Report
By the
Alaska Mental Health Board
Budget Committee
On the
2003 Budget Summit
With Recommendations

Adopted by AMHB Budget Committee – July 11, 2003
Adopted by AMHB – August 08, 2003

Report

By the Alaska Mental Health Board
Budget Committee
On the

2003 Budget Summit
And Recommendations

June, 2003

I. Table of Contents

I. Table of Contents i
II. Executive Summary 1
III. Proceedings 1
IV. Budgeting Process 2
V. Budget Data 4
VI. Results Data 7
A. Housing 7
B. Employment 8
VII. Evaluation of The Budget Building Process 8
VIII. Recommendations 9
A. Funding Should Be More Explicitly Tied to Desired Results 9
B. Medicaid/SSDI/SSI Should Be Re-Tooled as Possible to Achieve Desired Results 10
C. The Planning Committee Should Review Whether the Current Reliance on Psychiatric Medications is leading to Desired Results. 10
D. The Budget Building Process Should be Re-evaluated. 11
IX. Conclusion 11

II. Executive Summary

The focus of the Alaska Mental Health Board's 2003 Budget Summit was to look at what is being "purchased" by the Mental Health Program (Program) and, if it is not what is desired, make recommendations regarding how to make it do so.

Alaska's Mental Health Program funding, as is true in most of the country, is designed around eligibility criteria and authorized services. This is based on the assumption that the eligibility requirements identify those people who should receive services and the authorized services are what those people need. However, it has become increasingly clear that this may not be the optimal approach because evaluation of the Program rests on what services are provided, rather than whether desired results are achieved for the recipients of those services. The Budget Committee therefore suggests a budget based on the following:[1]

- Funding should be based on achieving desired results and those should be achieving the goals of consumers.
- In order to achieve this, the Mental Health System (System) should be flexible and needs based.
- The System should if at all possible respond before a person is in crisis.
- Medicaid, Social Security Disability Income (SSDI) and Supplemental Security Income (SSI) should allow or, better yet, facilitate people returning to the mainstream, including gainful employment in appropriate jobs.

There were discussions of what data the System should be collecting and using to evaluate and manage the Program as well as whether it was clear enough from the data that the current reliance on psychiatric medications substantially increases chronicity. These and similar items are referred to the full Board/Planning Committee for further development and consideration.

III. Proceedings

The Budget Summit was "kicked off" on March 8, 2003 in Juneau with an advertised public meeting as part of the regular Alaska Mental Health Board meeting. Approximately 25 people attended the meeting, including representatives of the Alaska Mental Health Trust Authority, the Department of Health and Social Services and numerous members of the public. Budget Committee Chair, Jim Gottstein gave a short presentation on the current budget process and posed certain issues and questions that might be addressed. Many attendees provided input and there was a general discussion of the issues among participants.

[1] This approach essentially follows what the Alaska Mental Health Trust Authority has been urging for the last few years.

The Budget Summit continued in Anchorage on April 11-12, 2003, with all 4 Budget Committee members present (Jim Gottstein, Tony Mander, Barry Creighton, Keggie Tubbs), 3 other Board Members attending, Jeanette Grasto, Tracy Barbee and Bill Hogan, staff Kate Webster and Kay Klose, 3 other Division of Mental Health and Developmental Disabilities (DMHDD) personnel, and 5 or so other people representing stakeholders and the public in attendance all or part of the time. April 11th was devoted to presentations of information, including updated budget and outcome data, public input, and a roundtable discussion over what should be in the final report and recommendations. On April 12th, the discussion of recommendations and conclusions continued. This Report was unanimously adopted in concept on April 12, 2003, subject to approval of final language. Approval of the final language of this report occurred during the Budget Committee's July 11, 2003 meeting.

