. A complete discussion of all cuts, including the number of clients affected, is included in the NEBS 220 (see “Budget Summary” section).

	2010 GEN FUND	OTHER	TOTAL CUTS	2011 GEN FUND	OTHER	TOTAL CUTS	STAFF CUTS
DRC	\$(12,429,288)	\$(7,509,381)	\$(19,938,669)	\$(12,447,823)	\$(7,525,013)	\$(19,972,836)	3.00
SRC	\$(4,055,200)	\$(2,336,287)	\$(6,391,487)	\$(4,056,145)	\$(2,336,916)	\$(6,393,061)	8.51
RRC	\$(1,486,310)	\$(707,254)	\$(2,193,564)	\$(1,537,830)	\$(708,037)	\$(2,245,867)	0.00
TOTAL	\$(17,970,798)	\$(10,552,922)	\$(28,523,720)	\$(18,041,798)	\$(10,569,966)	\$(28,611,764)	11.51

As demonstrated in the chart, general fund reductions result in a similarly large reduction in federal funding. These cuts will result in increased waiting lists and hardship to clients and their families. The Division may also face legal action, as its ability to comply with the Federal Olmstead court decision is further compromised due to these reductions. Olmstead essentially requires the State to provide essential services to allow clients to live in the least restrictive setting available within 90 days of a valid application. Currently, wait times for residential support services exceed one year. These reductions will further extend wait times.

Supported Living Arrangements (Residential Supports)

All three DS agencies have made deep cuts in funding used to provide residential supports for clients. These cuts have eliminated most of the growth for FY2009 which had been approved in the prior budget. Essentially this puts the DS agencies a full year behind in meeting increasing caseload demands. This will add to lengthy waiting lists and will create a greater risk to clients which may utilize other costly community services, such as hospitals and jails. This also increases the risk to clients of abuse or neglect in family settings and increases the risk of litigation due to the Olmstead decision.

Jobs and Day Training

DS agencies have similarly cut almost all growth to meet the demand for Jobs and Day Training services. These cuts will limit resources available to care for mentally-disabled clients during the day, and will limit the Division's ability to help clients live more independently. It increases strain on families and the risk of abuse or neglect. Waiting lists will grow significantly due to these reductions.

Self Directed Autism

In the previous budget, a self-directed Autism program was approved which was funded with both TANF and general funds. The majority of general fund dollars have been removed from the program with these cuts. This ensures that agencies will have no growth in FY2009. New placements will only be available as children leave the program. Waiting lists will grow which means that children and their families will need to wait longer to receive services. Studies have demonstrated that early intervention helps reduce the long-term effects of Autism. Further delays in providing services created by these reductions will hinder the Division's ability to provide assistance, resulting in potentially higher, long-term costs of serving these individuals.

Fiscal Intermediary

DS agencies provide funding to support clients who live with their families. The fiscal intermediary program ensures that clients acquire necessary community services, which the agencies will reimburse families for the cost of those services. The cuts have required the Division to reduce the maximum monthly payment to families and also limit the number of families which agencies can serve. This will put an increased financial burden on families and could reduce the services available to our clients.

Quality Improvement Initiatives

The agencies have terminated a contract with the University of Nevada, Reno (UNR) designed to provide an independent review of the quality of care delivered to clients. They have also reduced a contract with the Council on Quality and Leadership which provided training and reviewed systems designed to improve the quality of services. These reductions will lower the support to bare minimums, which are needed for the continuation of receiving accreditation. The agencies plan to supplement these losses with improved internal processes, and they do not anticipate significant problems due to these reductions.

Mental Health Cuts

Mental Health (MH) agencies are cutting client services, are significantly changing service delivery systems, are cutting costs to operate more efficiently, and are aggressively pursuing other funding sources to meet the budget reduction target.

Below (the chart) is an overview of the most significant reductions. A complete discussion of all cuts, including the number of clients affected, is included in the NEBS 220 (see “Budget Summary” section).

	2010 GEN FUND	OTHER	TOTAL CUTS	2011 GEN FUND	OTHER	TOTAL CUTS	STAFF CUTS
SNAMHS*	\$(16,611,108)	\$1,554,755	\$(15,066,353)	\$(16,745,161)	\$1,574,755	\$(15,170,406)	136.41
NNAMHS	\$(4,428,997)	\$485,458	\$(3,943,539)	\$(4,496,202)	\$515,744	\$(3,980,458)	38.15
RC	\$(2,341,404)	\$(31,336)	\$(2,372,740)	\$(2,314,619)	\$15,240	\$(2,299,379)	27.79
TOTAL	\$(23,381,509)	\$2,008,877	\$(21,382,632)	\$(23,555,982)	\$2,105,739	\$(21,450,243)	202.35

* SNAMHS cuts also include the absorption of a \$5.7 million dollar budget error that created a “phantom” revenue source in the base budget. The “phantom” revenue has been eliminated for FY2010 - FY2011 resulting in an FY2008 – FY2009 further reduction not reflected in the numbers above.

