

M00L
Mental Hygiene Administration
Department of Health and Mental Hygiene

Operating Budget Data

(\$ in Thousands)

	<u>FY 02</u> <u>Actual</u>	<u>FY 03</u> <u>Approp</u>	<u>FY 04</u> <u>Allowance</u>	<u>FY 03 - 04</u> <u>Change</u>	<u>FY 03 - 04</u> <u>% Change</u>
General Funds	\$505,740	\$534,866	\$566,032	\$31,166	5.8%
FY 2003 Cost Containment		-3,869		3,869	
FY 2003 Deficiencies		31,000		-31,000	
Contingent & Back of Bill Reductions		-125	-1,038	-912	
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Special Funds	44,566	16,784	2,823	-13,961	-83.2%
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Reimbursable Funds	3,195	2,283	3,895	1,612	70.6%
Contingent & Back of Bill Reductions			-5	-5	
Adjusted Reimbursable Funds	\$3,195	\$2,283	\$3,889	\$1,606	70.4%
Adjusted Grand Total	\$739,525	\$791,720	\$786,587	-\$5,132	-0.6%

- There are two deficiency appropriations: \$60 million (\$30 million each of general and federal funds) for deficits in community mental health services and \$1 million in general funds to cover personnel expenditures at various State-run psychiatric hospitals.
- The fiscal 2004 allowance substantially closes the ongoing structural deficit in funding for community mental health services.
- \$900,000 is provided for an initiative to treat persons with traumatic brain injury in community settings.
- Funding of services traditionally provided outside of the fee-for-service system is reduced by almost \$4.2 million.

Note: Numbers may not sum to total due to rounding.

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Personnel Data

	<u>FY 02</u> <u>Actual</u>	<u>FY 03</u> <u>Working</u>	<u>FY 04</u> <u>Allowance</u>	<u>Change</u>
Regular Positions	3,938.15	3,749.65	3,603.55	-146.10
Contractual FTEs	185.68	175.85	176.37	0.52
Total Personnel	4,123.83	3,925.50	3,779.92	-145.58

Vacancy Data: Regular Positions

Budgeted Turnover: FY 04	137.66	3.82%
Positions Vacant as of 12/31/02	336.95	8.99%

- Personnel expenditures fall by almost \$5.5 million.
- The fiscal 2004 allowance includes the abolition of 146.1 full-time equivalent positions.
- The allowance provides for significant turnover relief. The budgeted turnover rate of only 3.82% is easily met by available vacancies. However, the more troubling issue is that most State-run psychiatric hospitals are struggling to fill direct care positions.

Analysis in Brief

Major Trends

OLA Performance Audit: A performance audit of the community mental health services system reveals serious weaknesses in oversight.

Outcomes for Community Mental Health Services to Be Piloted: In the spring of 2003, the Mental Hygiene Administration (MHA) hopes to implement a pilot outcome study for community mental health services. To date, outcomes have been limited to consumer satisfaction surveys.

Outcomes for State-run Psychiatric Hospitals: Despite concerns over staffing levels, at this time outcomes do not reflect issues with quality of care. Generally, outcome measures for the State-run psychiatric hospitals have become more standardized.

Issues

Attacking a Three-headed Hydra: Settling Prior Year Deficits, Fixing the Base, and Providing for Reasonable Growth: The allowance provides significant funding for the community mental health system administered through the Administrative Services Organization (ASO). While prior year deficits are resolved and the fiscal 2004 budget reflects a restored base as well as some level of growth, the growth of prior year deficits has undermined efforts to fix problems in the current fiscal year.

Hospital Closure: The Ongoing Debate Over the “Big Three”: Demand for beds at the eight State-run psychiatric hospitals primarily serving adults continues to be strong. However, settling the age-old question of whether the State needs three large regional hospitals (Springfield, Spring Grove, and Crownsville) can yield long-term operating savings, significant capital savings, more efficiency, and a better treatment environment.

Privatization Options: Though not common, other states have undertaken privatization of public psychiatric hospitals.

Developing an Integrated System of Early Childhood Mental Health Services: A recent Casey Foundation action agenda for school readiness once again pointed to the importance of social-emotional development in young children as a foundation for early learning. Maryland has been moving forward in this area, although funding limitations remain an issue.

Recommended Actions

	<u>Funds</u>
1. Add language concerning the funding of non-Medicaid eligible services in fiscal 2004.	
2. Add language requiring that the budget committees review any privatization agreements or proposals.	
3. Add language requiring notification of major changes to the Community Services budget.	
4. Reduce funding for Core Service Agencies.	\$ 3,000,000
5. Reduce funding for drug purchases based on most recent expenditure levels.	125,000
6. Reduce operating expenditures at the Crownsville Hospital.	500,000
7. Reduce funding for operating expenditures at the Upper Shore Community Mental Health Center.	1,400,000
8. Reduce funding through the closure of the Regional Institute for Children and Adolescents Southern Maryland.	4,000,000
9. Adopt narrative requesting information on the implementation of recommendations made in the Office of Legislative Audits December 2002 performance audit.	
10. Adopt narrative requesting the Mental Hygiene Administration and Maryland State Department of Education to report back on the work of the Early Childhood Mental Health Steering Committee.	
Total Reductions	\$ 9,025,000

Updates

Maryland Psychiatric Research Center: A final report on the disposition of the Maryland Psychiatric Research Center has been delayed until September 2003.

JCR Items Need Follow-up: At the time of writing, numerous *Joint Chairmen's Report* items requested of MHA were unfulfilled.

M00L
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Operating Budget Analysis

Program Description

The Mental Hygiene Administration (MHA) is responsible for the treatment and rehabilitation of the mentally ill. MHA:

- plans and develops comprehensive services for the mentally ill;
- supervises State-run psychiatric facilities for the mentally ill;
- reviews and approves local plans and budgets for mental health programs;
- provides consultation to State agencies concerning mental health services;
- establishes personnel standards and develops, directs, and assists in the formulation of educational and staff development programs for mental health professionals; and
- oversees programs of basic and clinical research in the field of mental illness.

MHA administers its responsibilities through layers of organizational structure as follows:

- ***MHA Headquarters*** coordinates mental health services throughout the State according to the populations served, whether in an institutional or community setting.
- ***Core Service Agencies*** (CSAs) work with MHA, through signed agreements, to coordinate and deliver mental health services in the counties. There are currently 20 CSAs, some organized as part of local health departments, some as nonprofit agencies, and one as a multi-county enterprise.
- ***State-run Psychiatric Facilities*** include eight hospitals and three residential treatment centers – Regional Institutions for Children and Adolescents (RICAs) – for the mentally ill operated by the State, plus the Maryland Psychiatric Research Center (MPRC), which operates on the grounds of Spring Grove Hospital Center under contract with the University of Maryland, Baltimore School of Medicine.

As a result of waivers under the authority of Section 1115 of the federal Social Security Act, beginning in fiscal 1998, the State established a program of mandatory managed care for Medicaid recipients. While primary mental health services stayed within the managed care structure, specialty mental health services to Medicaid enrollees were carved-out and funded through the public mental health system. Specialty mental health services are defined as meeting certain medical necessity criteria utilizing accepted diagnostic tools.

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The carved-out system is overseen by MHA, although it contracts with an Administrative Services Organization (ASO), Maryland Health Partners (MHP), to administer the system. Services are also available to non-Medicaid clients. Prior to fiscal 2003, eligibility for non-Medicaid clients was up to 300% of federal poverty guidelines (FPG), with services provided on a sliding-fee scale. Since fiscal 2003, eligibility for new clients has been limited to 116% of FPG.

Prior to fiscal 2003, all services administered through the ASO were done through a fee-for-service system (although some grants were awarded in the transition from the previous system to the new fee-for-service structure). Beginning in fiscal 2003, in response to budget bill language, a number of services for the non-Medicaid population were switched back to grants and contracts in an effort to control costs.

The key goals of the agency include improving the efficacy of community-based care for persons with mental illness and promoting recovery among persons with mental illness in State-run psychiatric facilities so that they can move into less restrictive settings.

Performance Analysis: Managing for Results

Community Mental Health Services

Community Mental Health Populations

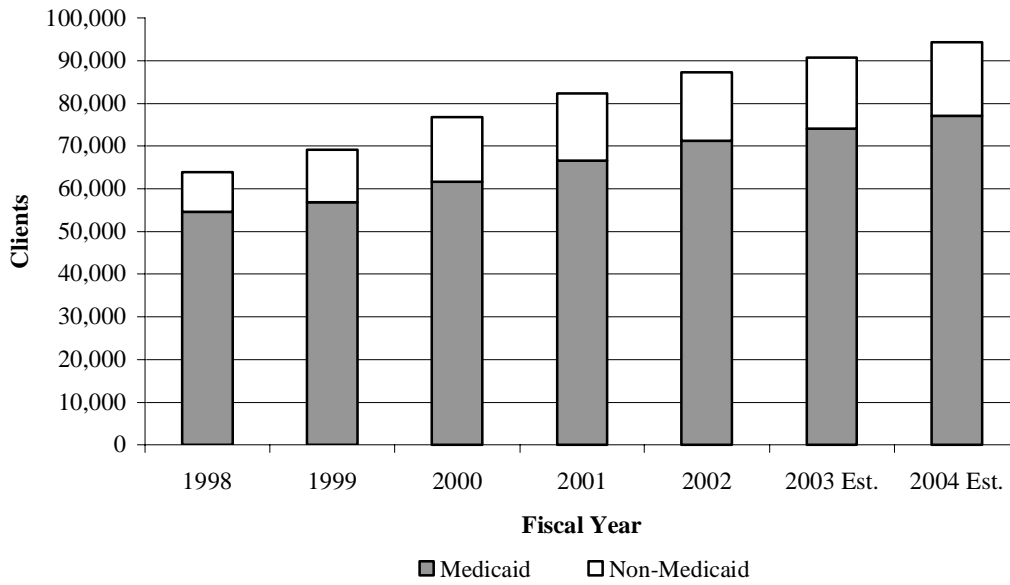
As shown in **Exhibit 1**, the number of clients seeking services currently or previously funded through the fee-for-service system continues to rise. MHA estimates that just over 94,000 people will be served in fiscal 2004. Medicaid clients comprise 82% of the total number served. Since fiscal 1999, even with the expansion of the Maryland Children's Program (MCHP) in fiscal 2000 and 2002, the extent of the Medicaid population in the program has remained constant.

The expansion of MCHP did cause a gradual increase in the number of persons under 21 served in the program, from 41% to 46% of total clients served between fiscal 1998 and 2002 (see **Exhibit 2**). This age group also saw an increase in relative share of total expenditures in the same time period, 42% to 45%, although the impact to the State was mitigated somewhat by the enhanced federal match for MCHP.

