M00L
Mental Hygiene Administration
Department of Health and Mental Hygiene

Operating Budget Data

($ in Thousands)

	FY 04 Actual	**FY 05 Working**	**FY 06 Allowance**	**FY 05-06 Change**	**% Change Prior Year**
General Fund	$556,386	$574,520	$573,092	-$1,427	-0.2%
Special Fund	2,378	5,903	7,859	1,955	33.1%
Federal Fund	265,895	225,606	220,386	-5,220	-2.3%
Reimbursable Fund	3,864	3,477	3,815	338	9.7%
Total Funds	**$828,524**	**$809,507**	**$805,153**	**-$4,354**	**-0.5%**
Contingent & Back of Bill Reductions			-1,135	-1,135	
Adjusted Total	**$828,524**	**$809,507**	**$804,018**	**-$5,489**	**-0.7%**

- Although funding for the Mental Hygiene Administration (MHA) falls by just under $5.5 million in fiscal 2006 from fiscal 2005, the decline is misleading. Funding for current community services purchased on a fee-for-service basis actually increases by almost $27 million. However, funding to cover payables from prior years declines by almost $34 million, more than offsetting the increase to current services.

- It is projected that MHA will carry over an estimated $26 million in unprovided for payables into fiscal 2006. Only a little over $5 million has been set aside in the fiscal 2006 allowance to cover this debt.

- Funding for community mental health services delivered through grants and contracts increases by over $3 million. While community mental health service expansion funded through savings from the closure of Crownsville does increase by the promised $5 million, other services (as yet unspecified) are cut by $2 million.

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

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Personnel Data

	FY 04 Actual	FY 05 Working	FY 06 Allowance	FY 05-06 Change
Regular Positions	3,530.45	3,401.15	3,386.55	-14.60
Contractual FTEs	220.08	189.75	195.88	6.13
Total Personnel	**3,750.53**	**3,590.90**	**3,582.43**	**-8.47**
Vacancy Data: Regular Positions				
Turnover, Excluding New Positions		135.80	4.01%	
Positions Vacant as of 12/31/04		264.30	7.77%	

- Employment at State-run psychiatric facilities continues to fall. The fiscal 2006 allowance abolishes 10.6 full-time equivalent (FTE) positions at the facilities in the dietary function as the department investigates creating efficiencies in that service.

- Four FTE positions, as yet undetermined, are abolished in program direction.

Analysis in Brief

Major Trends

Community Mental Health Fee-for-service System: Mental health services delivered to children now constitute the major driving-force behind enrollment, utilization, and expenditures.

Community Mental Health Fee-for-service System Outcomes: Almost eight years since the establishment of a new service delivery system for specialty mental health services, outcome data remains paltry.

State-run Psychiatric Facilities: With the closure of Crownsville Hospital at the end of fiscal 2004, a slight drop in overall average daily population was recorded. Despite problems recruiting direct care personnel, outcomes generally improved between fiscal 2003 and 2004.

Issues

Community Mental Health Fee-for-service Funding: Fiscal Stability but Still Haunted by Ghosts of Budgets Past: While the community mental health fee-for-service budget appears to have emerged from years of structural instability, problems from those prior years continue to dog MHA.

Residential Treatment Center (RTC) Capacity: Increasing numbers of vacant beds at private RTCs and further cuts proposed in fiscal 2006 to private RTC funding raises the issue as to the role of the State-run RTCs in the context of total RTC capacity.

Institutions for Mental Diseases Expanded Authority Waiver: Since 1998, under its Section 1115 waiver, Maryland has been able to claim limited federal Medicaid reimbursement for services delivered to patients at private psychiatric hospitals, services that would ordinarily be ineligible for Medicaid reimbursement. However, the federal government has indicated that when Maryland's waiver is renewed in July 2005, such claims will no longer be allowed.

Recommended Actions

		Funds
1.	Add language restricting funds for the community placement of hospital patients.	
2.	Add language withholding funds pending the submission of outcome data for all providers of community mental health services to adults.	
3.	Add language withholding funds pending the submission of a report concerning the use of State Residential Treatment Center beds.	
4.	Reduce funds through generating savings from the expansion of capitation programs.	$ 1,000,000
5.	Reduce general fund support for contractual employment to the fiscal 2005 working appropriation.	377,000
6.	Reduce general funds in the allowance based on the availability of special funds.	85,000
	Total Reductions	**$ 1,462,000**

Updates

Crownsville Hospital Center: An update on the various issues surrounding the closure of Crownsville will be provided.

Mental Health Services for Young Children: Progress on enhancing mental health services for the youngest age group (0 – 6 years old) will be detailed.

Maryland Psychiatric Research Center: Fiscal 2004 budget bill language expressed legislative intent that the grant provided to the Maryland Psychiatric Research Center be transferred from MHA to the University of Maryland, Baltimore pending the resolution of certain key issues. The status of that resolution is provided.

Management of the Public Mental Health System: The constant fiscal instability of the public mental health system in recent years raised doubts about the status of the current carve-out of specialty mental health services from the system of mandatory managed care for Medicaid recipients. While that status remains in place, recommendations have been made by an outside consultant to improve the management of the current system.

Task Force to Study Access to Mental Health Services: A Task Force to Study Access to Mental Health Services was created in the 2003 session. The recommendations of the final report, delivered in December 2004, will be highlighted.

M00L

Mental Hygiene Administration

Department of Health and Mental Hygiene

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 seven hospitals and three residential treatment centers – Regional Institutions for Children and Adolescents (RICAs) – for the mentally ill.

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.

The carved-out system is overseen by MHA, although it contracts with an Administrative Services Organization (ASO), APS Healthcare Inc. (APS), 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 the federal poverty level (FPL), with services provided on a sliding-fee scale. Since fiscal 2003, eligibility for new clients has been limited to 116% of FPL.

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. In fiscal 2004 MHA returned those services to the fee-for-service system.

In addition to those services administered by the ASO, MHA provides grant funds for other services (often delivered through the CSAs) that are not considered appropriate for delivery through the fee-for-service system (such as crisis services, a suicide hotline, drop-in centers) as well as a capitation project in Baltimore City.

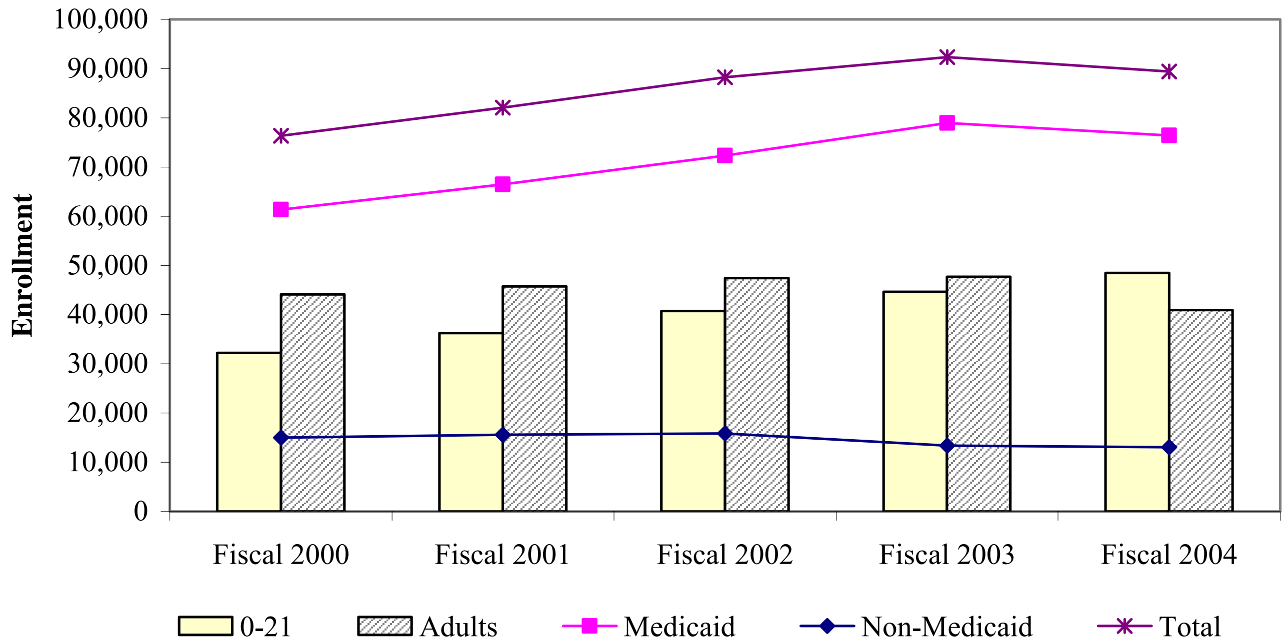
The key goals of the agency include improving the efficacy of community-based care for persons with mental illness and promoting recovery among persons with mental illness in State-run psychiatric facilities so that they can move into less restrictive settings.

Performance Analysis: Managing for Results

Community Mental Health Fee-for-service System: Enrollment, Utilization, and Expenditure Trends

As shown in **Exhibit 1**, enrollment in the fee-for-service community mental health systems has increased by an average annual rate of 4% from fiscal 2000 to 2004. The strongest growth has been amongst children (11% over the same period) and this growth is also reflected in spending patterns (**Exhibit 2**). Enrollment growth of children represents not only the numerical growth experienced by the Medicaid program as a whole especially through the expansion of the Maryland Children's Health Program (MCHP) in 2000, but also the increasing percentage of Medicaid children who are being served through the fee-for-service mental health system.

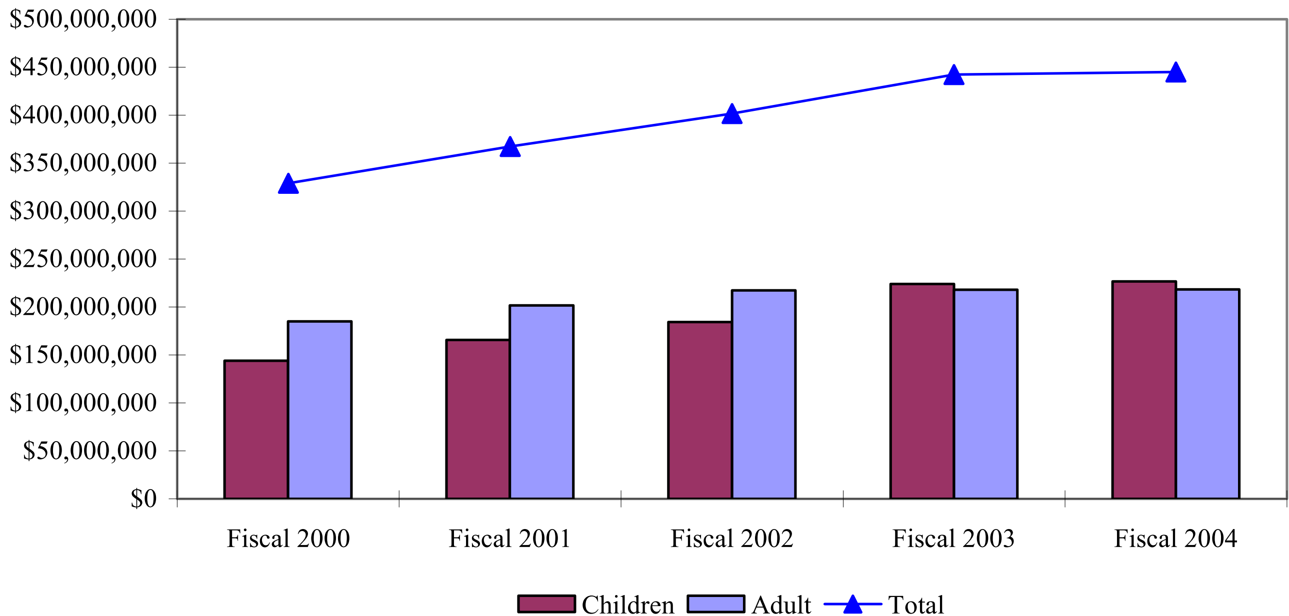
Exhibit 1
Community Mental Health Services Enrollment Trends
Fiscal 2000 – 2004



Note: Data for fiscal 2004 is incomplete.