IV. Budgeting Process

Alaska has a unique budgeting process as a result of the settlement of the Alaska Mental Health Lands Trust Lands Litigation in 1994 (Settlement). The Settlement, among other things, resulted in a cash payment of $200 million dollars and conveyed almost one million acres of land, some of it subsurface only to the Alaska Mental Health Trust Authority (Trust) created as part of the settlement. Under AS 47.30.046:

> (a) The [Trust] shall annually, not later than September 15, submit to the governor and the Legislative Budget and Audit Committee a budget for the next fiscal year and a proposed plan of implementation based on the integrated comprehensive mental health program plan prepared under AS 47.30.660(a)(1). The budget must include the authority's determination of the amount
>
> (1) recommended for expenditure from the general fund during the next fiscal year to meet the operating and capital expenses of the integrated comprehensive mental health program;
>
> (2) in the mental health trust settlement income account, if any, that is not reasonably necessary to meet the projected operating and capital expenses of the integrated comprehensive mental health program that may be transferred into the general fund; and
>
> (3) of the expenditures the authority intends to make under AS 37.14.041 and 37.14.045, including the specific purposes and amounts of any grants or contracts as part of the state's integrated comprehensive mental health program.

Under AS 37.14.045 and the Settlement Agreement, the Trust has the power to spend Trust Fund income (MHTAAR)[2] directly without an appropriation; however state

[2] The statute refers to this as Mental Health Trust Authority Authorized Receipts which becomes the acronym MHTAAR.

agencies need an appropriation to spend the funds. In order for the Trust to develop its budget recommendations, it requests recommendations from the four Trust beneficiary boards[3] (Request for Recommendations or RFR).

The Trust explains the process this way:

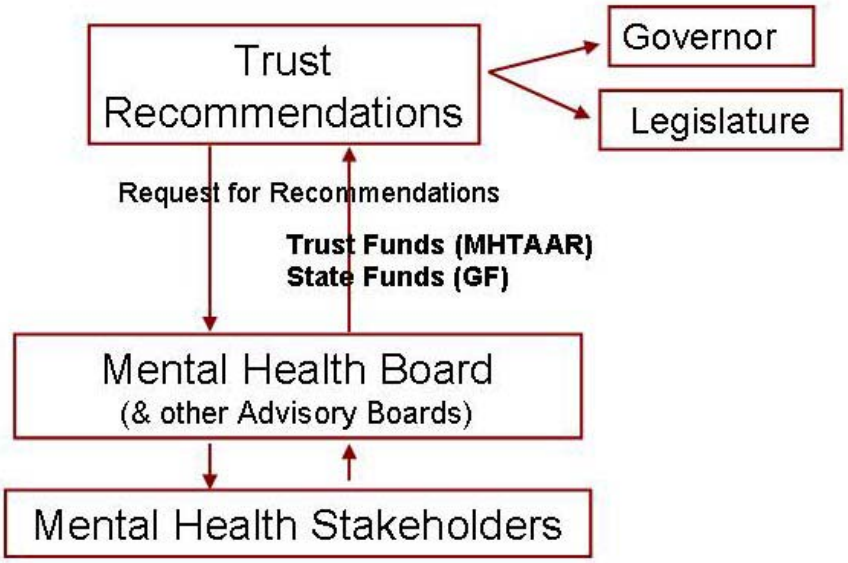
> **The Separate Appropriation Bill**
>
> The separate appropriations bill for the Comprehensive Integrated Mental Health Program includes several components. They are:
>
> **General Fund/Mental Health Base (GF/MH Base**): This is the amount established by identifying the mental health services funded within the state's general fund budget. The Trustees calculated that amount to be $131 million for fiscal year 2003. These general funds are designated as general fund/mental health dollars, or GF/MH Base. The final budget from the previous fiscal year establishes the GF/MH Base.
>
> **Adjustments to the Base:** As The Trust and the associated boards and commission further refine the definition of beneficiaries and accurately track funds for the Comprehensive Integrated Mental Health Program, the Trustees suggest adjustments to the base each year.
>
> **GF/MH Increments:** When the Trustees identify better and more cost efficient ways of providing on-going services or providing for unmet needs, they make recommendations in the form of GF/MH increments.
>
> **Capital Budget:** The separate appropriations bill includes that portion of the state's capital budget that funds mental health projects. This often includes funds from the Alaska Housing Finance Corporation to provide housing for beneficiaries as part of the Comprehensive Integrated Mental Health Program.
>
> **Mental Health Trust Authority Authorized Receipts (MHTAAR):** The Trustees authorize state agencies to spend Trust funds for specific operating and capital projects. These state agencies must have legislative approval to receive and expend Trust funds.
>
> The Trustee's recommendations for the mental health bill are due to the governor on September 15th for the following state

[3] Alaska Mental Health Board, Alaska Commission on Aging, Governor's Council on Disabilities and Special Education, and Advisory Board on Alcohol and Drug Abuse.

fiscal year. However, because the Trustees rely heavily on the recommendations of the four Advisory Boards, the Trust budget process actually begins early in the calendar year when the Trust sends the Advisory Boards a Request for Recommendations (RFR). The Trustees review these recommendations in late summer and make their funding decisions in time to meet the September 15th deadline.