Program eligibility for MCHP means that most fee-for-service mental health expenditures for this population are eligible for some level of federal match. Exceptions are for non-Medicaid eligible services. However, expenditure data provided from MHA indicate that significant levels of State-only spending on Medicaid-eligible services continued in fiscal 2002. **MHA should be prepared to explain why State-only funds seem to be being spent on Medicaid-eligible services for Medicaid-eligible populations.**

Exhibit 1

**Fee-for-service Utilization
Fiscal 1998 to 1994**

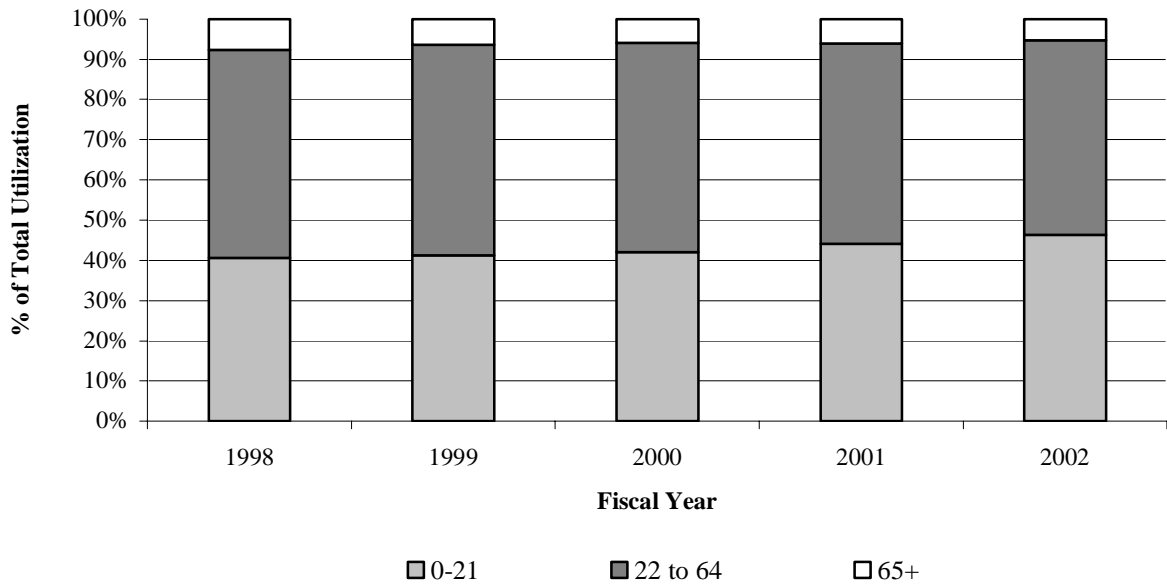


Note: Beginning in fiscal 2003 some non-Medicaid clients are being served through grants and contracts.

Source: Department of Legislative Services; Department of Health and Mental Hygiene

Exhibit 2

Fee-for-services Utilization by Age
Fiscal 1998 through 2002



Source: Department of Legislative Services; Department of Health and Mental Hygiene

MHA is predicting a 4% increase in clients served in both the Medicaid and non-Medicaid populations. Historically, there is a strong correlation between total enrollment in the State's Medicaid program and the percentage of those enrollees who utilize specialty mental health services. By this measure, utilization by Medicaid enrollees can be expected to be somewhat higher than the MHA estimate, an increase of 5%.

Performance Audit

Based on concerns about continuing deficits in the community mental health services budget, in the 2002 session the legislature adopted language requesting the Office of Legislative Audits (OLA) to conduct a performance audit of the community mental health service delivery system. That audit found significant gaps in system oversight and control and made a series of recommendations to redress these inadequacies. **In order to track how well recommendations are implemented, the Department of Legislative Services (DLS) recommends that MHA report back to the committees on September 1, 2003, itemizing steps taken to improve oversight and control.**

Developing Outcomes for Community Mental Health Services

Prompted by language in the 2001 *Joint Chairmen's Report* (JCR), MHA has been moving to improve the evaluation of community mental health services. The concern expressed by the committees was that no true outcome measures are available either in aggregate or disaggregated to the provider level for the considerable investment that is made in these services. MHA does undertake periodic consumer satisfaction surveys. These surveys are not without value, but they are not program-based and have other methodological limitations.

In December 2001 a Managing for Results (MFR) Steering Committee was established. Working with a variety of consultants from national and academic centers with expertise in mental health evaluation, the committee agreed upon a series of domains in which outcomes should be collected. The committee evaluated the various tools available to collect this data as well as the relative burden of doing so. As has been noted at the national level, the most useful outcome data is often that which requires relatively significant effort to collect.

At this point a pilot outcome study is being prepared for implementation in spring 2003. The pilot has two main purposes:

- to test the utility of specific evaluation measures chosen; and
- to develop and test a process for collecting outcome information from providers across the State.

While the steering committee identified 14 different domains for outcomes, the pilot limits data collection to five areas:

- psychiatric signs and symptoms and symptom distress;
- daily role and role performance;
- school performance;
- housing; and
- criminal and juvenile justice involvement.

Even though MHA will continue to face many varied demands on its resources, the implementation of the pilot project is key to developing data not only for policy-makers but also to improve system performance. Some results from the pilot study should be available for the 2004 session.

State-run Psychiatric Facilities

Population Trends

Like most states, Maryland has seen a significant decline in average daily census in recent years. According to a July 2002 report of the National Association of State Mental Health Program Directors Research Institute (NRI), of 36 states reporting inpatient census data in state psychiatric hospitals in 1996 and 2001, 31 states including Maryland reported decreases in daily census. **Exhibit 3** shows population trends at the facilities from fiscal 1999 to 2003 (through October). The data is broken up into three components:

- Hospitals, excluding the three RICAs and Assisted Living, that primarily serve adult populations (a small number of adolescents are treated at the Finan Center and Crownsville). This population has fallen by an average of 49 from fiscal 1999 to 2003, although populations appear to be edging up. At this point ADP appears to be more constrained by capacity than front-door demand.
- The three RICAs, serving exclusively children and adolescents. This population was falling steadily throughout the period, but again seems to have leveled off.
- Assisted living facilities located at Springfield and Spring Grove. These facilities are intended to be step-down programs to ease transition from the hospitals to the community. This population fell from fiscal 1999 to 2000 but has been relatively stable since that time.

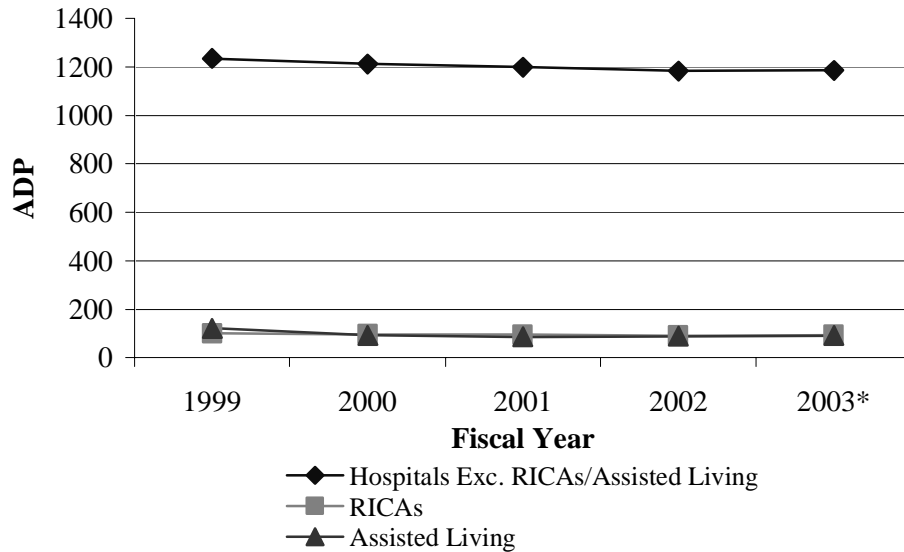
Profile of State-run Psychiatric Facility Inpatients

The most interesting characteristic of the current State-run psychiatric hospital patient profile is the extent of forensic patients, that is patients who have been found incompetent to stand trial, patients who have stood trial but been found not criminally responsible by virtue of their mental state, or patients committed by the courts to hospitals for evaluation. As shown in **Exhibit 4**, based on a one-day census, both the number and percentage of forensic clients have risen fairly steadily in the past five years. This trend is important because:

- It is a population that State hospitals are compelled to serve.
- The average-length-of-stay (ALOS) for forensic patients is significantly longer than for non-forensic patients. This serves to clog the State system and inhibit the flow of patients from acute general hospitals. There are two primary reasons for these longer ALOS: first, a patient committed by the court for evaluation remains in the facility after the evaluation has been completed pending trial, something which can take some considerable time; secondly, forensic patients are often difficult to place in the community because of the nature of their offense.

Exhibit 3

**State-run Psychiatric Institutions
Average Daily Population Trends
Fiscal 1999 through 2003**



*Fiscal 2003 through October.

Source: Department of Legislative Services; Department of Health and Mental Hygiene

Exhibit 4

**Forensic Patients in State-run Psychiatric Hospitals
Fiscal 1998 through 2002**

<u>Fiscal Year</u>	<u>Number of Forensic Patients</u>	<u>Forensic Patients As a Percentage of Total Population (%)</u>
1998	470	38.2
1999	464	37.6
2000	508	41.9
2001	521	43.2
2002	542	46.9

Source: Department of Legislative Services; Department of Health and Mental Hygiene

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This trend is not unique to Maryland. A survey of 38 states conducted by the National Association of State Mental Health Program Directors in 2002 found that between 1987 and 2002, the percentage of forensic patients as a percent of total state hospital inpatients rose from 18% in 1987, to 27% in 1997, and 30% in 2002. Comparisons from state-to-state are difficult because of such things as varying attitudes on competency issues, laws relating to the confinement of sex offenders following incarceration, and the way states operate beds (for example, in some states the Department of Corrections might operate beds for forensic patients). Nevertheless, the trend underscores that seen in Maryland.

In addition to a growing forensic population, there are other smaller populations currently in State-run psychiatric hospitals that also have long ALOS and serve to clog the system: for example, the traumatically brain-injured (TBI) and developmentally disabled (DD). In December 2002 MHA estimated that there were 22 TBI patients and 41 DD patients who from a clinical point-of-view could be served outside the State-run psychiatric hospitals. However, again, these patients are very difficult to place. As discussed below, MHA has found funds in their fiscal 2004 allowance to try and move a number of TBI patients out of the institutions. The State also funds beds at Spring Grove for the Maryland Psychiatric Research Center (MPRC). These patients are in research studies, which also necessitates greater lengths of stay.

Additional evidence underscores the fact that the patient profile in the State-run psychiatric hospitals is changing to patients with greater needs. Surveys of patient “impediments to discharge” from two hospitals done in fiscal 1995, 1998, and 2002 show interesting changes (see **Exhibit 5**). These surveys are grouped around four groups of variables:

- past treatment issues (number and length of hospitalizations, transfer from other facilities, and noncompliance with outpatient treatments);
- current treatment needs and issues (medical problems, medication complexity and tolerance, and IQ);
- social and financial issues (income, housing status, forensic status, other agency involvement, available community supports, history of violence, or sexual predatory behavior); and
- diagnostic factors.

