

M00L
Mental Hygiene Administration
Department of Health and Mental Hygiene

Operating Budget Data

(\$ in Thousands)

	FY 06	FY 07	FY 08	FY 07-08	% Change
	<u>Actual</u>	<u>Working</u>	<u>Allowance</u>	<u>Change</u>	<u>Prior Year</u>
General Fund	\$581,172	\$602,449	\$628,746	\$26,297	4.4%
Special Fund	4,487	4,697	4,995	298	6.4%
Federal Fund	218,864	252,728	263,984	11,255	4.5%
Reimbursable Fund	<u>5,473</u>	<u>4,376</u>	<u>5,242</u>	<u>866</u>	<u>19.8%</u>
Total Funds	\$809,996	\$864,250	\$902,966	\$38,716	4.5%

- The fiscal 2008 allowance for the Mental Hygiene Administration (MHA) is \$38.7 million, 4.5% above the fiscal 2007 working appropriation. After excluding the impact of one-time savings in employee and retiree health care costs, the underlying growth in the budget is \$47.8 million, 6%.
- The most significant increases are in community mental health services. The fiscal 2008 budget includes funding for rate increases as well as the elimination of cost containment measures concerning hospital day limits.
- Facility funding is relatively unchanged. Indeed, the fiscal 2008 allowance seems to present some challenges to the operations of the State-run psychiatric facilities, specifically in the personnel area.

Personnel Data

	FY 06	FY 07	FY 08	FY 07-08
	<u>Actual</u>	<u>Working</u>	<u>Allowance</u>	<u>Change</u>
Regular Positions	3,385.05	3,389.05	3,385.55	-3.50
Contractual FTEs	<u>243.55</u>	<u>210.11</u>	<u>235.22</u>	<u>25.11</u>
Total Personnel	3,628.60	3,599.16	3,620.77	21.61

Vacancy Data: Regular Positions

Turnover, Excluding New Positions	184.85	5.46%
Positions Vacant as of 12/31/06	277.80	8.20%

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

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- There are 3.5 regular full-time equivalent positions abolished in the fiscal 2008 allowance.
- The use of contractual employment increases in the fiscal 2008 allowance, aligning expenditures closer to the most recent actuals.

Analysis in Brief

Major Trends

Community Mental Health Service Enrollment Growth Continues to Be Minimal: Recent trends in enrollment in fee-for-service community mental health services, increases of 1% annually, are predicted to continue.

Expenditure Growth Picks Up: After flattening following the imposition of cost containment measures, expenditures in the fee-for-service system appear to be growing more robustly.

Staffing Concerns and the State-run Psychiatric Facilities: Vacancy rates at the State-run psychiatric facilities are high. While the data collected on hospital performance do not indicate systemic problems, disturbing incidents have recently come to light.

Issues

Forensic Issues: Given that half of all beds in the State-run psychiatric facilities are occupied by forensic patients, issues potentially impacting this population are important. Two disparate issues – a report jointly authored by the Judiciary and MHA on forensic matters and the decision not to move forward with an expansion of Perkins Hospital – are examined.

Emergency Department Utilization: A recent Maryland Health Care Commission report on emergency department overcrowding made a series of recommendations, including a number pointed at MHA.

Transformation Grant: Work under the Transformation Grant process proceeds apace. However, it is unclear if that process will, or can, address what appear to be MHA's most pressing concerns.

Performance-based Contracts: A review of various contracts, grants awards, and fee-for-service rates awarded and established by MHA reveals that more could be done to inject performance into those contracts, awards, and rates.

Recommended Actions

	<u>Funds</u>	<u>Positions</u>
1. Add language concerning the development of a plan for the future role and capacity of State-run psychiatric facilities.		
2. Reduce general fund support for contractual employment in Executive Direction to the most recent actual.	\$ 60,000	
3. Delete 4 long-term vacant positions.	266,213	4.0
4. Adopt narrative concerning the need to maximize enrollment of persons with severe mental illness in the Maryland Primary Adult Care program.		
5. Reduce funds to recognize savings from deferring full phase-out of hospital day limits cost containment.	6,000,000	
6. Adopt narrative concerning the establishment of fiscal 2008 rates.		
Total Reductions	\$ 6,326,213	4.0

Updates

Crownsville: New Anne Arundel County Executive Says “Yes”: A change in county executive brings a change of heart in terms of interest in the former Crownsville Hospital Center property.

Medicaid Audit Indicates Significant Issues with Claims Submissions from the Public Mental Health Fee-for-service System: A recent audit of the Medicaid program indicated significant issues with regard to claims originating from the fee-for-service community mental health system.

M00L – DHMH – Mental Hygiene Administration

M00L
Mental Hygiene Administration
Department of Health and Mental Hygiene

Operating Budget Analysis

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; and
- establishes personnel standards and develops, directs, and assists in the formulation of educational and staff development programs for mental health professionals.

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 (CSA)*** 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.

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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. After fiscal 2003, eligibility for new clients was limited to 116% of FPL. With the development of the Maryland Primary Adult Care (PAC) program beginning in fiscal 2007, persons with severe mental illness with incomes up to 116% of FPL were transitioned to the Medicaid program for the purposes of reimbursement of mental health services. However, a significant pool of non-Medicaid clients who do not meet the eligibility criteria for PAC continues to be served by MHA.

In addition to those services administered by APS, MHA provides grant funds for other services (often delivered through 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 may move into less restrictive settings.

Performance Analysis: Managing for Results

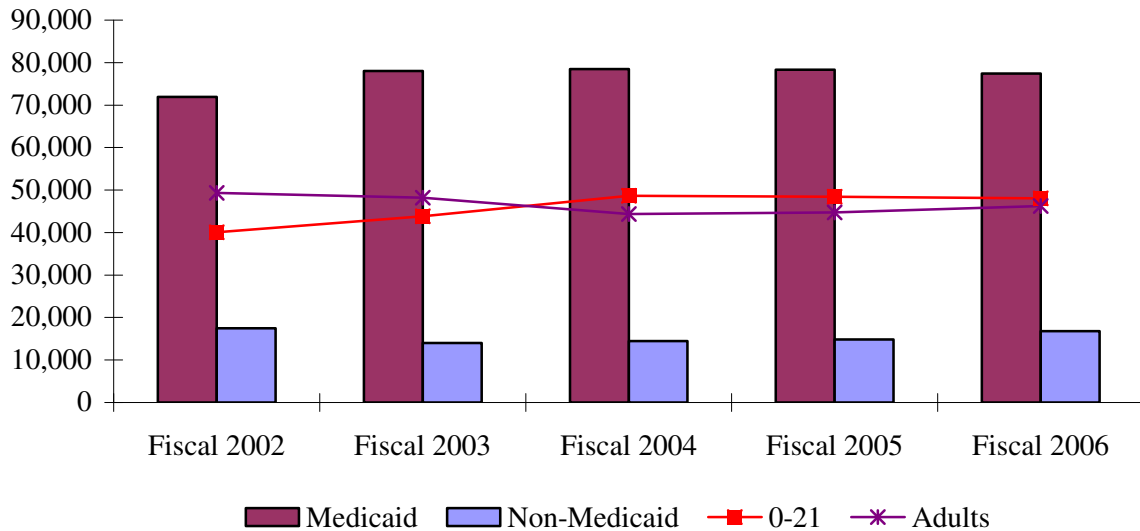
Community Mental Health Fee-for-service System: Enrollment, Utilization, and Expenditure Trends

As shown in **Exhibit 1**, total enrollment in the fee-for-service community mental health system (Medicaid and non-Medicaid) has increased by an average annual rate of 1% between fiscal 2002 and 2006. Looking at the total population served:

- The strongest growth has been amongst children aged 0-21 (5% over the same period), although that growth stopped after fiscal 2004 and the numbers served have essentially been flat since that time.
- The number of adults served actually fell between fiscal 2002 and 2006, due to a decline in the number of geriatric clients. That drop was due to a change in how clients are categorized rather than a drop in services. Specifically, beginning in fiscal 2004, claims for dually eligible Medicaid and Medicare clients were moved from the ASO process to Medicaid. Absent this change, growth amongst adults aged 22-64 was flat, although it rose 4% between fiscal 2005 and 2006.

MHA is predicting continued slow growth in total enrollment of 1% annually from fiscal 2006 through 2008.

Exhibit 1
Community Mental Health Services Enrollment Trends



Note: Data for fiscal 2006 is incomplete.

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

Within the two claims categories of clients served (Medicaid and non-Medicaid), a number of factors have influenced enrollment data:

- As noted above, beginning in fiscal 2004, growth in the Medicaid population served was flat, reflecting the transfer of claims for dually eligible Medicaid and Medicare clients to Medicaid. Without that change, enrollment would have grown in fiscal 2004 before leveling off in fiscal 2005.
- Between fiscal 2005 and 2006, a change in the definition of Medicaid clients was made that excluded clients receiving assistance to pay Medicare premiums (this assistance totaled some 2,265 clients in fiscal 2006). This change masks what would have been a small increase in Medicaid clients and a drop in the Medicaid-ineligible population.

Moving forward, MHA is projecting stronger growth in the Medicaid population and a drop in the Medicaid-ineligible population. This makes sense given the start of the PAC program in fiscal 2007. Under that program, among other benefits, persons with incomes up to 116% of FPL are eligible for specialty mental health services and the State can claim Medicaid reimbursement for those expenditures.

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If eligibility for non-Medicaid fee-for-service specialty mental health services is 116% of FPL, why would all of these persons not be eligible for PAC? During fiscal 2007 budget deliberations, MHA indicated that approximately 45% of its non-Medicaid clients would meet the income criteria for PAC. Subsequently, MHA revised this estimate down to approximately one-third. Even so, to date, it appears that only a quarter of its fiscal 2006 non-Medicaid clients have in fact enrolled in PAC, still below MHA's own data of those that appear to be eligible.

