Budget Issues and Recommendations

Iowa Department of Human Services

Division of Mental Health and Disability Services

February 15, 2007

Sources of Growth

- Since 2001, Federal (Medicaid) revenues/expenditures have been largest growth area in terms of real dollars and % growth in the Mental Health and Disability area.
- State and County dollars have remained relatively "stable" over time.

Growth in Revenue and Expenditures

- Revenue and expenditures have grown steadily in recent past (SFY2001 – SFY2005).

Clients Served by Iowa State Mental Health Authority and Expenditures (Uniform Report System)

Total Clients (MH+MR) Served by System	89,177	
Client Served in Community Settings	27,480	30.82%
Clients Served in State Hospitals	2,033	2.28%
FY2004 MH Block Grant Expenditures	$ 3,704,898.00	
SMHA Community MH Expenditures	$ 190,212,333.00	
Per Capita Community MH Expenditures	$ 64.62	
Community Percent of Total SMHA Spending	85%	
Total SMHA Mental Health Expenditures	$ 224,915,795.00	
Per Capita Total SMHA Mental Health Exp.	$ 76.41	

Direct and Non-Direct Mental Health Expenditures (URS)

Service Expenditures		Iowa	US	Variance from US Average
State Hospitals - Inpatient	$ 30,060,291.00	13.4%	28.0%	-14.6%
Other 24-hour Care	$ 43,797,979.00	19.5%	18.0%	1.5%
Ambulatory/Community	$ 146,414,354.00	65.1%	51.0%	14.1%
Total	$ 224,915,795.00			
Non-Direct Service Expenditures		**Iowa**	**US**	**Variance from US Average**
Technical Assistance Activities	$ 1,219,029.00	84%	32%	52%
Planning Council	$ -		3%	-3%
Administration	$ 157,218.00	11%	30%	-19%
Data Collection/Reporting	$ 45,000.00	3%	7%	-4%
Other Activities	$ 30,000.00	2%	27%	-25%
Total	$ 1,451,247.00			

Utilization Measures (1)

Utilization Measure	Iowa	US	Variance	Comment
Penetration Rate per 1,000 population	30.2	19.72	10.48	Iowa rate is 53% higher than US
Community Utilization per 1,000 population	9.3	18.44	-9.14	Iowa rate is 50% lower than US
State Hospital Utilization per 1,000 population	0.7	0.63	0.07	Iowa rate is 11% higher than US
Overall Utilization by Age Groups				
Age: 0 to 3	0.6%	0.7%	-0.10%	Iowa rate is 14% lower than US
4 to 12	16.5%	13.8%	2.70%	Iowa rate is 20% higher than US
13 to 17	12.7%	13.0%	-0.30%	Iowa rate is 2% lower than US
18 to 20	4.3%	4.4%	-0.10%	Iowa rate is 2% lower than US
21 to 64	35.1%	62.5%	-27.40%	Iowa rate is 44% lower than US
65 to 74	0.3%	2.7%	-2.40%	Iowa rate is 89% lower than US
75 and over	0.0%	1.9%	-1.90%	Iowa rate is 100% lower than US
Per cent in labor force	31.0%	37.0%	-6.0%	Iowa rate is 16% lower than US
Percent not in labor force	3.0%			
Percent Unemployed	67.0%			

Utilization Measures (2)

Persons served in State Psychiatric Hospitals				
Age: 0 to 17	24.0%	10.0%	14.0%	Iowa rate is 140% higher than US
18 to 20	10.0%	5.0%	5.0%	Iowa rate is 100% higher than US
21 to 64	64.0%	81.0%	-17.0%	Iowa rate is 21% lower than US
65 and over	1.0%	4.0%	-3.0%	Iowa rate is 75% lower than US
Civil state hospital readmissions: 30 days	4.9%	8.7%	-3.8%	Iowa rate is 44% lower than US
Civil state hospital readmissions: 180 days	7.8%	19.0%	-11.2%	Iowa rate is 59% lower than US
Civil state hospital readmissions 30 (adults)	5.5%	9.0%	-3.5%	Iowa rate is 39% lower than US
Civil state hospital readmissions 30 (children)	1.3%	6.6%	-5.3%	Iowa rate is 80% lower than US
Civil state hospital readmissions 180 (adults)	8.1%	19.6%	-11.5%	Iowa rate is 59% lower than US
Civil state hospital readmissions 180 (children)	6.1%	14.5%	-8.4%	Iowa rate is 58% lower than US
Living Situation: Private residence	46.0%	79.6%	-33.6%	Iowa rate is 42% lower than US
Living Situation: Homeless/Shelter	0.5%	3.8%	-3.3%	Iowa rate is 87% lower than US
Living Situation: Jails/Prisons	1.9%	2.7%	-0.8%	Iowa rate is 30% lower than US
Residential Care	2.4%			
Crisis Residence	0.2%			
Insitutional Setting	49.0%			

Evidence-based Practices???