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

Exhibit 2
Community Mental Hygiene
Fee-for-service Expenditures
Fiscal 2000 – 2004



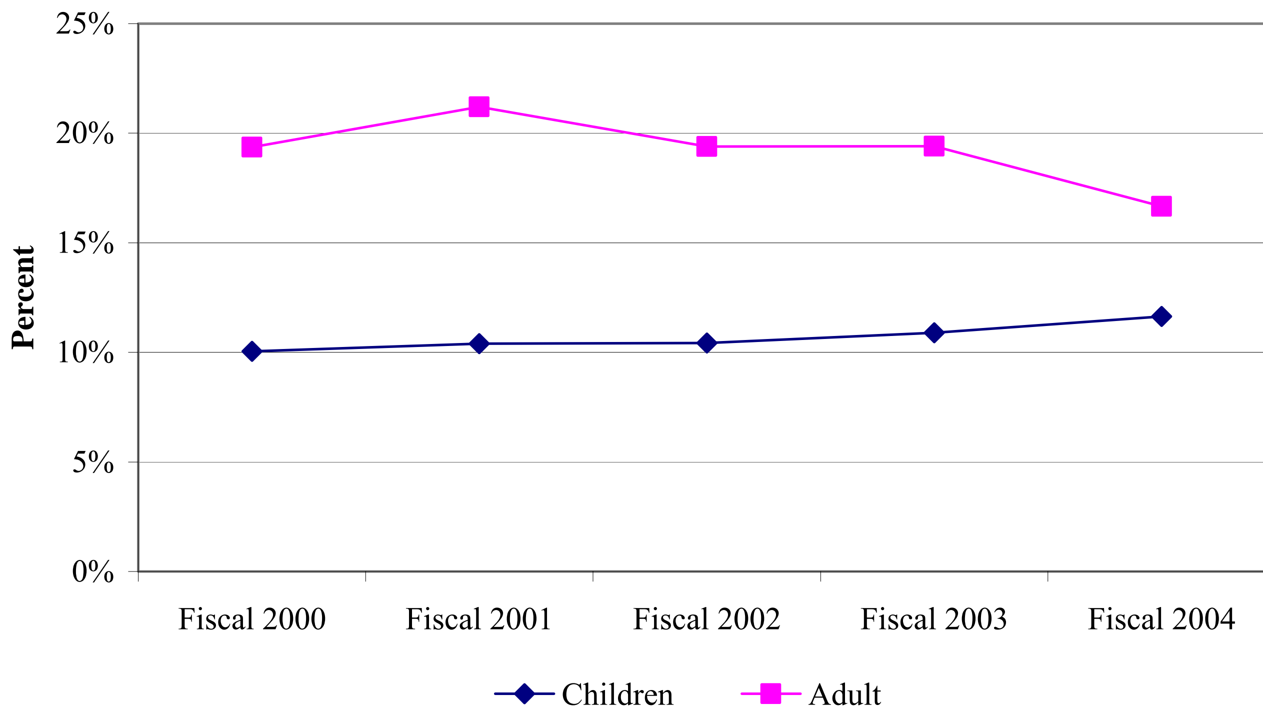
Note: Data for fiscal 2004 is incomplete.

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

Current estimates indicate that the rate of children enrolled in Medicaid who receive some level of mental health services through the fee-for-service system rose from 10.05% in fiscal 2000 to 11.64% in fiscal 2004 (see **Exhibit 3**). While the percentage of adults in the Medicaid system receiving mental health services through the fee-for-service system is actually much higher (16.66% in fiscal 2004), that rate is below the fiscal 2000 rate of 19.36% and has been falling since fiscal 2001.

Which mental health services are experiencing the most rapid growth? In the 2005 analysis, using data through fiscal 2002, psychiatric rehabilitation services were the major driving-force behind expenditure growth. However, with the imposition of a case rate in February 2004 as well as stronger enforcement of medical necessity criteria this trend has changed. As shown in **Exhibit 4**, spending on psychiatric rehabilitation services began slowing in fiscal 2003 and for the first time, in fiscal 2004 spending on outpatient services actually exceed spending on psychiatric rehabilitation.

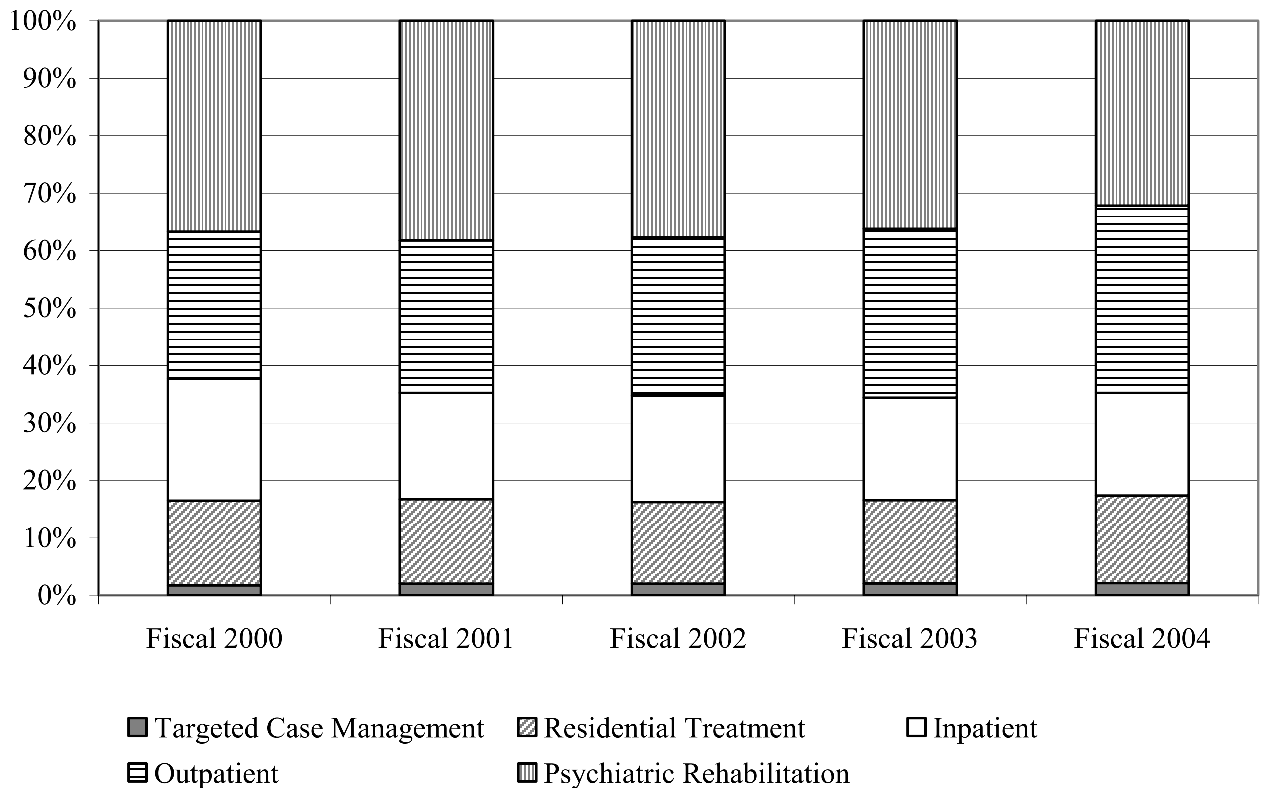
Exhibit 3
Medicaid Penetration Rates
Fiscal 2000 – 2004



Note: Data for fiscal 2004 is incomplete.

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

Exhibit 4
Community Mental Health Services Expenditures by Service Type
Fiscal 2000 – 2004
(% of Total Expenditures)

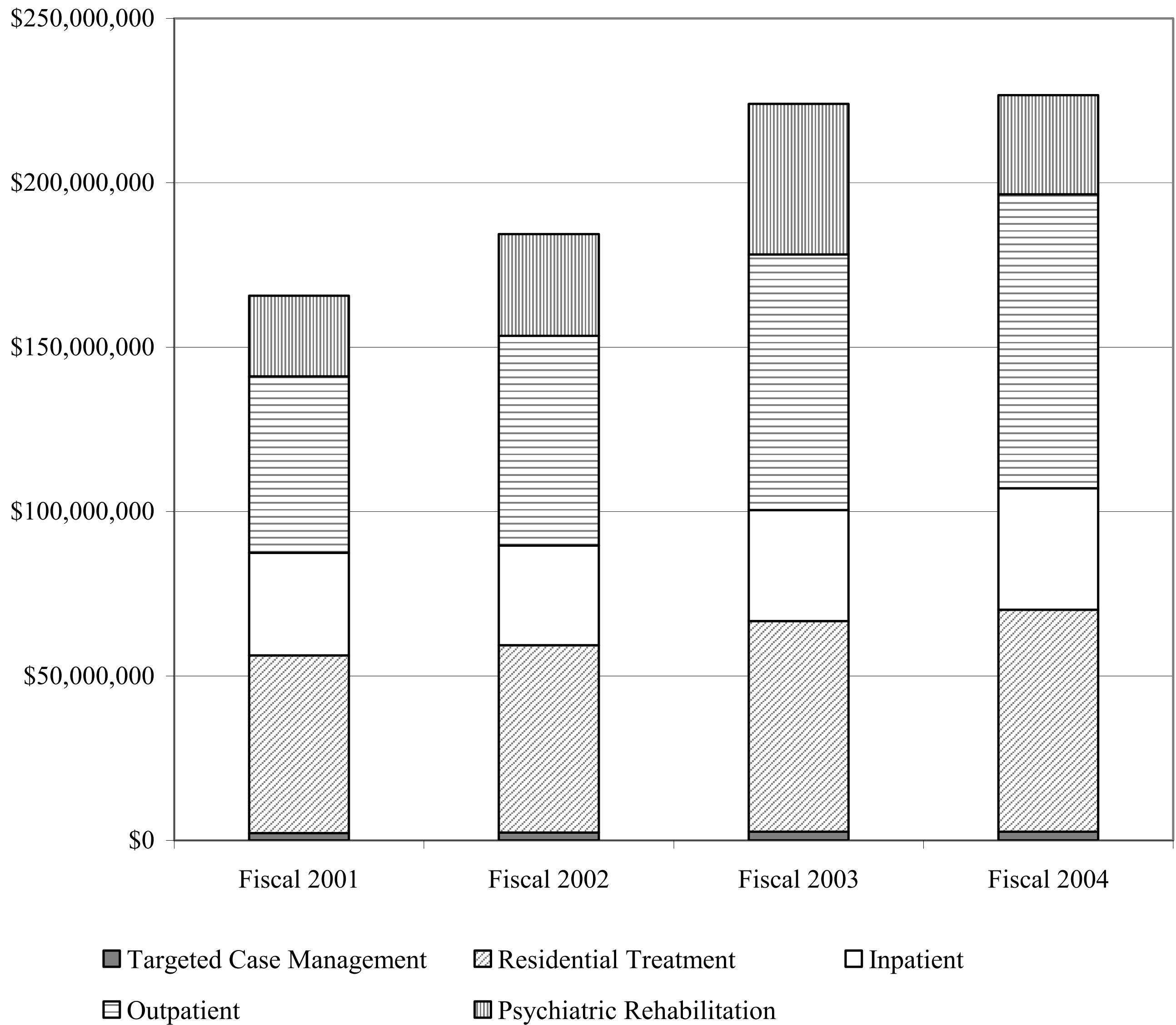


Note: Data for fiscal 2004 is incomplete.

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

The major shift in service delivery expenditures has been to children. As shown in **Exhibit 5**, spending on children's psychiatric rehabilitation has fallen sharply. While this has caused some concern in the provider and advocacy community, it should be noted that total spending on children's services continues to increase. Further, children do not appear to be utilizing more deep-end services (residential treatment) in any markedly different way. Rather, outpatient services have increased sharply.

Exhibit 5
Community Mental Health Services Expenditures by Service Type – Children
Fiscal 2001 – 2004



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

Developing Outcomes for Community Mental Health Services

While the State has plentiful data on enrollment, expenditures, and utilization, there is little in the way of outcome data for the significant investment in community mental health services made by the State. In the 2001 session, the committees added *Joint Chairmen's Report* (JCR) language requesting MHA to improve the evaluation of community mental health services. The committees expressed concern that no true outcome measures were available in aggregate or disaggregated to the provider level to measure the impact of the considerable and rising investment the State makes in community mental health services. A steering committee was established to determine what evaluation measures to use in assessing outcomes as well as identifying the tools to use to collect that data.

In the 2003 session, the Department of Legislative Services (DLS) reported that a pilot outcome study was to be implemented in the spring 2003, but the pilot was delayed. In the 2004 session, MHA indicated that data collection would begin in the 2004 interim and at least some amount of outcome data would be available for the current budget deliberations. Once again, MHA has failed to deliver on its promise.

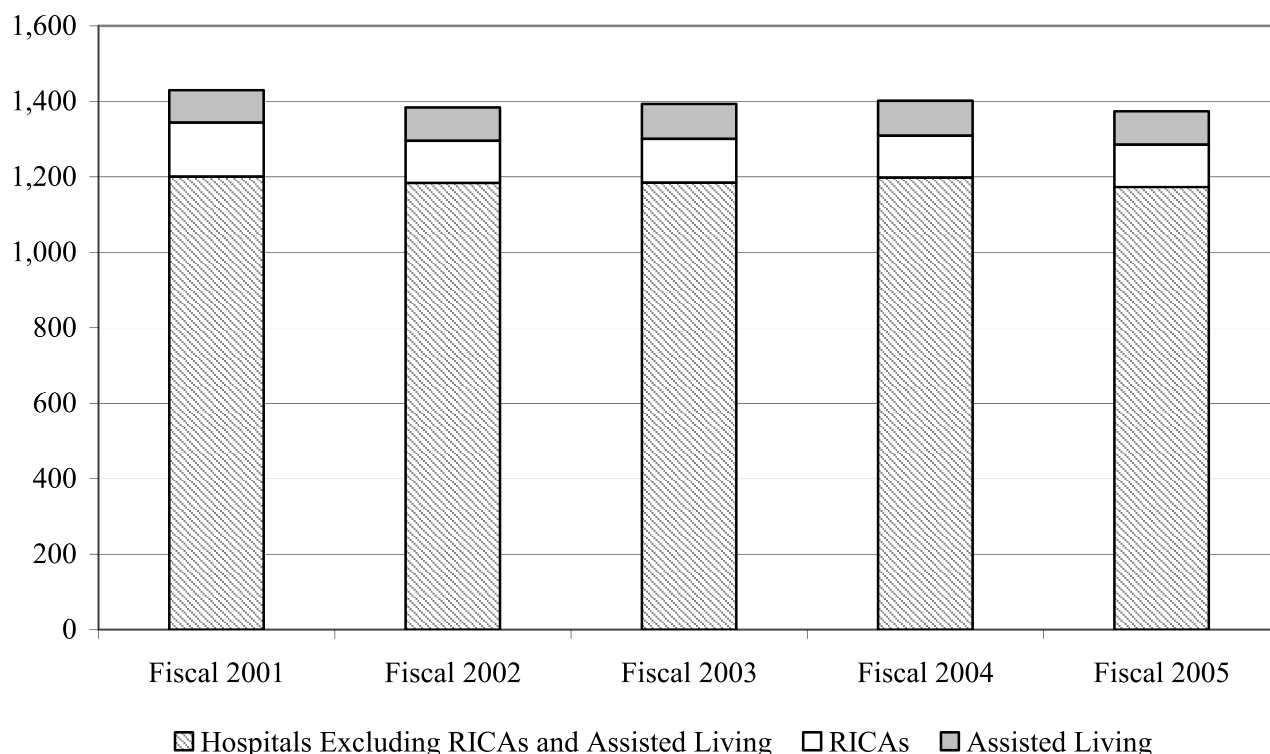
MHA was able to provide information on the status of the pilot outcomes project (Outcomes Management System) that it has contracted for with the Systems Evaluation Center at the University of Maryland. It notes that it currently applies only to adult clients and includes 23 programs. MHA has also submitted a detailed timeline as to the full roll-out of the adult program as well as the implementation of outcomes with providers of services to children and adolescents. According to this timeline, data collection will not be completed for providers of services to adults until February 2006. This means that outcome data is again unlikely to be available to the General Assembly for the discussion of the fiscal 2007 budget. Data collection for providers of services to children and adolescents is not expected until the fall of 2006, with data collection for providers of services to young children not anticipated until April 2007.