Each variable is assigned a point score, with the total number of points being 100 (or maximum impediment to discharge).

In both hospitals, average scores of those surveyed increased from 1995 to 2002 indicating increasing impediments to discharge. In both settings, the variable showing the most deterioration is social and financial issues. There is also an indication of higher prior hospitalization.

Exhibit 5

**Impediments to Discharge Survey Average Scores
Fiscal 1995, 1998, and 2002**

<u>Fiscal Year</u>	<u>Spring Grove Hospital</u>	<u>Eastern Shore Hospital</u>
1995	11	35
1998	16	33
2002	25	47

Source: Maryland Hygiene Administration

Staffing Levels

As shown in **Exhibit 6**, the number of authorized positions at the State-run psychiatric hospitals has fallen from just under 4,000 full-time equivalents (FTEs) in 1998 to just over 3,500 FTEs in the fiscal 2004 allowance. At the same time, vacancy rates have risen from 6% in fiscal 1998 to a high of 11% in fiscal 2002. The drop in fiscal 2003 authorized positions reduces the vacancy rate to 9%. Budgeted vacancy rates in fiscal 2004 are set at 3.8%. Like many hospitals, State hospitals are experiencing shortages amongst health care professionals and vacancy rates in key direct care positions are higher. For example, at the beginning of fiscal 2003, almost 13% of nursing positions were vacant. Vacancy rates for nursing positions varied from 6% at the Finan Center to 33% at Crownsville. At this time, Maryland does not have minimum staffing ratios, nor are there minimum ratios for accreditation. Nevertheless, the high level of vacancies raises concerns about the impact on quality of care.

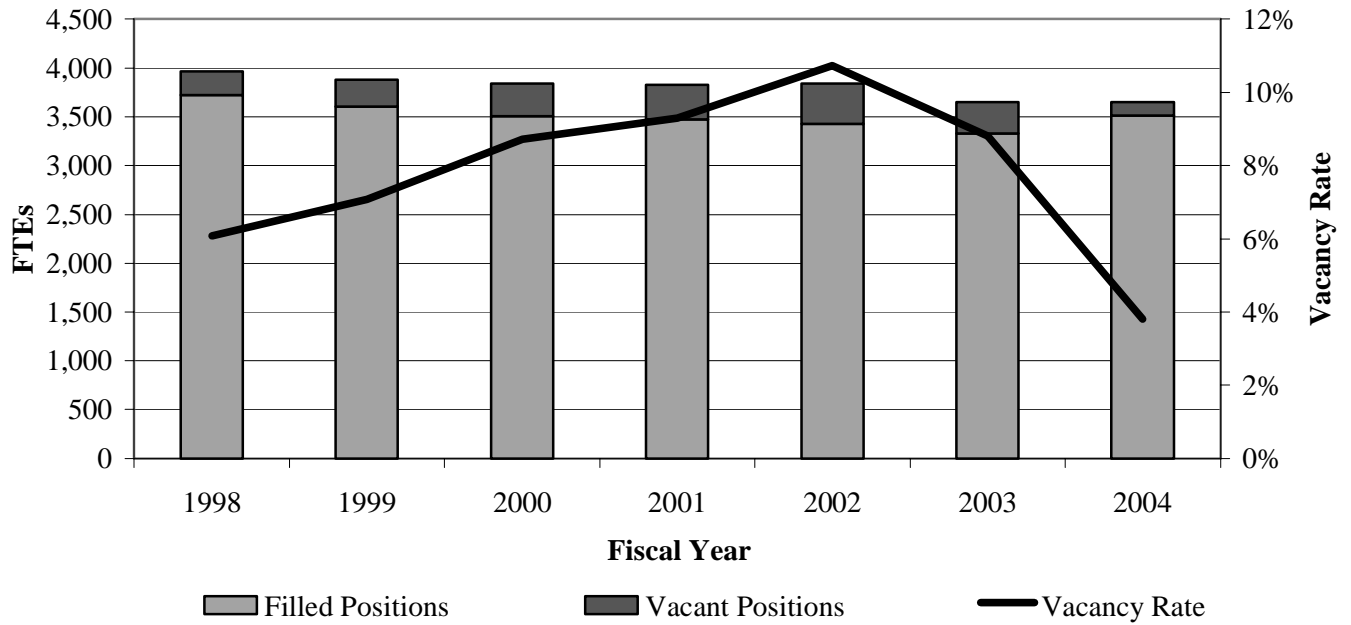
Outcomes

If quality of care is compromised, it should be reflected in such things as loss of the Joint Commission on Accreditation of Health Care Organizations (JCAHO) accreditation, higher rates of readmissions, greater use of seclusions and restraint, higher numbers of incidents of aggression, etc. There have been some recent media reports questioning quality of care. For example, a recent Centers for Medicare and Medicaid Services (CMS) audit at Springfield noted numerous deficiencies, especially in the area of medical record keeping. However, at this point the MFR data does not suggest that quality of care is being compromised.

Consider, for example, **Exhibit 7** that details rates of readmissions within 30 days. Generally, with the exception of Spring Grove, long-term trends are going down. Further, the most recent actuals for all hospitals are below the national average 30-day readmission rate of 6.23%.

Exhibit 6

**Department of Health and Mental Hygiene
State-run Psychiatric Facilities – Employment Levels
Fiscal 1998 through 2004**



Note: Fiscal 2004 vacancy rate is as budgeted.

Source: Department of Legislative Services; Department of Health and Mental Hygiene

Exhibit 7

**Readmission within 30 Days of Discharge
Fiscal 1999 through 2004
(% of Total Admissions)**

	<u>FY 99</u>	<u>FY 00</u>	<u>FY 01</u>	<u>FY 02</u>	<u>FY 03 Est.</u>	<u>FY 04Est.</u>
Carter		5.5	3.6	3.7	3.8	3.7
Finan			0.0	0.0	0.0	0.0
Crownsville	4.0	5.0	5.0	4.0	4.0	4.0
Eastern Shore	5.7	3.6	5.1	2.3	4.4	4.4
Springfield		8.7	5.9	3.7	4.3	4.3
Spring Grove	3.2	4.5	4.6	5.1	5.0	5.0
Upper Shore	9.0	6.2	4.8	6.2	6.1	6.1
RICA-Baltimore		8.0	5.0	0.0	5.0	5.0
RICA-Montgomery	0.0	0.0	0.0	0.0	4.0	2.0
RICA-Southern Maryland				0.0	2.3	2.3

Note: The nature of programming at Perkins does not lend itself to this measure.

Source: Department of Health and Mental Hygiene

Finally, it should be noted that a level of data uniformity is now present in the MFRs of the State-run psychiatric institutions. MHA's facilities should be commended for the marked improvement shown in the fiscal 2004 MFR compared to previous years where similar objectives were measured in different ways making comparisons difficult.

Fiscal 2003 Actions

Proposed Deficiency

There are two proposed fiscal 2003 deficiency appropriations:

- \$1 million in general funds to offset higher than budgeted personnel expenditures at various State-run psychiatric facilities; and
- \$60 million (\$30 million each of general and federal funds) to offset prior year deficits rolled-into fiscal 2003 and address gaps in the fiscal 2003 current services budget.

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Impact of Cost Containment

As part of fiscal 2003 cost containment reductions, the general fund appropriation for MHA was reduced by just under \$3.9 million. This amount was derived from three different sources:

- \$1.8 million in general funds as a result of utilizing available federal Community Mental Health Services Block Grant funding to cover other general fund expenditures.
- \$1.5 million in general fund savings based on improving utilization review in community mental health services. DLS would note that such improved utilization review has been cited previously by MHA as a cost containment strategy. MHA has a mixed record of following through with proposed cost containment strategies. Given the criticism of oversight efforts leveled at MHA in the recent OLA performance audit, DLS is skeptical about these savings actually being realized.
- \$569,000 available as a result of the deferral of energy loan payments to the Treasurer. The fiscal 2003 appropriation included funding to pay for an Energy Performance Improvement Program at Springfield Hospital. There were delays in the financing of the project that meant the funding was available for cost containment.

Contingent Reductions

There is a small reduction of \$125,000 proposed in the 2003 Budget Reconciliation and Financing Act (BRFA). This reduction relates to the employee transit initiative.

Taken together, these fiscal 2003 actions increase the fiscal 2003 appropriation by just over \$57 million (7.8%). Even with cost containment, general funds increase by just over \$27 million (5.1%).

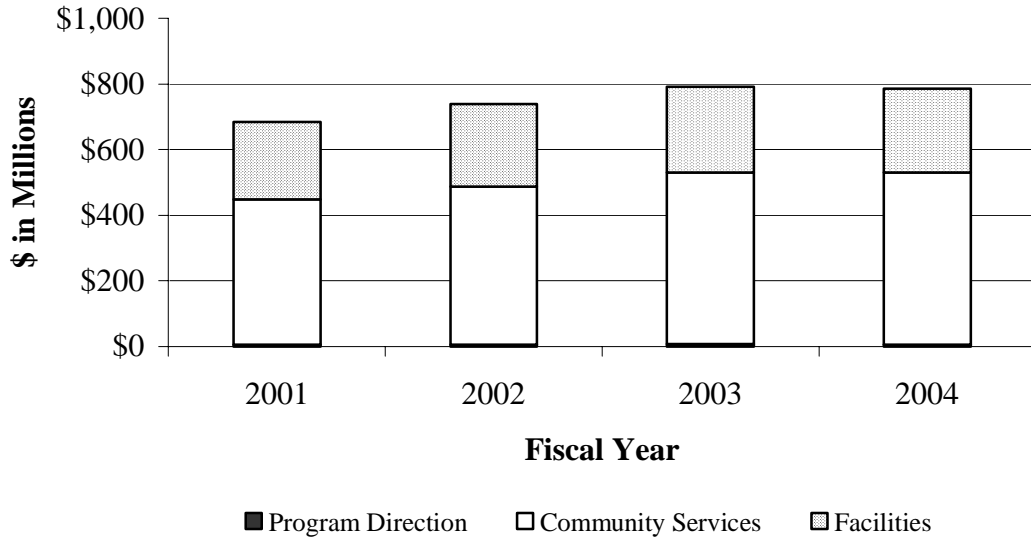
Governor's Proposed Budget

Exhibit 8 illustrates budget growth in the three major program areas in MHA. Over the period fiscal 2001 to 2004, there is a small relative growth in the funding of community mental health services, which is now over two-thirds of MHA's budget. That growth comes at the expense of the State-run psychiatric facilities. Program direction remains flat at under 1% of the total budget.

The Governor's fiscal 2004 allowance is \$5.132 million (0.6%) below the adjusted fiscal 2003 appropriation. The allowance actually includes general fund increases of \$3.1 million (0.6%) and federal fund increases of almost \$4.1 million (1.9%), but special funds fall by almost \$14 million (83%). This change reflects the fiscal 2003 use of special funds derived from higher than anticipated disproportionate share revenues to offset prior year deficits in community mental health services.