EBPs	US Rate	Iowa Rate
New Generation Meds: State Hospitals	78.3%	?
New Generation Meds: Community MH	53.1%	?
Medication Management	41.6%	?
Illness Self Management	25.3%	?
Dual Diagnosis Treatment	6.2%	?
Supported Housing	5.0%	?
MultiSystemic Therapy	3.7%	?
Supported Employment	2.5%	?
Assertive Community Treatment	2.2%	?
Therapeutic Foster Care	2.1%	?
Family Psychoeducation	1.8%	?
Functional Family Therapy	1.1%	?

State Fiscal Effort MR/DD

State Fiscal Effort Ranking*			
	IOWA Rank		
Total Spending 2002	6		
Total Spending 2004	8		
Change	***-2***		
Community 2002	13		
Community 2004	16		
Change	***-3***		
Institutional 2002	1		
Institutional 2004	2		
Change	***-1***		
*Fiscal effort is spending for MR/DD services per $1000 of aggregate statew ide personal			
income. Source: Braddock, 2005			

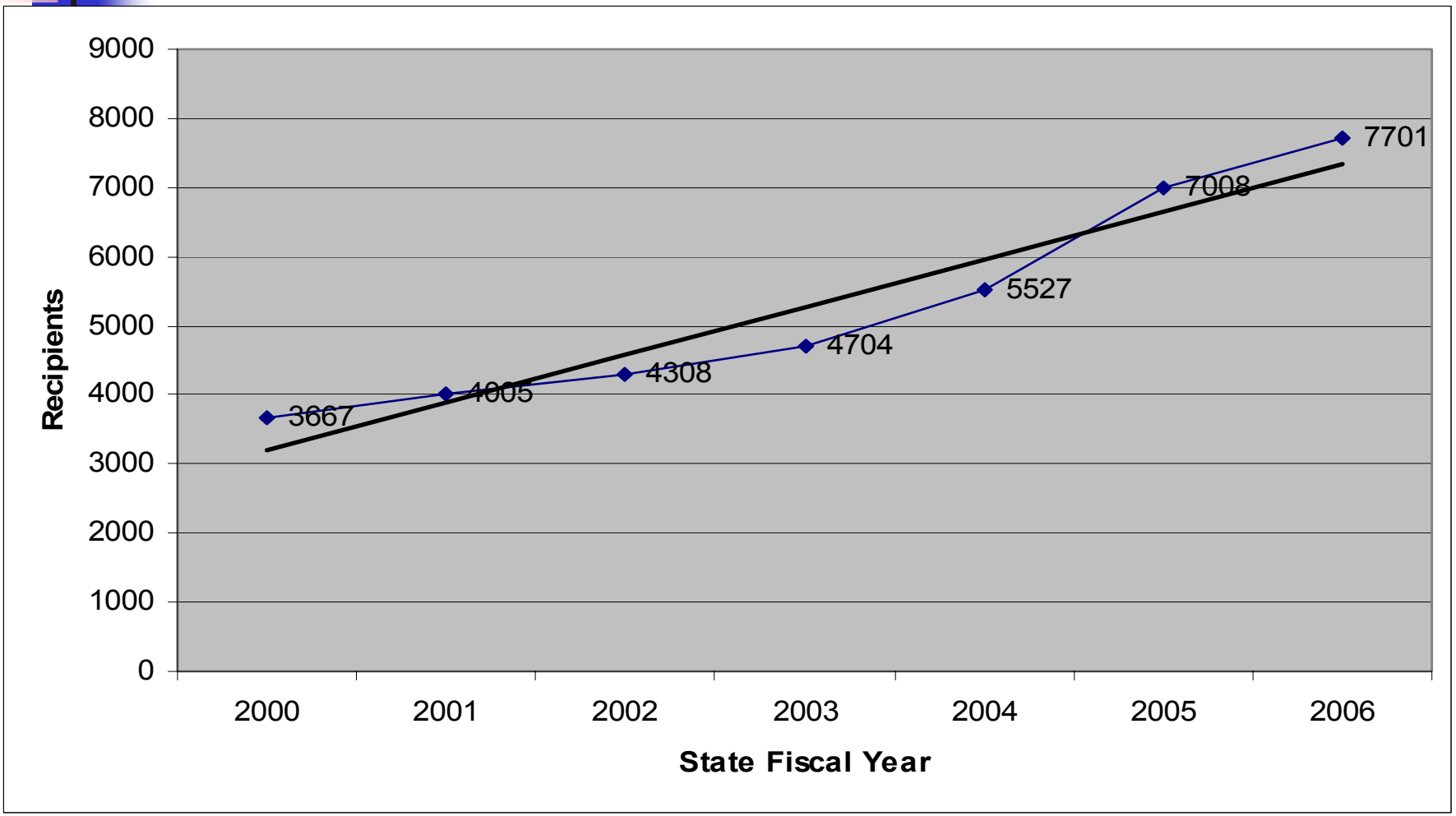
MR/DD Spending

MR/DD Spending Patterns*	% Real Change		
	2002-2004		
	US	**IOWA**	
Public MR/DD Spending for community Services in the US	9%	5%	
Utilization rate by individuals w ith MR/DD of 1-15 Persons	**2004 Rate**	**Rank**	**US Ave.**
Community Residential Settings (per 100,000 gen. pop.)	258	6	133
	IOWA	**US Ave.**	
Waiver Cost Per Participant	$ 24,058	$ 37,784	
Waiver Spending % of Total MR/DD Spending	30%	41%	
Waiver $s Per Capita	$ 61	$ 54	
Waiver Spending Rank	23		
*Braddock, 2005			

