

**M00L**  
**Mental Hygiene Administration**  
**Department of Health and Mental Hygiene**

***Operating Budget Data***

(\$ in Thousands)

	<u>FY 09</u> <u>Actual</u>	<u>FY 10</u> <u>Working</u>	<u>FY 11</u> <u>Allowance</u>	<u>FY 10-11</u> <u>Change</u>	<u>% Change</u> <u>Prior Year</u>
General Fund	\$637,949	\$621,597	\$636,273	\$14,675	2.4%
Contingent & Back of Bill Reductions	0	0	-4,392	-4,392	
<b>Adjusted General Fund</b>	<b>\$637,949</b>	<b>\$621,597</b>	<b>\$631,880</b>	<b>\$10,283</b>	<b>1.7%</b>
Special Fund	9,967	23,122	23,384	262	1.1%
Contingent & Back of Bill Reductions	0	0	-2	-2	
<b>Adjusted Special Fund</b>	<b>\$9,967</b>	<b>\$23,122</b>	<b>\$23,382</b>	<b>\$260</b>	<b>1.1%</b>
Federal Fund	288,529	299,403	321,933	22,530	7.5%
Contingent & Back of Bill Reductions	0	0	-115	-115	
<b>Adjusted Federal Fund</b>	<b>\$288,529</b>	<b>\$299,403</b>	<b>\$321,819</b>	<b>\$22,415</b>	<b>7.5%</b>
Reimbursable Fund	7,721	8,295	5,784	-2,511	-30.3%
Contingent & Back of Bill Reductions	0	0	-14	-14	
<b>Adjusted Reimbursable Fund</b>	<b>\$7,721</b>	<b>\$8,295</b>	<b>\$5,770</b>	<b>-\$2,524</b>	<b>-30.4%</b>
<b>Adjusted Grand Total</b>	<b>\$944,166</b>	<b>\$952,417</b>	<b>\$982,851</b>	<b>\$30,433</b>	<b>3.2%</b>

Note: For purposes of illustration, the Department of Legislative Services has estimated the distribution of selected across-the-board reductions. The actual allocations are to be developed by the Administration.

- There is one deficiency, \$1,137,834 in general funds, for expanded community services on the Eastern Shore associated with the closure of the Upper Shore Community Mental Health Center. A deficiency to cover fiscal 2009 reported unprovided-for general fund payables of almost \$6.9 million is not included in the allowance.
- Enrollment growth in the fee-for-service system is placing severe strains on the budget for that system. Deficits for fiscal 2010 and 2011 are projected.

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***Personnel Data***

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	<b><u>FY 09 Actual</u></b>	<b><u>FY 10 Working</u></b>	<b><u>FY 11 Allowance</u></b>	<b><u>FY 10-11 Change</u></b>
Regular Positions	3,182.20	2,914.05	2,906.55	-7.50
Contractual FTEs	<u>215.91</u>	<u>203.04</u>	<u>187.84</u>	<u>-15.20</u>
<b>Total Personnel</b>	<b>3,398.11</b>	<b>3,117.09</b>	<b>3,094.39</b>	<b>-22.70</b>

***Vacancy Data: Regular Positions***

Turnover and Necessary Vacancies, Excluding New Positions	138.35	4.76%
Positions and Percentage Vacant as of 12/31/09	225.10	7.72%

- The working appropriation reflects significant position reduction due to fiscal 2010 cost containment, 268.15 regular positions.
- The fiscal 2010 allowance abolishes 7.5 regular positions, all vacant, at the Eastern Shore Hospital. These positions are associated with the establishment of a lower-intensity assisted living unit at the hospital during fiscal 2010, also a response to cost containment actions.

## ***Analysis in Brief***

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### **Major Trends**

***Enrollment Growth in the Fee-for-service System Is Strong:*** Buoyed by the Medicaid expansion to parents, enrollment growth in the fee-for-service community mental health system was 9% between fiscal 2008 and 2009.

***Administrative Services Organization Performance:*** The transition from the old to the current Administrative Services Organization vendor has been far from smooth. Some improvement is visible, but more needs to come.

### **Issues**

***The Reconfiguration of the State-run Psychiatric Hospitals:*** Fiscal 2010 has seen a major upheaval in operating capacity at the State-run psychiatric hospitals. An overview of these changes will be provided.