Exhibit 8

MHA Budget Overview
Fiscal 2001 through 2004



Source: Department of Budget and Management

Specific areas of change are detailed in **Exhibit 9** and include:

- **Personnel Expenses.** Personnel expenditures fall by almost \$5.5 million. The allowance includes a healthy increase for turnover relief, leaving the budgeted turnover rate at 3.82% or requiring on average 138 vacant positions. The current vacancy rate is almost 9%, or an average of almost 337 vacant positions. This vacancy rate is inflated by positions that are currently vacant but that will be abolished in fiscal 2004. However, after making that adjustment, there are still just over 53 more vacancies than required to meet turnover requirements. As discussed above, the issue for the State-run psychiatric facilities is not meeting turnover requirements, but staffing the facilities to maintain an appropriate level of care.
- **Community Mental Health Services.** Funding for community mental health services (those currently or previously delivered through the fee-for-service system) appears flat from fiscal 2003 to 2004. However, based on deficit estimates utilized by MHA, the fiscal 2003 appropriation includes \$37.8 million in funding for prior year deficits rolled over into fiscal 2003. This \$37.8 million includes \$8.3 million of the proposed fiscal 2003 general fund deficiency, \$14.1 million in special funds derived from higher than anticipated federal disproportionate share revenues, and \$15.4 million in federal funds based on anticipated federal fund attainment. As shown in **Exhibit 10**, an increase provided in the allowance for current services is visible when this funding is accounted for. The adequacy of this funding is discussed in Issue 1.

Exhibit 9

**Governor's Proposed Budget
Mental Hygiene Administration
(\$ in Thousands)**

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Where It Goes:

Personnel Expenses	-\$5,460
Employee and retiree health insurance	\$5,895
Turnover relief	4,115
Other fringe benefit adjustments	320
Fiscal 2003 deficiency	-1,000
Deferred compensation match	-1,034
Miscellaneous adjustments	-2,000
Workers' compensation premium assessment	-5,699
Abolished positions (146.1 FTE)	-6,057
Community Mental Health Services	-\$708
Medicaid-eligible Population	
Fee-for-service increase based on utilization and enrollment	80,308

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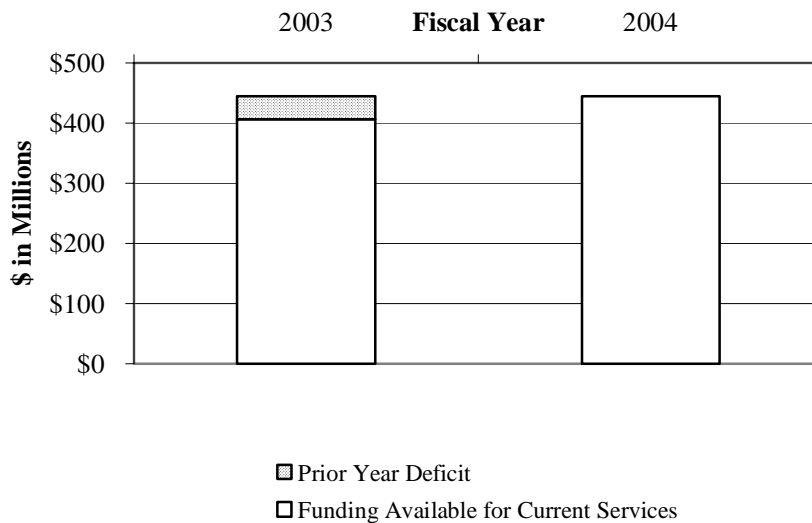
Where It Goes:

Adjustment for prior year deficit funding	-21,156
Fiscal 2003 deficiency.....	-60,000
Medicaid-ineligible Population	
Funding for services that were previously in the fee-for-service system.....	632
Other Grants/Contracts	
Various federal grants	2,183
Traumatic Brain Injury initiative.....	900
ASO contract	600
Other mental health services historically funded through grants and contracts	-4,175
Facilities (Excluding Personnel)	\$825
Contractual expenses.....	617
Spring Grove Hospital pharmacy and somatic care contracts	336
Food.....	106
Fuel and utilities	-234
Other	211
Total	-\$5,132

Note: Numbers may not sum to total due to rounding.

Exhibit 10

**Community Mental Health Funding: Where It Goes
Fiscal 2003 and 2004**



Source: Department of Legislative Services

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Funding of services that have historically been provided outside of the fee-for-service system (for example, specialized inpatient services, the Baltimore City capitation project, crisis services, suicide hot line, etc.) plus administrative expenses for both the CSAs and ASO is slightly lower in fiscal 2004 than 2003. Within this amount, significant changes include \$900,000 to provide services to (1) individuals under a TBI waiver approved by CMS in June 2002 and (2) individuals currently in State psychiatric hospitals eligible for discharge but who require specialized community services that are not currently well provided. This initiative may improve bed availability at the State-run psychiatric facilities, but DLS does not anticipate any immediate reduction in bed capacity given current demand.

Funding increases for the TBI initiative as well as the ASO contract are essentially generated from reductions to other existing grants and contracts.

- **Facility** spending outside of personnel expenditures is relatively flat. The most significant increase is in funding for contractual support.

Issues

1. Attacking a Three-headed Hydra: Settling Prior Year Deficits, Fixing the Base, and Providing for Reasonable Growth

Since the 2001 session, budget deliberations surrounding MHA have revolved around how to resolve significant deficits in the fee-for-service community services budget (for the purpose of this discussion, references to the fee-for-service system includes those services administered by the ASO that up until fiscal 2003 were delivered through fee-for-service but are now delivered through grants and contracts). In both the 2001 and 2002, the legislature provided one-time solutions to deficit problems:

- Chapter 275, Acts of 2001 established a Tax Amnesty Program that resulted in \$28.5 million being applied against mental health deficits.
- Chapter 440, Acts of 2002, the BRFA, established a special fund into which were deposited federal disproportionate share revenues in excess of the Bureau of Revenue Estimates official estimate. This higher attainment was based on applying a different methodology for collecting the State share of these payments. Just over \$54 million was subsequently applied to deficits in fiscal 2002 and 2003.

Additional funds to cover deficits were found from other MHA grants and contracts and the Department of Health and Mental Hygiene (DHMH) programs such as Medicaid and the Alcohol and Drug Abuse Administration. However, while funding covered deficits, a structural deficit (the gap between the current year appropriation and the cost of current levels of services) remained. Despite outlining numerous cost containment strategies, MHA's efforts to limit expenditures were inconsistently applied and unable to close this structural deficit. Given the nature of this gap (anywhere between 12% -17% of expenditures on current services in fiscal 2000 through 2003), this failure is hardly surprising.

Further, the prior DHMH Secretary candidly admitted in June 2002 to a joint hearing of the appropriate budget subcommittees that DHMH was not going to radically reduce services to the mentally ill.

Meeting the Various Needs

The extent to which funding provided in the fiscal 2004 budget adequately addresses payment of prior year deficits, fixing the base, and providing for reasonable growth is illustrated in **Exhibit 11**. As shown in Exhibit 11:

- **Resolving the Prior Year Deficit.** At fiscal 2002 close out, MHA estimated that \$22.3 million in prior year deficits would be rolled into fiscal 2003. Based on revised expenditure reports, DLS believes this amount will rise to \$27.9 million and could increase further as fiscal 2002 claims can be made through March 2003. This deficit can be closed by \$14 million in higher-than-anticipated disproportionate share revenues remaining after fiscal 2002 deficits were resolved and \$13.9 million of the proposed fiscal 2003 deficiency.

Exhibit 11

**Resolving Multiple Problems in the Fee-for-service
Community Mental Health System
MHA's Fiscal 2004 General Fund Budget
(\$ in Millions)**

Resolving Prior Year Deficit

Prior Year Deficit at Fiscal 2002 Close Out	-\$22.3
Increase in Prior Year Deficit Since Close Out	-5.6
Total Prior Year Deficit	-\$27.9
 Available DSH Funds	 \$14.0
Use of Proposed Fiscal 2003 Deficiency	\$13.9
 Prior Year Deficit	 \$0.0

Fixing the Base: Fiscal 2003

<i>Fiscal 2002 Service Year Expenditures</i>	<i>231.5</i>
Fiscal 2003 Appropriation and Remaining Deficiency	229.2
Estimated Fiscal 2003 Expenditures	\$247.8
 Projected Fiscal 2003 Deficit	 -\$18.6

Fixing the Base: Fiscal 2004

Fiscal 2004 Allowance	254.6
Estimated Fiscal 2004 Expenditures	261.4
 Projected Fiscal 2004 Deficit	 -\$6.8

Source: Department of Legislative Services

- **Fixing the Base: Fiscal 2003.** The remaining deficiency appropriation when added to the original fiscal 2003 appropriation and offset by the \$1.5 million fiscal 2003 cost containment reduction results in \$229.2 million in general funds available for fee-for-service community mental health services. This amount is already \$2.3 million below estimated fiscal 2002 expenditures. Based on estimated growth, adjusting for an unfunded rate increase for physicians in outpatient mental health clinics approved in November 2002 and retroactive to July 1, 2002, and allowing for a minimal increase in non-Medicaid expenditures (based on cost containment actions taken in the summer to cap

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expenditures and lower program eligibility), DLS estimates that MHA has a potential \$18.6 million gap in fiscal 2003.

To date, MHA has identified just over \$4 million that it can use to offset that amount: \$2.2 million from a grant for school-based mental health centers which level funds those contracts, \$1.1 million from various grants to the CSAs, and \$750,000 in additional block grant funds. Other funds may be available from other programs in DHMH, but cost containment has already stripped funds from many of the more obvious sources.

This situation was hardly unexpected. Last session DLS argued that the fiscal 2003 appropriation was unable to support current services. MHA was required to report back to the budget committees on measures necessary to live within its fiscal 2003 appropriation. They did so in June 2002, when limited cost containment measures were outlined including reducing non-Medicaid eligibility, capping expenditures on certain services, and generating \$4 million in savings from utilization management. Even then, DLS pointed out that the MHA response did not match the size of problem. As noted above, the former DHMH Secretary responded that he was not willing to drastically reduce services to resolve the budget shortfall.