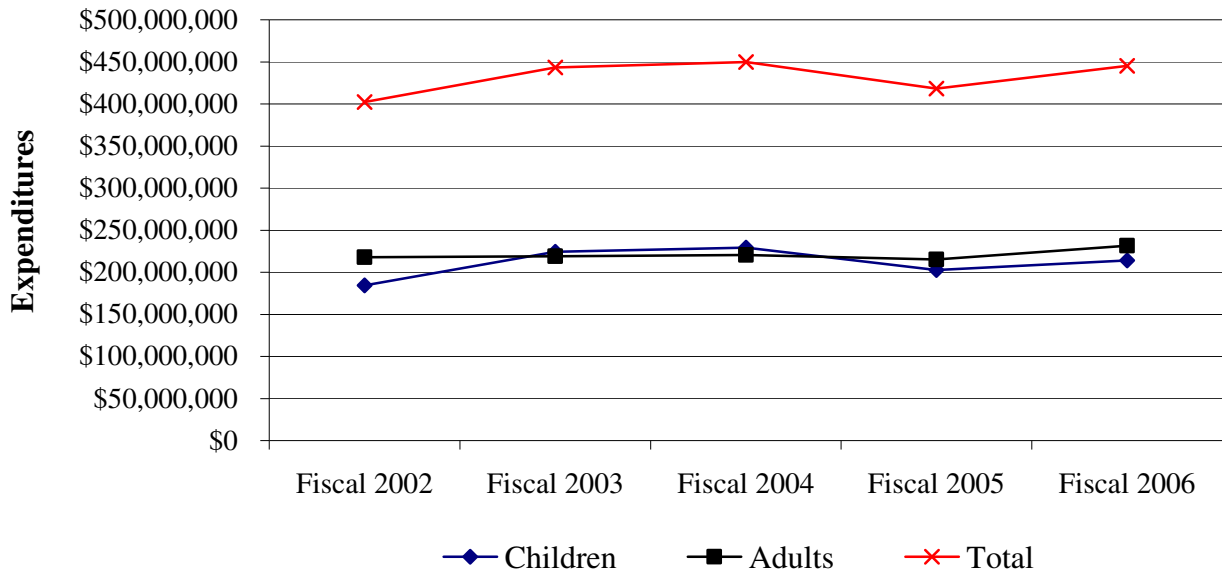
MHA has essentially developed a "safety-net" program for persons with severe mental illness. This safety net, funded at approximately \$100 million per year, consists of two broad elements:

- grant and contract funding provided directly to CSAs and other organizations (including the Baltimore City Capitation Project); and
- participation in the fee-for-service system for a group of individuals (for example, the homeless, persons coming out of jails and prisons, and persons coming out of State psychiatric facilities receiving services as a condition of release) regardless of income criteria.

This having been said, it still appears that MHA together with CSAs could do more to increase eligibility for PAC amongst the non-Medicaid population it continues to serve. For example, over half of the persons served as Medicaid-ineligible in fiscal 2006 indicated that they were homeless. While this particular group has issues with documentation and MHA's focus is clearly on providing services first and worrying about eligibility second, it would appear logical that more of these individuals could be eligible for PAC. **The Department of Legislative Services (DLS) recommends the adoption of narrative requesting MHA to clarify its eligibility criteria for its non-Medicaid eligible population and to develop strategies to maximize the enrollment of this population in the Maryland Primary Adult Care program.**

Spending patterns broadly mirror enrollment growth (**Exhibit 2**), although cost containment actions taken in late fiscal 2004 are easy to identify. As shown in the exhibit, cost containment actions clearly slowed the overall rate of growth in expenditures during the period. Spending on children rose by 4% between fiscal 2002 and 2006, while spending on adults rose 2%, with overall expenditure growth of 3%. However, recent growth has been stronger. Spending growth between fiscal 2005 and 2006 was 6% for children, 8% for adults, and 7% overall.

Exhibit 2
Community Mental Hygiene
Fee-for-service Expenditures



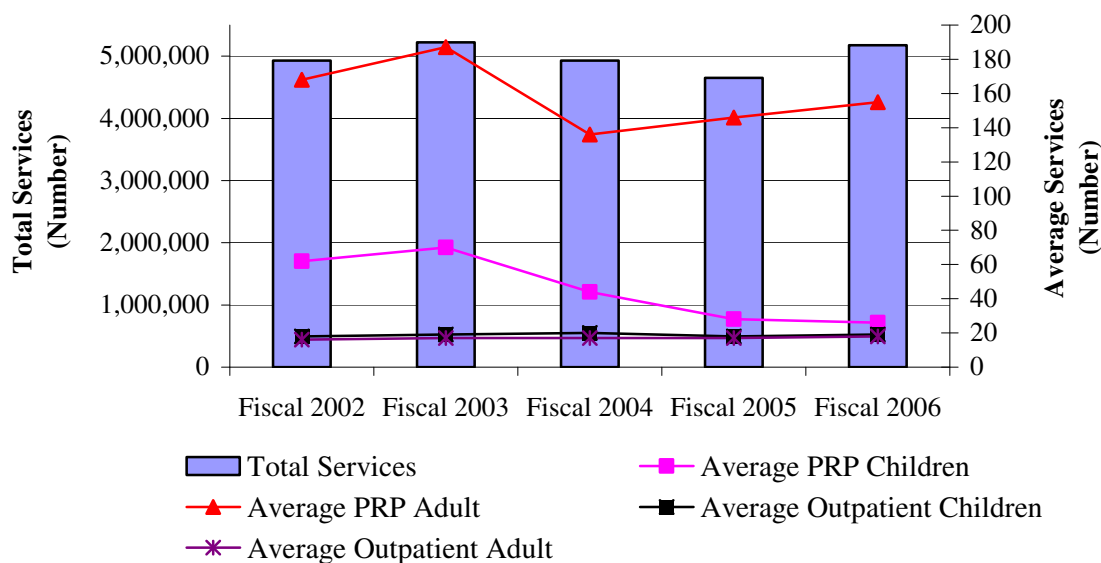
Note: Data for fiscal 2006 is incomplete.

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

Expenditures between fiscal 2006 and 2008 as reflected in the allowance show growth of 8% annually. Given relatively flat enrollment growth, this level of expenditure increase reflects a combination of:

- rate increases implemented in fiscal 2007 and proposed in fiscal 2008;
- the end of the hospital day limit cost containment measure implemented in prior years; and
- a continuation of recent service utilization trends whereby total service and average services used are increasing (see **Exhibit 3**).

**Exhibit 3
Various Service Utilization Measures**



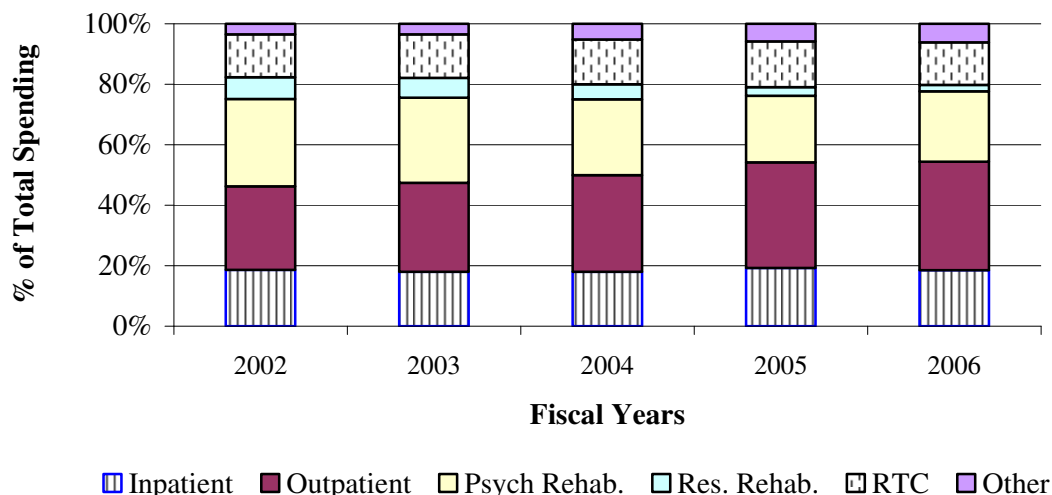
PRP: Psychiatric Rehabilitation Programs

Note: Data for fiscal 2006 is incomplete.

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

Which mental health services are experiencing the most rapid growth? While the fiscal 2006 data is incomplete, as shown in **Exhibit 4**, it confirms the trends from the prior years. Namely, with the imposition of a case rate in February 2004 as well as stronger enforcement of medical necessity criteria, there has been a clear shift away from psychiatric rehabilitation services to outpatient services. For children’s psychiatric services, an additional factor was the decision of MHA not to reimburse for some services that were being provided in schools. It should be noted that the growth in “other” services since fiscal 2004 represents the inclusion of the Baltimore City Capitation Project into this data.

Exhibit 4
Community Mental Health Services Expenditures by Service Type
 (% of Total Expenditures)



RTC: Residential Treatment Center

Note: Data for fiscal 2006 is incomplete.

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. As reported in the fiscal 2007 budget analysis, MHA began to pilot an Outcomes Management System (OMS) that it has been developing over several years. Initially dealing with 18 providers serving adults and encompassing a total of 32 clinical programs, the OMS then began a limited pilot program with child and adolescent providers (6 providers representing 8 programs). Use of the OMS has since been expanded. MHA is currently resolving issues related to this wider implementation, designing methodologies for scoring responses as well as reporting structures and formats. Ultimately, MHA intends to integrate an outcomes management tool within the ASO's web-based authorization system although that is still some way off.

All this being said, for the moment MHA can report only limited outcome data for community mental health services based on survey data of a very small sample of clients (less than 2%):

- the percentage of adults who report that mental health services have allowed them to deal more effectively with daily problems (74% in fiscal 2004, 70% in fiscal 2005, and 76% in fiscal 2006); and

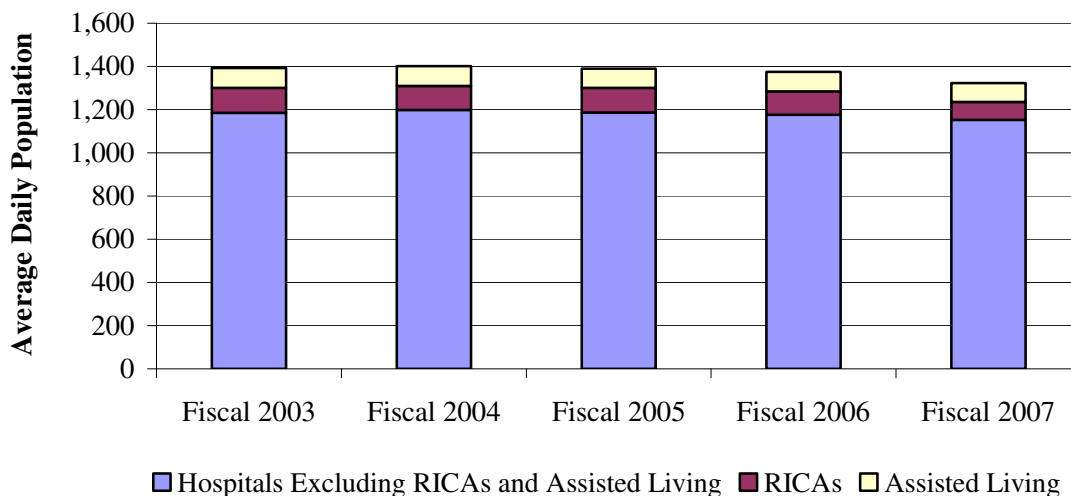
- the percentage of parents/caretakers who report that the child receiving mental health services is better able to control their behavior (53% in fiscal 2004, 55% in fiscal 2005, and 53% in fiscal 2006).