### **Recommended Actions**

	<b><u>Funds</u></b>
1. Add budget bill language to reduce funding for residential programming at Regional Institutions for Children and Adolescents-Baltimore and Regional Institutions for Children and Adolescents-Gildner through downsizing bed capacity.	
2. Reduce grant funding by \$1.5 million.	\$ 1,500,000
<b>Total Reductions</b>	<b>\$ 1,500,000</b>

### **Updates**

***The Closure of the Walter P. Carter Center:*** Fiscal 2010 budget bill language withheld funds pending a report on the department's closure of the Carter Center. That report is summarized.

***Cost of Somatic Care:*** A report on the cost of somatic care for forensic patients is summarized.

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## ***Operating Budget Analysis***

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### **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; 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 1 as a multi-county enterprise.
- ***State-run Psychiatric Facilities*** include six hospitals (with one of those six, the Upper Shore Community Mental Health Clinic scheduled to close at the end of February 2010) and two residential treatment centers – Regional Institutions for Children and Adolescents (RICA) – 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), ValueOptions, 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 illnesses 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. Specifically, the safety-net serves those who have received services within the public mental health system in the past two years (alleviating continuity of care issues for those who occasionally lose Medicaid coverage); the homeless; people who received Social Security Disability Insurance due to psychiatric impairment and are eligible for Medicare (excluding them from PAC) but who need services beyond those covered by Medicare; people who are on court-ordered conditional releases from a State-run psychiatric hospital; anybody discharged from a Maryland psychiatric hospital in the past three months; and anybody within three months of release from a correctional institution.

In addition to those services administered by the ASO, 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, and drop-in centers) as well as a capitation project in Baltimore City.

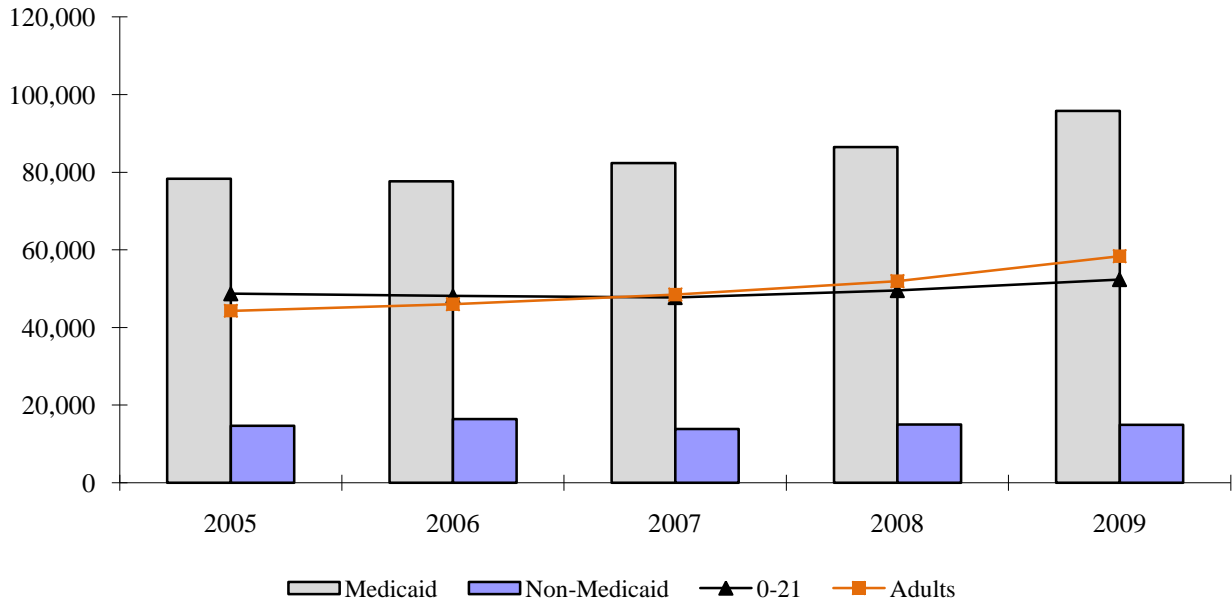
The key goals of the agency include improving the efficacy of community-based care for persons with mental illness and promoting recovery among persons with mental illness in State-run psychiatric facilities so that they may move into less restrictive settings.