The inability of the administration to move forward with the development of outcomes undermines discussions concerning the adequacy of mental health funding and program oversight. **DLS recommends that MHA expedite the roll-out of its Outcomes Management System so that outcome data for providers of adult services is available to the General Assembly for fiscal 2007 budget deliberations.**

State-run Psychiatric Facilities: Population and Outcome Trends

As shown in **Exhibit 6,** between fiscal 2001 and 2005 year-to-date, the average daily population (ADP) at the State-run psychiatric facilities has fallen slightly. While ADP was relatively flat between fiscal 2002 and 2004, the closure of Crownsville and the movement of a small number of former Crownsville clients into the community has resulted in a small but noticeable drop in ADP.

Exhibit 6
State-run Psychiatric Facilities: ADP Trends
Fiscal 2001 – 2005



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

In terms of staffing resources at the State-run psychiatric facilities, these facilities have borne the brunt of position reductions in recent years with many of these cuts to direct care positions. Although direct care positions have been generally exempted from the State's recent hiring freeze, facilities have struggled to hire direct care workers. Overall, after accounting for the reduction in authorized regular positions following the closure of Crownsville, as of December 31, 2004, the State-run psychiatric facilities had 50 less filled positions than December 31, 2003, and over 100 less filled positions than July 1, 2003.

Is quality of care being compromised due to these staffing shortages? If quality of care is being compromised, it should be reflected in such things as loss of the Joint Committee on Health Care Organizations (JCAHO) accreditation, higher rates of readmissions, greater use of seclusion and restraint, higher numbers of incidents of aggression, and so forth. All facilities continue to retain

accreditation from JCAHO. In terms of other outcomes, **Exhibits 7, 8,** and **9** examine trends in these three outcomes at the State-run psychiatric hospitals. For the purposes of this discussion, Perkins is excluded given the nature of programming at that facility.

Exhibit 7

State-run Psychiatric Hospitals Readmissions within 30 days of Discharge

Fiscal 2001 –2004

(% of Total Admissions)

	Fiscal 2001	Fiscal 2002	Fiscal 2003	Fiscal 2004	Trend 2001-2004	Trend 2003-2004
Carter	3.6%	3.7%	3.9%	2.4%	↓	↓
Eastern Shore	5.1%	2.3%	6.5%	5.8%	↑	↓
Finan	5.0%	4.0%	1.7%	1.5%	↓	↓
Spring Grove	4.6%	5.1%	4.2%	3.6%	↓	↓
Springfield	5.8%	3.7%	5.5%	4.4%	↓	↓
Upper Shore	4.8%	6.1%	5.0%	4.0%	↓	↓

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

Exhibit 8

State-run Psychiatric Hospitals: Use of Seclusion

Fiscal 2001 – 2004

(Rate per 1,000 Patient Hours)

	Fiscal 2001	Fiscal 2002	Fiscal 2003	Fiscal 2004	Trend 2001-2004	Trend 2003-2004
Carter	n/a	0.38	0.48	0.81	n/a	↑
Eastern Shore	0.51	0.76	0.76	1.58	↑	↑
Finan	0.08	0.11	0.17	0.17	↑	↔
Spring Grove	0.47	0.13	0.33	0.42	↓	↑
Springfield	1.29	0.88	0.38	0.38	↓	↔
Upper Shore	3.06	0.68	1.18	0.97	↓	↓

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

Exhibit 9
State-run Psychiatric Hospitals: Elopements
Fiscal 2001 – 2004
(Number per 1,000 Patient Days)

	Fiscal 2001	Fiscal 2002	Fiscal 2003	Fiscal 2004	Trend 2001-2004	Trend 2003-2004
Carter	0.73	0	0.39	0.72	↓	↑
Eastern Shore	0.27	0.05	0.22	0.36	↑	↑
Finan	n/a	0.93	0.34	0.25	n/a	↓
Spring Grove	1.22	1.3	0.58	0.30	↓	↓
Springfield	0.42	0.43	0.47	0.64	↑	↑
Upper Shore	0.16	1.90	1.25	0.85	↑	↓

Elopement is generally considered as a client who is absent, unaccounted for, not found on the grounds, or has left the grounds without permission.

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

Mindful of the different resource and patient factors that apply to different facilities when making comparisons, a number of points can be made from these exhibits. In budget deliberations from the 2004 session, the conclusion was that long-term trends (comparing fiscal 2000 to 2003) in these three outcomes were generally positive, but that short-term trends were mixed. This year, with fiscal 2001 as the base year compared with 2004 a number of observations can be made.

- Long-term trends are mixed. In only one outcome, readmissions within 30 days, are trends overwhelmingly moving in a positive direction.

- Short-term trends are not much different with only readmission rates uniformly positive.

One measure, the use of seclusion, has a national benchmark of 0.6 per 1,000 patient hours. As shown in Exhibit 8, three of the six hospital fall below the national average in fiscal 2004, while three (Carter, Eastern Shore and Upper Shore) are above the national average.

Governor's Proposed Budget

As shown in **Exhibit 10**, at just over $804 million, the adjusted fiscal 2006 allowance falls by just under $5.5 million from the fiscal 2005 working appropriation, 0.7%. The adjustment reflects a reduction of just over $1.1 million contingent on budget reconciliation and financing legislation to eliminate the employee deferred compensation contribution.

Exhibit 10
Governor's Proposed Budget
Mental Hygiene Administration
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimbursable Fund	Total
2005 Working Appropriation	$574,520	$5,903	$225,606	$3,477	$809,507
2006 Governor's Allowance	573,092	7,859	220,386	3,815	805,153
Contingent & Back of Bill Reductions	-1,125	-2	-7	-1	-1,135
Adjusted Allowance	**$571,967**	**$7,857**	**$220,380**	**$3,814**	**$804,018**
Amount Change	-$2,552	$1,954	-$5,227	$337	-$5,489
Percent Change	-0.4%	33.1%	-2.3%	9.7%	-0.7%

Where It Goes:

Program Direction	**$196**	
Regular earnings and increments		$368
Other fringe benefit adjustments		90
Savings from abolished positions (4 full-time equivalents (FTEs))		-250
Nonpersonnel changes		-12
Community Mental Health Services	**$ -3,915**	
Fee-for-service Expenditures		
Increase in enrollment/utilization in services to the Medicaid-eligible		31,980
Change in funding available for deficit reduction		-33,750
Savings in Residential Treatment Center (TRC) expenditures from the implementation of wrap-around		-4,600
Funding for services to the Medicaid-ineligible		-1,001
Grants and Contracts Program		
Community mental health expansion as a result of Crownsville closure		5,000
Changes in various federal grants (Shelter Care, PATH, Community Mental Health Services Block Grant, Emergency Response Capacity		234
Other contract changes		222
As yet unspecified cuts to services and programs operated by CSAs		-2,000
Facilities	**-$1,770**	
Personnel Expenses (Excluding Crownsville Savings)		
Retirement contributions		2,312
Social Security contributions		1,360

Where It Goes:

Overtime	1,285
Workers' compensation premium assessment	1,277
Other fringe benefit adjustments	172
Turnover and cost containment	-2,371
Regular earnings and increments (savings from fiscal 2005 and 2006 position abolitions)	-1,767
Employee and retiree health insurance	-166
Other changes	
Hospital drug costs	1,283
Fuel and utilities	849
Somatic care at Springfield Hospital Center	644
Insurance coverage	385
Other	344
Transfer of Maryland Psychiatric Research Center grant to University of Maryland, Baltimore (UMB)	-3,810
Fiscal 2006 savings from the closure of Crownsville	-3,567
Total	**-$5,489**

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

Program Direction

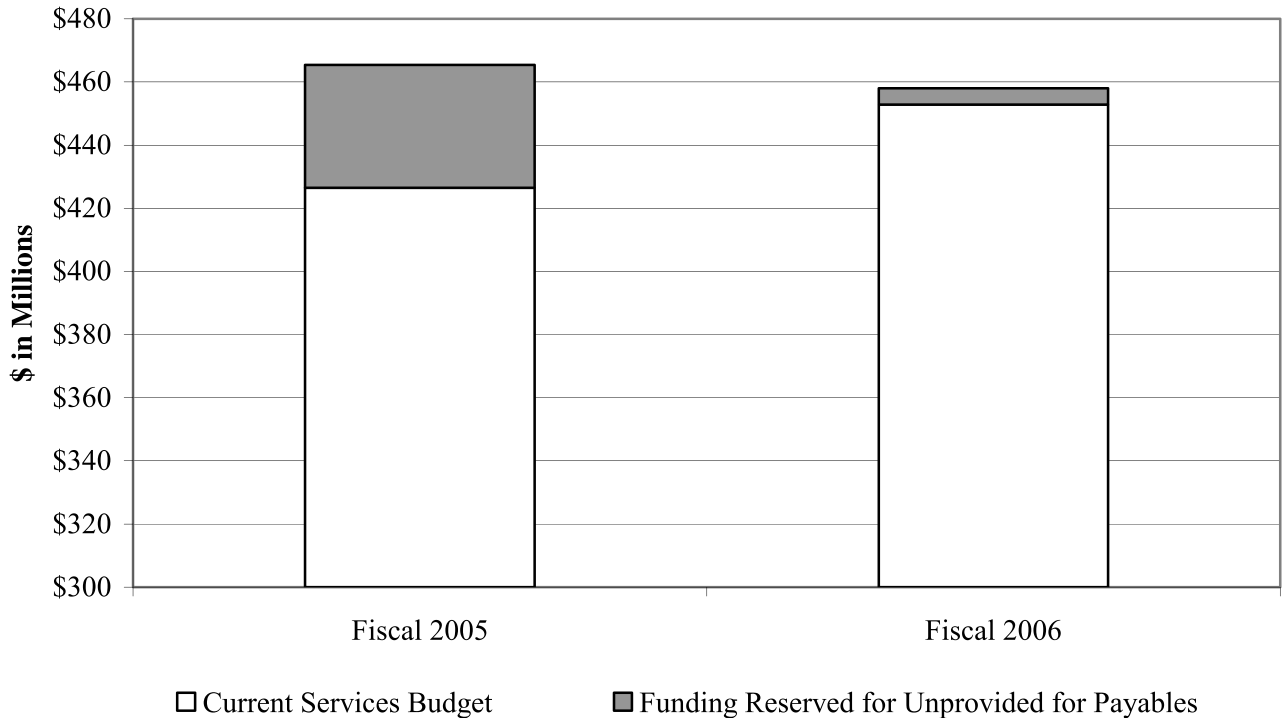
There is little change in program direction. The most striking proposed change is the elimination of four positions. These positions have yet to be identified.

Community Mental Health Services

Overall, fiscal 2006 spending on community mental health services falls by just under $4 million from the fiscal 2005 working appropriation. This decline is driven by a drop of over $7.4 million in the fee-for-service system. However, this drop is misleading because almost $39 million of the fiscal 2005 working appropriation has been reserved by MHA to cover unprovided for payables (discussed in more detail in Issue 1 below). Only a little over $5 million has been reserved for the same purpose in fiscal 2006. As shown in **Exhibit 11**, backing out these reserved funds more clearly shows the proposed growth in fee-for-service expenditures.

Current services growth from fiscal 2005 to 2006 would have amounted to almost $32 million had they not been offset by savings of $4.6 million in residential treatment expenditures assumed in fiscal 2006 with the implementation of a new wrap-around initiative and a $1 million reduction to fee-for-services expenditures on non-Medicaid-eligible clients. It should also be noted that the fiscal 2006 allowance assumes the continuation of a prior cost containment action limiting hospital day limits. This action is estimated to save $11.3 million in fiscal 2006.