State-run Psychiatric Facilities: Population and Outcome Trends

As shown in **Exhibit 5**, between fiscal 2003 and 2006, the average daily population (ADP) at the State-run psychiatric facilities has remained virtually unchanged. However, in recent months the population served appears to fall:

- A drop of about 25 ADP at the State-run psychiatric hospitals. This drop is scattered across various facilities, although the drop is the largest at the Carter Center. One unit at Carter was recently closed because the State has been unable to procure sufficient contract psychiatrists from the University of Maryland, Baltimore to keep all of the units open. A decline at the Finan Center was also attributed to a lack of psychiatrists. At one point, MHA had to limit admissions to that facility. These actions obviously limit access to State hospital-level care, forcing MHA to purchase additional capacity in community hospital beds.
- A similar drop of about 25 ADP at the 3 RICAs. Part of this relates to MHA changing its methodology for calculating ADP at the RICAs, although it should also be noted that one unit at RICA-Gildner has also recently been closed.

Exhibit 5
State-run Psychiatric Facilities: ADP Trends



ADP: Average Daily Population

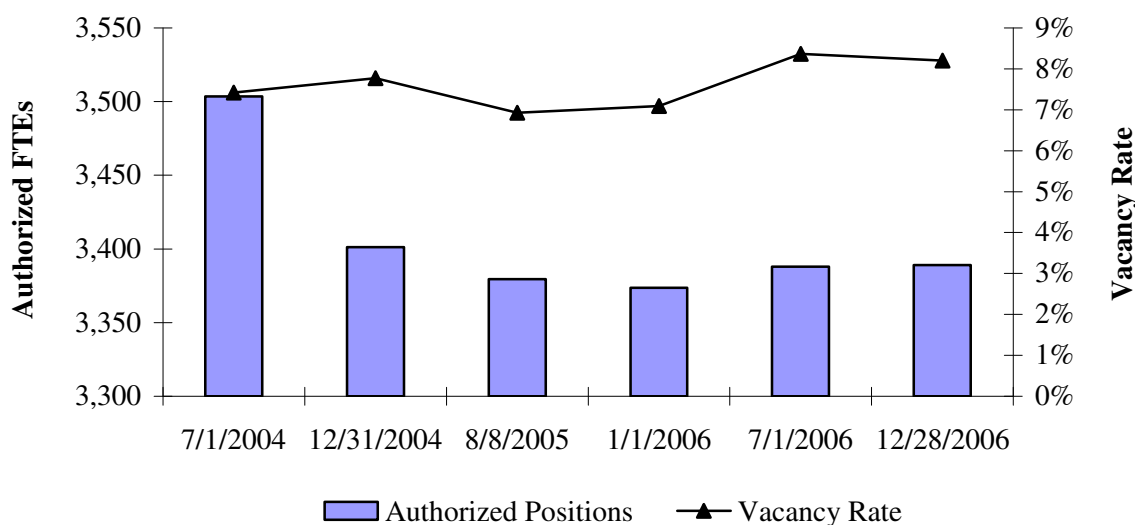
RICA: Regional Institutions for Children and Adolescents

Note: Fiscal 2007 data is through November, 2006

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. As shown in **Exhibit 6**, MHA’s vacancy rate, since the beginning of fiscal 2005, (after the closure of Crownsville) has increased at the same time that the total number of authorized positions has fallen. MHA recently commissioned a staffing study to ascertain staffing needs at the facilities. This study is anticipated in March 2007. MHA has indicated that depending on the results of the study, decisions may need to be made about the overall capacity of State-run psychiatric beds it can operate.

Exhibit 6
MHA Vacancy Rate
Fiscal 2004-2006



FTE: Full-time Equivalent

Source: Department of Legislative Services; Department of Budget and Management

Has quality of care been compromised as a result of staffing shortages? If so, it should be reflected in such things as loss of the Joint Committee on Accreditation of Healthcare 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. However, RICA-Southern Maryland was threatened with the loss of accreditation in the summer of 2006 due to the potential falsification of performance evaluations. In terms of other outcomes, **Exhibits 7, 8, and 9** examine trends in 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
 (% of Total Admissions)

	Fiscal <u>2002</u>	Fiscal <u>2003</u>	Fiscal <u>2004</u>	Fiscal <u>2005</u>	Fiscal <u>2006</u>	Trend <u>2002-2006</u>	Trend <u>2005-2006</u>
Carter	3.7%	3.9%	2.3%	1.7%	4.0%	X	X
Eastern Shore	2.3%	6.5%	5.8%	2.0%	5.9%	X	X
Finan	4.0%	1.7%	1.5%	2.3%	2.2%	☺	☺
Spring Grove	5.1%	4.2%	3.6%	3.5%	3.6%	☺	☺
Springfield	3.7%	5.5%	4.4%	4.6%	4.2%	X	X
Upper Shore	6.1%	5.0%	4.0%	1.3%	2.6%	☺	☺

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

Exhibit 8
State-run Psychiatric Hospitals: Use of Seclusion
 (Rate Per 1,000 Patient Hours)

	Fiscal <u>2002</u>	Fiscal <u>2003</u>	Fiscal <u>2004</u>	Fiscal <u>2005</u>	Fiscal <u>2006</u>	Trend <u>2002-2006</u>	Trend <u>2005-2006</u>
Carter	0.38	0.48	1.16	0.62	0.25	☺	☺
Eastern Shore	0.76	0.76	1.58	2.77	0.55	☺	☺
Finan	0.11	0.17	0.17	0.15	0.08	☺	☺
Spring Grove	0.13	0.33	0.42	0.29	0.10	☺	☺
Springfield	0.88	0.38	0.38	0.29	0.29	☺	No Change
Upper Shore	0.68	1.18	0.97	0.79	1.45	X	X

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

Exhibit 9
State-run Psychiatric Hospitals: Elopements
(Number Per 1,000 Patient Days)

	<u>Fiscal</u> <u>2002</u>	<u>Fiscal</u> <u>2003</u>	<u>Fiscal</u> <u>2004</u>	<u>Fiscal</u> <u>2005</u>	<u>Fiscal</u> <u>2006</u>	<u>Trend</u> <u>2002-2006</u>	<u>Trend</u> <u>2005-2006</u>
Carter	0.00	0.39	0.50	0.05	0.28	X	X
Eastern Shore	0.05	0.22	0.36	0.21	0.11	X	☺
Finan	0.93	0.34	0.25	0.18	0.15	☺	☺
Spring Grove	1.30	0.58	0.30	0.35	0.32	☺	☺
Springfield	0.43	0.47	0.64	0.63	0.51	X	☺
Upper Shore	1.90	1.25	0.85	0.41	0.92	☺	X

Note: 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.

- Long-term trends continue to be mixed in terms of readmissions within 30 days and elopements, but generally positive in terms of the use of seclusion.
- Short-term trends (fiscal 2005 to 2006) are essentially unchanged since the 2006 session. However, three facilities show a higher rate of readmission within 30 days in fiscal 2006 compared to fiscal 2005. Last year only two facilities had a higher rate of readmission over the prior year, and in the 2005 session all facilities showed an improvement over the prior year.
- Compared to national benchmarks, Maryland’s State psychiatric facilities have a low readmission rate within 30 days. According to the Substance Abuse and Mental Health Services Administration (SAMHSA) data, for 45 reporting states and jurisdictions (including Maryland), 8.7% of patients returned to a state hospital within 30 days of discharge.
- Similarly the use of seclusion has a national benchmark of 0.6 per 1,000 patient hours. As shown in Exhibit 8, only one hospital (Upper Shore) is above this benchmark.

While the Managing for Results (MFR) data paints a picture that is essentially little changed in terms of care provided at the State-run psychiatric facilities, there have been a number of individual incidents in the past year that offer a different perspective, although at this point it is hard to know if these incidents are part of a wider systemic problems. These incidents include media

reports of the sexual abuse of patients at the Eastern Shore Hospital Center and a November 2006 report by the Office of Health Care Quality (OHCQ) concerning the quality of care provided to a patient who died subsequent to a broken leg suffered at Spring Grove Hospital Center. Specifically, OHCQ determined that:

- the hospital had failed to review and investigate the alleged fall and subsequent death of a patient;
- nursing staff failed to document evaluation of the care received by the same patient after the patient sustained a fall; and
- the patient's medical record did not document information pertinent to the care and treatment of the patient.

Overall Assessment of the State's Mental Health System

In September 2006, the National Alliance on Mental Illness (NAMI) issued a state-by-state evaluation of the nation's mental health system. The evaluation was based around four categories:

- **Infrastructure:** including an evaluation of innovation in terms of responding to complex problems, prioritization of services to clients with severe and persistent mental illness, addressing health disparities, and workforce development.
- **Information Access:** including access to basic information about services via the Internet and phone, and consumer and family involvement.
- **Services:** including imposition of co-pays, restrictions on antipsychotic medications, wrap-around coverage, addressing the needs of clients with co-occurring disorders, access to inpatient care, and hospital safety and quality issues.
- **Recovery Supports:** including supported employment, supported housing, and other housing issues.

Relative weight was applied to each category, with the greatest emphasis placed on services.

As shown in **Exhibit 10**, while Maryland's grade scores are not high, they are above the national average with the exception of recovery supports. Overall, it has to be said that NAMI is not enthused with the state of mental health systems nationwide as Maryland's C+ actually ranks sixth nationwide. This is actually consistent with the level of mental health spending in Maryland; Maryland's per capita mental health spending also ranking sixth nationally.

Exhibit 10
NAMI: Grading the States – 2006 – Maryland and the United States

<u>Category</u>	<u>Maryland</u>	<u>United States</u>	<u>Maryland Ranking</u>
Infrastructure	C	D	12
Information Access	B	D	5
Services	C+	D+	7
Recovery Supports	C-	C-	27
Overall	C+	D	6

NAMI: National Alliance on Mental Illness

Source: NAMI; Department of Legislative Services

Governor’s Proposed Budget

As shown in **Exhibit 11**, the fiscal 2008 allowance for MHA is an increase of \$38.7 million, 4.5%, over the fiscal 2007 working appropriation. This increase is depressed by the significant one-time savings in employee and retiree health insurance. After adjusting for the impact of that change, the allowance is actually growing by over \$47.8 million, 6%.