## **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 at an average annual rate of 4% between fiscal 2005 and 2009. More importantly, enrollment growth has accelerated in recent years, rising by 9% between fiscal 2008 and 2009. As will become clear in discussions on the budget below, this growth in enrollment is straining the fee-for-service budget.

**Exhibit 1**  
**Community Mental Health Services Enrollment Trends**  
**Fiscal 2005-2009**



Note: Data for fiscal 2009 is incomplete. Enrollment counts may be duplicated across coverage types. Includes enrollment in the Baltimore City capitation project which serves up to 354 individuals.

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

The exhibit also shows:

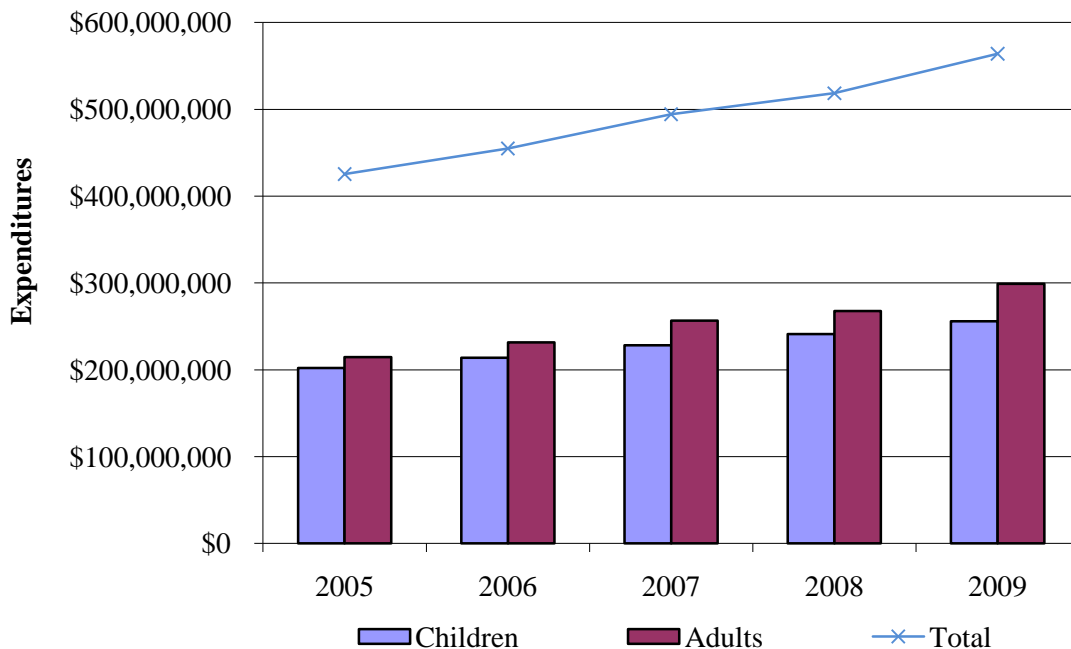
- Enrollment growth over the period has been driven by adults (7% between fiscal 2005 and 2009) which is also behind the most recent growth between fiscal 2008 and fiscal 2009 (9%). The key programmatic change driving this growth was the Medicaid expansion to parents.
- Within the two claims categories of clients served (Medicaid and non-Medicaid), historical trends are distorted by a number of factors that have influenced enrollment data, including definitional changes as to who is counted as Medicaid-eligible, as well as programmatic changes such as the start of the PAC program. However, the fiscal 2009 data is in sharp contrast to the fiscal 2008 data. In fiscal 2008, the rate of growth in the non-Medicaid program over the prior year was greater than the growth in the Medicaid program (4%) or total enrollment (5%) even though in absolute terms, the Medicaid enrollment growth is obviously much higher. Compare that to fiscal 2009 when growth over the prior year is exclusively in Medicaid (11%) while uninsured enrollment falls slightly (1%). Again, this is attributable primarily to the Medicaid expansion program as well as the growth in the Medicaid population generally.

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Spending patterns broadly mirror enrollment growth (**Exhibit 2**) with the pace of spending increased markedly beginning in fiscal 2006. Expenditure growth over the period fiscal 2005 to 2009 is 7% although more recent growth is higher (9% between fiscal 2008 and 2009). This growth reflects:

- increased enrollment, and, in particular, growth among adults as a result of Medicaid expansion; and
- rate increases (in addition to the Health Services Cost Review Commission and cost-based rates increases, provider rates were increased on average by 2% in each of fiscal 2007, 2008 and 2009).