As demonstrated above, MH agencies are actually projecting increases in other revenues. This is due to a Division initiative to place a concerted effort at pursuing federal Medicaid/Medicare funds, private insurance, and client collections. We anticipate these increased revenues will help offset some operational costs and limit cuts in services. Also noted above are significant reductions in staff within the MH agencies. This is largely driven by changes in staffing ratios within inpatient facilities and a change in the service delivery model within Rural Clinics. These and other material budget reductions are discussed below.

Inpatient Staffing Reductions

Northern and Southern Nevada Adult Mental Health Services (NNAMHS and SNAMHS) have proposed significant reductions in staffing at their inpatient facilities. This is primarily driven by reductions in the number of nurses and mental health technicians used to serve clients. These reductions are accompanied by the appropriate reductions in support staff and supervisory staff positions.

Inpatient staffing reductions at SNAMHS total 107 positions. We have provided contract funding to re-hire 14 positions resulting in a net reduction of 93. At NNAMHS, we have eliminated 13 positions and transferred another 4.51 positions to the outpatient facilities where other cuts have been made, resulting in a total reduction of 17.51 positions.

Research of staffing ratios used in private psychiatric facilities and at comparable facilities in other states has revealed that both of our inpatient facilities have maintained higher staff to client ratios than comparably situated facilities. Through these staffing cuts, ratios of staff to client will be reduced as follows:

	<u>Current</u>	<u>Proposed</u>
Staff Nurse -	1 to 7 day/evening 1 to 10 night 1 to 4 (POU)	1 to 10 day/evening 1 to 13 night 1 to 5 (POU)
Mental Health Techs -	1 to 7 day/ evening 1 to 7 night 1 to 5 (POU)	1 to 8 day/ evening 1 to 10 nights 1 to 5.5 (POU)
Licensed Psychologist -	1 to 33	1 to 47

Further, our average cost per occupied bed of \$575 to \$725 per day exceeds estimated private facility costs by a significant margin. While we do not have confirming data, anecdotal information indicates private facilities operate at less than \$400 per bed per day. These staffing changes significantly reduce the gap in costs between our facilities and private facilities.

The Division is confident these cuts can be completed without compromising client care; however, concerns exist. The State personnel system prevents management from quickly adjusting staffing levels to meet client counts and acuity levels. Further, it severely limits management's ability to address employee performance issues in a timely manner. These issues make it very difficult for the State to compete equally with private operations. We are attempting to address this issue by converting some positions to contract labor (thereby providing increased flexibility), but this will likely be inadequate to fully address these concerns.

North Las Vegas Clinic Closure

In FY2008, SNAMHS lost the lease for its North Las Vegas facility. This forced a temporary closure of the facility while a suitable location was secured. Budget cuts in FY2008 and FY2009 forced SNAMHS to delay the reopening of this facility. Targets set for FY2010 and FY2011 make the reopening of this facility and hiring of vacant staff positions impractical. Therefore, the North Las Vegas clinic will not be reopened, resulting in savings. Clients can still receive service at other clinics but may face difficulties due to travel distances.

Supported Living Arrangements (Residential)

SNAMHS, NNAMHS, and Rural Clinics have reduced funds available to support clients residing in the community. This eliminates a significant portion of growth in FY2009 for all three regions. As the Division focuses on reducing the average length of stay in its inpatient facilities, the existence of residential supports in the community becomes critical. Reduced client care may require added supports to prevent a repeat visit to local emergency rooms and our inpatient facilities. At \$800 to \$6,000 per month, a residential placement is still less expensive than our inpatient facilities, which will still exceed \$400 per day after budget reductions. Therefore, reductions in residential services may result in higher “per client” costs to the State.

Pharmacy (Medication Reductions)

NNAMHS and SNAMHS have reduced their medications budget to achieve a portion of their cuts. In FY2007 and FY2008, these agencies have had surpluses in medications. This is due to a number of factors, including manufacturer rebates, patient’s assistance programs for free medications, extensive use of samples, lower than projected caseloads, and lower costs due to availability of generic medications. Therefore, we feel comfortable in proposing reductions, as our operations are more efficient than projected.