Exhibit 11
Governor's Proposed Budget
Mental Hygiene Administration
(\$ in Thousands)

How Much It Grows:	<u>General Fund</u>	<u>Special Fund</u>	<u>Federal Fund</u>	<u>Reimb. Fund</u>	<u>Total</u>
2007 Working Appropriation	\$602,449	\$4,697	\$252,728	\$4,376	\$864,250
2008 Governor's Allowance	<u>628,746</u>	<u>4,995</u>	<u>263,984</u>	<u>5,242</u>	<u>902,966</u>
Amount Change	\$26,297	\$298	\$11,255	\$866	\$38,716
Percent Change	4.4%	6.4%	4.5%	19.8%	4.5%

Where It Goes:

Personnel Expenses	-\$2,088	
Increments and other compensation		\$3,922
Retirement contributions		3,049
Additional step increase for physicians as approved by DBM in November 2006.....		760
Overtime.....		639

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Where It Goes:

Accrued leave payouts.....	134
Shift differentials.....	117
Social Security contributions.....	116
Other fringe benefit adjustments	81
Abolished positions (3.5 FTEs).....	-139
Reclassifications	-345
Workers' Compensation assessment	-1,050
Turnover adjustments (after adjustments for increment requirements).....	-3,273
Employee and retiree health benefits one-time savings	-6,099
Community Mental Health Services	
Fee-for-Service expenditures	36,554
Rate increases for community mental health providers.....	15,898
End of hospital day limits cost containment.....	12,000
Increase in enrollment/utilization	9,095
Fee-for-service expenditures on the uninsured.....	-439
Grants and Contracts	2,116
Mental health services at the Hickey School (reimbursable funds)	1,135
Provider 2% cost-of-living adjustment.....	1,120
Baltimore City capitation project	416
Administrative Services Organization contract.....	258
Adult and juvenile competency evaluations.....	250
Other.....	-132
Seclusion and restraint grant (federal funds).....	-237
Emergency preparedness grant (federal funds)	-320
Community Mental Health Services Block Grant	-374
State-run Psychiatric Facilities	1,779
Contractual employment	949
Off grounds medical care	538
Drug costs.....	407
Food and dietary costs	293
Fuel and utilities (major increase budgeted in DHMH Administration budget)	-408
Other	
Other.....	355
Total	\$38,716

DBM: Department of Budget and Management

FTE: Full-time Equivalent

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

Community Mental Health Services

The major growth area in MHA's budget is for community mental health services. A number of observations may be made about the budget growth in this area:

- There is almost \$16 million in the allowance to provide a rate increase to community mental health providers. The rate increase averages 2% for most providers although higher rate increases are assumed for Residential Treatment Centers (RTCs) (4%) and for inpatient care (7% based on the most recent Health Services Cost Review Commission (HSCRC) hospital update factor). However, MHA indicates that it will be evaluating current rates to determine what services will actually receive rate increases and the levels of those increases. MHA also intends to implement differential rate increases for certain services where providers adhere to evidence-based practices. The proposed fiscal 2008 budget is for this differential rate increase to apply to children's respite services and services to persons with co-occurring illnesses. However, MHA was unable to provide an estimate of the cost of implementing such a rate differential for those services (although it anticipates that initial costs would be low as only a small number of providers can meet evidence-based practice fidelity requirements). **DLS recommends that committee narrative be adopted requiring MHA to submit a report detailing specific fiscal 2008 service rate increases and estimated cost impacts prior to their implementation.**
- For most community providers, the increase is less than the 3.71% update factor recommended by the Community Services Reimbursement Rate Commission.
- Fiscal 2008 funding for services to the Medicaid-ineligible population falls by \$439,000 from the fiscal 2007 working appropriation.
- There is a 2% provider cost-of-living adjustment (COLA) in the grants and contracts budget. The prime beneficiaries of this increase are the CSAs. This is the first COLA provided in this area since fiscal 2002.
- One important fund switch in the fiscal 2008 allowance concerns funding for the Institutions for Mental Diseases (IMDs). Under Maryland's Section 1115 waiver, the State was able to claim matching federal funds for certain services provided at an IMD. Specifically, private psychiatric hospitals could receive federal payments for 30 days per episode, up to 60 days per year, and 120 days in a lifetime for adult patients aged 22 to 64. Maryland lost this authority to claim federal funds when its waiver came up for renewal in 2005. The fiscal 2007 budget assumed partial billing to Medicaid (a 25% federal match rather than 50%), and the fiscal 2008 allowance assumes Medicaid billing being fully phased out. Because the State needs the capacity provided by the IMDs (approximately 1,000 admissions per year), it intends to continue paying for this inpatient treatment solely with general funds. This results in a \$1.9 million additional general fund cost in fiscal 2008.

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- The fiscal 2008 allowance does not contain specific funding for two recent federal demonstration grants received by Maryland:
 - The Money Follows the Person Rebalancing Demonstration Project. It is anticipated that this may involve up to 75 persons with mental illness currently in State-run psychiatric facilities. While it may take 12 months to complete the demonstration planning and operational protocol required before services begin to be funded, there could still be a fiscal 2008 impact, although MHA expects it to be small.
 - RTC Waiver Demonstration Project. As required under Chapter 438 of 2006, MHA applied for and received approval to participate in an RTC Waiver Demonstration Project. Again, it would appear that there could be a fiscal 2008 impact. MHA has indicated that it expects to serve 50 youth in fiscal 2008 at a State cost of \$1.7 million. This amount will increase in successive years as the State serves an additional 25 youth per year up to 150 at the end of year five. No funding is included in the fiscal 2008 allowance for this waiver.
- The allowance includes \$250,000 to support adult and juvenile competency evaluations as provided by Chapter 580 of 2005 and Chapters 353 and 387 of 2006. That legislation requires MHA to perform juvenile competency evaluations and provide competency attainment services as well as establishing new requirements for adult competence reporting. However, the fiscal notes on those bills indicated that expenditures to implement that legislation would be as much as \$880,000 in fiscal 2008 (the bulk of these expenses related to juvenile competency evaluations and services).

It should also be noted that the Subcabinet Fund contains over \$20.5 million in fiscal 2008 to expand services to certain children with mental or developmental disabilities. This funding is available pursuant to Chapter 428 of 2003 that required the establishment of a pool of funding for that purpose that was generated from savings made by attaining federal Medicaid dollars for certain therapeutic costs provided in residential settings. The funding represents savings generated in fiscal 2005 and 2006 that are now being recognized by the State. At this point, the Office for Children is still developing plans for expending these funds.

DLS would comment that these funds could represent a potential funding source to fully support juvenile competency evaluations and competency services as well as children to be served under the RTC demonstration waiver. Additionally, if properly targeted, these funds could be used to significantly reduce or close residential care at one of the State RICAs.

State-run Psychiatric Facilities

Perhaps the most troubling aspect of the MHA budget concerns the operation of the State-run psychiatric facilities. Specifically, in order to fund regular employee increments and other fringe benefits and the additional step increase being provided to physicians, the actual turnover rate that must be assumed in the budget is 7% rather than the budgeted 5.5%. While this level of turnover is

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supported by current vacancy rates, staffing the facilities at that higher vacancy rate raises operating concerns. Further, since higher vacancy rates typically result in higher use of contract labor and overtime, it is unclear if the budget can support potential additional expenses. For example, operating the facilities at a higher vacancy rate in fiscal 2006 cost over \$2 million more in overtime than provided for in the fiscal 2008 allowance.

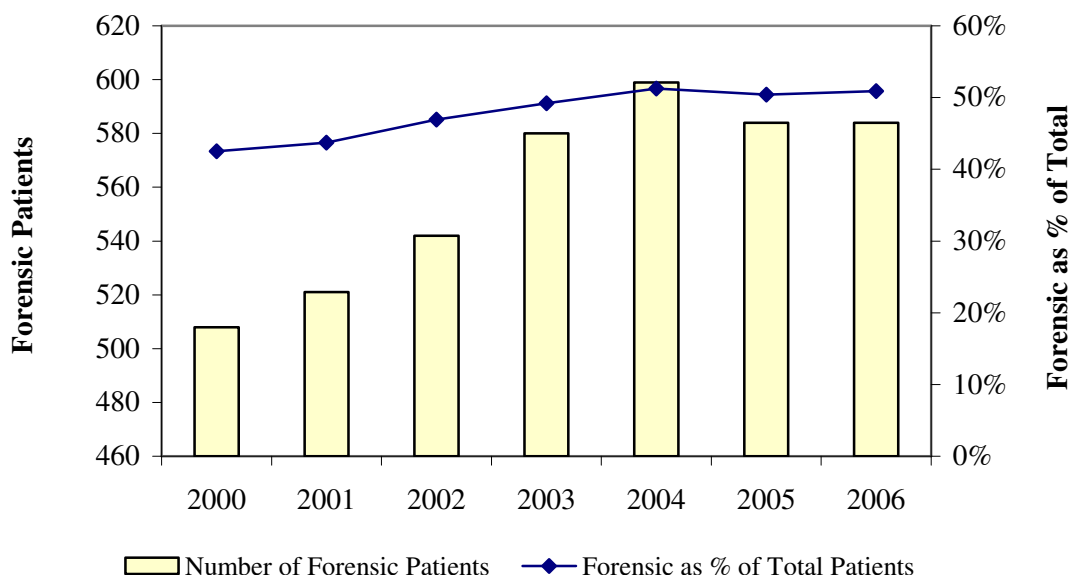
As noted above, MHA has already had to limit admissions and downsize various units in recent months because of staffing issues associated with psychiatrists. It is also awaiting the results of a staffing study from the University of Maryland in March 2007. If that study recommends any immediate increases to staffing ratios at the facilities, MHA may be faced with difficult choices in terms of preserving existing capacity.

Issues

1. Forensic Issues

As has been noted in the prior MHA analyses, an increasing share of the bed capacity at the State-run psychiatric facilities is occupied by forensic patients. Forensic patients include patients court ordered for pretrial evaluations, court committed and not criminally responsible or incompetent to stand trial, and involuntary or voluntary returns from conditional release. As shown in **Exhibit 12**, data from 2006 cements the prior year data: 50% of State-run beds are occupied by adult forensic patients. Excluding admissions to Perkins and RICAs but including admissions to purchase of care beds in private psychiatric hospitals as an alternative to placement in State-run psychiatric hospitals, **Exhibit 13** shows that the number of forensic admissions is also flat. As a percentage of total admissions, forensic admissions have increased as other admissions have shrunk.