The Board also seeks input from its stakeholders in the Request for Recommendations process and many stakeholders identify mental health service needs that they would like to have funded. The Board takes this information and then makes decisions on what to recommend to the Trust. In doing so, the Board does not normally recommend that any particular program get funding; rather it takes specific proposals that it receives and converts them into a "generic" budget category.

The following graphic illustrates this budget building process:



V. Budget Data

It is not possible at this juncture to say what the total mental health budget is because it is spread across so many different budget categories and agencies. No one has attempted to compile such a total since the early 1990's when it was done in connection with the Mental Health Trust Lands Litigation. In addition there is not agreement as to what expenditures should be included as being part of the Mental Health Program. What could be identified follow:

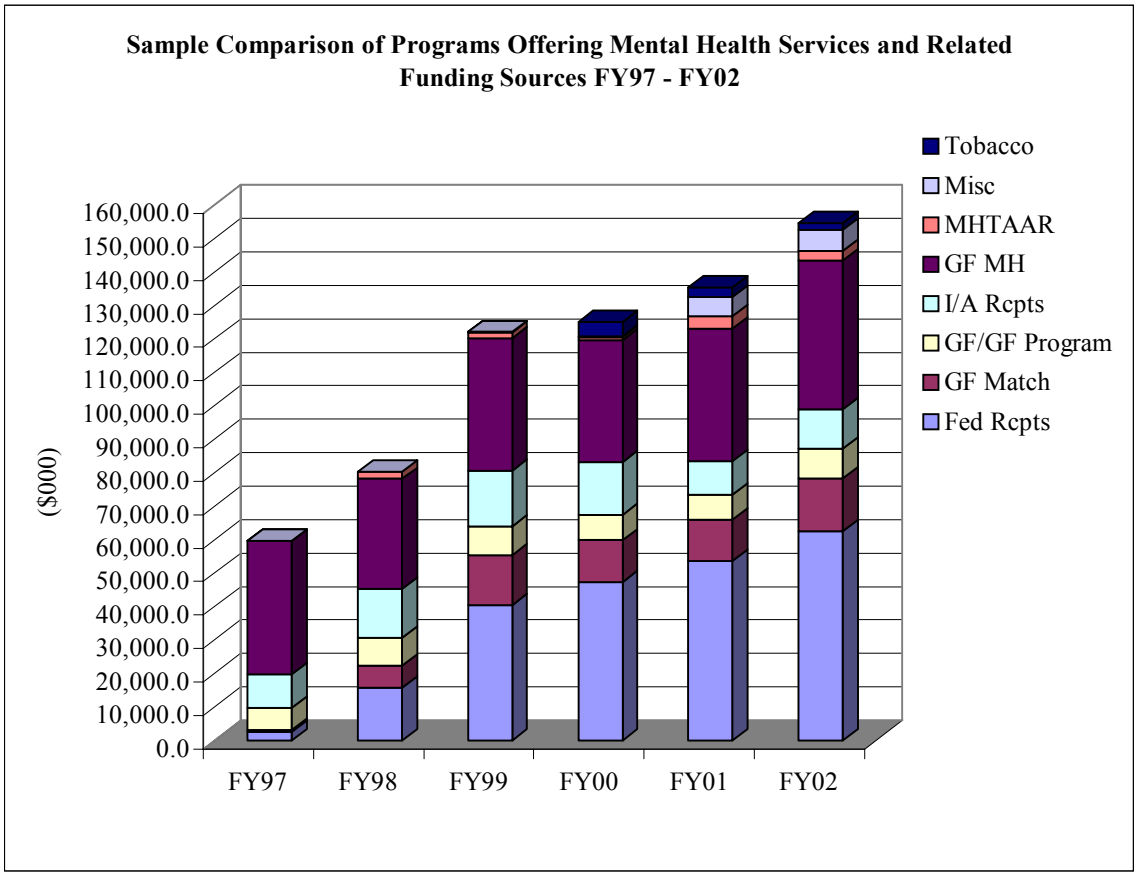
AMHB Sample Comparison of Programs Offering Mental Health Services and Related Funding Sources FY98 - FY03