Exhibit 11
Community Mental Health Fee-for-service System
Funding for Current Services
Fiscal 2005 – 2006



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

For those community mental health services not delivered through the fee-for-service system, there is an increase of almost $3.5 million. A small amount of this increase ($234,000) is derived from a variety of federal grants. Most of the remaining grants are flat. However, it would be expected that grants and contracts spending would have increased by $5 million in fiscal 2006 to reflect the community mental health expansion funded through savings from Crownsville Hospital Center. While $5 million for program expansion is included in the fiscal 2006 allowance, $2 million in as yet unspecified service and program cuts is also reflected (more detail on the proposed service expansion is provided in the Updates section dealing with the closure of Crownsville).

Facilities

Spending at the State-run psychiatric facilities drops just under $1.8 million. In terms of personnel, aside from changes related to the closure of Crownsville, personnel costs increase by just over $2.1 million. The fiscal 2006 allowance also abolishes 10.6 FTE regular positions as part of a reduction across all the Department of Health and Mental Hygiene (DHMH) facilities of 17.6 FTEs. This reduction is part of an effort to improve the efficiency of dietary operations. In reviewing dietary costs across State facilities, DHMH observed that average costs varied significantly. Currently, dietary services are provided in a wide variety of ways both in terms of State employees versus private contracts as well as the specific method of food preparation.

The increase in personnel costs is more than offset by fiscal 2006 savings from the closure of Crownsville as well as the transfer of the grant for the Maryland Psychiatric Research Center to the budget of UMB. It should be noted that the savings noted here from the closure of Crownsville are not in addition to the $5 million in savings that was expected from the closure in fiscal 2005. Rather, they reflect the fact that fiscal 2005 savings have yet to be transferred to the community mental health services grants and contracts program. Further, it should be noted that the $5 million in assumed savings in fiscal 2005 is not expected to reach that level because costs associated with facility closure were higher than anticipated.

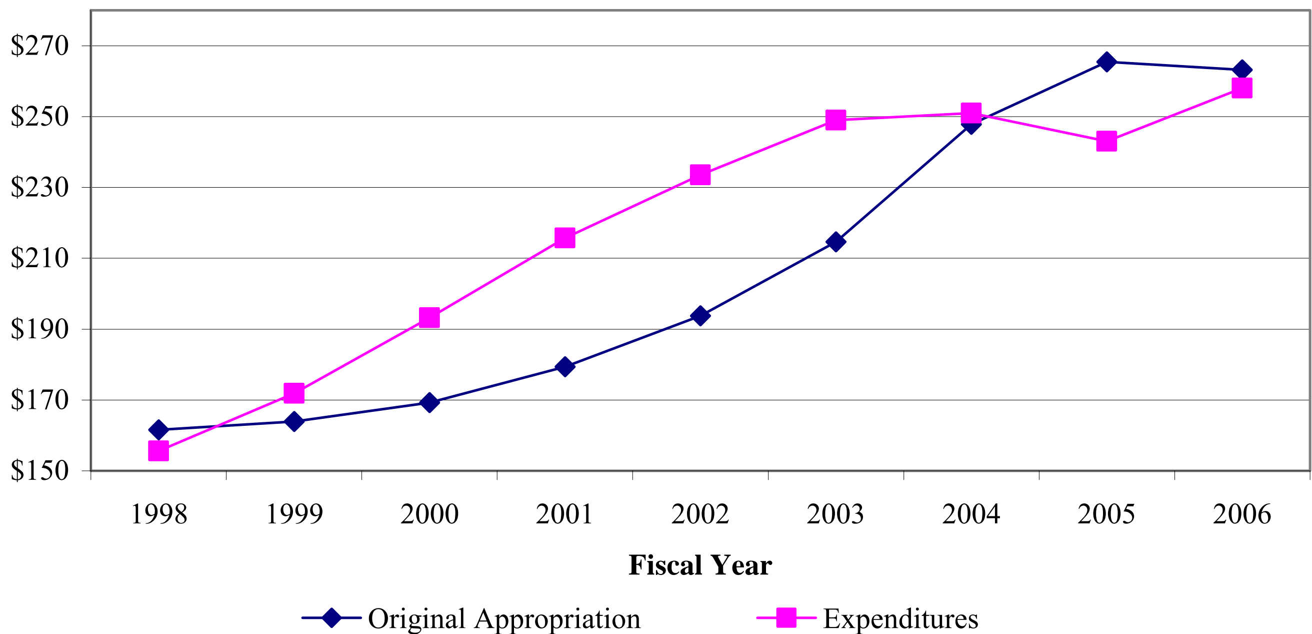
The allowance also shifts just over $2 million of costs from general to special funds to recognize general fund savings from charging of local education authorities for those ancillary services (for example, housekeeping) currently provided for educational programming at the three RICAs. The intent is for MHA to have financial responsibility for only mental health services.

Issues

1. Community Mental Health Fee-for-service Funding: Fiscal Stability but Still Haunted by Ghosts of Budgets Past

For the past several years, budget discussions concerning the fee-for-service community mental health system focused on funding instability. Expenditures on current services in several fiscal years out-stripped the available appropriation by as much as 17%. Deficiency appropriations and other one-time fixes were routinely conjured up in order to try and resolve ongoing deficits. Cost containment measures were proposed, but rarely implemented. However, as shown in **Exhibit 12**, the combination of stronger appropriation growth and the realization of actual savings from cost-containment measures appears to have finally resolved MHA's structural imbalance.

Exhibit 12
Community Mental Health Fee-for-service System
Structural Deficit
($ in Million, General Funds Only)



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

Indeed, as indicated in Exhibit 12, based on the most recent expenditure data, it would appear that MHA will not spend all of its fiscal 2005 appropriation for community mental health services. It is this funding that MHA assumes to begin to pay off two significant deficits.

The Ghosts of Budgets Past

At fiscal 2004 close-out, MHA reported two significant unprovided for payables:

- $19.1 million in prior year bills rolled over into fiscal 2005 and paid for with fiscal 2005 dollars. Based on the most recent data available, that estimate appears reasonable.

- $29.3 million in unattainable federal funds claimed in prior years. This reflects federal funds claimed by MHA and booked with the Comptroller as received from the federal government for which actual attainment appears unlikely. Over the years MHA had reported that there was some problem with unattainable federal funds, but the scale of the problem was not properly disclosed until the Office of Legislative Audits (OLA) fiscal 2003 close-out audit. At that time, anticipated unattainable federal funds exceeded $50 million.

  While MHA has been able to reduce this number by over $20 million in the past fiscal year, the easier claims to resolve have been worked through. While MHA continues to hope that this $29.3 million figure can be further reduced, it is no closer to doing so now than 6 months ago because of the recent transition to a new ASO.

As shown in **Exhibit 13**, using general fund data only, MHA anticipates having just over $22 million in general funds available in fiscal 2005 to pay off prior year deficits and to begin to address the issue of unattainable federal funds. Similarly, in fiscal 2006 MHA estimates being able to resolve another $5.2 million of its federal fund claim problem. Based on DLS's analysis of expenditures, these estimates again appear reasonable. Indeed, MHA's estimate of growth in fiscal 2006 appears rather generous but any unspent funds should be applied to MHA's unprovided for payables.

In summary, MHA appears to have resolved its long-standing structural problems and has made strides addressing problems from prior years. At this point, it might be expected that at the end of fiscal 2006, MHA would report unprovided payables of approximately $20 million. This assumes:

- no unanticipated rate increases;

- the ability to generate the savings in residential treatment expenditures assumed in the fiscal 2006 budget;

- the continuation of savings from hospital day limits; and

- current expenditure trends continue.

Exhibit 13
Community Mental Health Fee-for-service System
($ in Millions, General Funds Only)

	Fiscal 2005	Fiscal 2006
Appropriation	$265.4	$263.2
Projected spending for fee-for-service	243.0	258.0
Unprovided for payables	-48.4	-26.0
Unprovided for payables carried into next fiscal year	**-$26.0**	**-$20.8**

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

2. Residential Treatment Center Capacity

In the 2003 session, the committees requested DHMH to provide them with a report on statewide Residential Treatment Center (RTC) capacity. RTCs are psychiatric institutions providing residential treatment to children and adolescents with severe and chronic emotional disturbances. The request was made based on concern that there was excess RTC capacity and that the three State-run RTCs or RICAs contributed to that over-capacity. DHMH did not provide that report to the committees in time for consideration with the fiscal 2005 budget. However, the report did raise interesting issues for discussion.

Licensed RTC Bed Capacity

As shown in **Exhibit 14**, as of December 2004, there were 751 licensed RTC beds in Maryland. This capacity is relatively unchanged from 2001, when there were 765 licensed beds.

Exhibit 14
RTC Licensed Bed Capacity
December 2004

RTC Facility	Jurisdiction	Licensed Beds	
Private			
Adventist Behavioral at Crownsville	Anne Arundel	26	
Woodbourne Center	Baltimore City	54	
Good Shepherd Center	Baltimore	105	
New Directions at the Hickey School	Baltimore	26	
Mann RTC at Sheppard Pratt	Baltimore	34	*
Villa Marie	Baltimore	86	
Chesapeake Treatment Center	Dorchester	44	
Jefferson School	Frederick	50	
Adventist Behavioral at Potomac Ridge	Montgomery	83	
Sheppard Pratt at Taylor Manor	Howard	17	*
Edgemeade	Prince George's	61	
Private Subtotal		***586***	
State-run			
RICA-Baltimore	Baltimore City	45	
RICA-Montgomery	Montgomery County	80	
RICA-Southern Maryland	Prince George's	40	**
State Subtotal		***165***	
Total		**751**	***

* 17 of the beds at Mann RTC and all 17 of the Sheppard Pratt beds at Taylor Manor are Lisa L. beds. Lisa L. beds were established as part of a settlement agreement to a federal class action lawsuit brought in 1987 that alleged that children and adolescents were being held in State and private psychiatric hospitals after the time that they were ready for discharge.

** While RICA-Southern Maryland has 40 licensed beds, budget documents note that only 32 beds are actually operated.

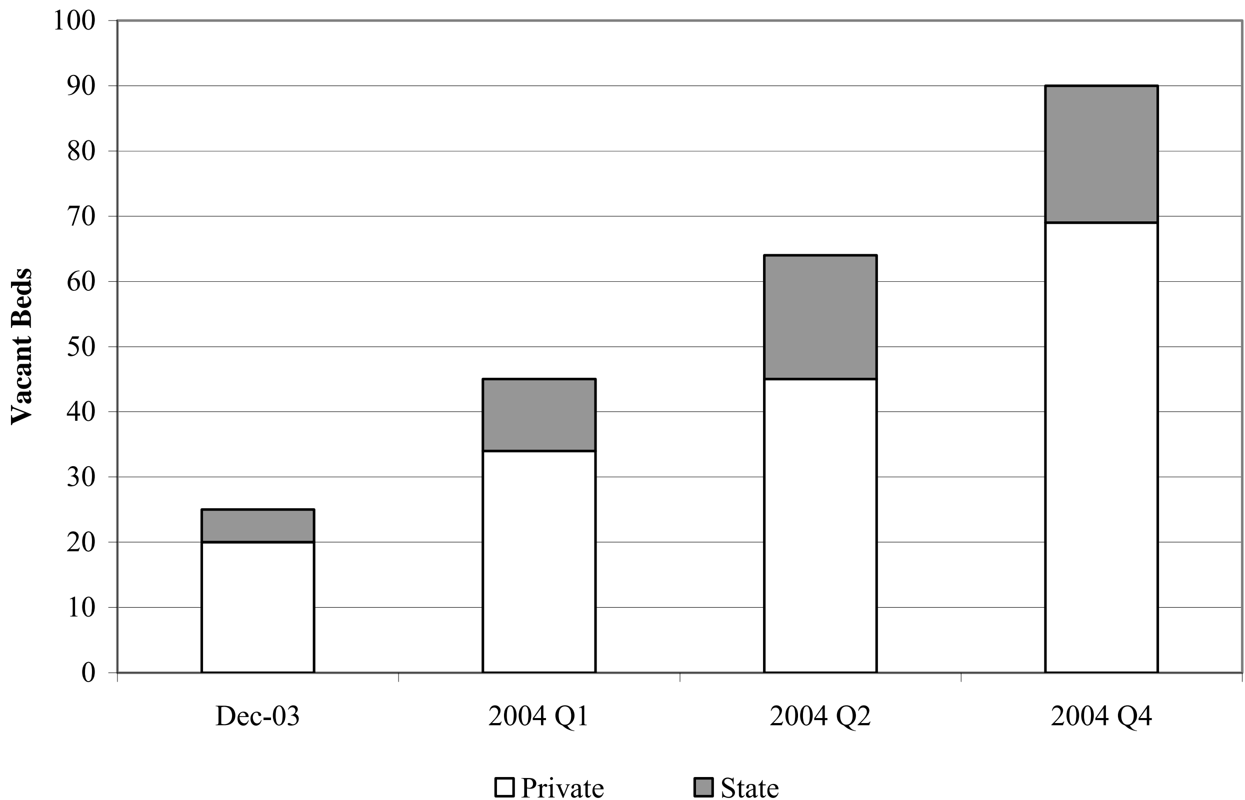
*** Total licensed capacity cited in the DHMH JCR response was 770.

Source: DHMH Office of Health Care Quality; Department of Legislative Services; Maryland Health Care Commission

In terms of vacancy rates, the DHMH report based its analysis on one month, December 2003, when there were 25 reported vacancies. Based on that number and the licensed capacity provided in the report of 770 beds, the report considered RTCs to be operating at 97% capacity, or more than full capacity (90% capacity is considered full capacity based on the turnover of beds).