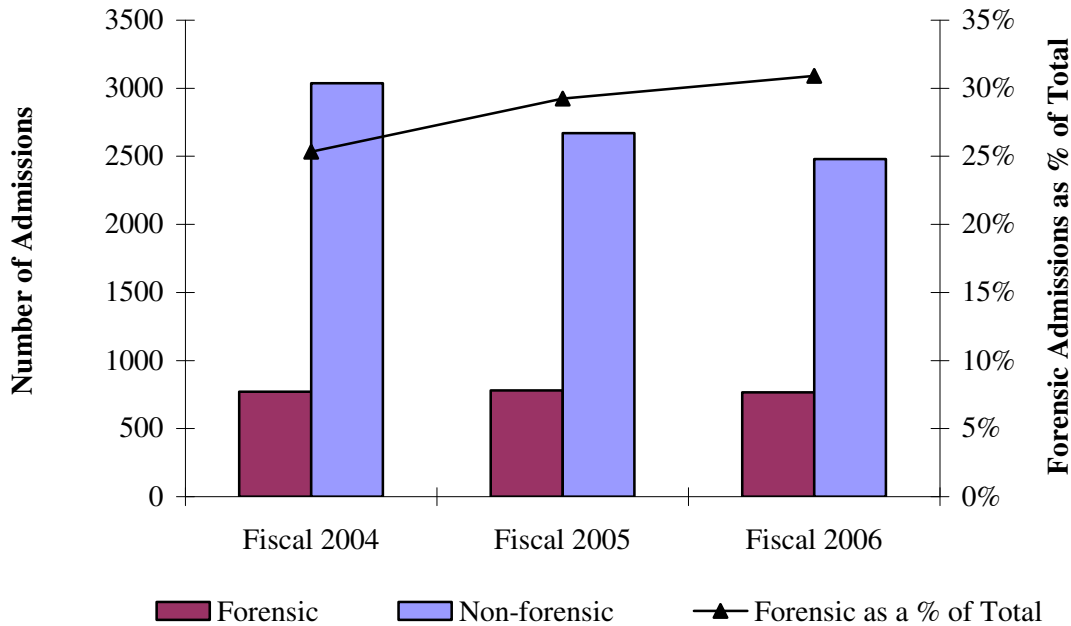
Exhibit 12
State-run Psychiatric Hospitals
Forensic Data
Fiscal 2000-2006



Note: Data is from a one-day census taken every May 14. Excludes juveniles and adults on a juvenile court order. Excludes conditional release patients in domiciliary care at Springfield and Spring Grove.

Source: Mental Hygiene Administration; Department of Legislative Services

**Exhibit 13
State-run Psychiatric Hospitals
Forensic Admissions**



Note: Excludes admissions to Perkins and Regional Institutions for Children and Adolescents. See text for full explanation.

Source: Mental Hygiene Administration; Department of Legislative Services

Given the extent of the forensic population within the State psychiatric system, issues impacting this population are important. There are two disparate issues concerning the forensic population:

- The findings of a report issued jointly by the Judiciary and DHMH concerning the flow of forensic patients into and out of the mental health system; and
- The decision not to extend capacity at Clifton T. Perkins Hospital Center.

Joint Report from the Judiciary and DHMH

In the 2006 *Joint Chairmen’s Report*, narrative was adopted asking DHMH and the Judiciary to jointly examine the issue of demand for forensic beds and to discuss issues relating to interaction between the criminal justice and mental health systems. That report was submitted. Key findings included:

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- The number of evaluation orders, both for competency and criminal responsibility has remained relatively constant. However, the Judiciary clearly believes that this number will increase based on:
 - an increased emphasis on early identification of arrestees with serious mental illness; and
 - the existence of active jail diversion programs.

This will in turn increase the demand for readily accessible resources including inpatient hospital beds, aftercare planning, and community services.

- Lengths of stays for forensic patients are typically longer than for non-forensic patients. This has been the case for some time and is expected based on:
 - the additional time required to conduct evaluations on these patients;
 - the subsequent need to try and restore competence;
 - compliance with reporting required to satisfy the court of the appropriateness of release; and
 - court scheduling.
- There is certainly a documented delay in moving forensic patients out from their hospital stay when determined clinically appropriate. This delay may be days to (atypically) months. Barriers to movement include:
 - the ability to quickly and easily place these patients in a community placement because of the person's criminal involvement; and
 - the lack of housing options that offer the level of care and security needed for individuals with a history of severe mental illness and violent behavior.
- Recommendations of the report included:
 - Continuing to develop partnerships between local health authorities and law enforcement agencies and correctional officials to promote alternatives to incarceration, including the development in Baltimore City, for example, of a crisis intervention unit or center perhaps affiliated with a hospital where police can bring evaluatees for emergency psychiatric evaluations. A key component of such a unit is the ability to effectively serve persons with co-occurring mental illness and substance abuse problems.

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- Coordinating re-entry programs for jail and prison inmates needing mental health services upon their release to the community (something that was the focus of both Chapter 82 of 2005, and Chapter 628 of 2006).
- Continuing to expand awareness among all players in the legal community on both new competency requirements, as well as substance abuse commitments.

In summary, the substance of the report, while not quantifying demand for the State-run psychiatric beds places, certainly places greater emphasis on the need to divert individuals with severe mental illness away from the criminal justice system into appropriate care. To the extent that these individuals are not Medicaid-eligible (and it appears that this is a group currently served by MHA primarily using State-only dollars), this emphasis will add to the demand on a limited community services budget. It will also increase pressure on State-run psychiatric capacity.

The Judiciary and DHMH should be prepared to comment on the ability to provide adequate services to persons with severe mental illness that the Judiciary and DHMH wish to divert from the criminal justice system given the lack of new funding in the MHA budget to accommodate additional diversion.

Expansion of Perkins Deferred

Perkins hospital was established in 1960 and serves as the State's sole maximum security psychiatric hospital. Defendants charged with murder, rape, arson, armed robbery, car jacking, kidnapping, or assault with intent to murder ordinarily receive evaluations at Perkins. The hospital will also handle patients with less serious charges in instances where elopement is a concern or other factors indicate the need for maximum security.

Recent capital bills have included just over \$11.6 million in bond funding to add a 48-bed maximum security wing at Perkins. The project had been delayed, and it appeared that additional funding would be necessary to move forward. However, the fiscal 2008 capital bill not only does not include additional funding, it also deauthorizes previously approved funding, effectively consigning the project to some indeterminate future date if it gets funded at all. At this point it is not included in the 2008-2112 *Capital Improvement Plan*.

The expansion of Perkins was part of the State's proposal to slightly expand overall State-run psychiatric inpatient capacity at the same time that it consolidated that capacity into one fewer facility with the closure of Crownsville. It also reflected the philosophy of the previous Administration concerning the handling of the more serious forensic patients. Specifically, there are two models for handling such clients:

- confining and treating those patients at a maximum security facility; and
- treating those patients in State-run regional psychiatric hospitals with appropriate security procedures in place.

Maryland essentially operates a bifurcated system: operating Perkins but also having a significant number of patients with "Perkins level" charges (an estimated 60) at other State-run psychiatric facilities. In allowing those patients to be served outside of Perkins, a determination is

obviously made that those patients may be treated in a less-secure setting. The prior Administration was uncomfortable with this situation and decided to move forward with an expansion of Perkins.

The decision to deauthorize funding for the expansion of Perkins marks a clearly different direction and raises two issues:

- It appears to limit any near-term expansion in State-run psychiatric capacity (although given staffing issues at the facilities, it is unclear how much of an impact this would actually have had).
- It will require MHA to continue to manage the risks associated with patients that have serious criminal charges, as well as severe mental illness. This may entail operating programming at State-run psychiatric hospitals other than Perkins with a level of security that impinges on the treatment of other patients.

MHA should comment on the risks associated with not moving forward with the expansion of capacity at Perkins.

2. Emergency Department Utilization

The issue of emergency department overcrowding has been receiving much attention nationally and in Maryland in recent years. In the DHMH overview analysis, emergency department utilization data from the HSCRC noted trends in utilization and also focused on utilization by Medicaid recipients as well as Medicaid recipients who present at the emergency department with psychiatric symptoms. The data supported the need for DHMH to more closely examine the utilization of emergency departments by Medicaid recipients as the rate of use by that population was higher compared to the rest of the population.

For MHA, the data indicates the need to reconcile the differences between the data presented in the DHMH overview that showed an increase in inpatient and outpatient admissions to emergency departments among Medicaid recipients presenting with psychiatric symptoms between fiscal 2001 and 2005 with its own data on emergency department usage by persons with severe mental illness which showed little change in the same period.

Further, in its recent report on emergency department overcrowding, the Maryland Health Care Commission (MHCC) made a series of recommendations, including two directly pointed to MHA:

- working with community health centers to improve access to community-based mental health services to limit the use of emergency departments for non-emergent problems; and
- the development of a plan to guide the future role and capacity of State-run psychiatric hospitals in the continuum of care for mental health clients. This plan is needed given the recent decline in inpatient beds for psychiatric patients across all settings (State-run psychiatric hospitals, private psychiatric hospitals, and acute care hospitals).

DLS has three observations about this current discussion on emergency department utilization as it impacts the mental health system:

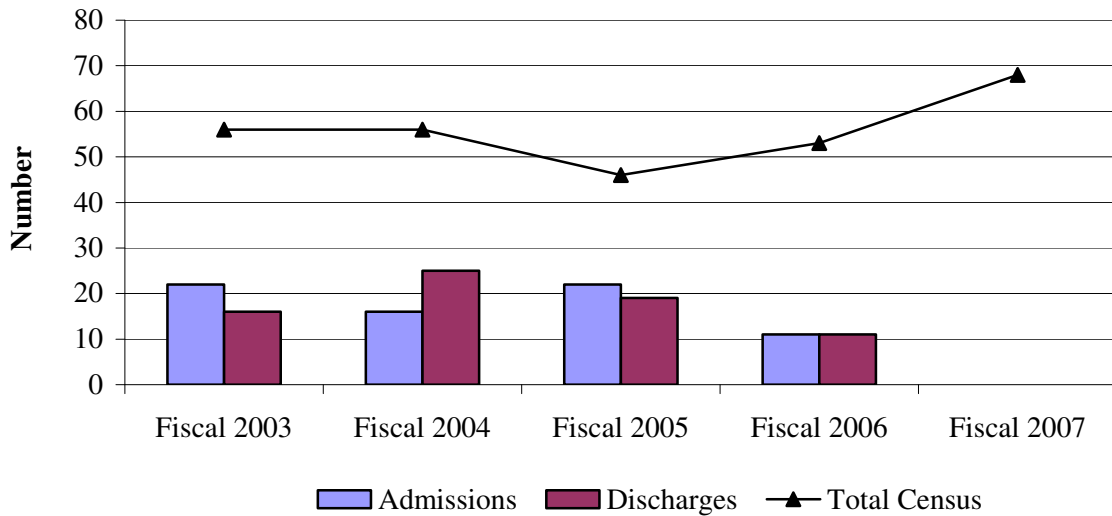
- As noted in the DHMH overview analysis, MHA has a variety of programming aimed at diverting individuals (primarily the uninsured) from emergency departments and also purchasing inpatient care at private psychiatric hospitals when that service is not available at an acute general hospital. Interestingly, diversion programming in Montgomery County was recently developed by recycling existing hospital bed purchase of care dollars. MHA has indicated it wishes to develop similar programming elsewhere, including in Baltimore City again by recycling existing dollars. Certainly, there is nothing in MHA's proposed fiscal 2008 budget that speaks to the ability to fund this expansion.
- It should be noted that limited evidence from Montgomery County's emergency department diversion project points to addictions as a primary problem amongst the population presenting at the emergency department with psychiatric symptoms. This is a population that has always seemed to be difficult to deal with effectively.
- Given the discussion about forensic hospital capacity and staffing issues noted above, a plan to guide the future role and capacity of State psychiatric hospitals in the continuum of care for mental health clients is sorely needed. A report specifically about the role of State psychiatric hospitals was requested in the 2006 *Joint Chairmen's Report*, but that report lacked specificity.