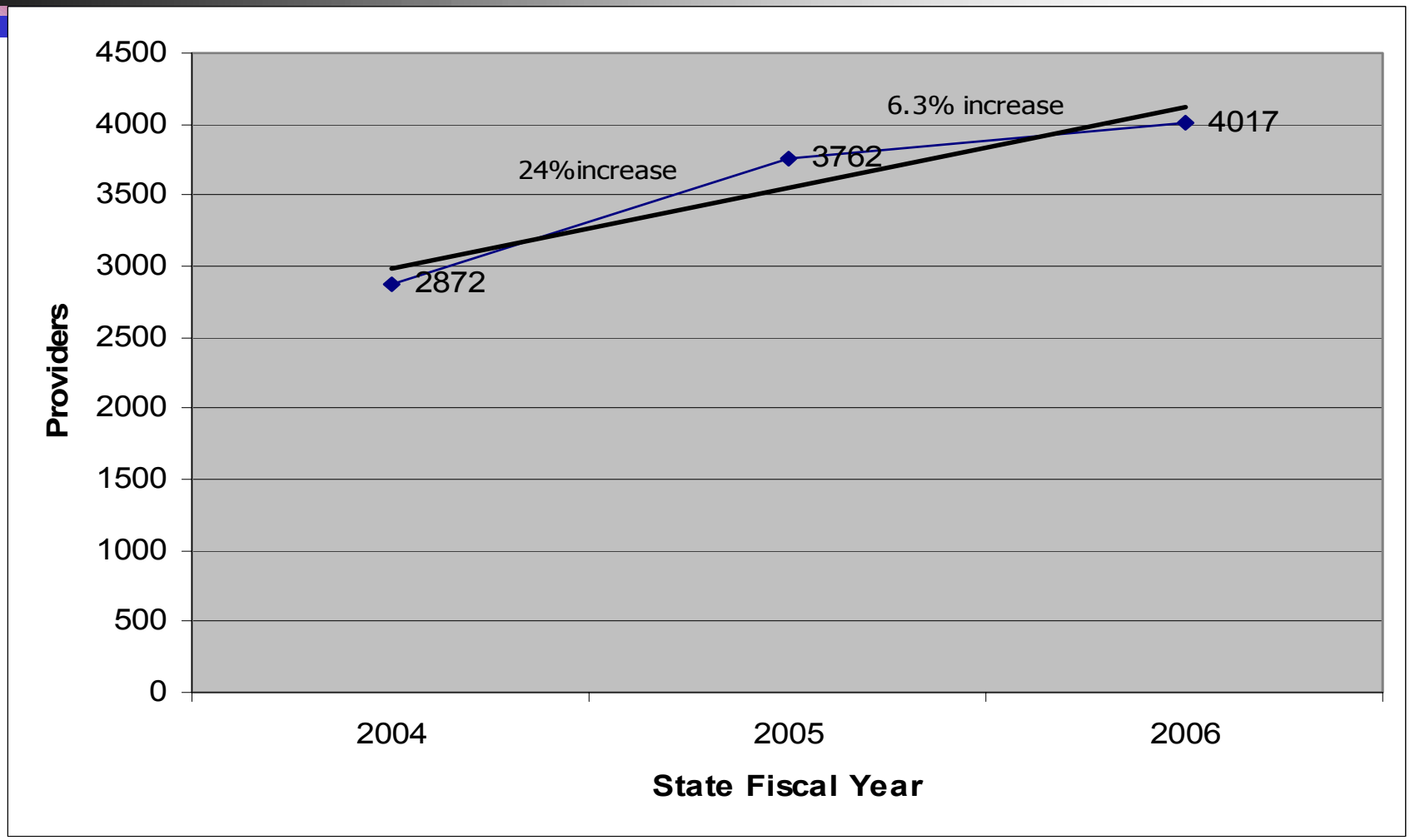
Comparative Statistics

Annual Cost of Care in Five MR/DD Settings: FY 2004*					
Institutions for 16+ persons				**US Ave.**	**IOWA**
	Private ICF/MR			$ 66,163	$ 88,463
	Non-ICF/MR			$ 18,959	$ 20,961
	State Operated			$ 146,325	$ 145,671
ICFs/MR for =<15 Persons					
	Private			$ 75,431	$ 76,833
Supported Living Personal Assistance				$ 21,021	$ 23,283
*Braddock, 2005					