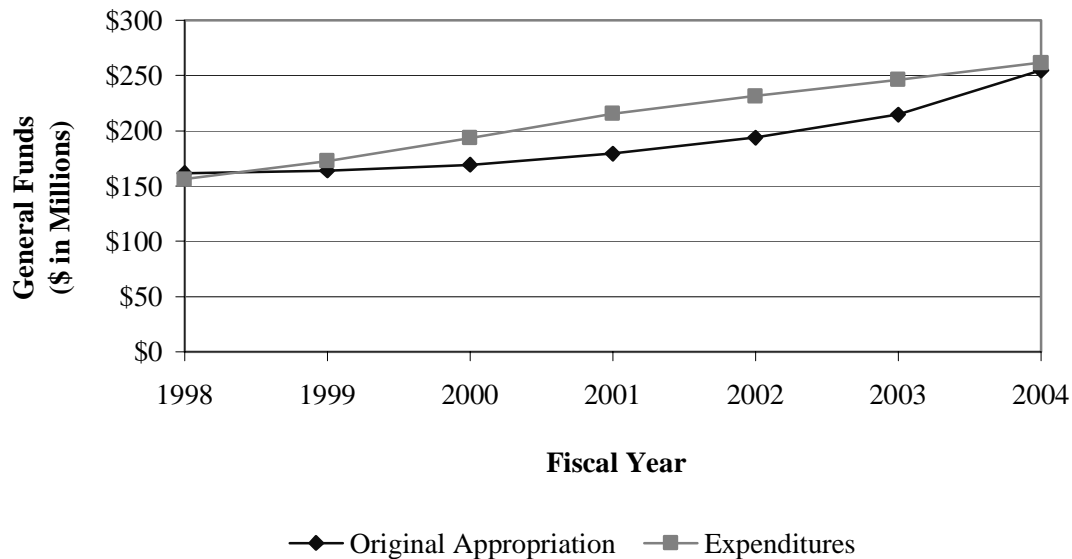
While that position recognizes the demand for mental health services and the potential impact that cutting those services would have, it was a position that passed the buck to the next administration. Nonetheless, there were other cost containment measures proposed by MHA in previous years that have never been implemented, for example enforcing existing payment rules, reducing authorizations in order to manage high-cost users, and eliminating payments to the Health Services Cost Review Commission-regulated (HSCRC) clinics for non-Medicaid clients.

MHA should be prepared to detail how and when it intends to implement measures beyond those proposed in June 2002 to limit deficits in fiscal 2003. MHA should offer specific details on the implementation of measures to generate \$4 million in savings from utilization management.

- **Fixing the Base: Fiscal 2004.** While MHA faces considerable challenges in fiscal 2003, as illustrated in **Exhibit 12**, the fiscal 2004 allowance significantly attacks, if not completely resolves, the fee-for-service structural deficit. Based on DLS's estimate of growth in Medicaid-only expenditures (an estimate that produces average annual growth of 9% in Medicaid-only expenditures over fiscal 2002 compared to the allowance which provides growth of 6% over the same period), assuming no rate increases, and minimal growth in non-Medicaid expenses, the allowance is \$6.8 million below estimated expenditures or 3% of estimated expenditures. **DLS recommends budget bill language expressing legislative intent that MHA contain expenditures for non-Medicaid eligible services and services to non-Medicaid eligible clients to the budgeted level, limit payments for rate increases formulated after April 1, 2003, and requiring MHA to rigidly apply existing payment rules.**

Exhibit 12

The Community Services Structural Deficit Fiscal 1998 through 2004



Note: Fiscal 2002 through 2004 expenditures are DLS estimates.

Source: Department of Legislative Services

Other Lingering Issues

In addition to the funding of the fee-for-service system, a number of other issues are still outstanding:

- Fiscal 2003 budget bill language required MHA to move to a grants- and contracts-based system for non-Medicaid eligible clients in order to control costs. MHA has only partially complied with this requirement: outpatient mental health services remain fee-for-service. MHA has argued that the disruption associated with such a move outweighs any fiscal benefits. DLS would note that if MHA expenditures outside Medicaid can be contained, how those services are delivered is less relevant.
- There is still demand for rate increases. The last general rate increase (outside HSCRC-regulated providers) was in 2000, although rate increases have been awarded since then for freestanding private psychiatric hospitals, Residential Treatment Centers (RTC), and physicians in outpatient mental health clinics. Bills continue to be introduced mandating regular rate increases.

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- There are still a number of outstanding cost settlements. The Kennedy Krieger Institute, for example, owes the State an estimated \$4 million, while other facilities are owed funding.
- A number of local health department outpatient mental health clinics are still seeking State support for accumulated deficits. According to MHA, Charles County has a problem of at least \$600,000.
- The State has already written off \$6 million in prior year advances that were made to providers with cash-flow problems. These advances were especially prevalent in the first years of the fee-for-service system but continued until recently. There are an estimated \$2 million in outstanding advances.
- There are still issues surrounding federal fund collections. For example, the State may stand to gain up to \$2 million based on RTC billings from 1998 through 2000.
- The State remains reliant on its ASO, MHP, to administer the system. However, MHP's parent company, Magellan, is in significant fiscal difficulties. MHA's contingency plans in the event of MHP's demise are at best ill defined.

In summary, the fiscal 2004 allowance provides significant relief for MHA except for the extent of deficits that can be expected in fiscal 2003. However, many other challenges remain. Now is the time for MHA to firmly establish controls and improve oversight rather than to relax believing its fiscal woes are over.

2. Hospital Closure: The Ongoing Debate Over the “Big Three”

In recent years, inpatient psychiatric admissions in Maryland have risen steadily both in terms of absolute numbers (from just over 24,000 in 1982 to just under 40,000 in 2001) and rate (5.6 per 1,000 population in 1982 to 7.7 per 1,000 population in 2001). At the same time, the role of State hospitals in treating this population has changed significantly while the configuration of State hospitals has remained relatively unchanged.

Overview of Current State Hospital Capacity and Role

According to the Maryland Health Care Commission (MHCC), Maryland has experienced significant changes in the nature of State institutional psychiatric care in the past 20 years. For example:

- The number of State-operated psychiatric beds declined by 69% between 1982 and 2001. The most significant decline occurred in 1985 when over 1,000 beds were closed. Aside from that year, the decline has been gradual over the period.
- The average daily census in State-operated psychiatric hospitals fell by 62% in the same period. The decline here was more gradual over the whole period.

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- However, while the State system downsized the number of beds, only one hospital (Highland Health in 1998) was closed.

The result is the current system of eight hospitals dealing primarily with adults, plus three RTCs. Focusing on the eight primarily adult-serving hospitals the system represents a mix of smaller regional facilities (e.g., Finan, Eastern Shore, Upper Shore), specialist hospitals (e.g., Perkins which specializes in forensic patients although forensic patients are found throughout the system), as well as the so-called “big three” regional hospitals (Springfield, Spring Grove, and Crownsville), all of which are now much smaller facilities on sprawling campuses. Basic population and budget data is provided in **Exhibit 13**.

Exhibit 13

**State-run Psychiatric Hospitals Various Data
Fiscal 2004 Unless Stated**

Facility	Authorized FTEs	Operated Beds*	Budgeted ADP*	FY 2003 ADP (First 4 Months)	FY 2004 Allowance** (\$)
Carter (Baltimore City)	136.3	51	49	49	\$12,588,730
Finan (Allegany)	211.0	114	80	74	15,154,943
Crownsville (Anne Arundel)	482.3	204	200	198	34,246,829
Eastern Shore (Dorchester)	219.6	84	76	73	15,150,536
Springfield (Carroll)	789.5	275	275	267	51,548,024
Spring Grove (Baltimore)	719.5	291	250	270	48,629,359
Clifton Perkins (Howard)	480.5	220	218	217	33,285,572
Upper Shore (Kent)	100.0	55	37	38	7,472,030
Total	3,138.7	1,294	1,185	1,186	\$218,076,023

* Data excludes assisted living facilities at Springfield and Spring Grove.

** Allowance data is before 2004 contingent reductions but excludes an amount for assisted living.

Source: Department of Legislative Services; Governor’s Fiscal 2004 Operating Budget; Department of Budget and Management; Department of Health and Mental Hygiene

In addition to serving fewer patients, the role of the State-run psychiatric hospitals has also changed in the context of the statewide system of inpatient psychiatric beds (which includes the private psychiatric hospitals and psychiatric wards of acute general hospitals). Perhaps the two key trends are:

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- State-run psychiatric hospitals are seldom now a point-of-entry for inpatient psychiatric care. This reflects a decision by MHA to allow the other hospitals to be the entry point to the system. In 2001, only 8% of admissions were directly to State hospitals compared to 44% in 1980. Most admissions (71%) are to acute general hospitals.
- On any given day the State-run psychiatric hospitals still house most psychiatric inpatients, 61% in 2001. As ALOS has declined significantly in acute general hospitals (from 18 days in 1980 to just over 6 days in 2001), the pressure to place clients at State-run hospitals has increased. Although ALOS has declined at State-run psychiatric facilities, it remains higher than at either acute general hospitals or private psychiatric hospitals. Significantly in the past four years ALOS at State hospitals has risen from a low of 19 days in fiscal 1998 to 31 days in fiscal 2001. This rise in ALOS portends a changing role for those hospitals as the location for more long-term hospitalizations (see the discussion of the changing patient profile in the MFR section which reinforces this finding).

The importance of the changing role for State-run psychiatric hospitals is that it is clearly part of a continuum system of care that includes private inpatient capacity as well as other community-based resources. If State hospitals are not able to admit and appropriately discharge patients to less intense levels of care, the result is what has been witnessed in the past several years: back-ups in emergency rooms and State purchase of bed capacity in the private sector.

If there is clearly a demand for State hospital beds at the front-end, what about efforts to increase community capacity in order to reduce ALOS and potentially limit bed capacity? This was the basis for an August 1999 proposal that called for reducing State hospital bed capacity while investing an additional \$57 million in community resources. That plan was partially successful. As shown in Exhibit 3, ADP levels have fallen, but of course the State is now forced to buy bed capacity elsewhere.

The August 1999 proposal was never fully implemented:

- At no time did the prior administration add to the budget the additional investments in community resources proposed in the 1999 proposal. This fact is important; as most observers underscore that the successful transition from an institutional setting to a community placement requires adequate community resources.
- At the same time, other populations, for example those with co-occurring substance abuse and mental illness have found that the mental health system is more accessible than the substance abuse system, again increasing demand on State beds.
- By the middle of fiscal 2000, MHA's deficit overshadowed the downsizing efforts, effectively ending any implementation of the August 1999 plan. The budget problems resulted, for example, in MHA imposing a moratorium on the creation of residential rehabilitation beds. These beds are vital to the successful movement of persons from State hospitals into the community because most of these clients have no housing. However, residential rehabilitation beds are 100% State funded (even if a client is Medicaid-eligible, Medicaid does not cover the cost of residential rehabilitation services).

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At this time, there is no evidence to indicate that anything other than the current capacity should be the basis for system planning.

Hospital Closure and the “Big Three Debate”

While it might seem strange to be discussing hospital closure in the context of preserving capacity, there is flexibility for increasing bed capacity within the system that would allow for hospital closure elsewhere. Some of these options are relatively straightforward, for example reopening previously closed wards. Other options are more complicated. For example, the capacity at Finan could be increased that much more if the Developmental Disabilities Administration (DDA) clients at the Brandenburg Center (which is physically connected to Finan) were moved to the Potomac Center. Similarly, reclaiming cottages currently controlled by the Department of Public Safety and Correctional Services can further increase capacity at Springfield.