However, that plan should not only address issues about capacity, but also how, if at all, to accommodate the different types of patients using the State-run psychiatric hospitals. This includes not just forensic patients but also the long-standing practice whereby individuals with co-occurring mental illness and developmental disabilities and traumatic brain injury (TBI) are treated in those hospitals. For example, as of January 2007, 68 developmentally disabled individuals eligible or pending eligibility for either the full range of DDA services or individual support services (over half of which are forensic patients), and 27 TBI patients were housed at various State-run psychiatric hospitals. As shown in **Exhibit 14**, the number of developmentally disabled individuals in this category has grown in recent years.

The average length of stay for these developmentally disabled patients is considerable (7.6 years for those patients remaining in State-run psychiatric hospitals as of January 31, 2007), and many of these patients wait for long periods to be appropriately placed. This is a concern for MHA because it is under a consent decree prohibiting the placement of individuals with developmental disabilities on mental health units and because clinical protocols for individuals with developmental disabilities are different to those with mental illness.

DLS recommends withholding funds pending the development of the plan recommended by MHCC. However, that plan should focus not only on demand for beds, but also evaluate the appropriateness of hospital-level care for certain groups as well as assess the current infrastructure of the State-run psychiatric hospitals and the ability of those hospitals to meet all of the different needs of their patients.

Exhibit 14
State-run Psychiatric Hospitals
Developmentally Disabled Eligible/Pending Eligibility Patients



Note: Data is for December of the fiscal year, except for fiscal 2007 which is for January.

Source: Mental Hygiene Administration; Department of Legislative Services

3. Transformation Grant

SAMHSA recently awarded Maryland a \$13.5 million five-year grant (\$2.7 million per year) for the infrastructure development and planning of a system to deliver mental health services in Maryland. No part of these funds may be used for direct care services. Thus, the grant offers Maryland a unique opportunity to identify the need for mental health services, define how those services should ideally be delivered, and develop a plan to implement the changes necessary to deliver the needed services in the best way.

The initial part of the transformation grant process has included the completion of an inventory of resources and needs assessment for all involved agencies and the development of a State Comprehensive Mental Health Plan. The amount of work undertaken in completing the resource inventory and the State Comprehensive Mental Health Plan has been considerable.

Moving forward, the transformation grant process is focusing on such things as developing web sites to improve access to services, anti-stigma initiatives, employment projects, training, and improving the collection of outcomes. These are all valid concerns. However, with some limited exceptions, there seems to be a disconnect between the key issues facing the public mental health system and the issues being dealt with through the transformation process. DLS would characterize those issues as including:

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- Should the current carve-out of specialty mental health services be preserved?
- Does the current funding mechanism provide sufficient resources to maintain access to quality mental health resources? MHA inevitably seems to be competing for resources with the MCOs, nursing homes, and developmental disabilities providers. Over the past five years, it has clearly not been able to compete effectively to enhance provider rates.
- How are safety-net services best delivered, and who should that safety-net encompass?
- Who should deliver acute inpatient care? MHA continues to articulate an inpatient continuum that has private psychiatric and acute care general hospitals delivering acute care, with the State-run psychiatric facilities delivering longer-term care. However, it is by no means clear that all relevant parties accept this model. Indeed, those hospitals may have other models in mind.
- What should be the capacity of the State-run psychiatric facilities?
- How should forensic patients be treated?
- Are current staffing trends at State-run psychiatric hospitals sustainable?

Ultimately, the focus of the Transformation Grant process may simply reflect the requirements of the federal grant itself. **MHA should be prepared to update the committee on the status of the Transformation Grant process and whether the State may use that process to pursue what appear to be its most pressing priorities.**

4. Performance-based Contracts

In recent years, at all levels of government, greater emphasis has been placed on the effectiveness of government programs. In Maryland, this emphasis is best reflected in the MFR process. A natural adjunct of MFR with its development of performance goals and the measurement of outcomes is the concept of performance-based contracting.

Performance-based contracting means different things to different people. However, at its core, performance-based contracting is intended to change the behavior of contractors (and by extension, the agencies overseeing those contracts and contractors) to focus more on performance. Supporters of performance-based contracts point to such potential benefits as the encouragement of contractors to be innovative, increased emphasis on better outcomes and lower costs, and increased accountability (on the part of the contracting agency as well as the contractor). Skeptics note that performance-based contracts are best used for contracts that are well-defined, have accepted metrics, and have a reasonably predicted time-frame for achieving the desired outcomes, something often absent.

Four major service areas were reviewed to assess the extent to which they contain performance elements:

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- Grant awards to CSAs.
- The ASO contract.
- Fee-for-service rates for community mental health services.
- Pharmacy contracts at the State-run psychiatric facilities.

The following observations may be made based on that review:

- MHA's use of specific performance goals is mixed. The administration includes specific performance goals in its ASO and pharmacy contracts. CSA grants include a provision that makes payments for service performed with that grant funding conditional on the achievement of performance standards (and CSAs are certainly collecting outcome data), but no standards are set by MHA. Fee-for-service rates bear no direct relation to performance (not least because the collection of outcome data is still in its infancy). However, MHA did link rate increases in fiscal 2007 in three service areas (family psychoeducation, assertive community treatment (ACT), and supported employment) to evidence-based practices as a proxy for performance.
- No incentives were included in the contracts or grant awards even though MHA collects data that would easily allow it to offer such incentives. In the case of the pharmacy contracts, this data includes national benchmarks against which to measure performance (for example, across all the facilities, the medication error rate was lower than the national benchmark in fiscal 2004 and 2005 but exceeded it in fiscal 2006).
- Incentives in the fee-for-service system are linked to the use of evidence-based practices through higher rates paid for providers faithfully implementing evidence-based practices:
 - Family psychoeducation \$50 per family group per individual versus \$37.
 - ACT \$1,100 per month per recipient versus \$780.
 - Supported employment extended support service \$400 per month versus \$325.
- In terms of ease of attainment of the higher rates, MHA is using the University of Maryland and other groups to provide training as well as fidelity assessments to the evidence-based practice to ensure that recipients are adhering to the model. Based on initial data, meeting fidelity assessments have by no means been a sure thing:
 - For family psychoeducation services, four outpatient mental health clinics requested training through November 2006, two were successful in meeting the fidelity threshold, one clinic was pending its assessment, and another withdrew.
 - For ACT, of the seven mobile treatment teams requesting training, four were successful in meeting the fidelity threshold, one fidelity assessment was pending, one team failed, and one team withdrew.

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- For supported employment, 16 programs requested training, 8 were successful in meeting the fidelity threshold, 7 failed, and 1 was determined as ineligible for the higher rate.
- No penalties are contained in the contracts. As noted above, in the ASO contract for example, MHA establishes plentiful goals in the contract. **Exhibit 15** details some of those goals and also points to the fact that the ASO’s record in meeting those goals is mixed. MHA confirms that it has, in fact never penalized the contractor despite failure to meet goals.

Exhibit 15
ASO Performance Goals and Outcomes
Fiscal 2005-2007 (First Quarter)

	<u>Goal</u>	<u>2005</u>	<u>2006</u>	<u>QI</u> <u>2007</u>
Timeliness of Claims Processing (percent)				
Electronic claims processed in 14 days	100%	98.46%	98.55%	99.33%
Paper claims processed with 21 days	99%	94.00%	91.11%	94.30%
Paper claims processed with 30 days	100%	98.05%	96.33%	99.60%
Call Center Statistics (percent)				
Call abandonment	3%	3.24%	3.20%	1.98%
Wait time less than 3 minutes for referrals	90%			97%
Wait time less than 5 minutes for authorizations	90%			99%
Staffing				
Total ASO staff	85.0	80.3	81.2	78.8

ASO: Administrative Services Organization

QI: First Quarter

Source: Mental Hygiene Administration; Department of Legislative Services

- It should be noted that MHA provides direct care itself through the State-run psychiatric hospitals and RICAs, and in those facilities, there is no direct link between pay and performance as measured in patient outcomes. For example, what limited bonus funding is available, to nurses, is tied to attendance and evaluations rather than outcomes achieved by the facility as a whole.

In summary, while MHA is utilizing elements of performance within its major contracts and programs, more could be done.

Recommended Actions

1. Add the following language to the general fund appropriation:

, provided that \$100,000 of this appropriation may not be expended until the Mental Hygiene Administration, in consultation with the Department of Budget and Management, develops a plan to guide the future role and capacity of State-run psychiatric hospitals in the continuum of care for mental health clients. This plan should include an assessment of the demand for:

- (1) acute care inpatient services;
- (2) evaluation and treatment services for forensic patients, including the treatment of patients with serious criminal charges; and
- (3) services to any other population for which hospital-level care is considered appropriate.

The plan should also make a determination of how best to serve the following patient groups currently found in hospital-level settings:

- (1) persons with co-occurring mental illness and developmental disabilities;
- (2) persons with co-occurring mental illness and substance abuse problems;
- (3) persons with traumatic brain injury;
- (4) persons with mental illness and significant medical acuity; and
- (5) geriatric patients with mental illness.

Finally, the plan should assess the current infrastructure needs at the State-run psychiatric hospitals, and evaluate how able those hospital are to provide appropriate care to patients requiring different levels of security, treatment protocols, and lengths of stay. The plan should be submitted to the budget committees by November 1, 2007. The budget committees shall have 45 days to review and comment on the plan.

Explanation: A recent report from the Maryland Health Care Commission concerning emergency department overcrowding recommended that the Mental Hygiene Administration (MHA) develop a plan to guide the future role and capacity of State-run psychiatric hospitals. This plan is warranted given the many demands on the State-run psychiatric hospitals, the mix of patients served, and the recent decision to at best postpone the expansion of capacity at Perkins Hospital.