The 25 reported vacancies figure used as the basis for the analysis was probably a little low. As shown in **Exhibit 15,** using available data for calendar 2004, the number of vacant beds appears to be rising. Between 20 – 25% of these vacant beds are reported at State facilities.

Exhibit 15
RTC Vacant Beds
Various Times



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

Changes in RTC Capacity and Utilization?

Utilizing the 90% capacity figure as the benchmark for full capacity, the RTC system appears to be running at that level. Nevertheless, it appears that the higher number of vacant beds has prompted some private providers to think about downsizing capacity. This question is even more pertinent than at the time of the original report given the proposed reduction to private residential treatment capacity in the fiscal 2006 budget.

As noted above, the State is proposing a $1 million (all general funds) wraparound initiative to be funded in the Subcabinet Fund. The program is a pilot, to be initially developed in Montgomery County and Baltimore City. Wraparound is essentially the development of a service plan tailored to the unique needs of an individual that utilizes community services and natural supports. Services can be traditional (for example, case management, respite care, and after school care) as well as non-traditional (for example, family support activities, art opportunities, and big brother/big sister programs). The intent of wraparound is to divert youth from restrictive residential placements which tend to be more expensive and in the case of juvenile detention programs for example, lacking in extensive treatment options.

There is some evidence that wraparound programs can reduce reliance on residential programs, although it is unclear from the available data if the savings projected for this particular initiative are realistic. At this time, it is not known how many federal dollars will be claimed for the wraparound services used. Certainly, the notion of saving $4.6 million in residential treatment expenditures on the basis of $1 million of wraparound services is extremely optimistic based on data from other programs which have been touted as national models.

It should also be noted that the financial risk associated with the initiative remains solely with MHA even though they are but one of four State agencies that provides the bulk of referrals to RTCs (together with the Department of Human Resources (DHR), Department of Juvenile Services (DJS), and the Maryland State Department of Education (MSDE)).

Nevertheless, the fiscal 2006 allowance assumes the savings and, if realized, will result in lowered demand for approximately 13,100 bed days. This translates into approximately 36 beds. Given the trend in vacant beds and given the comment in the JCR response that "The mission of State RTCs is not to provide services that can be provided by the private sector", it needs to be asked why DHMH did not downsize bed capacity at the State RICAs rather than passing the impact of the cut onto the private providers?

One reason might be that the JCR response contends that "due to the inability or some reluctance to meet the special needs of youth, the private sector has not taken sufficient responsibility for the provision of treatment for these individuals". In other words, the report contends that the State RTCs take the more difficult to handle children. Ironically, a 2004 report prepared for the Governor's Office of Children, Youth, and Families on RTC capacity noted that professionals involved in the residential placement of children and adolescents "felt that RICA facilities were unwilling to accept children with more complicated disorders".

While all of the youth entering an RTC placement have significant mental health needs, it could be argued that the State RTCs are not meeting the needs of the most hard-to-place youth. In recent years DJS has had a significant pending placement problem (that is, youth who are adjudicated delinquent but are kept in secure detention [pre-adjudication] facilities pending placement in a committed facility). The youth that wait the longest for placement are those youth awaiting RTC-level placements. Further, a recently completed gap analysis of DJS treatment options specifically noted the need to develop a RTC-level facility for DJS youth, and DJS itself tried to expand RTC-level care as part of its ultimately aborted 2004 Request for Proposals for the operation of the Hickey School.

Exhibit 16 presents a snap-shot of the referring agency for RTC placements. As shown in the exhibit, as a group (public and private), a third of the youth served were referred from DJS. Broken out, the State RTCs served 29%. Given the problem facing the State in terms of RTC placements for DJS youth and if the purpose of State RTCs is to handle those hard to place, it would seem it is the responsibility of the State RTCs to serve those youth. Indeed, as shown in Exhibit 16, RICA-Southern Maryland and RICA-Baltimore did serve slightly more DJS youth than RTCs as a whole, whereas, RICA-Montgomery did not.

Indeed, while on average only 12% of the youth in RTCS were referred by MSDE, at RICA-Montgomery the figure was 44%. MHA notes that RICA-Montgomery's population contains so many education referrals because of the close links with the local school system. Further, it notes that the State RTCs are not secure facilities, making it difficult to handle youth that require a secure environment. However, that does not seem to be such a problem at RICA-Southern Maryland and RICA-Baltimore. In fact, MHA notes that it has been working with DJS to house up to eight DJS youth at RICA-Southern Maryland.

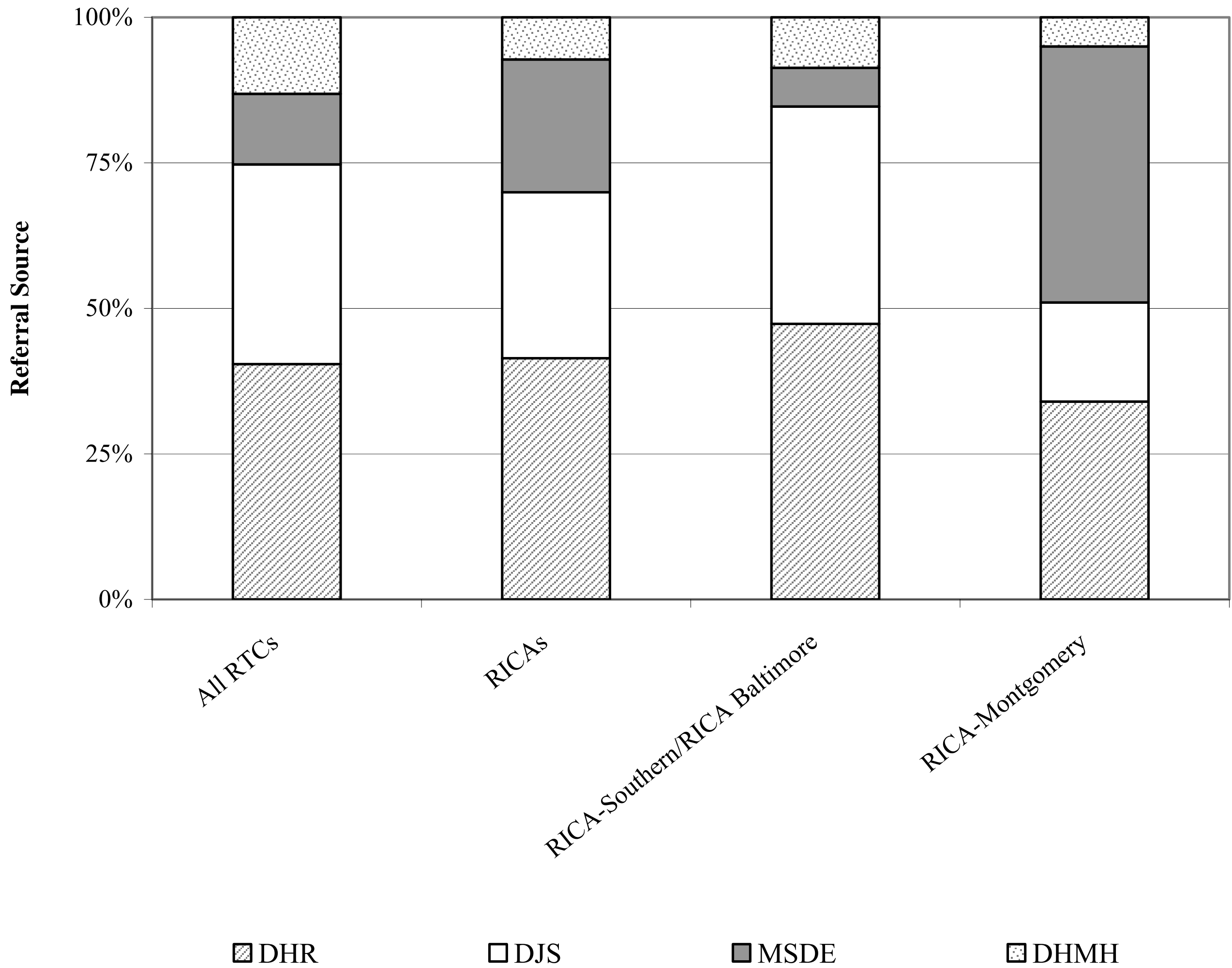
Nevertheless, if the State RTCs are supposed to supplement the private RTCs and take those hard-to-place youth requiring RTC-level care MHA should refocus efforts to change the programming to meet the State's most pressing need. Further, it is MHA that should take the lead responding to the needs of DJS youth requiring RTC-level care because it has more expertise and experience with this population and because the State cannot claim Medicaid dollars for youth in RTC-level care operated by DJS.

Finally, the JCR report and an earlier hospital consolidation report before that both mentioned the possibility of privatizing the State RTC facilities. This option was not pursued in the fiscal 2006 budget.

In summary, there remain significant questions about:

- The extent of State RTC bed capacity especially at a time that RTC bed vacancies are growing and private RTC capacity sector is effectively being cut in the fiscal 2006 allowance; and
- The role of State RTC facilities and if these facilities are doing as much as they can to serve the most hard-to-place youth requiring RTC-level care.

Exhibit 16
RTC Referral Sources



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

DLS recommends withholding funds from MHA until it provides the committees with a detailed proposal for the future use of State RTC beds that reflects current occupancy and funding trends. Part of that proposal should include the development of additional dedicated space for DJS youth that currently languish in pending placement awaiting an RTC bed.

3. Institutions for Mental Diseases Expanded Authority Waiver

Under amendments made to the Social Security Act in 1950, federal assistance for residents in Institutions for Mental Diseases (IMDs) was prohibited as was funding for patients diagnosed with a psychosis found in other medical institutions. IMDs are defined as:

- a hospital, nursing facility, or other institution of more than 16 beds;
- a facility specializing in the treatment of persons with mental illness;
- the current need for institutionalization for at least 50% of the residents results from mental diseases;
- a facility licensed and/or accredited as a psychiatric facility; and
- a facility operating under the jurisdiction of a State mental health authority.

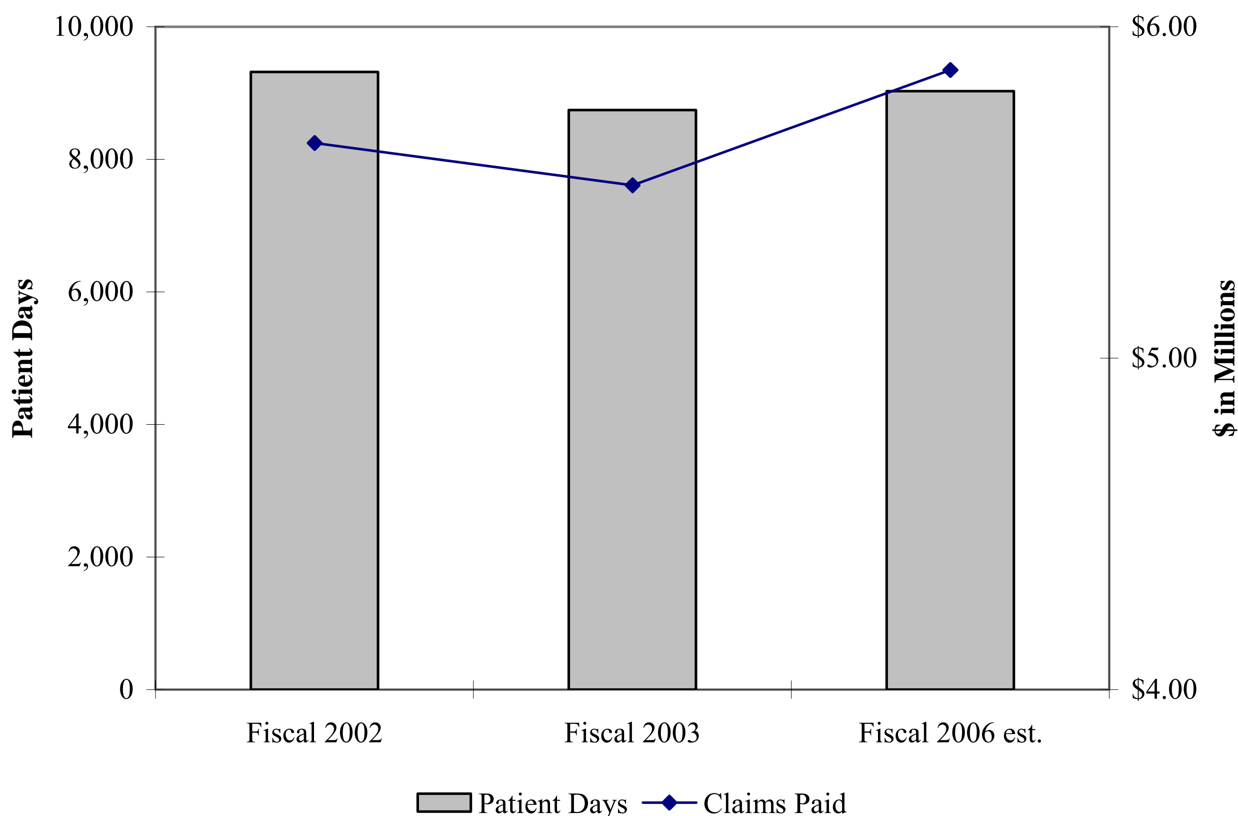
This prohibition was loosened when the Medicaid program was created in 1965 by allowing Medicaid funding for inpatient psychiatric care rendered in general hospitals as well as funding for specific services provided to IMD residents age 65 years and older. Further changes to the Medicaid program came in 1972 and allowed for optional coverage for IMD residents under 21 years of age (or in some limited cases 22 years of age). Thus, the IMD exclusion generally prohibits Medicaid reimbursement for services obtained in IMDs by Medicaid-eligible adults 22-64 years of age.