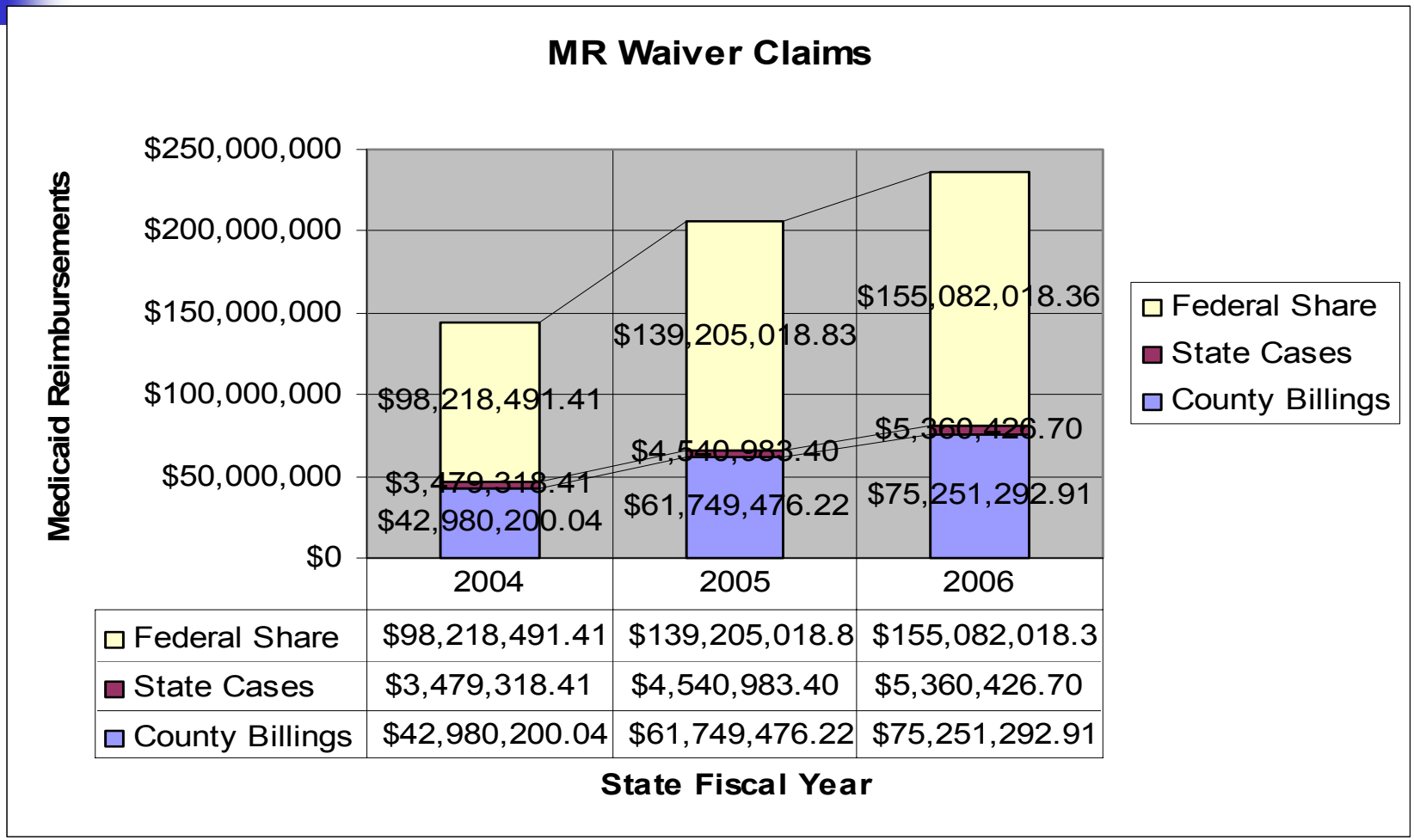
MR Waiver Recipient Growth



MR Waiver Provider Growth



Recent growth of MR Waiver Claims



Sources of Current Budget "Crisis" in the MHDS System

- Increased consumer demand > more flexible, community-based services. **(+)**
- County tax levy law limits County spending - creating a "pressure cooker" environment. **(-)**
- The System continues to "rebalance", change and grow. **(+)**
- Overall expenditures increasing due to wider array of available services primarily through federal Medicaid funding. **(+)**
- However, there are no "mandated" or "core services". **(-)**
- Also, there are no "regionalization/collaboration" or "core service agencies" for "efficiencies". **(-)**
- Key components of the system and their roles lack clarity in terms of populations, locations served (I.e., CMHCs, Emergency Service Providers). **(-)**
- While they are part of the "solution" there is growing resistance to Evidence-based Practices and Outcomes approaches that demonstrate efficacy. **(-)**
- There are inadequate infrastructures to set rates, train the system workforce in general and specifically in Quality Improvement, Evidence-based Practices, and Outcomes, and monitor system performance through IS. **(-)**

Issues/Recommendations I:

- The System continues to "rebalance", change and grow.
- Increased consumer demand for flexible, community based services. Overall expenditures increasing due to wider array of available services primarily through federal Medicaid funding.
- County tax levy law limits spending - creating a "pressure cooker" environment.
- There are no "mandated" or "core services".

