Advisory Committee on Problem Gambling
December 15, 2014 Meet

Discussion Document

Issue 1: DHHS Procurement of Problem Gambling Services

Per NAC 458A.100, DHHS publish a request for applications (RFA) for programs and services once every 2 years. RFA needs to be developed within the next three months in order to have grants in place for the next 2 year cycle.

Problem

There appears to be a budget shortfall entering into SFY0216 due to the combination of increased demand for gambling treatment services and decreasing revenues into the Revolving Account to Support Problem for the Prevention and Treatment of Problem Gambling.

Needs

To develop RFA, need to determine the percent of total program budget for each program component. Next, program elements will need to be re-structured to best fit needs with new budget realities.

Possible Solutions to Estimated $398,000 Budget Shortfall for SFY2016

Note: Estimated budget shortfall based on the following assumptions: $136K fewer funds + $149K projected FY15 shortfall + $113K for 10% projected growth in treatment need

1. Increase the proportion of total Problem Gambling Funds going to treatment by reducing the current portion going towards other service areas (prevention, workforce development, program evaluation, program development/consultation).

2. Incorporate a mix of cost containment measures to stretch the gambling treatment dollars to serve more people in need. Possible measures may include:

   a. Reduce service rates to SFY2014 levels (approximately a 10% decrease).
      i. *Estimated savings of $35,000 to $50,000*
   b. Reduce client benefit levels to SFY2015 caps: $2,000 for residential problem gambling treatment; $1,500 for outpatient problem gambling treatment; $1,000 for the treatment of person with a primary diagnosis of Relational Problem Related to Gambling Disorder.
      i. *SFY12 Tx budget = $630,000, treated 548 gamblers, 58 concerned others, 47 residential clients (653 total); average case cost = $965*
      ii. *SFY14 Tx budget = $925,000, treated 608 gamblers, 76 concerned others, 66 residential (750 total); average case cost = $1,233*

iii. *Estimated savings between $100,000 to $150,000 ($128,250 based on $900,000 allocation)*

c. Restructure residential problem gambling treatment services by restricting access to this level of care for only those individuals with an active Gambling Disorder in the "severe" range (8-9 criteria met). This would exclude those clients being transferred from substance abuse residential treatment into problem gambling residential treatment (a significant portion of current residential gambling treatment clients).

i. *Estimated savings of $35,000 to $50,000 based on eliminating one fourth of residential enrollments with an average case cost of $2,500.*

3. Require providers to seek funding from other sources prior to utilizing DHHS Problem Gambling Funds. With changes in the DSM 5 and in the broader healthcare system, a larger portion of federally funded programs and private insurance companies are expected to cover expenses related to the treatment of Gambling Disorder. *Note: Unclear when institutional changes will enable greater third-party payment.*

Issue 2: Funds to Support Current Problem Gambling Treatment System

Problem

The first quarter problem gambling treatment fiscal report shows that treatment grantees submitted encounter claims totaling 31% of the annual cumulative treatment grantee budget. If this trend continues, there will be insufficient funds to support fourth quarter services (projected $225,000 shortfall excluding reserve).

Possible Short-term Solutions

1. Do nothing. Historically there have been fluctuations in claims totals for each quarter with no clear pattern emerging. Claim totals for remaining SFY15 quarters may be lower and there is approximately $76,000 in reserve that can be allocated based on the mid-year treatment reallocation.
2. Develop a more restrictive policy on the use of requesting and granting client benefit extensions. Reserve client benefit extensions for only those clients who have relapsed within 4 weeks of completing the treatment program.
3. Reduce the client benefit level for all clients enrolled after January 1, 2015. This measure would reduce claim amounts by approximately $70,000. With adding reserves of $76,000 there will still be a projected shortfall of $79,000.
4. Others? Open to discussion.