Since 1998, Maryland has operated mental health services under a Section 1115 waiver that carved out mental health services from the State's program of mandatory managed care for Medicaid recipients. The waiver also granted the State IMD expenditure authority and allowed private psychiatric hospitals to receive payment for 30 days per episode, up to 60 days per year, and 120 days in a lifetime for adult patients ages 22 to 64.

When Maryland's Section 1115 waiver was renewed in 2002, the IMD extended authority was continued. However, the Centers for Medicare and Medicaid Services (CMS) has announced that it is no longer granting IMD expenditure authority waivers, and Maryland expects to lose this authority when its waiver comes up for renewal in 2005. At this time, it is anticipated that CMS will allow full Medicaid billing for IMDs in fiscal 2006, partial (50%) billing in fiscal 2007 before phasing out Medicaid billing in fiscal 2008.

The loss of the waiver will mean either the creation of an estimated 30 beds in State-run psychiatric hospitals to accommodate patients currently served in the private psychiatric hospitals or the State assuming the full cost to continue the current arrangement. As shown in **Exhibit 17**, based on expenditure data on patients under the waiver from fiscal 2002 and 2003, it is estimated in fiscal 2006, there will be just over 9,000 patient days of services provided in Maryland's private

Exhibit 17
Patient Days and Claims for Persons Covered under the IMD Waiver
Various Years



Note: Based on Claims Data through May 2004 which is the most recent data available. Fiscal 2006 estimate assumed an average of the patient days in fiscal 2002 and 2003 at an estimated daily rate of $650.

Source: Maryland Hygiene Administration; Department of Legislative Services

psychiatric hospitals that are paid for by the public mental health system under the waiver. Using an average daily rate of $650 this translates to a total cost of just under $5.9 million, of which just over $2.9 million is general funds. As federal funding is phased out in fiscal 2007 and 2008, additional State dollars ($1.5 million+ in fiscal 2007 and $3 million+ in fiscal 2008) will be required to continue placements in private psychiatric hospital beds.

While assuming the full cost of these beds may be difficult in the current fiscal environment, it does allow the State to better preserve a mental health system that has State-run psychiatric beds catering to patients with more long-term needs and private hospitals serving acute care patients. **MHA should inform the committees if it intends to develop additional capacity at the State-run psychiatric facilities to accommodate patients that are currently served at the private psychiatric hospitals under the IMD waiver or if it intends to back-fill unavailable federal funds with general funds.**

Recommended Actions

1. Add the following language:

   Provided that $500,000 in funds appropriated in Object 01 for salaries and wages at the State-run Psychiatric Facilities may only be spent for the development of community resources to support the placement of patients who are ready to be discharged from State-run Psychiatric Hospitals.

   Explanation: During the closure of Crownsville Hospital at the end of fiscal 2004, $1 million in potential savings was set-aside to serve patients in community settings rather than transfer them to another hospital bed. This action appears to have been successful. There has long been concern that there are patients in State hospitals who could be served in the community if funding was available for community supports (especially housing). The language restricts $500,000 in funding for salaries and wages at the State-run Psychiatric Facilities for additional community placement efforts. Since operational savings are not generally realizable unless the State is able to close wards and not scattered beds, the effort will serve to see if such savings can be garnered in the future. It should be noted that this action should not impinge on the operational programming at the State-run Psychiatric Facilities as budgeted turnover is significantly lower than actual turnover rates.

2. Add the following language:

   , provided that $200,000 of this appropriation may not be expended until the Mental Hygiene Administration includes outcome data as developed through its Outcomes Management System for all providers of community mental health services to adults in its fiscal 2007 Managing for Results submission.

   Explanation: No outcome measures are currently provided to the General Assembly concerning the expenditure of over $400 million for fee-for-service community mental health services. Despite prompting from the legislature, the Mental Hygiene Administration (MHA) has been slow to develop and implement these outcome measures. They are beginning to roll-out an Outcomes Management System, but the pace of roll-out is slow. The language provides an incentive to roll-out that system prior to the submission of the Governor's fiscal 2007 budget.

Information Request	Author	Due Date
Outcome measures for providers of community mental health services to adults	MHA	For inclusion in the fiscal 2007 Managing for Results submission

3. Add the following language:

, provided that $1,000,000 of this appropriation may not be expended until the Department of Health and Mental Hygiene submit a report to the legislature outlining the future use of State Residential Treatment Center beds that reflects current occupancy trends throughout the State's public and private residential treatment centers as well as the additional proposed reduction in private bed use contained in the fiscal 2006 budget. The report should include, but not be limited to, the development of dedicated bed space for youth in the juvenile justice system that cannot be quickly and appropriately placed in a residential treatment facility and thus are confined to secure detention facilities. In developing the report, the department shall work with other Executive Branch agencies as appropriate. The report shall be submitted to the budget committees by October 1, 2005. The budget committees shall have 45 days from receipt of the report for review and comment.

Explanation: In calendar 2004, vacancies at the State's public and private residential treatment centers (RTCs) rose significantly. At the same time, the fiscal 2006 budget includes a $4.6 million reduction in private RTC funding based on the development of a wraparound initiative to divert youth from such placements, thereby further reducing the demand for private RTC capacity. Further, there is concern that the current RTC system does not respond to the needs of the most hard to place youth, and in particular youth in the juvenile justice system. The language withholds funds until the Department of Health and Mental Hygiene (DHMH), in consultation with appropriate other State agencies, produces a report outlining a vision for future RTC capacity that reflects current occupancy and funding trends as well as the specific need to place youth from the juvenile justice system. The language establishes an October 1, 2005, reporting date and a review and comment period.

Information Request	**Author**	**Due Date**
Future use of State and Private RTC capacity	DHMH	October 1, 2005

	Amount Reduction	
4. Reduce funds through generating savings from the expansion of capitation programs. Baltimore City has been operating a capitation project for some years and currently receives almost $9 million to support the initiative. While the project has been noted for delivering services at relatively low cost, the Administration has been slow to replicate the initiative.	$ 500,000	GF
	$ 500,000	FF

5.	Reduce general fund support for contractual employment to the fiscal 2005 working appropriation. The reduction is taken at one institution but may be allocated across all facilities.	377,000	GF
6.	Reduce general funds in the allowance based on the availability of special funds. A recent audit report noted that Spring Grove Hospital charges fees for the training of medical students. These fees are placed in the general donation fund for discretionary expenditures. The reduction directs them to offset general fund expenditures.	85,000	GF
	Total Reductions	**$ 1,462,000**	
	Total General Fund Reductions	**$ 962,000**	
	Total Federal Fund Reductions	**$ 500,000**	

Updates

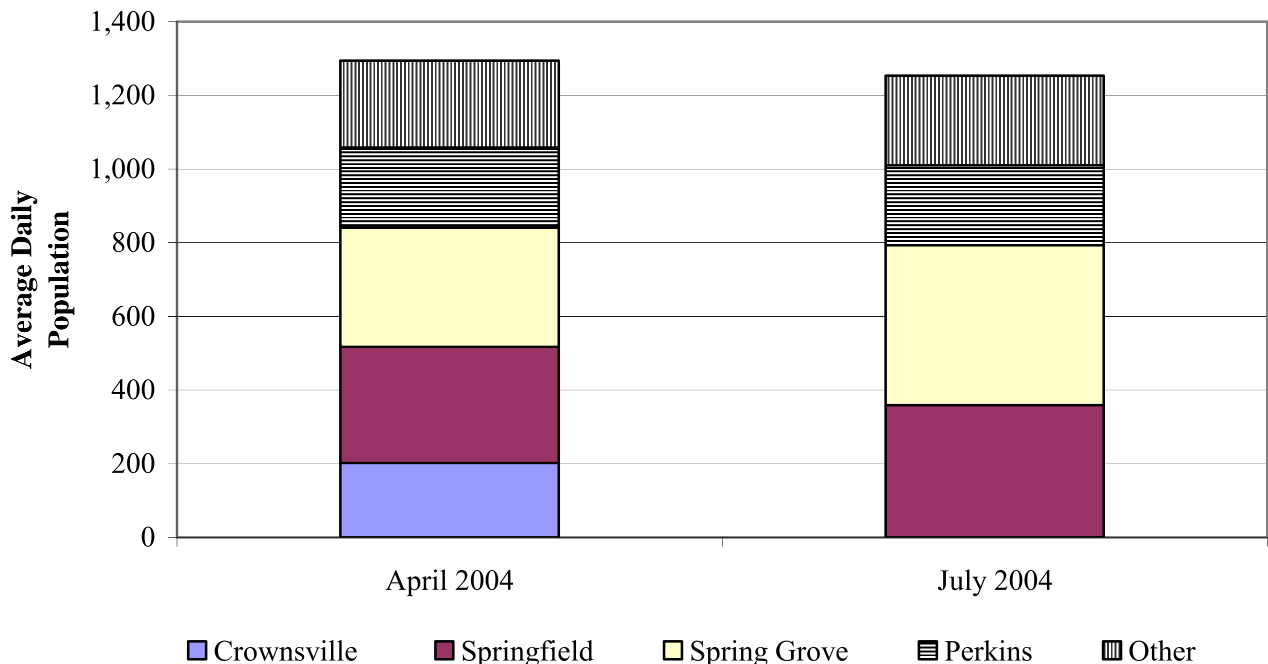
1. Crownsville Hospital Center

The closure of Crownsville Hospital Center to patients was effective July 1, 2004. The closure had numerous repercussions, including the impact on existing patients; the impact on staff; the future re-use of the site; and the generation of savings to be reinvested in community services.

Movement of Patients

In April 2004, there were 202 inpatients at Crownsville. By July 2004, all had been moved to other hospital or community settings. Most patients were transferred to Springfield and Spring Grove Hospitals. A small number of patients were transferred to State Residential Centers for the developmentally disabled. An estimated 16 clients were placed with community providers. As expected and as shown in **Exhibit 18**, the closure of Crownsville has resulted in larger populations at the other two large State-run psychiatric hospitals – Springfield and Spring Grove.

Exhibit 18
State-run Psychiatric Hospital Census
April and July 2004



Source: Department of Legislative Services; Mental Hygiene Administration

It should be noted that a review of resident grievance data reveals no marked change in the pattern of resident grievances at Crownsville in fiscal 2004. This appears to confirm that the transfer of patients from Crownsville was handled successfully.

Movement of Employees

As of January 2004, there were 468.8 authorized FTE positions at Crownsville. According to MHA:

- 336.5 FTE employees were transferred to other State psychiatric facilities;
- 5 FTE employees were transferred to MHA headquarters;
- 63 FTE employees were transferred to other positions in DHMH;
- 25 FTE employees retired;
- 12 FTE employees resigned;
- 3 FTE employees had completed internships and were not offered jobs;
- 5 FTE employees were laid-off; and
- 17.3 FTE vacant positions were transferred to other State psychiatric facilities.

This accounts for 466.8 FTE positions. The status of the other 2 FTE positions is not known.

Future Re-use of Hospital Site

In accordance with fiscal 2005 budget bill language, DHMH has almost completed the Phase I and II environmental impact assessments. An appraisal of the property was due at the end of January 2005, and the Department of Planning has notified agencies that the property is surplus. Interest in the property has to be reported back to them by March. Additionally, there has been legislation introduced in the 2005 session to investigate the possibility of developing a Veterans Home on the site.

Expansion of Community Services

Chapter 429, Acts of 2004 (Fiscal 2005 Budget Bill) included language added by the General Assembly to specifically recognize that a portion of the savings expected from the closure of Crownsville Hospital should be used to expand community mental health services in five counties (the counties that traditionally had been served by Crownsville). However, at the time of budget consideration, DHMH had no clear plan for the expenditure of those funds. Thus, the language withheld the use of those funds until DHMH submitted a plan detailing how the funds would be spent.

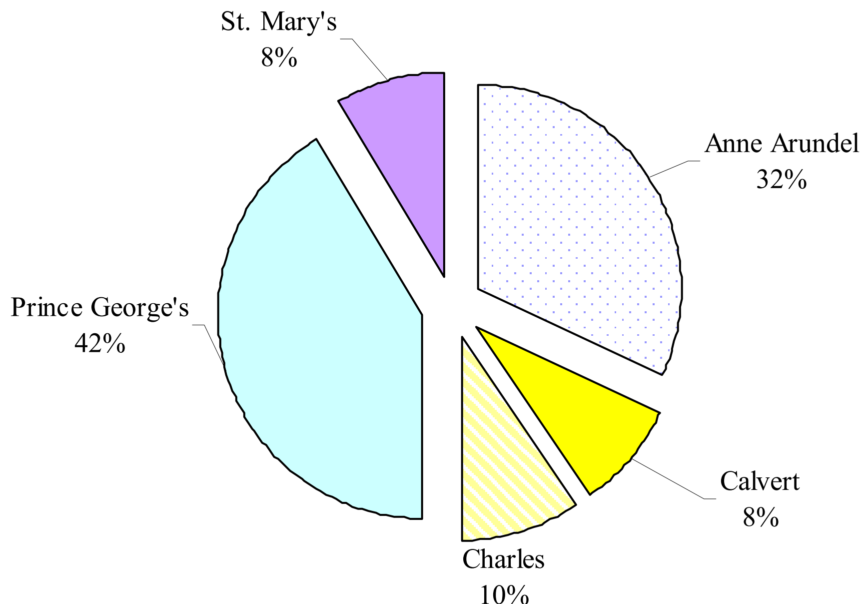
In late October 2004, DHMH submitted its proposed service expansion plan for budget committee review. The focus of the spending plan is twofold:

- Services to adults through an Assertive Community Treatment (ACT) model. This model has seven key elements: services being available at all times; a full array of services being offered including medical, psychiatric, employment, housing, and substance abuse treatment; specified staffing ratios; the use of teams for service delivery; at least 80% of the services are delivered in the community; admission is based on greatest need; and peers are used as staff. Initially, ACT will be used in Anne Arundel and Prince George's counties, spreading to the Southern Maryland counties in fiscal 2006.