There are risks associated with these reductions. If caseloads continue to increase, or the availability of free medications is reduced, these agencies could experience shortfalls.

Reduction of Outpatient Services Growth

In the FY2007 – 2009 budget, NNAMHS and SNAMHS each received growth in outpatient services. Both agencies have made significant reductions in order to meet required targets. NNAMHS has eliminated growth in FY2008 and FY2009 in its medication clinic and psychiatric ambulatory services. While NNAMHS has still been able to open its Reno clinic, it has reduced staffing at the main Sparks facility and moved inpatient staff to outpatient staff to accomplish this objective. SNAMHS has eliminated growth in its program for assertive community treatment. Both agencies have reduced the funding available for the community Triage centers.

Federal/Insurance Revenue Enhancements

MH agencies are projecting increases in billing revenues which will offset some of the general fund costs for its operations. Division management is focused on revenue increases for the efficiency of operations by the following factors:

Improved Eligibility Efforts – MH agencies are in the process of reconfiguring its front end billing processes. This will result in improvements in securing financial information from clients and also in the timeliness of obtaining complete information regarding our clients’ eligibility for Medicare, Medicaid, and private insurance.

Rate Increases – The Division is in the process of converting to cost allocation for all service areas. This will allow MH agencies to bill the full rate of providing services. Many rates have not been adjusted in several years. This will provide for increases in rates which are billed for many services rendered. We anticipate full completion of cost allocation and resetting of rates by spring 2009. In the meantime, the Division has increased rates to the maximum allowed by Medicare.

Billing All Available Services – From 2004 to 2007, the Division converted to a single client management and billing system. This centralized system provides the ability to evaluate service hours and ensure proper billing for all client services. The Division's and agencies' management are focused on ensuring all services rendered are properly billed to payers. Recent development of system reports provide key information that will allow management to identify areas where service hours are not properly recorded and take appropriate corrective action.

Medicare Inpatient Billing Changes – Medicare has fully converted from a standard daily rate reimbursement process to the Prospective Payment System (PPS). This allows inpatient facilities to recover additional revenues when caring for clients that suffer from both mental illness and physical ailments, such as diabetes or heart problems. PPS also provides additional payments for caring for elderly clients and/or clients that require special services. In its new model, Medicare is also providing the maximum funding for clients during the early days of care and reduces payments for extended care. MH agencies are in the process of converting to the PPS method of billing. Additionally, one of the Division's primary goals is to reduce lengths of stay in our inpatient facilities. These adjustments will help to maximize Medicare revenues.

The revenues proposed exceed historical collections. It is possible that MH agencies will not meet these revenue enhancements. In that event, the agencies will need to reduce costs to match collections.

Rural Clinics Budget Reductions

Unlike all other MHDS agencies which met most of their budget cut targets by eliminating FY2008 and FY2009 growth and other previously planned program reductions, rural mental health had very little growth and no planned program reductions. As a result, rural mental health proposes closing eleven clinics and consolidating services in the larger population centers of rural Nevada. This will result in savings from rent and associated facility costs, but it will also eliminate several clinical and support staff positions.

In conjunction with this reduction, rural mental health will restructure its business model to focus more on medication services with service coordination and paraprofessional services. Counseling services will be de-emphasized and will better focus on time-limited and specific skills development groups which are evidence based. Rural mental health will also foster relationships with community health providers, as well as primary care providers, to better serve rural consumers.

To further these business model changes, Rural Clinics is eliminating several hard-to-fill or expensive positions, such as mental health counselors and psychologists, and replacing them with easier to hire, lower-level positions such as mental health technicians and psychiatric caseworkers. This will allow the agency to provide basic services and facilitate this business delivery system change.

Lakes Crossing Budget Reductions

In 2006, Lakes Crossing Center (LCC) increased its capacity to 76 beds to comply with the provisions of a federal lawsuit settlement. This expansion was accomplished by adding bed capacity to the facility and converting 20 civil beds at Dini-Townsend Hospital into forensic beds. Census data indicates that the 76-bed capacity may be excessive, and the current budget is adjusted to a 70-bed capacity. In accordance with the reduction to 70 beds, LCC is also eliminating four forensic specialist positions. In the event that census spikes and sustains beyond the 70-bed capacity it may be necessary to seek additional resources through the Interim Finance Committee (IFC).