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Information Request	Author	Due Date
Future Role and Capacity of State-run Psychiatric Hospitals	MHA in consultation with the Department of Budget and Management	November 1, 2007

		<u>Amount Reduction</u>		<u>Position Reduction</u>
2.	Reduce general fund support for contractual employment in Executive Direction to the most recent actual. As of December 31, 2006, there were 11 vacant positions in the Executive Direction function and the proposed new contractual positions appear to be for ongoing functions.	\$ 60,000	GF	
3.	Delete 4 long-term vacant positions. These positions (#015806, #018562, #018634, and #062167) have all been vacant over 12 months.	204,984	GF	4.0
		61,229	FF	
4.	Adopt the following narrative:			

Mental Health Services to the Medicaid-ineligible: The Mental Hygiene Administration (MHA) serves a significant number of Medicaid-ineligible individuals through the fee-for-service community mental health system. With the development of the Maryland Primary Adult Care (PAC) program, there appeared to be an opportunity to claim federal dollars for a significant amount of the services provided to this population. However, enrollment in PAC by the population has been disappointing. This in part due to MHA providing services to individuals in community settings regardless of income who, but for the availability of those services, could find themselves institutionalized or in the correctional system. However, based on the data available on the non-Medicaid eligible population still served by MHA, the committees remain concerned that the administration could do more to maximize participation in the PAC program. The committees request MHA to report back to them on specific eligibility criteria for services delivered in the fee-for-service system to the Medicaid-ineligible, why MHA has not adopted regulations on services to this population, the barriers to enrolling this population in the PAC program, and strategies to maximize enrollment of this population in the PAC program.

Information Request	Author	Due Date
Mental Health Services to the Medicaid-Ineligible	MHA	October 1, 2007

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	<u>Amount</u> <u>Reduction</u>	<u>Position</u> <u>Reduction</u>
5. Reduce funds to recognize savings from deferring full phase-out of hospital day limits cost containment.	3,000,000	GF
	3,000,000	FF
6. Adopt the following narrative:		

Fiscal 2008 Rates in the Fee-for-service Community Mental Health System: The fiscal 2008 allowance includes almost \$16 million to increase fee-for-service rates for community mental health providers. Except for Residential Treatment Centers and Hospitals, the rate increase averages 2%. However, the Mental Hygiene Administration (MHA) has indicated that it will be evaluating rates to determine which services receive increases and the extent of those increases. MHA has also indicated the intent to implement differential rates for the use of evidence-based practices in children’s respite services and services to individuals with co-occurring illness. Again, however, the specific rates are not known. The committees request MHA to report back to them on the finalized fiscal 2008 rates and cost estimates attached to those proposed rates prior to implementation.

Information Request	Author	Due Date	
Proposed fiscal 2008 Fee-for-service Rates	MHA	30 days prior to implementation	
Total Reductions		\$ 6,326,213	4.0
Total General Fund Reductions		\$ 3,264,984	
Total Federal Fund Reductions		\$ 3,061,229	

Updates

1. Crownsville: New Anne Arundel County Executive Says “Yes”

The closure of Crownsville Hospital Center to patients was effective July 1, 2004. In accordance with fiscal 2005 budget bill language, the Department of Health and Mental Hygiene (DHMH) has completed Phase I and II environmental impact assessments. An appraisal of the property was done, and the Department of Planning notified agencies that the property was surplus. However, the intent from the beginning was that if Anne Arundel County wanted the property, it would be turned over to the county.

The biggest concern about the property was the potential cost of hazardous waste and other clean-up that would be required prior to any subsequent re-use. Based on the State’s assessments:

- clean-up of asbestos for buildings to be renovated or demolished would cost \$3 million;
- lead paint abatement for buildings to be renovated or demolished would cost \$2.2 million; and
- other hazardous waste clean-up would cost \$15,000 – \$20,000.

Anne Arundel County undertook its own comprehensive environmental analysis in September 2005 and concluded that the short-term costs associated with resolving issues at Crownsville would be \$25 million, exclusive of bringing currently occupied buildings up to code. The county executive at that time decided that absent State support to rehabilitate the site, the county would not take control over it.

However, in a turnaround, following the 2006 elections, the new county executive has indicated that he would like the property. At this stage, disposition is still at the clearinghouse. Once that process is complete, the legislature must approve of any transfer, and the department will need to negotiate details of any transfer with Anne Arundel County. No specific timetable has been set.

DHMH continues to maintain the facility and allows the numerous tenants to retain occupancy of buildings. The fiscal 2008 budget includes \$1.5 million in general funds for ongoing maintenance.

2. Medicaid Audit Indicates Significant Issues with Claims Submissions from the Public Mental Health Fee-for-service System

A July 2006 audit of the Medical Care Programs Administration by the Office of Legislative Audits (OLA) included two findings that concerned the handling of claims from the Public Mental Health System:

- In fiscal 2005, \$145 million in claims from MHA were submitted while bypassing automated edits in the Medicaid Management Information System (MMIS) in order to claim federal reimbursement. The automated edits are in place to detect errors. Specifically, in accordance with federal certification, MMIS was designed to pass submitted claims through those

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automated edits in order to be approved for payment. These claims had previously been rejected by system edits because of potential errors (for example, duplicate payments and claims not submitted in a timely manner). OLA identified \$1 million in potentially duplicate charges based on its computer analysis of the claims processed in this manner. DHMH agreed with the OLA finding and indicated that it would process all claims through standard system edits and also document and retain documentation of any overrides of those edits. Medicaid is still preparing a final response to this particular finding based on its own review of the claims data submitted.

- Claims, including those submitted by MHA, continued to be paid beyond the time set in State regulation for payment, namely nine months from the date of service. DHMH concurred with this finding although noted that exceptions to the nine-month rule are permitted.

The department also observed that since specialty mental health claims are approved and paid by the ASO and subsequently submitted in order to obtain federal funds, those claims are not truly claims payments, and the nine-month limit applies to the approval and payment of the claim by ASO but does not apply to any additional time taken to process the claims for federal dollars. While this may be the case, ignoring the State regulation concerning when a claim can be paid has been a problem for MHA in the past and this finding reignites concern about such payments. However, MHA indicates that in the past 10 months, only 43 transactions have been approved by the ASO for claims beyond the 9-month window from the date of service.

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 2006					
Legislative Appropriation	\$571,717	\$7,858	\$219,884	\$3,815	\$803,275
Deficiency Appropriation	2,500	0	1,899	0	4,399
Budget Amendments	7,044	-3,203	4,205	1,780	9,826
Reversions and Cancellations	-89	-168	-7,124	-122	-7,504
Actual Expenditures	\$581,172	\$4,487	\$218,864	\$5,473	\$809,996
Fiscal 2007					
Legislative Appropriation	\$598,274	\$3,408	\$249,780	\$3,996	\$855,458
Budget Amendments	4,174	1,289	2,948	380	8,792
Working Appropriation	\$602,449	\$4,697	\$252,728	\$4,376	\$864,250

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

Fiscal 2006

The fiscal 2006 legislative appropriation for MHA was increased by just over \$6.7 million. This increase was derived as follows:

- Deficiency appropriations added almost \$4.4 million. Of this amount, \$2.5 million in general funds was required to support higher fuel and utility costs. An increase in federal funds of \$1.9 million represented the first installment of a federal SAMHSA Mental Health Transformation Grant. SAMHSA has awarded Maryland a \$13.5 million five-year grant for the infrastructure development and planning of a system to deliver mental health services in Maryland.
- An increase in just over \$9.8 million through budget amendments. Specifically:
 - General fund budget amendments increased the legislative appropriation by just over \$7 million. This increase is almost entirely explained by several large amendments. Three increased the appropriation. First, an increase of \$4.57 million transferred from the Department of Budget and Management (DBM) to supplement underfunded health insurance costs. Second, \$3.5 million transferred from the Maryland State Department of Education (MSDE) as authorized by budget bill language in Chapter 443 of 2005 (the fiscal 2006 budget bill). The transferred funds are derived from funds appropriated in MSDE for nonpublic placements and are to be used to support education costs at the three State-operated RICAs. Chapter 444 of 2005 (Budget Reconciliation and Financing Act) removed education at the three RICAs from the nonpublic placement formula thereby returning responsibility for education costs to the State rather than being a shared State and local responsibility as provided for under the formula. However, no funds for education at the RICAs were provided in the fiscal 2006 budget for the RICAs thus necessitating the transfer. The 2005 action reverses the action taken in Chapter 430 of 2004. Third, \$2.3 million represents MHA's share of the fiscal 2006 COLA originally budgeted in DBM.

Partially offsetting this increase were actions in two other amendments. First, a closeout amendment transferred just under \$3.2 million out of MHA's budget to offset higher than anticipated expenditures in other DHMH units. This funding was derived from lower than anticipated expenditures on Medicaid-eligible clients. A second close-out amendment reduced general fund expenditures for health insurance by a further \$184,000.

- Special fund budget amendments decreased the legislative appropriation by just over \$3.2 million. The major change was the reduction of \$3.5 million in special funds that was a corollary of the increased general fund appropriation resulting from the transfer of funds from MSDE for education at the three RICAs noted above. This reduction was partially offset by a variety of increased special fund expenditures for software, equipment, training, dietary, fuel and utility, housekeeping, and laundry services. Special funds for these expenditures were derived from a variety of sources such as patient workshops, tenant income, and grants.

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- Federal fund budget amendments added just over \$4.2 million to the legislative appropriation. The major items included in this increase were almost \$2.3 million based on expectation of federal fund attainment in the fee-for-service specialty mental health services program (although even at the time of submittal it was clear that this expectation was going to be unrealized and simply add to the level of federal fund cancellations), almost \$1.7 million in additional Mental Health Transformation Grant funds, and almost \$261,000 in additional federal Medicaid attainment supporting a variety of personnel and information technology expenses in Program Direction.
- Reimbursable budget amendments added just under \$1.8 million to the legislative appropriation. Major expenditures included \$733,000 in emergency preparedness training, \$612,000 to support a grant for Baltimore Mental Health Services to provide mental health services at the Hickey School, and \$386,000 to support a grant to Howard County's CSA to develop outreach efforts in order to ensure that relocated Hurricane Katrina victims received appropriate mental health care. The remaining funds were derived from a variety of sources to support such things as higher fuel and utility expenses, and personnel costs associated with discharge planning for institutionalized children and adolescents.
- The increase to the legislative appropriation derived from deficiencies and budget amendments was partially offset by just over \$7.5 million in reversions and special, federal, and reimbursable fund cancellations. Virtually all of this, almost \$7.1 million, relates to overestimates of federal fund attainment in the fee-for-service community mental health services program.