- In-home support services to children and adolescents to limit out-of-home and institutional placements. The program will serve youth in all counties.

The allocation of dollars among the counties has been based on the services to be delivered and adjusted by each jurisdiction's population. There will also be one-time start-up costs in fiscal 2005. As shown in **Exhibit 19,** once the programs are fully operational, DLS anticipates that Prince George's County will receive 42% of available funding, Anne Arundel County – 32%, with the remainder split among the three Southern Maryland counties.

Exhibit 19
Community Mental Health Expansion
Proposed Funding Distribution



Source: Department of Legislative Services

In fiscal 2005, DHMH anticipates that the amount of savings from the closure of Crownsville available for community mental health expansion will be $2.5 million. This is in addition to $1 million in savings that has been designated for the movement of patients out of Crownsville into community settings. The $2.5 million for expanded community mental health services is less than originally thought because of higher-than-anticipated costs associated with the hospital closure.

2. Mental Health Services for Young Children

In the 2003 session, it was noted in the MHA budget analysis that the Annie E. Casey Foundation, in conjunction with State and local government officials, academics, and advocacy groups, had recently published a five-year Action Agenda for Maryland to achieve school readiness, an agenda that included a component promoting healthy socio-emotional growth for young children. Action points for that component were:

- to gather data on the current capacity of all counties to provide services and supports to children 0 to 6 and their families;

- to examine State policies and programs focused on children 0 to 6 and identify gaps and areas of overlap;

- to develop a plan to provide mental health consultation to all child care providers; and

- to expand in-service and pre-service training opportunities for professionals interested in early childhood mental health.

This focus on socio-emotional growth was based on 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. MHA, in collaboration with other State agencies, was working on this issue through an Early Childhood Mental Health Steering Committee. The committee, co-chaired by MHA and MSDE, was 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.

In the 2003 session, the budget committees adopted narrative requesting MHA to report back to them prior to the 2004 session on the work of the steering committee in moving forward the Action Agenda. However, that report was not released until after the 2004 session. Key points from the report included:

- There is a need to build an infrastructure and expand capacity in order to infuse mental health services and supports into the multitude of early childhood programs and settings.

- How to incorporate into in service training what providers of services for young children and their families need to know about early childhood mental health.

- Funding remains inadequate.

- While the overall volume of services provided to young children is impressive, there are still service and system gaps.

Chapter 148, Acts of 2003 implemented pilot programs in Baltimore City and the Eastern Shore for enhanced early childhood mental health services, although no evaluation of these pilots has yet been done. At this point, efforts to expand services appear thwarted by a lack of funding. MHA's efforts to seek federal grant support have to date been unsuccessful.

3. Maryland Psychiatric Research Center

The Maryland Psychiatric Research Center (MPRC) had long had a reputation as a leading research institution in the field of mental health, specifically in the area of schizophrenia. Statutorily, oversight of MPRC is shared by DHMH and UMB although State financial support is provided through the MHA budget.

In recent years, the center has embarked on significant programmatic and physical expansion. This expansion coincided with the attainment of a significant research contract with Novartis, a private pharmaceutical company. However, the loss of that contract on September 30, 2003, resulted in significant retrenchment and raised concerns about MPRC's ability to retain its preeminent position.

Chapter 429, Acts of 2004 (the Fiscal 2005 Budget Bill) included language added by the General Assembly expressing intent that the State grant to MPRC be transferred from DHMH to UMB. The intent of this was to enhance financial oversight of MPRC. The transfer was to take place only if DHMH and UMB could reach a written agreement addressing facility issues and any unresolved operating budget concerns.

In July, DHMH and UMB submitted a copy of the agreement reached between them. Specifically, the agreement:

- calls for DHMH to continue to provide clinical support services and access to at least 48 inpatients at Spring Grove Hospital Center, provide appropriate maintenance of Spring Grove facilities assigned to MPRC, and maintain financial support for MPRC's research in Spring Grove's budget at existing levels; and

- calls for UMB to provide oversight of MPRC's finances and research, continue MPRC's provision of patient-based research and services as well as basic research, make efforts to

maximize federal and private funding, and maintain reimbursement to Spring Grove for ancillary services and space at existing levels.

The Governor's fiscal 2006 allowance duly transfers the MPRC grant from MHA to UMB.

4. Management of the Public Mental Health System

During the 2004 session, there was considerable discussion about the future of the public mental health system in its current format. Years of fiscal instability had finally forced real cost containment actions changing the rate structure, tightening implementation of medical necessity criteria, and eliminating the funding for some services. The question arose as to whether the current structure, one in which specialty mental health services are carved out of the system of mandatory managed care for Medicaid recipients, was effective in balancing fiscal stability with quality care. In Chapter 305, Acts of 2004 the legislature established that the carve-out was sufficiently important that it required legislative action to end. However, it was also acknowledged that it was important to investigate possible changes to the current system. JCR narrative from the 2004 session requested such an investigation.

In October 2004, a consultant's report was submitted to MHA proposing new directions for the public mental health system. Recommendations were grouped around four areas:

- **Clinical Design**
  - Ensure that program service standards are clear, that practitioners allowed to provide services are appropriate (in terms of education, experience, and training), and that service standards meet best practices. Initial focus should be on outpatient and psychiatric rehabilitation services.
  - Initiate clinical management, to include a clinical home. Initial focus should be on high-end users.
- **Utilization Management**
  - Consolidate all external utilization management activities at the ASO with all guidelines approved by MHA.
  - Adopt a level of care determination instrument and develop an implementation plan for systemwide use.

- **Network Management**

  - Develop a network management plan that emphasizes any "qualified" and willing provider. Review existing regulations and program standards to determine whether they can serve as certification standards to determine which providers are "qualified."

  - Delegate network management to regionally-organized CSAs after assuring that CSAs divest themselves of direct service provision. This will require the development of a tool to assess the abilities of CSAs to perform this task and potential statutory change to provide CSAs with the authority to manage the local networks.

- **Financing and Financial Management**

  - With the ASO, build a financial/utilization planning and monitoring infrastructure to assure expenditures do not exceed revenues.

  - Develop a monitoring system for case rate payment.

  - Include selected performance risk in the next ASO contract.

  These recommendations address key concerns about the current system. Specifically:

  - that there needs to be a shift towards evidence-based practices and to ensure effective implementation of those practices;

  - that providers are qualified to provide the services that they are offering;

  - that additional oversight needs to be conducted at the local level;

  - that fiscal stability must be attained; and

  - that the current system whereby the State assumes the total risk for expenditures can be altered without changing what has become a touch-stone of the system, namely preserving the carve-out.

At this point, MHA is still in the process of finalizing the proposed implementation activities. It indicates that key areas to be further developed are:

- to design and implement a clinical home for high-end users;

- to establish more robust service and provider requirements consistent with evidence-based or best practices; and

- to re-evaluate the case rate strategy implemented in fiscal 2004.

5. Task Force to Study Access to Mental Health Services

Chapter 224, Acts of 2003 created a Task Force to Study Access to Mental Health Services. This task force was a response to the perceived need to improve access to mental health services for Marylanders with private health insurance. The task force produced an Interim report in December 2003 with a final report submitted in December 2004.

The task force made a series of recommendations around a variety of topics including:

- ***Health Care Benefits:*** For example, ensuring that under the mental health parity law that in-home treatment services and other treatment services outside the traditional clinical setting when medically necessary are not precluded, and creating a State administered insurance product which offers services equal to those in the public system.

- ***Administrative Burden:*** For example, implement an electronic process for physician credentialing, and requiring automatic payment of a disputed claim once a final decision has been made in favor of the consumer or provider.

- ***Education:*** For example, requiring a consumer education program be developed by the Maryland Insurance Administration (MIA) in collaboration with the Attorney General's office to assist consumers insured by commercial carriers understand the benefits to which they are entitled under their benefit plan and under law, and requiring MIA to develop a program for employers to better understand what benefits to choose for their employees.

- ***Oversight:*** For example, establish an ongoing Joint Legislative Committee on Access to Mental Health Services, and requiring the Maryland Health Care Commission to include mental health performance indicators in its annual consumer guides to Maryland HMO and Point of Service (POS) plans.

Appendix 1

Current and Prior Year Budgets

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

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2004					
Legislative Appropriation	$560,620	$2,823	$214,879	$3,895	$782,217
Deficiency Appropriation	916	0	54,000	0	54,916
Budget Amendments	5,038	82	7,455	201	12,776
Cost Containment	-10,100	0	0	0	-10,100
Reversions and Cancellations	-87	-527	-10,438	-232	-11,285
Actual Expenditures	**$556,386**	**$2,378**	**$265,895**	**$3,864**	**$828,524**
Fiscal 2005					
Legislative Appropriation	$571,116	$2,798	$225,606	$3,530	803,050
Budget Amendments	3,404	3,105	0	-53	6,457
Working Appropriation	**$574,520**	**$5,903**	**$225,606**	**$3,477**	**$809,507**

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

Fiscal 2004

The fiscal 2004 legislative appropriation for MHA was increased by just over $46.3 million. This increase was derived as follows:

- A decline of just over $4.2 million in general funds. The appropriation was increased by $916,000 in deficiency appropriations: $200,000 to Springfield Hospital Center and $716,000 to Spring Grove Hospital Center, for work to prepare those facilities to house patients transferred from the closing Crownsville Hospital Center.

  Budget amendments also increased the appropriation by almost $5 million. Of this amount, almost $6.9 million represented the realignment of general funds among various programs in DHMH at fiscal 2004 close-out to close gaps elsewhere. For MHA, the most significant realignment was the addition of funds to the fee-for-service community mental health services system to partially offset ongoing deficits. This increase was offset by the reduction of $1.9 million in unspent health insurance funds. These funds were withdrawn as part of an amendment realigning health insurance spending that ultimately resulted in the reversion of almost $3.2 million in general funds (reflected in the DHMH Administration budget).

  More than offsetting these increases was cost containment of $10.1 million approved by the Board of Public Works (BPW) in July 2003. These cost containment reductions are summarized in **Exhibit 20**.

  General fund reversions also reduced the appropriation by a further $88,000.

- Special funds also declined by $445,000. An increase of $82,000 in budget amendments more than offset by $527,000 in cancellations.

- Federal funds increased by just over $51 million. MHA received a deficiency appropriation of $54 million in federal funds (based on the temporary higher federal fund participation rate enacted by the U.S. Congress to provide fiscal relief to the states). Other federal fund budget amendments totaled just under $7.5 million representing revenues from a variety of federal grant sources. Among the larger grant increases included just over $2.6 million in Community Mental Health Services Block Grant funds, $1.5 million in Medical Assistance funds to cover a variety of CSA activities, $1.1 million to cover costs associated with Hurricane Isabel, $0.7 million in Shelter Plus Care grants, and $0.5 million in Public Health and Social Services Emergency Fund support for various disaster relief activities.

  Federal fund cancellations totaled just under $10.5 million.

- Reimbursable funds declined by $31,000, a combination of budget amendments ($201,000) and cancellations ($232,000).

Exhibit 20
MHA Cost Containment Items Approved by BPW
July 2003
($ in Millions)

Action	**State Funds**	**Total Funds**
Elimination of proxy beds at five hospitals (Carroll, St. Mary's, Union of Cecil, North Arundel, and Peninsula Regional)	$1.2	$1.2
Limit psychiatric rehabilitation services to uninsured to no more than 115 visits per year and requiring written authorization for more than 60 services per year.	1.1	1.1
Substitute federal block grant funds for general fund expenditures.	1.8	0.0
Utilization review of inpatient hospitalization.	2.0	4.0
Utilization review of non-Medicaid eligible services utilized by Medicaid-eligible clients.	3.0	3.0
Expenditure review of prior year hospital expenditures.	1.0	2.0
Total	**$10.1**	**$11.3**

Source: Board of Public Works; Department of Legislative Services

Fiscal 2005

To date, the fiscal 2005 legislative appropriation has been increased by just under $6.5 million. This increase is derived as follows:

- General fund budget amendments totaling just over $3.4 million. Of this just over $2.8 million represents the administration's share of the fiscal 2005 cost-of-living adjustments originally budgeted in DBM, with the remainder reflecting the realignment of salaries in the department following the elimination of positions at the beginning of fiscal 2005.

- Special fund budget amendments of just over $3.1 million. Virtually all of this is an increase to the special fund appropriation at the RICA-Baltimore and relates to funding for education at RICA-Baltimore. In the 2004 session, the legislature made the provision of education services at the three State RICAs subject to the same funding requirements as other nonpublic school education placements. For RICA-Montgomery and RICA-Southern Maryland, where education costs were previously provided through local school systems, this resulted in the elimination of

contractual expenses. However, for RICA-Baltimore, which was providing education services through State-employed teachers as well as additional teaching support provided by various local education authorities that was not previously budgeted, it results in an increase in special fund expenditures to reflect the actual cost of providing those services.