**Exhibit 2**  
**Community Mental Hygiene**  
**Fee-for-service Expenditures**  
**Fiscal 2005-2009**



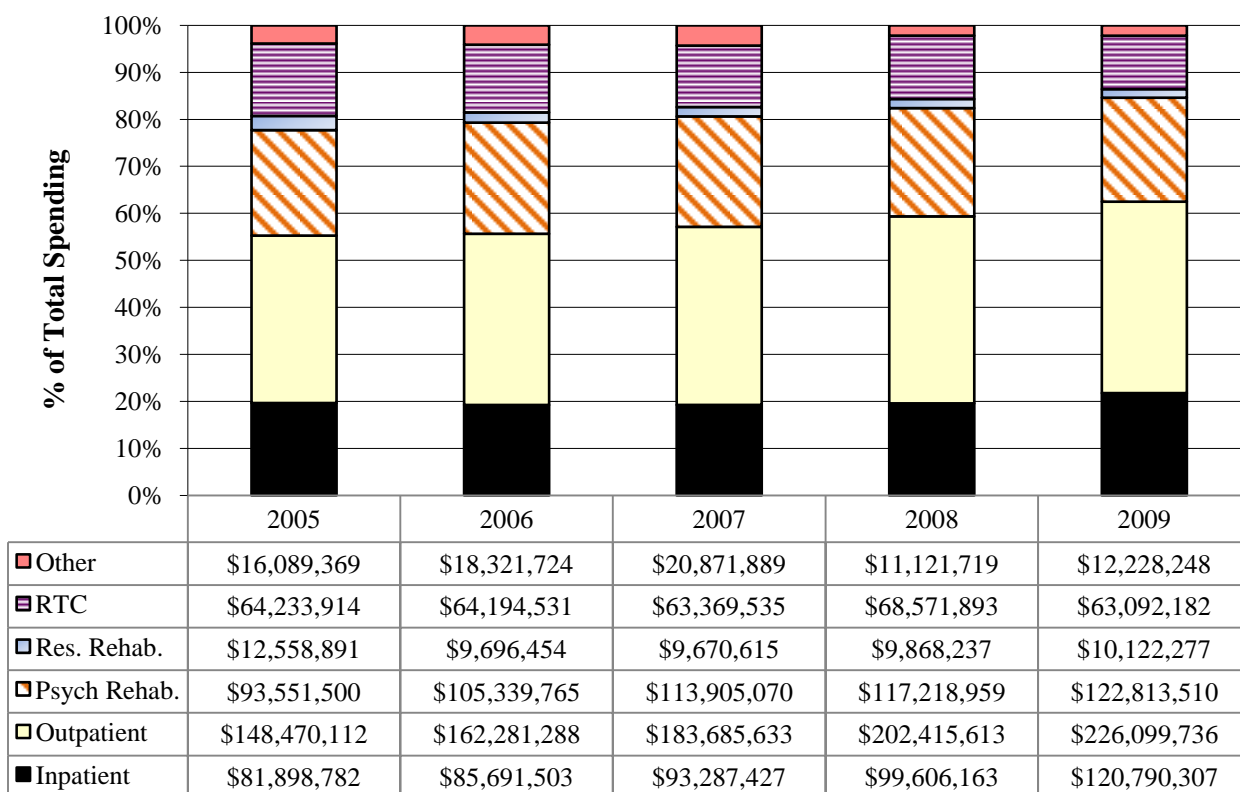
Note: Data for fiscal 2009 is incomplete. Total expenditures include funding for the Baltimore City Capitation project at approximately \$9-10 million per year. Funding for children and adults does not reflect that project.

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

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Which mental health services are experiencing the most rapid growth? As shown in **Exhibit 3**, outpatient services continue to consume the bulk of the mental health fee-for-service dollars. However, there was a significant increase in inpatient spending in fiscal 2009. Some of this was the 4.5% update factor provided by the Health Services Cost Review Commission (HSCRC) in fiscal 2009. Another contributory factor may have been that this was a full year without Medicaid day limits. As noted last year, the drop in spending in the “other” category (spending on case management, crisis services, respite care, and supported employment) in fiscal 2008 relates to case management expenditures being delivered via contracts rather than on a fee-for-service basis. This will change beginning in fiscal 2010 as case management services in Maryland were recently reapproved for federal fund attainment by the Centers for Medicare and Medicaid Services and will once again be shown as fee-for-service expenditures.