Bare Bones Mental Health Budget FY97-02

	Fed Rcpts	GF Match	GF/GF Program	I/A Rcpts	GF MH	MHTAAR	Misc	Tobacco	Totals
FY97	2,649.0	564.4	6,575.8	9,982.1	39,789.7	37.5	0.0		59,598.5
FY98	15,742.9	6,682.0	8,309.6	14,530.6	32,886.5	2,039.0	142.4		80,333.0
FY99	40,528.8	14,740.5	8,766.0	16,516.5	39,559.4	1,769.9	146.5		122,027.6
FY00	47,269.6	12,500.0	7,586.6	15,871.2	36,465.0	696.6	247.2	4,314.2	124,950.4
FY01	53,611.2	12,419.5	7,389.2	9,908.9	39,628.2	3,917.5	5,562.3	2,956.8	135,393.6
FY02	62,399.1	15,994.5	8,696.0	11,895.9	44,466.6	2,897.5	6,264.0	1,963.6	154,577.2

Notes:
FY97 Does not include any Medicaid Funding--Not included in Enacted Summary
Tobacco revenue begins in FY00 with majority of funds supporting Medicaid services
All Medicaid Expenses calculated at 15% of total Medicaid (Tobacco tax also calculated at 15%)
FY00 $25,447.7 went into Medicaid Services

Miscellaneous categories, depending on FY, include: 1047, Title20; 1050 PFD; 1077 Gifts/Grt; 1091 GF/Desig; 1061 CIP Rcpts; 1108 Stat Desig; 118 Pioneers;1156 Rcpt Svcs; 1171 PFD Criminal



As can be seen from the below figures expenditures for inpatient services is very close to that spent on Community Mental Health.

Some Mental Health Services Purchased FY '02		
Inpatient Medicaid	$ 44,000,000	
API GF/MH	$ 17,000,000	
DET GF/MH	$ 3,000,000	
Total Inpatient		$ 64,000,000
Community Mental Health		$ 75,000,000

Also, Medicaid paid $19 Million for psychiatric drugs in FY 02.

Another comparison raising questions is the per capita and per client range of Community Mental Health Grant and Medicaid Expenditures:[4]

Catchment Area Ranges			
	High	Low	Avg
Per Capita	$ 233	$ 44	$ 117
Avg Client Cost	$ 7,068	$ 361	$ 4,120
Medicaid (per capita)	$ 203	$ 0	$ 65
Grant Funds (per capita)	$ 197	$ 21	$ 52

While it is clear there are great disparities in per capita and per client expenditures between community mental health centers it is important to be careful in drawing conclusions because of various factors. For instance, there is a high probability that high needs clients migrate to the larger cities where more intensive (costly) services are provided and that community mental health centers with small catchment populations can not spread their overhead across as many people. Having said that, however, there are still great differences that suggest widely varying Medicaid billing practices and possible over reliance on grant based services.

As to where Community Mental Health dollars are going, the available data revealed:

Community Mental Health Grand Funding FY '03		
General Community Mental Health	$ 3,377,700	9%
Psychiatric Emergency Services	$ 8,368,400	23%
Services to Seriously & Persistent Mentally Ill	$ 15,450,700	43%
Designated Evaluation & Treatment (DET)	$ 1,836,800	5%
Severely Emotionally Distrubed Youth	$ 7,165,500	20%
Total	$ 36,199,100	100%

[4] A detailed analysis of these expenditures for all of the community mental health centers in the state is attached as Appendix A.

VI. Results Data

At the end of the "Kick-Off" in March, the following question was posed. Is the Budget Purchasing?