Certainly, closure is by no means an easy task. It requires the transitioning of patients and staff to new facilities; probable lay-offs of administrative and maintenance staff; reducing patient access; and deciding which facility to close, a decision that presents different wrinkles and different levels of political opposition. Nonetheless, it is possible and would achieve some level of operating savings. Savings would be in administrative, household, and property expenditures and would vary depending on which facility or facilities were closed.

Adopting a broader perspective of system change can yield at least equal levels of operating savings in the long-term, generate significant capital savings, while most importantly improving the treatment environment and efficiency of MHA hospitals. However, to do this requires ending the debate on whether the State will have two or three large regional facilities.

The most recent proposal surrounding hospital closure, completed at the request of the legislature and submitted in August 1999, called for the retention of all three hospitals, the replacement of existing facilities at Crownsville and Spring Grove with new, smaller facilities, and some limited improvements at Springfield. Funding for those two new hospitals has at various times been in the *Capital Improvement Program* (CIP), but never in the capital budget bill considered by the legislature. The current CIP, for example, includes funding for a new 136-bed hospital at Crownsville beginning in fiscal 2007. There is little doubt that the physical plant of all three hospitals is in poor condition. Indeed, the legislature recently approved funding to upgrade the electrical distribution system at Springfield earlier than originally anticipated because of the urgent need to do so.

If there is the will from the administration and legislature to replace existing hospitals at both Spring Grove and Crownsville, then there is room to close a smaller facility immediately. **DLS would recommend that the Upper Eastern Shore hospital be closed at a savings of \$1.4 million.** The remainder of the funding provided in the allowance for the hospital would transfer with the patients. This recommendation mirrors that made in a draft of the August 1999 closure report.

Alternatively, the administration and legislature may wish to consider a plan to build a new larger hospital that provides the system with at least the existing bed capacity and ultimately close either Spring Grove or Crownsville. (Recent investment in Springfield and the relative need for physical improvements there eliminates it as a candidate for replacement.)

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Of the two hospitals, Spring Grove offers by far the biggest upside development potential. The campus abuts the University of Maryland, Baltimore County and the Baltimore Beltway and is ten minutes from downtown Baltimore. However, there are other considerations that must be addressed:

- How to transfer the assisted living program.
- How to accommodate MPRC that has administrative and laboratory space on the Spring Grove campus as well as clinical programs (outpatient and inpatient). It might be possible to leave a much smaller space for MPRC's use.
- How to accommodate those buildings that currently house administrative staff including MHA Headquarters, Alcohol and Drug Abuse Administration, and the Office of Health Care Quality staff.

The Crownsville campus does not have a great development potential. Almost 600 acres of the campus were transferred to the Department of Natural Resources by the prior administration and placed in a perpetual easement prohibiting development. There is also no public water and sewer. However, there are a number of community-based service organizations that currently use surplus space on the campus that would likely want to expand into space vacated by MHA.

Closing Crownsville also raises more access issues compared to Spring Grove, especially for clients in Anne Arundel County and Southern Maryland.

DLS would argue that if the administration and legislature want to move forward toward a more efficient system with an improved treatment environment the best option is to partially close Crownsville (leaving the Meyer building open), moving patients to other facilities through expanding system capacity, and implementing the phased development of what would ultimately be a 368-bed hospital at Crownsville.

This would involve the construction of a new 284-bed hospital and the subsequent renovation of the Meyer Building. Once completed, there would then be the opportunity to close Spring Grove.

As shown in **Exhibit 14**, this would result in a configuration that would provide close to current capacity assuming only a 95% occupancy rate. The current occupancy rate is close to 100%.

Long-term, the operating savings to be gained from closing Spring Grove could be as much as \$10 million. As shown in **Exhibit 15**, potential capital savings from having two rather than three large regional facilities range from \$48 to \$70 million, the larger amount of savings coming from closing Spring Grove.

Exhibit 14

Consolidation Plan: Maintaining Capacity and Closing Spring Grove

<u>Facility</u>	FY 2004 Status		Maintain Capacity/Close Spring Grove	
	<u>Budgeted ADP*</u>	<u>FY 2003 ADP (First 4 Months)</u>	<u>Proposed Beds</u>	<u>ADP**</u>
Carter	49	49	49	47
Finan	80	74	96	91
Crownsville	200	198	368	350
Eastern Shore	76	73	80	76
Springfield	275	267	340	323
Spring Grove	250	270		
Clifton Perkins	218	217	250	238
Upper Shore	37	38	58	55
Total	1,185	1,186	1,241	1,180

* ADP data exclude assisted living facilities.

** ADP based on 95% occupancy.

Source: Department of Legislative Services; Department of Health and Mental Hygiene

Exhibit 15

**Capital Cost Estimates for Three Versus Two Large Regional Hospitals
(Current Year \$)**

<u>Facility*</u>	<u>Three Large Regional Facilities (1999 Plan)</u>	<u>Two Large Regional Facilities: Close Crownsville</u>	<u>Two Large Regional Facilities: Close Spring Grove</u>
Crownsville	\$62,068,000	\$0	\$88,281,000
Spring Grove	96,219,000	110,122,000	0
Springfield	15,835,000	15,835,000	15,835,000
Total Capital Costs	\$174,122,000	\$125,957,000	\$104,116,000
<i>Net Savings over 1999 Plan</i>		<i>\$48,165,000</i>	<i>\$70,006,000</i>

*Facility size varies according to option chosen. In each case, facility capacity is sufficient to maintain current capacity.

Source: Department of Health and Mental Hygiene

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While it might be tempting to further study the issue, it should be noted that bookshelves could be filled with studies that have been undertaken and subsequently ignored on hospital closure in Maryland. **As an alternative to closing one of the smaller facilities, DLS recommends that \$2,637,000 in design funds for a new 284-bed facility at Crownsville be added to the Capital Budget. Movement of patients out of Crownsville in fiscal 2004 should generate limited operating savings of \$500,000.**

This recommendation still leaves room for MHA to look at the rest of its hospital system and perhaps make additional recommendations for consolidation. It also provides additional time to develop a final proposal for the utilization of the Spring Grove campus and also to see how current bed capacity matches up to future demand.

3. Privatization Options

Increasingly, states are investigating and implementing various privatization options with regard to public hospitals. Options include sale, lease, joint operating agreements, joint ventures, or other form of community partnerships, as well as comprehensive outsourcing. While most examples of privatization involve public acute general hospitals, there are limited examples of such privatization at State-run psychiatric hospitals.

According to a 2001 survey by NRI, five states were undertaking some form of privatization:

- **Florida:** Privatization efforts included the transfer of the operation of South Florida State Hospital as well as privatization of food services at two other hospitals.
- **Hawaii:** Purchase of child and adolescent bed capacity in private hospitals.
- **Illinois:** The purchase of bed space for children and adolescents in the private sector allowed the closure of child and adolescent wards in one state hospital.
- **Kentucky:** Two hospitals are operated by two private hospital systems under contract.
- **South Carolina:** A private facility provides forensic services.

Privatization inevitably raises fears from employees and advocates about quality of care. There does not appear to be any body of literature speaking to outcomes from privatization of psychiatric facilities. The experience in Florida has attracted most attention. In that state, a firm that made a name in prison privatization was awarded a contract to take over South Florida State Psychiatric Hospital. While long-term outcome data is still being compiled, advocates are reported as being generally pleased by the changes at the hospital (including the construction of a new consolidated hospital space) and the level of care. The hospital gained JCAHO accreditation during this time, and the company has reported an ability to make a profit. Much of that has to do with eliminating one-third of the staffing positions as well as reducing benefit packages for the remaining staff. The state has seen the elimination of waiting lists to get into the facility, shorter ALOS (from five years to six months), without losing control over admissions.

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One of the keys to this apparent success was the detailed Request for Proposals (RFP) developed for privatization. The RFP was prescriptive in terms of minimum staffing levels, the need to make capital improvements, a list of performance benchmarks that had to be met, and the need to gain accreditation.

In Maryland, hospitals already outsource activities (for example, contracting for therapy services, housekeeping etc.). The State also purchases bed capacity. However, these efforts are more limited compared with some of the examples noted above.

The three service areas where significant privatization could occur are RICAs; assisted living facilities; and hospital services:

- There are numerous other RTCs operating in the State and a private vendor could operate a State facility. Savings would depend on the contract award.
- The State currently operates assisted living facilities at Springfield and Spring Grove hospitals. These facilities are essentially “step-down” or transitional programs for patients that the hospitals are hoping to move into community placements. Patients live in cottages on the hospital campus.

The assisted living programs operated at Springfield and Spring Grove are similar to residential rehabilitation programs operated in the community (which would most likely be the next step for these clients) and could be operated by programs that currently have experience providing these services. Consideration would have to be given to how clients are accepted into these facilities in order to avoid impediments to movement out of State hospital beds. Again, savings would depend on the contract award.

- There are probably additional services that can be outsourced to generate savings. It is unclear if this extends to privatization of a hospital although there has been some speculative interest in privatization of the Carter Center in Baltimore City. For the State, again, the issue would be how much could be saved by some other entity operating the beds while ensuring that the beds are used to treat the same profile of patients as currently served.

MHA has indicated that some interest is being expressed in privatization of certain activities and facilities. **DLS recommends that budget bill language be adopted requiring that MHA submit any privatization agreement or RFP for privatization to the budget committees for review and comment prior to implementation/issuance.**

4. Developing an Integrated System of Early Childhood Mental Health Services

There is an increasing body of research linking school readiness to the healthy social-emotional development of young children as much as attention to literacy and numeracy. Media reports are increasingly referring to the problem of children being suspended from kindergarten for behavioral issues. In the first four months of the current school year in Philadelphia for example, 33 kindergartners were suspended. While no national data is kept in this area, officials with the U.S. Department of Education note that anecdotal evidence seems to support this view. The prevailing opinion points to the need for

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better pre-school development environments and earlier social-emotional interventions. A number of states are vigorously pursuing strategies in this regard, for example Florida, Indiana, Ohio, and Vermont.

In Maryland, the Annie E. Casey Foundation, in conjunction with State and local government officials, academics, and advocacy groups, recently published a five-year Action Agenda for Maryland to achieve school readiness, an agenda that included a component promoting healthy socio-emotional growth. Action points for that component were:

- Gathering data on the current capacity of all counties to provide services and supports to children 0 to 6 and their families.
- Examining State policies and programs focused on children 0 to 6 and identifying gaps and areas of overlap.
- Developing a plan to provide mental health consultation to all child care providers.
- Expanding in-service and pre-service training opportunities for professionals interested in early childhood mental health.

MHA, in collaboration with other State agencies, has been working on this issue through an Early Childhood Mental Health Steering Committee. The committee, co-chaired by MHA and the Maryland State Department of Education (MSDE), is actively pursuing the action points identified in the Casey Foundation Action Agenda: mapping service capacity, coordinating trainings, and piloting mental health consultation on a limited basis.