**Exhibit 3**  
**Community Mental Health Service Expenditures by Service Type**  
**Fiscal 2005-2009**



RTC: Residential Treatment Centers

Note: Data for fiscal 2009 is incomplete.

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

## Outcomes for Community Mental Health Services

Outcome data from MHA’s Outcomes Measurement System that has been under development for several years is becoming more available. Initial data is limited to outpatient clinics and is restricted to clients:

- with at least two data points (generally six months but up to three years apart);
- with the same questionnaire type (*i.e.*, the same age group) for those responses;
- in treatment during that period with the same provider; and
- with discharge data.

Data reported is drawn from questionnaires from 18,371 adults and 20,042 children for fiscal 2008 and from questionnaires from 18,677 adults and 17,506 children for fiscal 2009. The data presented in **Exhibit 4** compares data from the fiscal 2008 and 2009 cohorts. While this is not an unduplicated sample, there are gains in improved functioning for adults and children. However, other indicators are mixed: homelessness is down but, perhaps unsurprisingly, employment among adults is down (although it should be noted that in fiscal 2009 fewer adults reported being unemployed at both observations).

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### Exhibit 4 Community Mental Health Services Outpatient Fee-for-service Selected Outcomes

<u>Adult Outcomes</u>	<u>Reported in Fiscal 2008</u>	<u>Reported in Fiscal 2009</u>
Net improvement in functioning (% of total observations)	8.0%	9.0%
Increase in employment between observations (%)	3.0%	-4.1%
Persons unemployed in both observations (%)	69.0%	59.5%
Homelessness in both observations (%)	18.0%	5.3%
 <u>Children and Adolescents Outcomes</u>		
Net improvement in functioning (% of total observations)	8.0%	8.2%
School suspensions in both observations (%)	12.0%	11.2%

Source: Department of Legislative Services; Mental Hygiene Administration

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## **ASO Performance**

In 2009, MHA rebid its ASO contract. The existing vendor, APS, was replaced by ValueOptions, although there was a lengthy transition period where ValueOptions at its own expense contracted with another company, ACS, to help process claims. The new ASO contract price is significantly lower than under the prior contract. Several problems were experienced during the transition, including:

- transfer of information regarding provider enrollment and service authorizations;
- some ValueOptions' system procedures were not on-line in a timely manner;
- ValueOptions' systems require eligibility to be determined before services are authorized, which represented a change in practice from the previous ASO and caused initial confusion;
- the information required for authorization of higher levels of care; and
- call waiting times were excessive.

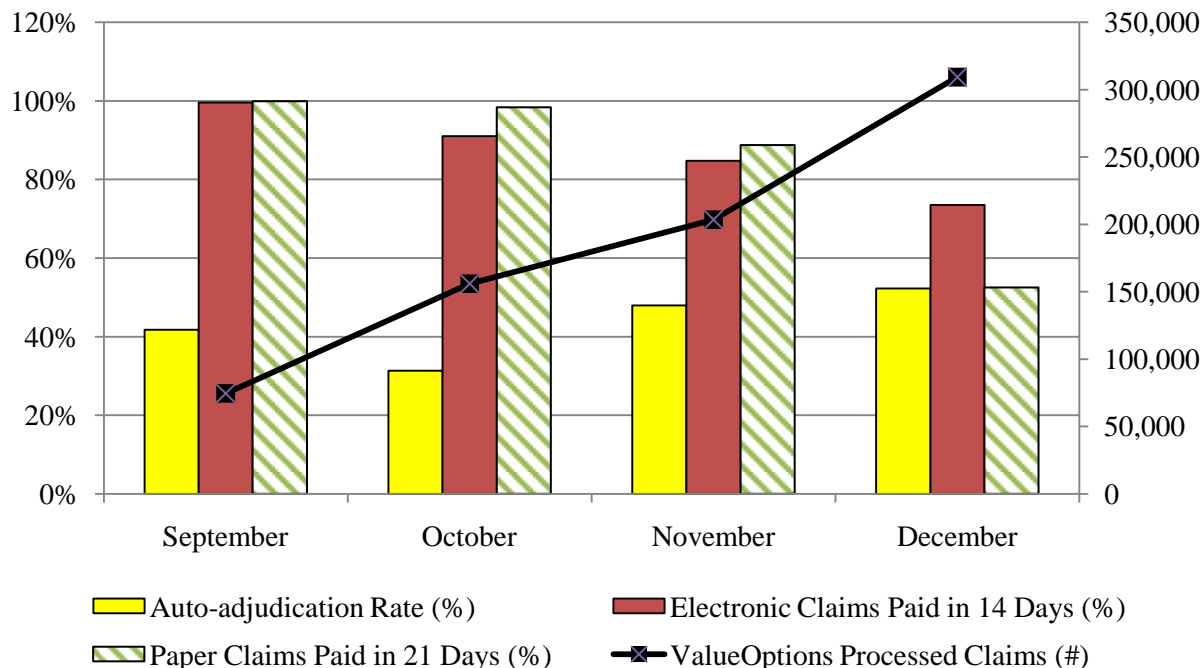
At one point, the ASO's performance was of sufficient concern that MHA was withholding payment to ValueOptions. However, MHA has been working closely with the vendor and provider community to resolve these transition issues and resumed payments to ValueOptions in November.