- A reimbursable fund budget amendment reduction of $53,000.

Appendix 2

Audit Findings

Clifton T. Perkins Hospital Center

Audit Period for Last Audit:	January 9, 2001 through October 27, 2003
Issue Date:	April 22, 2004
Number of Findings:	4
Number of Repeat Findings:	2
% of Repeat Findings:	50%
Rating: (if applicable)	N/A

Finding 1: **Perkins did not provide adequate oversight of a housekeeping contract resulting in the overpayment of $146,000. Perkins disagreed with OLA's methodology for calculating payment arguing that it is not a "time and materials" contract but has other specified performance standards.**

Finding 2: Proper internal controls were not established over materials and supplies. Perkins agreed to comply with the recommendation.

Finding 3: **Missing equipment items identified during inventories were not investigated and resolved in a timely manner. Perkins disagreed with the finding and cited receiving notice of compliance with the requirements of the Department of General Services' Inventory Control Manual.**

Finding 4: Supervisory review of payroll adjustments was not always documented. Perkins agreed to comply with the recommendation.

Walter P. Carter Community Mental Health Center

Audit Period for Last Audit:	February 1, 2001 through January 4, 2004
Issue Date:	June 23, 2004
Number of Findings:	4
Number of Repeat Findings:	1
% of Repeat Findings:	25%
Rating: (if applicable)	N/A

Finding 1: Carter did not provide adequate oversight of contracts resulting in the overpayment of $21,300 and the inability to determine if other payments were appropriate. Carter concurred with the finding and recommendation.

Finding 2: **Proper internal controls were not established over the processing of certain disbursement transactions. Carter concurred with the finding and recommendation.**

Finding 3: Carter improperly retained funds totaling $76,300 rather than reverting the funds to the general fund. Carter concurred with the finding and recommendation.

Finding 4: Proper controls were not established over the centers contractual payroll. Carter concurred with the finding and recommendation.

Spring Grove Hospital Center

Audit Period for Last Audit:	Special Review of allegations received through the fraud hotline resulting in the review of time records from July 2003 through February 2004
Issue Date:	August 23, 2004
Number of Findings:	2
Number of Repeat Findings:	N/A
% of Repeat Findings:	N/A
Rating: (if applicable)	N/A

Finding 1: Questionable payments totaling approximately $8,800 were made to a Spring Grove management employee who also worked at another State department. Spring Grove concurred with the finding and noted that the employee had been dismissed.

Finding 2: The same management employee entered into several contracts with another DHMH facility as a private vendor for on-call services in apparent violation of State law and DHMH policy. Spring Grove concurred with the finding and recommendation.

Crownsville Hospital Center

Audit Period for Last Audit:	April 28, 2003 through June 30, 2004
Issue Date:	November 8, 2004
Number of Findings:	2
Number of Repeat Findings:	0
% of Repeat Findings:	N/A
Rating: (if applicable)	N/A

Finding 1: Crownsville had not complied with the provision of an opinion rendered by the State Ethics Commission regarding a former employee's purchase of a motor vehicle donated to the Crownsville Hospital Center auxiliary organization. Crownsville concurred with the finding and recommendation.

Finding 2: Equipment was not properly accounted for. The audit concluded that at the time of the hospital's closure, over 1,800 items valued at over $2.3 million remained on the premises. Crownsville disagreed with this finding contesting that all equipment had been accounted for.

*Bold denotes item repeated in full or part from preceding audit report.

Object/Fund Difference Report
DHMH – Mental Hygiene Administration

Object/Fund	FY04 Actual	FY05 Working Appropriation	FY06 Allowance	FY05 - FY06 Amount Change	Percent Change
Positions					
01 Regular	3530.45	3401.15	3386.55	-14.60	-0.4%
02 Contractual	220.08	189.75	195.88	6.13	3.2%
Total Positions	**3750.53**	**3590.90**	**3582.43**	**-8.47**	**-0.2%**
Objects					
01 Salaries and Wages	$ 192,384,923	$ 200,635,759	$ 202,544,508	$ 1,908,749	1.0%
02 Technical & Spec Fees	9,181,431	7,654,102	8,002,676	348,574	4.6%
03 Communication	1,428,332	1,159,076	965,433	-193,643	-16.7%
04 Travel	148,895	144,605	151,055	6,450	4.5%
06 Fuel & Utilities	10,138,651	9,824,232	9,434,940	-389,292	-4.0%
07 Motor Vehicles	755,582	576,151	623,851	47,700	8.3%
08 Contractual Services	595,970,187	569,981,189	563,059,702	-6,921,487	-1.2%
09 Supplies & Materials	16,278,754	17,377,364	18,246,097	868,733	5.0%
10 Equip - Replacement	852,106	530,383	534,571	4,188	0.8%
11 Equip - Additional	452,420	234,521	127,721	-106,800	-45.5%
12 Grants, Subsidies, and Contributions	285,948	384,064	225,796	-158,268	-41.2%
13 Fixed Charges	570,518	915,363	1,236,639	321,276	35.1%
14 Land & Structures	75,853	90,000	0	-90,000	-100.0%
Total Objects	**$ 828,523,600**	**$ 809,506,809**	**$ 805,152,989**	**-$ 4,353,820**	**-0.5%**
Funds					
01 General Fund	$ 556,386,264	$ 574,519,767	$ 573,092,462	-$ 1,427,305	-0.2%
03 Special Fund	2,378,362	5,903,333	7,858,777	1,955,444	33.1%
05 Federal Fund	265,895,410	225,606,479	220,386,469	-5,220,010	-2.3%
09 Reimbursable Fund	3,863,564	3,477,230	3,815,281	338,051	9.7%
Total Funds	**$ 828,523,600**	**$ 809,506,809**	**$ 805,152,989**	**-$ 4,353,820**	**-0.5%**

Note: The fiscal 2005 appropriation does not include deficiencies, and the fiscal 2006 allowance does not reflect contingent reductions.

Appendix 3

Fiscal Summary
DHMH – Mental Hygiene Administration

Program/Unit	FY04 Actual	FY05 Wrk Approp	FY06 Allowance	Change	FY05 - FY06 % Change
01 Mental Hygiene Administration	$ 575,250,272	$ 551,292,425	$ 547,599,250	-$ 3,693,175	-0.7%
02 Maryland Psychiatric Research Center	3,809,691	3,809,691	0	-3,809,691	-100.0%
03 Walter P. Carter Community Mental Health Center	12,635,946	12,966,278	13,093,428	127,150	1.0%
04 Thomas B. Finan Hospital Center	14,890,381	15,400,324	15,856,252	455,928	3.0%
05 Regional Institute or Children and Adolescents – Baltimore	10,001,987	11,722,204	12,141,672	419,468	3.6%
06 Crownsville Hospital Center	31,607,794	5,914,656	2,347,632	-3,567,024	-60.3%
07 Eastern Shore Hospital Center	14,687,987	15,635,967	15,575,135	-60,832	-0.4%
08 Springfield Hospital Center	54,932,665	65,767,581	67,656,052	1,888,471	2.9%
09 Spring Grove Hospital Center	52,920,841	67,197,414	69,547,392	2,349,978	3.5%
10 Clifton T. Perkins Hospital Center	33,065,498	36,010,199	36,937,536	927,337	2.6%
11 Regional Institute for Children and Adolescents – Montgomery Co.	11,646,709	10,651,451	11,054,634	403,183	3.8%
12 Upper Shore Community Mental Health Center	7,232,532	7,635,540	7,723,846	88,306	1.2%
14 Regional Institute For Children and Adolescents – Southern Maryland	5,841,297	5,503,079	5,620,160	117,081	2.1%
Total Expenditures	**$ 828,523,600**	**$ 809,506,809**	**$ 805,152,989**	**-$ 4,353,820**	**-0.5%**
General Fund	$ 556,386,264	$ 574,519,767	$ 573,092,462	-$ 1,427,305	-0.2%
Special Fund	2,378,362	5,903,333	7,858,777	1,955,444	33.1%
Federal Fund	265,895,410	225,606,479	220,386,469	-5,220,010	-2.3%
Total Appropriations	**$ 824,660,036**	**$ 806,029,579**	**$ 801,337,708**	**-$ 4,691,871**	**-0.6%**
Reimbursable Fund	$ 3,863,564	$ 3,477,230	$ 3,815,281	$ 338,051	9.7%
Total Funds	**$ 828,523,600**	**$ 809,506,809**	**$ 805,152,989**	**-$ 4,353,820**	**-0.5%**

Note: The fiscal 2005 appropriation does not include deficiencies, and the fiscal 2006 allowance does not reflect contingent reductions.

Appendix 4

Fiscal 2006 Cost Containment Actions
As Submitted by the Agency
Estimated Fiscal 2006 Savings
Compated to Fiscal 2005

	Describe Each Cost Saving Action/Efficiency Measure	Program Code	Sub-Program Code	Total Funds	General Funds	Special Funds	Positions Reduced	Impact of Action
MHA	Reduce carryover account in MHA FFS system (to $5 million)	M00L0103	M320	$15,000,000	$15,000,000	-	-	(1)
MHA	Implement wrap-around program with DJS and DHR	M00L0103	M307	4,600,000	2,300,000	-	-	(2)
MHA	Reduce Core Service Agency grants	M00L0102	M208	2,000,000	2,000,000	-	-	(3)
MHA	Reduce mental health community services for uninsured	M00L0102	various	1,000,000	1,000,000	-	-	(4)
MHA	Obtain payment for support costs of education in RICAs	M00L0501	various	-	703,298	-	-	(5)
MHA	Obtain payment for support costs of education in RICAs	M00L1101	various	-	825,514	-	-	(5)
MHA	Obtain payment for support costs of education in RICAs	M00L1401	various	-	517,305	-	-	(5)
MHA	Privatize dietary operations in State hospitals	M00L00	various	670,374	670,374	-	$10.60	(6)
MHA	Increase pharmacy savings in State psychiatric hospitals	M00L0901	MH65	10,000	10,000	-	-	(7)

(1) Reducing the carryover account in the MHA fee-for-service system (to $5,000,000) saves $15,000,000 general funds.

- For several years MHA needed deficiency appropriations to resolve its budget. At the end of fiscal 2004, MHA reported a deficit of $48 million.

- To manage these cost overruns, the following actions have been taken:

- In mid-fiscal 2004, MHA instituted strong cost containment measures, including revisions to the payment methodology for rehabilitation services. The new payment method provides a monthly capitation rate for rehabilitation services. These measures reduced average weekly costs by 9% from the first six months of fiscal 2004 ($9 million) to the second six months ($8.2 million).

- In fiscal 2005 weekly costs are projected at $8.2 million, resulting in a surplus of $22 million, which will be used to reduce the fiscal 2004 carryover deficit. Actual year-to-date costs through January 15 have averaged $8.0 million.

- The fiscal 2006 budget for MHA includes $5 million as part of a two year plan to eliminate the $29 million carryover deficit that is related to inability to obtain federal funds in prior fiscal years. Delaying the payback extends the plan to resolve the carryover deficit into fiscal 2007.

(2) Implementing a wrap-around program with DJS and DHR will save of $4,600,000 total funds; $2,300,000 general funds.

- Currently, DJS and DHR refer children for residential treatment, and MHA pays the costs for this treatment.

- This initiative will reduce the State's reliance on in-patient and residential mental health services for children. MHA provides funding to care for Medicaid children in private hospitals and RTCs, including those referred from DHR, DJS, and MSDE.

(3) Reducing Core Service Agency (CSA) grants saves $2,000,000 general funds. MHA provides $28 million in grants to local core service agencies for mental health services not available through the public mental health fee-for-service system.

- CSAs are the local mental health authorities responsible for planning, managing, and monitoring public mental health services at the local level. CSAs and joint local-state entities. Their organizational structure is approved by the counties. The functions of core service agencies are to plan, develop, and manage a full range of treatment and rehabilitation services for persons with serious mental illness in their jurisdiction

- The proposed reductions have yet to be decided.

(4) Reducing community mental health services for uninsured saves $1,000,000 general funds.

- This proposal would incur savings as the result of tighter management of community services.

(5) Obtaining payment for support costs of education in RICAs saves $2,046,000 general funds.

- RICAs are community-based, public residential, clinical, and educational facilities serving children and adolescents with severe emotional disabilities. The program is designed to provide residential and day treatment for students ranging in age from 10 to 18.

- Budget reconciliation legislation for fiscal 2005 authorized DHMH to bill local education agencies for educational and support costs in the RICA school programs. DHMH has assessed the local school systems for direct education costs in the current fiscal year.

- This item would add the support costs (food, utilities and building services, and therapy costs) in fiscal 2006.

- Overall, the commitments made under Thornton will increase funding for education by approximately $400 million.

(6) Re-engineering dietary operations in MHA hospitals saves $670,374 general funds and a reduction of 10.6 positions.

- The department currently has food service contracts at three facilities with average costs of $6.70 per meal. At facilities operated with State employees the average cost is $8.30 per meal.

- The department proposes to privatize or re-engineer dietary operations in the State hospitals, reducing the cost per meal to approximately $7.30.

- Under re-engineering, State workers could organize to compete for the food service contracts.

(7) Increasing pharmacy savings in State psychiatric hospitals saves $10,000 general funds. This action will reduce pharmacy utilization in the State mental hospitals.

- This action will be achieved through improved management of prescribing patterns in the State facilities.