However, as shown in **Exhibit 16**, current State spending on mental health services in the fee-for-service system is heavily weighted toward older children. **Exhibit 17** illustrates spending patterns on service type and shows significant resources dedicated to deep-end interventions, even though spending on residential placements appears to be falling. Exhibit 16, and perhaps to a lesser extent Exhibit 17, do raise old arguments about whether the State should be spending more on early intervention programs for younger children to prevent subsequent deep-end and expensive residential placements.

At a time of limited State resources, finding dollars to expand services for the youngest children remains a stumbling block. There is some research to suggest that states can find some funding through a variety of different federal sources as well as by soliciting foundation grants. One of the tasks of the Steering Committee is in fact to look at funding options to expand services.

DLS recommends that the Steering Committee through MHA and MSDE report back to the committees on its ongoing work, to include a review of existing as well as other funding options that may be available to expand early childhood mental health services.

Exhibit 16

**Fee-for-service Spending on Children 0 to 17
Fiscal 1998 through 2002
(\$ in Millions)**

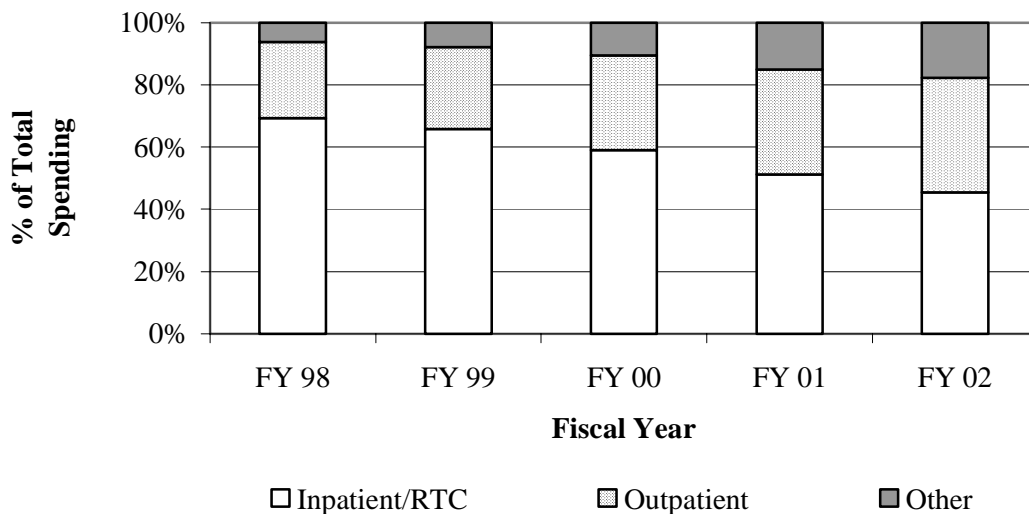
<u>Age</u>	<u>FY 98</u>	<u>FY 99</u>	<u>FY 00</u>	<u>FY 01</u>	<u>FY 02</u>	<u>Annual % Change FY 98 - 02</u>
0-6	\$3.5	\$3.9	\$5.4	\$4.9	\$5.4	11%
12-17	40.2	48.7	59.1	69.4	72.5	16%
13-17	55.3	61.7	65.6	71.1	72.2	7%
Total	\$99.0	\$114.3	\$130.1	\$145.4	\$150.1	11%
>6 as % of Total	4%	3%	4%	3%	4%	

Note: Fiscal 2002 data are incomplete.

Source: Department of Legislative Services; Department of Health and Mental Hygiene

Exhibit 17

**Fee-for-service Spending on Children 0 to 17
Fiscal 1998 through 2002**



Source: Department of Legislative Services; Department of Health and Mental Hygiene

Recommended Actions

1. Add the following language:

Provided that it is the intent of the General Assembly that both non-Medicaid eligible mental health services delivered to Medicaid-recipients and mental health services delivered to non-Medicaid eligible clients be done within the constraints of the Community Services and Community Services for Medicaid Recipients appropriation for those services.

Further provided that, with the exception of payments made under the regulatory authority of the Health Services Cost Review Commission, payments to providers may not be raised above levels set in regulations in effect April 1, 2003, except as specifically authorized in legislation. Further provided that the Mental Hygiene Administration may not waive payment regulations in effect April 1, 2003, except as specifically authorized in legislation.

Explanation: The language expresses legislative intent that the Mental Hygiene Administration (MHA) limit expenditures for non-Medicaid eligible services and for non-Medicaid eligible clients to the funding provided in the budget. In fiscal 2004 this equals \$65 million in general funds for services currently or previously provided through the fee-for-service system. The language also restricts the ability of MHA to raise rates or waive payment rules. In all instances, the language is intended to help constrain spending to avoid future deficits.

2. Add the following language:

Further provided that before the Mental Hygiene Administration may enter into any privatization agreement or issue a Request for Proposals for the privatization of any of its current facilities or portions thereof, that agreement or Request for Proposals shall be submitted to the budget committees for review and comment. The budget committees shall have 30 days to review and comment on any agreement or request for proposals.

Explanation: There has been some speculation that all or part of a State-run psychiatric facility will be privatized. Few states have much experience with the privatization of psychiatric facilities. However, experience from other states indicates that successful privatization requires that any agreement or Request for Proposals (RFP) must be very specific as to required outcomes. The language offers the budget committees an opportunity to review and comment upon any proposed agreement or RFP concerning the privatization of all or part of a State-run psychiatric facility.

Information Request	Author	Due Date
Privatization agreement or RFP to undertake privatization of all or part of a State-run psychiatric facility	MHA	30 days prior to the implementation of an agreement or the issuance of an RFP

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3. Add the following language:

Further provided that it is the intent of the General Assembly that the Community Services and Community Services for Medicaid Recipients budgets be reimbursed in accordance with the budget detail presented to, and approved by, the General Assembly. Should the administration wish to make a regulatory, policy, or procedural change which increases or decreases the budget by a sum greater than \$500,000, it shall inform the budget committees of the change and the committees shall have 30 days to review and consider it before it becomes effective. In reporting any change, the administration shall also include an assessment of the impact on clients and providers.

Explanation: The language requires the Mental Hygiene Administration (MHA) to notify the budget committees of any regulatory, policy, or procedural changes that increase or decrease the Community Services and Community Services for Medicaid recipients budgets by more than \$500,000. The report should also include the potential impact on clients and providers.

Information Request	Author	Due Date
Notification of regulatory, policy, or procedural changes of \$500,000 or more	MHA	As needed, with 30 day review

	<u>Amount Reduction</u>
4. Reduce funding for Core Service Agencies (CSAs). The majority of CSAs are organized along county lines. A recent study reported that CSAs not already functioning regionally generally oppose a regional approach. However, given the State's ongoing structural deficit, savings can be made if such an approach is adopted.	\$ 3,000,000 GF
5. Reduce funding for drug purchases under the State's Atypical Anti-Psychotic Drug Program based on most recent expenditure levels. Spending on these drugs has fallen from \$540,000 in fiscal 2000 to \$130,000 in fiscal 2002 through the use of generics. The proposed reduction still allows for a 24% increase over fiscal 2002 levels.	125,000 GF

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6. Reduce operating expenditures at the Crownsville Hospital. If the General Assembly wishes to pursue a strategy of closing one of the three large regional hospitals, redeveloping Crownsville appears to be the best option. A phased development results in the transfer of some patients to other facilities during the construction of a new hospital and limited operating expenditure savings can be expected. Much larger benefits accrue in capital savings and long-term treatment benefits and operating efficiencies should also accrue. This action assumes the addition of funds in the fiscal 2004 Capital Budget to begin design. 500,000 GF
7. Reduce funding for operating expenditures at the Upper Shore Community Mental Health Center. If the General Assembly wants to retain three large regional facilities, the system has sufficient flexibility to expand bed capacity so that a smaller facility can be closed. Remaining funding at the Upper Shore would transfer with the patients. 1,400,000 GF
8. Reduce funding through the closure of the Regional Institute for Children and Adolescents Southern Maryland. Based on data provided by the Mental Hygiene Administration, there is currently excess Residential Treatment Center (RTC) bed capacity in Maryland. Although closure of a State facility raises regional access issues, given the State's ongoing structural deficit, closure provides ongoing cost savings. Sufficient funding is retained to provide alternative RTC placement. 4,000,000 GF
9. Adopt the following narrative:

Performance Audit Follow-up: Based on concerns about continuing deficits in the community mental health budget, fiscal 2003 budget bill language requested the Office of Legislative Audits (OLA) to undertake a performance audit of the fee-for-service mental health system. That audit was completed in December 2002. The OLA audit was critical of Mental Hygiene Administration's (MHA) oversight and control of the system and made numerous recommendations. The committees request that MHA report back to them by September 1, 2003, detailing implementation of recommendations made in the OLA performance audit.

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Information Request	Author	Due Date
Implementation of recommendations made by OLA in its December 2002 performance audit	MHA	September 1, 2003

10. Adopt the following narrative:

Early Childhood Mental Health Steering Committee: A growing body of research recognizes that the healthy social-emotional development of young children is a critical foundation for school readiness. The Annie E. Casey Foundation recently published an action agenda on school readiness for Maryland that recognized this principle. The Early Childhood Mental Health Steering Committee co-chaired by the Mental Hygiene Administration (MHA) and the Maryland State Department of Education (MSDE) has spearheaded Maryland’s efforts in this area. One of the key issues confronting progress in the committee’s work is funding. However, recent reports indicate that federal funding sources can be more fruitfully utilized, and this is an area the committee is pursuing. The committees request that MHA and MSDE provide a progress report.

Information Request	Authors	Due Date
Update on the work of the Early Childhood Mental Health Steering Committee	MHA MSDE	December 1, 2003

Total General Fund Reductions **\$ 9,025,000**

Updates

1. Maryland Psychiatric Research Center

The 2002 JCR asked DHMH and the University of Maryland, Baltimore (UMB) to report back on the feasibility and desirability of transferring responsibility for the MPRC to UMB. MPRC is established in statute as part of DHMH but maintained as a partnership between DHMH and the Department of Psychiatry in the UMB School of Medicine. One of the concerns in recent years is that the grant funding provided by DHMH has not increased. Indeed, the fiscal 2004 allowance is \$112,000 below fiscal 2002 funding, increasing MPRC's reliance on federal and private funding.

DHMH and UMB did respond to the committees on October 2002. The recommendation in the report was to maintain the current statutory arrangement but to request an additional year to develop a long-range plan for MPRC. For example, the letter noted the potential changing use of the Spring Grove campus and the impact that would have on MPRC and its program.

DHMH and UMB intend to report back to the committees in September 2003 with a final report.

2. JCR Items Need Follow-up

Due to MHA's budget problems, the administration was the focus of much legislative attention in the 2002 session and numerous pieces of budget bill language and narrative were adopted requiring MHA to report back on various issues. To date, as shown in **Exhibit 18**, MHA has not fulfilled a number of reporting requirements.