A review of various ASO performance indicators speaks to both the challenges that ValueOptions has had and continues to have, as well as some indication of improvement. **Exhibit 5** illustrates that ValueOptions initially had significant issues with its auto-adjudication process for claims which would tend to slow the claims processing process because of the need for more manual oversight and is still well below the goal that ValueOptions has set for itself of 90% of claims being auto-adjudicated.

ValueOptions has also had issues meeting the ASO contract goal of processing electronic claims within 14 days and paper claims within 21 days. As the transition period has progressed, and ValueOptions has been processing more claims as opposed to APS processing claims, these issues have intensified. MHA attributes these problems among other things to provider set-up issues, the volume of claims being handled, and the fact that MHA directed ValueOptions to resolve claims to assure providers were paid rather than deny claims.

Importantly, other claims processing measures do show improvement, and MHA believes that the initial transition problems will be fully resolved by the spring. In addition, MHA maintains that the systems used by ValueOptions will allow for much more control over the system. Given that much of the fiscal 2010 cost containment measures rely on this kind of control, it is hoped that the administration is correct.

**Exhibit 5  
ASO Performance  
Auto-adjudication and Claims Processing Data**



ASO: Administrative Services Organization

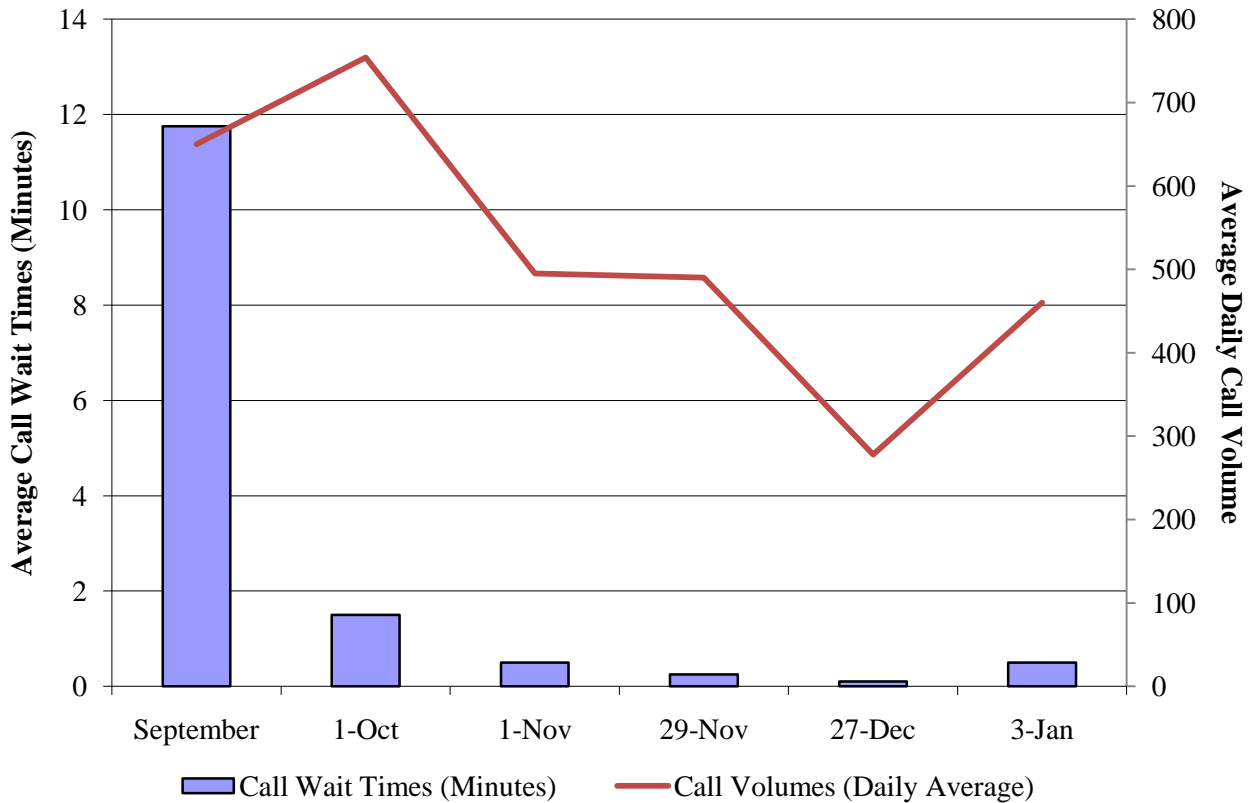
Source: Mental Hygiene Administration; Department of Legislative Services