Fiscal 2007

To date, the fiscal 2006 legislative appropriation has been increased by just under \$8.8 million. This increase is derived as follows:

- General fund budget amendments have increased the appropriation by almost \$4.2 million. Increases include \$3 million representing MHA's share of the fiscal 2007 COLA originally budgeted in DBM, \$2.3 million for higher than budgeted utility costs (funding transferred from the AIDS Administration that had been intended to offset the loss of drug rebate funds as a result of an accounting change, a change that was preempted by legislation enacted during the 2006 session), \$1.2 million in funding transferred from DBM to support various annual salary reviews at the State psychiatric facilities, and a further \$619,000 in internal transfers within DHMH that is also attributed to the cost of the fiscal 2007 COLA. These increases were reduced by the transfer out of MHA of almost \$3 million to the Family Health Administration to support an operating grant subsidy for Prince George's County Hospital. This transfer was in turn offset by an increase in federal funds noted below.

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- A special fund budget amendment of almost \$1.3 million, virtually all due to an increase at RICA Baltimore. All of these funds are derived from local education agencies (primarily Baltimore County), and will be used to cover the cost of educational services provided at RICA Baltimore. As noted above, in 2005 Budget Reconciliation and Financing legislation, DHMH was prohibited from billing local education agencies for services at the three State-operated RICAs. However, local education agencies retained the discretion to fund services at those facilities that would otherwise not be provided without that funding. DHMH did not anticipate that these funds would be received in fiscal 2007. However, at RICA-Baltimore, locally funded services have continued to be provided.
- Federal funds are increased by almost \$3 million to offset the transfer of general funds to support a Prince George’s County Hospital operating subsidy noted above. These funds are available through higher prior year Medicaid attainment and higher than anticipated Community Mental Health Services Block Grant funding.
- A reimbursable fund budget amendment increase of \$380,000, \$280,000 for emergency preparedness training, and \$100,000 related to a study of supported employment services.

Audit Findings

Administrative Unit	Springfield Hospital Center
Audit Period for Last Audit:	December 1, 2002 – November 30, 2005
Issue Date:	June 2006
Number of Findings:	5
Number of Repeat Findings:	1
% of Repeat Findings:	20%
Rating: (if applicable)	n/a

Finding 1: Pharmaceutical invoices were paid without verifying that the costs charged were proper. DHMH concurred with the finding.

Finding 2: Springfield Hospital Center lacked adequate controls and recordkeeping procedures for pharmaceutical inventories. DHMH concurred with the finding.

Finding 3: **Physical inventories had not been conducted and equipment records were not being properly maintained. DHMH concurred with the finding but felt that Springfield had demonstrated significant progress toward completion of this task.**

Finding 4: Springfield Hospital Center did not comply with the Comptroller of the Treasury's closing instructions and, thus, inappropriately retained approximately \$67,000 of its fiscal 2005 general fund appropriation. DHMH concurred with the finding and indicated that funding in the amount of \$67,000 would be reverted during the fiscal 2006 closeout process.

Finding 5: Proper internal controls were not established over the processing of certain purchasing transactions. DHMH concurred with the finding.

Administrative Unit:	RICA-Southern Maryland
Audit Period for Last Audit:	August 20, 2002 – November 30, 2005
Issue Date:	June 2006
Number of Findings:	2
Number of Repeat Findings:	0
% of Repeat Findings:	0%
Rating: (if applicable)	n/a

Finding 1: Certain payments to two heating, ventilation, and air conditioning vendors did not comply with contract terms or were questionable and the related contracts, which began in fiscal 2002, were not procured in accordance with State procurement regulations. DHMH concurred with the finding.

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Finding 2: The institute did not maintain property records and related control accounts on a current basis, had not performed certain physical inventories, and did not report the value of its property to the Department of General Services. DHMH concurred with the finding.

Administrative Unit:	RICA-Baltimore
Audit Period for Last Audit:	June 17, 2002 – October 31, 2005
Issue Date:	April 2006
Number of Findings:	1
Number of Repeat Findings:	0
% of Repeat Findings:	0%
Rating: (if applicable)	n/a

Finding 1: Adequate controls were not in place to ensure that collections were subsequently deposited. DHMH concurred with this finding.

Administrative Unit:	Perkins Hospital Center
Audit Period for Last Audit:	October 28, 2003 – July 20, 2006
Issue Date:	January 2007
Number of Findings:	4
Number of Repeat Findings:	2
% of Repeat Findings:	50%
Rating: (if applicable)	n/a

Finding 1: Perkins Hospital Center lacked adequate controls and recordkeeping procedures for pharmaceutical inventories. DHMH concurred with the finding.

Finding 2: Pharmaceutical invoices were paid without verifying that the costs charged were proper. DHMH concurred with the finding.

Finding 3: Missing equipment items were not reported to DGS in a timely manner and related recordkeeping controls were inadequate. DHMH concurred with the finding.

Finding 4: Proper internal controls were not established over materials and supplies held in the dietary storeroom. DHMH concurred with the finding.

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Administrative Unit:	Carter Center
Audit Period for Last Audit:	January 5, 2004 – July 31, 2006
Issue Date:	January 2007
Number of Findings:	3
Number of Repeat Findings:	1
% of Repeat Findings:	33%
Rating: (if applicable)	n/a

Finding 1: Proper internal controls were not established over the processing of certain disbursement transactions. DHMH concurred with the finding.

Finding 2: Internal controls over cash receipts were not sufficient. DHMH concurred with the finding.

Finding 3: Internal control and recordkeeping deficiencies were noted over certain materials and supplies storerooms. DHMH concurred with the finding.

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

**Object/Fund Difference Report
DHMH Mental Hygiene Administration**

<u>Object/Fund</u>	<u>FY06 Actual</u>	<u>FY07 Working Appropriation</u>	<u>FY08 Allowance</u>	<u>FY07-FY08 Amount Change</u>	<u>Percent Change</u>
Positions					
01 Regular	3385.05	3389.05	3385.55	-3.50	-0.1%
02 Contractual	243.55	210.11	235.22	25.11	12.0%
Total Positions	3628.60	3599.16	3620.77	21.61	0.6%
Objects					
01 Salaries and Wages	\$ 203,819,302	\$ 220,932,984	\$ 218,845,052	-\$ 2,087,932	-0.9%
02 Technical and Spec. Fees	10,384,720	8,659,827	9,691,741	1,031,914	11.9%
03 Communication	971,442	1,028,077	1,036,796	8,719	0.8%
04 Travel	160,626	197,053	210,965	13,912	7.1%
06 Fuel and Utilities	12,740,864	13,040,184	12,632,580	-407,604	-3.1%
07 Motor Vehicles	727,762	738,671	779,513	40,842	5.5%
08 Contractual Services	560,736,391	599,270,336	638,575,006	39,304,670	6.6%
09 Supplies and Materials	17,792,215	18,727,855	19,419,267	691,412	3.7%
10 Equip – Replacement	589,076	557,065	643,244	86,179	15.5%
11 Equip – Additional	574,242	103,467	81,508	-21,959	-21.2%
12 Grants, Subsidies, and Contributions	178,295	247,738	286,571	38,833	15.7%
13 Fixed Charges	1,307,397	746,616	764,091	17,475	2.3%
14 Land and Structures	13,995	0	0	0	0.0%
Total Objects	\$ 809,996,327	\$ 864,249,873	\$ 902,966,334	\$ 38,716,461	4.5%
Funds					
01 General Fund	\$ 581,172,156	\$ 602,448,626	\$ 628,746,006	\$ 26,297,380	4.4%
03 Special Fund	4,487,090	4,696,783	4,995,048	298,265	6.4%
05 Federal Fund	218,864,224	252,728,401	263,983,659	11,255,258	4.5%
09 Reimbursable Fund	5,472,857	4,376,063	5,241,621	865,558	19.8%
Total Funds	\$ 809,996,327	\$ 864,249,873	\$ 902,966,334	\$ 38,716,461	4.5%

Note: The fiscal 2007 appropriation does not include deficiencies, and the fiscal 2008 allowance does not reflect contingent reductions.

**Fiscal Summary
DHMH Mental Hygiene Administration**

<u>Program/Unit</u>	<u>FY06 Actual</u>	<u>FY07 Wrk Approp</u>	<u>FY08 Allowance</u>	<u>Change</u>	<u>FY07-FY08 % Change</u>
01 Mental Hygiene Administration	\$ 544,309,968	\$ 584,350,865	\$ 622,826,961	\$ 38,476,096	6.6%
03 Walter P. Carter Community Mental Health Center	13,671,485	13,626,635	13,960,049	333,414	2.4%
04 Thomas B. Finan Hospital Center	16,358,751	17,551,999	17,171,361	-380,638	-2.2%
05 Regional Institute For Children & Adolescents-Balt	12,031,340	13,028,977	12,696,721	-332,256	-2.6%
06 Crownsville Hospital Center	2,497,314	2,040,460	2,010,252	-30,208	-1.5%
07 Eastern Shore Hospital Center	16,374,638	17,038,533	16,995,246	-43,287	-0.3%
08 Springfield Hospital Center	67,502,166	72,626,563	72,525,873	-100,690	-0.1%
09 Spring Grove Hospital Center	73,466,353	76,572,559	77,558,756	986,197	1.3%
10 Clifton T. Perkins Hospital Center	38,246,982	40,902,131	40,560,714	-341,417	-0.8%
11 Regional Institute For Children & Adolescents-Gildner	11,438,006	12,215,895	12,106,605	-109,290	-0.9%
12 Upper Shore Community Mental Health Center	8,275,142	8,346,879	8,576,401	229,522	2.7%
14 Regional Institute For Children & Adolescents-S.Md	5,824,182	5,948,377	5,977,395	29,018	0.5%
Total Expenditures	\$ 809,996,327	\$ 864,249,873	\$ 902,966,334	\$ 38,716,461	4.5%
General Fund	\$ 581,172,156	\$ 602,448,626	\$ 628,746,006	\$ 26,297,380	4.4%
Special Fund	4,487,090	4,696,783	4,995,048	298,265	6.4%
Federal Fund	218,864,224	252,728,401	263,983,659	11,255,258	4.5%
Total Appropriations	\$ 804,523,470	\$ 859,873,810	\$ 897,724,713	\$ 37,850,903	4.4%
Reimbursable Fund	\$ 5,472,857	\$ 4,376,063	\$ 5,241,621	\$ 865,558	19.8%
Total Funds	\$ 809,996,327	\$ 864,249,873	\$ 902,966,334	\$ 38,716,461	4.5%

Note: The fiscal 2007 appropriation does not include deficiencies, and the fiscal 2008 allowance does not reflect contingent reductions.