Exhibit 18

Unfulfilled 2002 JCR Reporting Requirements

<u>Information Request</u>	<u>Purpose</u>	<u>Author</u>	<u>Due Date</u>
Priority List of System Enhancements	The identification of prioritized areas requiring enhancement	MHA	February 1, 2003
Quarterly Reports on service delivery to Medicaid-eligible clients	The identification of any impact of changes in the mental health system, for example, the switch to grants and contracts and the capping of expenditures on certain services	MHA	Quarterly beginning January 1, 2003
Report on the movement out of the mental health system of persons with a primary diagnosis as being developmentally disabled	The need to ensure that persons with a primary diagnosis as being developmentally disabled are served, and paid for, by the Developmental Disabilities Administration.	DHMH	November 1, 2002

Source: Department of Legislative Services

MHA should expedite the completion of the required reports.

Current and Prior Year Budgets

Current and Prior Year Budgets Mental Hygiene Administration (\$ in Thousands)

	<u>General Fund</u>	<u>Special Fund</u>	<u>Federal Fund</u>	<u>Reimb. Fund</u>	<u>Total</u>
Fiscal 2002					
Legislative Appropriation	\$504,809	\$2,675	\$155,951	\$2,334	\$665,769
Deficiency Appropriation	0	0	419	0	419
Budget Amendments	11,801	42,498	32,237	1,102	87,638
Reversions and Cancellations	-10,870	-606	-2,582	-242	-14,300
Actual Expenditures	\$505,740	\$44,566	\$186,024	\$3,195	\$739,525
Fiscal 2003					
Legislative Appropriation	\$534,866	\$2,766	\$173,642	\$2,283	\$713,558
Budget Amendments	0	14,018	7,137	0	21,155
Deficiencies	31,000	0	30,000	0	61,000
Cost Containment	-3,869	0	0	0	-3,869
Contingent Reductions	-125	0	0	0	-125
Working Appropriation	\$561,872	\$16,784	\$210,781	\$2,283	\$791,720

Note: Numbers may not sum to total due to rounding.

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Fiscal 2002

The fiscal 2002 legislative appropriation for MHA was increased by just under \$74 million. A deficiency appropriation of \$419,000 in federal funds was approved by the General Assembly in the 2002 session. These funds were to cover increased overtime costs at the State-run psychiatric hospitals resulting from the response to the September 11, 2001, terrorist attacks.

Budget amendments further increased the appropriation by just under \$88 million. This increase was derived as follows:

- General fund budget amendments of \$11.8 million. Most of the funds, \$6.3 million, were transferred into MHA as part of DHMH's close-out process to cover deficiencies at the State-run psychiatric hospitals. A further \$1.5 million was the remainder of the \$20 million originally appropriated to cover the estimated deficiency in Medicaid that was transferred to MHA in order for MHA to continue to pay bills in fiscal 2002. Of the \$20 million transferred to MHA, \$18.5 million was subsequently transferred back to Medicaid to cover the deficiency in that program. A final \$4 million was transferred into the community service budget from unspent Alcohol and Drug Abuse Administration drug treatment and Maryland Children's Health Program funds.
- Special fund budget amendments of almost \$42.5 million. Of this amount, almost \$40.7 million is the amount of disproportionate share revenue that the State expects to receive in fiscal 2002 above the previous estimates as developed by the Board of Revenue Estimates. This significant increase resulted from a different interpretation in the methodology for claiming disproportionate share payments. The funds were dedicated to the mental health deficit in Chapter 440, Acts of 2002 BRFA. The bulk of the remaining special funds were unspent Cigarette Restitution Funds transferred from the Alcohol and Drug Abuse Administration.
- Federal fund budget amendments of just over \$32.2 million. Of this, \$29.2 million was derived from higher than expected federal fund earnings under the federal Medical Assistance Program. These higher federal earnings were attributed to higher than anticipated enrollment and utilization of services during fiscal 2002 (\$17.2 million); expenditures on Medicaid services from prior years but paid in fiscal 2002 (\$5.7 million); higher than anticipated attainment from the Maryland Children's Insurance Program (\$2.5 million); increased reimbursement rates for freestanding private psychiatric hospitals (\$1.9 million); Medicaid reimbursement for the Baltimore capitation project (\$1.4 million); and Medicaid support for MHA headquarters operating expenditures (\$0.5 million). A further \$3.0 million derived from a variety of federal grants, the bulk of which (\$2.7 million) from the Community Mental Health Services Block Grant. The remaining \$300,000 is derived from a variety of other federal fund sources such as the School Breakfast Program and Institutional Libraries Aid Program.
- Reimbursable fund budget amendments of \$1.1 million, the bulk of which was funding from the Department of Juvenile Justice (DJJ) to cover the cost of providing mental health services to youth in DJJ aftercare.

Increases to the appropriation derived through deficiencies and budget amendments were offset by reversions and cancellations of \$14.3 million. This figure includes just under \$10.9 million in general fund

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cost containment reductions (see the fiscal 2003 operating budget analysis for further details), \$606,000 in special fund cancellations, just under \$2.6 million in federal fund cancellations, and \$242,000 in reimbursable fund cancellations.

Fiscal 2003

To date, the fiscal 2003 legislative appropriation has been increased by just over \$78 million. Budget amendments represent just over \$21 million of this, including just over \$14 million in special funds again derived from the higher than anticipated disproportionate share payments and just over \$7 million in higher than expected federal fund earnings under the federal Medical Assistance Program. Proposed deficiencies further increase the appropriation by \$61 million, with cost containment and contingent reductions reducing the appropriation by just under \$4 million. The deficiencies, cost containment, and contingent reductions are discussed in greater detail above.

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Appendix 2

Object/Fund Difference Report
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Object/Fund	FY 02	FY 03	FY 04	FY 03 - 04	Percent Change
	Actual	Working Appropriation	Allowance	Amount Change	
Positions					
01 Regular	3938.15	3749.65	3603.55	-146.10	-3.9%
02 Contractual	185.68	175.85	176.37	0.52	0.3%
Total Positions	4,123.83	3,925.50	3,779.92	-145.58	-3.7%
Objects					
01 Salaries and Wages	\$ 198,040,974	\$ 204,664,209	\$ 201,126,104	-\$ 3,538,105	-1.7%
02 Technical & Spec Fees	8,385,459	7,513,041	8,174,326	661,285	8.8%
03 Communication	1,121,778	1,289,791	1,195,562	-94,229	-7.3%
04 Travel	169,390	206,767	169,908	-36,859	-17.8%
06 Fuel & Utilities	9,010,033	11,093,195	10,299,670	-793,525	-7.2%
07 Motor Vehicles	580,130	707,406	646,441	-60,965	-8.6%
08 Contractual Services	505,229,490	491,095,216	547,782,235	56,687,019	11.5%
09 Supplies & Materials	14,399,838	16,180,252	16,245,413	65,161	0.4%
10 Equip – Replacement	1,094,048	642,087	626,815	-15,272	-2.4%
11 Equip – Additional	386,566	122,578	171,498	48,920	39.9%
12 Grants,Subsidies,Contr	417,144	436,790	421,604	-15,186	-3.5%
13 Fixed Charges	601,011	656,915	669,587	12,672	1.9%
14 Land & Structures	89,453	105,840	105,840	0	0%
Total Objects	\$ 739,525,314	\$ 734,714,087	\$ 787,635,003	\$ 52,920,916	7.2%
Funds					
01 General Fund	\$ 505,739,783	\$ 534,866,266	\$ 566,032,392	\$ 31,166,126	5.8%
03 Special Fund	44,566,279	16,783,967	2,823,411	-13,960,556	-83.2%
05 Federal Fund	186,024,010	180,780,978	214,884,482	34,103,504	18.9%
09 Reimbursable Fund	3,195,242	2,282,876	3,894,718	1,611,842	70.6%
Total Funds	\$ 739,525,314	\$ 734,714,087	\$ 787,635,003	\$ 52,920,916	7.2%

Note: Fiscal 2003 appropriations and fiscal 2004 allowance do not include cost containment and contingent reductions.

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Fiscal Summary
DHMH - Mental Hygiene Administration

<u>Unit/Program</u>	<u>FY 02 Actual</u>	<u>FY 03 Legislative Appropriation</u>	<u>FY 03 Working Appropriation</u>	<u>FY 02 - 03 % Change</u>	<u>FY 04 Allowance</u>	<u>FY 03 - 04 % Change</u>
01 Mental Hygiene Administration	\$ 487,985,421	\$ 452,941,380	\$ 474,097,249	-2.8%	\$ 529,829,610	11.8%
02 Maryland Psychiatric Research Center	3,921,614	3,809,691	3,809,691	-2.9%	3,809,691	0%
03 Walter P. Carter Community Mental Health Center	12,456,384	12,785,982	12,785,982	2.6%	12,558,730	-1.8%
04 Thomas B. Finan Hospital Center	14,735,436	15,225,706	15,225,706	3.3%	15,154,943	-0.5%
05 Regional Institute For Children & Adolescents – Baltimore	9,864,995	10,362,055	10,362,055	5.0%	10,141,192	-2.1%
06 Crownsville Hospital Center	33,800,055	34,493,716	34,493,716	2.1%	34,246,829	-0.7%
07 Eastern Shore Hospital Center	14,498,319	15,137,246	15,137,246	4.4%	15,150,536	0.1%
08 Springfield Hospital Center	53,991,756	56,699,679	56,699,679	5.0%	55,702,124	-1.8%
09 Spring Grove Hospital Center	51,644,095	52,993,862	52,993,862	2.6%	52,417,459	-1.1%
10 Clifton T. Perkins Hospital Center	31,955,910	33,708,957	33,708,957	5.5%	33,285,572	-1.3%
11 Regional Institute For Children & Adolescents – Montgomery County	11,427,873	11,675,569	11,675,569	2.2%	11,812,231	1.2%
12 Upper Shore Community Mental Health Center	7,121,170	7,515,086	7,515,086	5.5%	7,432,440	-1.1%
14 Regional Institute For Children & Adolescents Southern Maryland	6,122,286	6,209,289	6,209,289	1.4%	6,093,646	-1.9%
Total Expenditures	\$ 739,525,314	\$ 713,558,218	\$ 734,714,087	-0.7%	\$ 787,635,003	7.2%
General Fund	\$ 505,739,783	\$ 534,866,266	\$ 534,866,266	5.8%	\$ 566,032,392	5.8%
Special Fund	44,566,279	2,766,967	16,783,967	-62.3%	2,823,411	-83.2%
Federal Fund	186,024,010	173,642,109	180,780,978	-2.8%	214,884,482	18.9%
Total Appropriations	\$ 736,330,072	\$ 711,275,342	\$ 732,431,211	-0.5%	\$ 783,740,285	7.0%
Reimbursable Fund	\$ 3,195,242	\$ 2,282,876	\$ 2,282,876	-28.6%	\$ 3,894,718	70.6%
Total Funds	\$ 739,525,314	\$ 713,558,218	\$ 734,714,087	-0.7%	\$ 787,635,003	7.2%

Note: Fiscal 2003 appropriations and fiscal 2004 allowance do not include cost containment and contingent reductions.