LCC is also eliminating an IT position and one psychologist to meet reduction targets.

SAPTA Budget Cuts

In the FY2007 – FY2009 budget, SAPTA received several growth packages. The FY2008 and FY2009 cuts reduced growth in funding for wait list reduction, methamphetamine education, prevention programs, and co-occurring programs.

Wait List Reduction Cuts

Due to funding limitations, SAPTA's community providers have not been able to serve all clients requiring drug abuse treatment upon request. They have established waiting lists. For FY2008, SAPTA providers had a total of 2,233 clients which were placed on waiting lists. Clients averaged a 22-day wait to receive services.

Timing is critical when clients request services. Studies have indicated that 25 percent to 50 percent of applicants for treatment services will drop off a waiting list between the initial assessment and initiation of treatment.

Methamphetamine Education Cuts

One of the Governor's key initiatives is to reduce the problems stemming from methamphetamine abuse. SAPTA received \$1 million in funding to provide education designed to reduce the prevalence of abuse and to entice those with methamphetamine problems to seek treatment. SAPTA has cut 10 percent of this new funding to meet budget targets.

Direct Service Prevention Programs

As part of the Governor's initiatives to reduce drug abuse of methamphetamines and other addictive drugs, State funds were provided to SAPTA to replace federal dollars which were lost due to the discontinuation of a prevention grant. This cut reduces this replacement funding by 16.7 percent.

Reduction of prevention funding limits the Division's ability to reduce the occurrence of substance abuse.

Co-Occurring Treatment

One primary reason for merging SAPTA with mental health is the prevalence of clients who suffer from both substance abuse and mental health disorders. Information from the Substance Abuse and Mental Health Services Administration in May 2004 indicated that more than 20 percent of mentally ill clients also suffered from substance abuse. Funding was provided to establish a pilot program to target treatment of both disorders. Often the treatment of only one disorder will not fully address clients' issues if the other problem is also not addressed.

Funding for this pilot program has been cut by approximately 26 percent, thereby reducing the implementation and limiting the number of clients we can serve.

General Issue Related to Budget Reductions

Public Employees Retirement System Buyout

The potential Public Employees Retirement System (PERS) buyout associated with approximately 230 full time employee position reductions could be significant. Although MHDS has established a hiring freeze in the affected staff classifications and developed a plan to minimize the number of staff to be laid off, these lay offs are inevitable. Projecting the potential PERS buyout is extremely difficult at this point. However, given the recent experience at Sierra Regional Center (SRC), the potential buyout could possibly be millions of dollars. By holding positions vacant, MHDS may accrue enough salary savings to fully fund these buyouts. In the event sufficient salary savings are not accrued, there would need to be another mechanism in place to fund these buy outs.

CASELOAD GROWTH

MH agencies, DS agencies, and SAPTA have developed growth packages for service areas where current funding is not adequate to meet service delivery needs. In accordance with budget instructions, services have been cut in the budget reductions outlined above. Growth is then requested in maintenance packages. This is discussed in further detail in the "Caseload" section and "Narrative" sections of this package.

PRIVATIZATION

There has been much discussion concerning privatization of existing mental health services, particularly inpatient services. Although there is merit in furthering the study of privatization, the PERS buyout issue may be a major barrier. If large mental health programs are privatized, the number of lay offs could result in a potential PERS buyout of millions of dollars. Another, perhaps more palatable, strategy would be to privatize caseload growth. The various M200 packages for mental health and substance abuse programs total 26 staff in the next biennium. Rather than funding growth in the State programs, this funding could be used to contract for private services. This could be supplemented with a program to convert vacant positions into contract labor through the budget process. This would result in privatization of a portion of the workforce, creating operational efficiencies.

MEDICAL CLEARANCE AT SNAMHS

This item for special consideration proposes a public/private partnership involving three entities: (1) the State of Nevada, (2) Clark County local governmental entities, and (3) Clark County local hospitals. With equal contributions from all three entities, the program would be housed at the Rawson-Neal Psychiatric hospital which would provide a single medical clearance program for Clark County. While this would not eliminate the need for medical clearance through local hospital emergency departments, it would greatly reduce the number of medical clearances handled at the various Clark County emergency departments. The proposed staffing configuration was developed by a Clark County task force involving state and local professionals. Because it is difficult to project actual staff requirements, staffing would be phased in if this item is approved. In this fashion, if optimal staffing levels are lower than the planned levels, it would be unnecessary to fill all budgeted positions.