Housing Relationships Jobs/Meaning In life Recovery		Protection Control Stabilization Dependency

The system increasingly talks about the items on the left as being the desired results, but with the possible exception of "dependency" the other results have also been seen as desirable. In fact, "protection" and "control" have been suggested as the primary reason that the public pays for mental health services. Protection includes the community as well as the recipient and is clearly a highly valued result. While perhaps not viewed as positively, controlling disturbed and disturbing behavior has also been a major goal of the public mental health system. Stabilization is a good outcome when compared with deterioration and also if the course of mental illness is assumed to be a steady or progressive worsening of condition. However, good housing, relationships, being productive and recovery are all preferred and, to the extent they are achieved, the other goals no longer need to be achieved.

It is being accepted around the country that recovery from mental illness is possible for many people that have previously been considered to be destined to a life of great disability. The most important factors identified in recovery are Hope, Housing, Relationships, and Employment/Meaningful Activity. As the focus of the program shifts towards improvement in the lives of mental health system recipients the question arises whether we are purchasing these results. There is even more limited data regarding these results.

A. Housing

Data from the Division of Mental Health and Developmental Disabilities' Management Information System on housing status indicates that 29 % of community mental health center clients live either alone or with an unrelated person(s) and 54% live with a relative(s) (54%). The remaining 17% are shown as "Housing Unknown." It does not seem safe to assume that all of the unknown are homeless, nor is there great confidence that the other categories exclude being homeless. The Mental Health Board, as part of its planning process, has estimated there are approximately 1,400 of its beneficiaries who are homeless. Another factor that is not addressed is whether consumers consider their current housing situation ‘ideal’ or whether they even consider it safe and affordable.

B. Employment

One area that there is some data on is employment:

- Only 1% of Community Mental Health Center clients are receiving employment services from the Community Mental Health Center.
- Less than 1% of people go from SSDI to Employment
- Less than 10% of people on SSI are gainfully employed.

This data starkly shows that under the present system once a person gets placed on SSDI they are very unlikely to ever return to the workforce. Since placement on SSDI and SSI are criterion for receiving Medicaid services, and that people have to be both disabled and very poor to be in these programs, the clear result of this funding mechanism is that **the Medicaid/SSDI/SSI eligibility and funding mechanism is essentially a one way ticket to permanent disability and poverty**. This is probably the single most important information contained in this report.

VII. Evaluation of The Budget Building Process

The Trust was extraordinarily successful in leveraging its relatively small financial contributions to the mental health program to not only prevent budget declines, but increase the mental health program budget during a time of budget declines. It was able to do this at least in part through the process outlined above by recommending "increments" (increases) and using Trust Funds to get programs going and then moving them to other funding sources, which was typically the General Fund.[5] The value of being able to bring even the relatively small amount (but in the millions of dollars) it has "to the table" is much more than the amount it has to contribute and the Trust has been incredibly skillful in this process. However, due to the financial crisis the state is facing, it appears that for the first time this strategy was unsuccessful and Program funding is faced with a substantial General Fund decline.

All processes should be periodically reviewed to determine if they continue to optimize results. The state's budget crisis, the new administration resolved to reduce spending to address this crisis, the increasing reliance on federal funds (e.g., Medicaid) and data results suggests this is a good time to re-evaluate Alaska's mental health budget building process.

A number of things leap out from the circumstances and data. The first is the absence of consideration of Medicaid mental health expenditures in the budget building process, which equals or exceeds the parts of the budget that is part of the Trust's Request for Recommendation process. The second is that the focus on increments (increases) may no longer be tenable. Perhaps even more important is by not looking at the effectiveness of expenditures in the "base" (which this Report suggests should include

[5] The Trust calls this an "Exit Strategy" meaning that the Trust, as a general matter, is not prepared to continue funding programs indefinitely.

Medicaid) in achieving desired Results, there has been little, if any incentive or requirement to achieve desired Results. In other words, the entire mental health budget program should be evaluated.

Therefore, it is suggested that the Board should regularly and rigorously review results and identify gaps, rather than relying so heavily on stakeholders bringing specific proposals for consideration. A somewhat similar proposal, known as "Strategic Budgeting" has been before the Board as a proposal for a number of years. The Budget Committee believes results based budgeting (i.e., the Friedman Model) will be a beneficial way to proceed in the future.