- **Stay the course**. Continue rebalancing through "Money-Follows-the-Person" and other system redesign initiatives.
- Legislative relief through modification of levy tax.
- Develop a defined set of "Core Services" and develop Core Service Agency (CSA) approach.
- "*Incentivize*" the formation of county collaboratives, regionalize care through: the design of Core Service Agencies, low-incidence services based at state institutions and CMHCs.
- Define roles of CSAs, institutions and CMHCs as part of a delivery "system" vs. separate parts.

Issues/Recommendations II:

- Key components of the system lack clarity in terms of roles, populations, locations served (i.e., CMHCs, Emergency Service Providers).
- While they are part of the "solution" there is growing resistance to Evidence-based Practices and Outcomes approaches that demonstrate *efficacy and results*.
- Presently, there are inadequate infrastructures to set rates, train the system workforce to improve the quality of care, and in specific areas such as Quality Improvement, Evidence-based Practices and Outcomes, and an ability to monitor system performance through Information Systems.

- Continue to mandate Continuous Quality Improvement, Evidence-based, and Outcomes practices.
- Redesign Co-Occurring Mental Health and Substance Abuse Disorders in order to implement a comprehensive, integrated System of Care – eliminating agency silos.
- Enhance Rate-setting oversight capacity.
- Develop and Implement a Collaborative Behavioral Health Workforce Competency Training Plan.
- Continue to fund and develop adequate IS capacity to "manage the system".