VIII. Recommendations

The Budget Summit proved to be a useful endeavor and resulted in a number of recommendations, which can be categorized into these four broad categories:

A. Funding Should Be More Explicitly Tied to Desired Results

B. Medicaid/SSDI/SSI Should Be Re-Tooled as Possible to Achieve Desired Results

C. The Planning Committee Should Review Whether the Current Level of Reliance on Psychiatric Medications is leading to Desired Results.

D. The Budget Building Process Should be Re-evaluated.

There are a number of parts to each of the main recommendations.

A. Funding Should Be More Explicitly Tied to Desired Results

The Budget Committee wholeheartedly supports moving to results based budgeting that the Trust has been advocating for a number of years, known as the "Friedman Model." In essence, the approach is to (1) define what results (also known as outcomes) are desired, (2) develop measurement(s) for determining how well the system is doing in "purchasing" desired results, and (3) this data should be regularly collected, analyzed and acted upon. In other words, what does the data reveal about effectiveness of programs? Where are the gaps? What changes in program funding should be made to achieve desired results? In order to achieve this the Budget Committee recommends that:

1. The Planning Committee develop a recommendation to the full board regarding the desired results; and

2. The Planning Committee determine/develop recommendations to the full board regarding what results to measure

3. Programs should be evaluated and funded based on recipient results. In other words, goals and benchmarks should be established and funding based on the extent to which these are achieved.

4. Financial incentives should be given providers for producing desired results.

5. Grants should be re-tooled to produce desired results.

6. Non-traditional and flexible approaches should be part of the Program and evaluated for achieving desired results along with traditional approaches.

7. The following data should be acquired:

    a. Who Are the Recipients of the Mental Health Program?
    b. What services constitute the Mental Health Program?
    c. What is spent on the total Mental Health Program, including Indian Health Service spending (Alaska Native Tribal Health Consortium)?
    d. Who are receiving services?
    e. What are the results for various populations? In other words, are there differences in results for different groups of people, such as Natives or other minorities?
    f. What are the SSDI/SSI Recipient Population Trends?
    g. What are the Indian Health Service Population Trends?
    h. What Are the Results Geographically?
    i. Which Programs are Achieving Desired Results and Vice Versa?
    j. Why is There Such a Difference in per capita Medicaid Billing?

B. Medicaid/SSDI/SSI Should Be Re-Tooled as Possible to Achieve Desired Results

The Medicaid/SSDI/SSI eligibility mechanism has come to dominate Program financing. Thus, to the extent possible within federal requirements, this mechanism should be reviewed and adjusted to achieve desired results. To the maximum extent possible:

1. Eligible services should be based on achieving desired results.

2. Eligible services should be flexible in order to allow services to be tailored to what individuals need to achieve desired results including, if possible, non-traditional approaches.

3. Disincentives to achieving desired results should be ferreted out and corrected, where possible.

C. The Planning Committee Should Review Whether the Current Reliance on Psychiatric Medications is leading to Desired Results.

The Mental Health System currently relies heavily on psychiatric medications. It is recommended that further research on how the use of these medications impact desired results should be conducted.

D. The Budget Building Process Should be Re-evaluated.

1. In developing budget recommendations, the entire Program budget and desired outcomes should be considered.

2. While stakeholder input should always be sought, it should be evaluated in the context of results based budgeting that considers the entire mental health budget.

3. The Trust should consider reviewing its RFR process to determine if it is producing optimal results. Specifically, in addition to taking the entire Program budget into consideration, the Trust might re-evaluate its policy of requiring an Exit Strategy to be eligible for Trust funding.

4. The Board should remember that its budgetary responsibilities are broader than the Trust's.

5. Existing and potential revenue sources should be more seriously pursued, such as:

a. Federal Medicaid
b. Federal Discretionary
c. Community Mental Health Services Block Grants
d. State
e. Recipients
f. Foundations
g. Trust Lands - Find Oil and/or Gas on Trust Land.
h. Partnering
i. Federally Qualified Health Centers
j. Others

IX. Conclusion

The Budget Committee's conclusions arising from the Summit are (1) more data needs to be developed and regularly evaluated to help steer program funding to achieve desired results based on data, (2) the precise desired results need to be determined, based on consumer and community values, and (3) the budget should be built around purchasing the desired results.