**Exhibit 6** offers a similar tale with regard to call waiting times. The ASO contract states that 90% of all calls to have a wait time of less than three minutes (with a less than 3% call abandonment rate). Initially, the daily call volume and complexity of calls was clearly overwhelming ValueOptions’ staff. However, the company assigned more resources to Maryland and call waiting times have clearly improved.

Unfortunately, MHA was not able to provide the Department of Legislative Services (DLS) with comparable data from prior ASO transitions. Certainly, in each instance, there have been provider concerns about changes from one vendor to another. Typically, after the initial transition period, complaints about process tend to abate.

Finally, DLS would also note that issues remain with data reports that ValueOptions is supposed to generate for MHA and to which DLS has access. For example, data concerning Medicaid penetration rates and service utilization which are typically part of the quarterly reporting are not being provided because of data issues. Similarly, fiscal 2010 expenditure data clearly does not reflect current demand for services.

**Exhibit 6  
ASO Performance  
Call Volumes and Call Wait Times**



ASO: Administrative Services Organization

Source: Mental Hygiene Administration; Department of Legislative Services

**Fiscal 2010 Actions**

**Proposed Deficiency**

There is one proposed deficiency appropriation for MHA, \$1,137,834 related to the closure of the Upper Shore Community Mental Health Center (USCMHC). Specifically, as part of the decision to close USCMHC, a series of community service expansions was proposed. This proposal is consistent with actions that the department has taken in the past with regard to facility closure. The plan has the following three broad components to deal with the admissions currently handled by USCMHC:

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- Consistent with its overall admissions policy, MHA plans to maximize the use of Purchase of Care (POC) beds on the Eastern Shore. For the uninsured, hospitals will be kept whole through the Health Services Cost Review Commission uncompensated care system with MHA paying physician service costs. MHA plans to have POC agreements at the Union Memorial Hospital in Cecil County, Peninsula Regional in Wicomico County, and Rockford Center in Delaware and is also anticipating entering into an agreement with Dorchester General Hospital. Patients requiring long-term care (or the occasional forensic admission), would be handled by other State-run psychiatric facilities as appropriate, but preferably at the Eastern Shore Hospital.
- Expanding community-based services includes the development of an emergency operations center, mobile crisis teams, four behavioral health crisis beds, access to urgent care clinics, Assertive Community Treatment teams, additional psychiatric staffing capacity at Chester River Emergency Department, as well as a range of ancillary services. Many of these services were also integral to the community service enhancement funded when Crownsville Hospital closed.
- Given the preponderance of co-occurring admissions to USCMHC, specifically of individuals with a primary diagnosis of substance abuse, expanding residential substance abuse treatment capacity through the Kent County Health Department, accommodating 200 admissions annually. The plan calls for 16 beds offering detox and residential services also integrating appropriate mental health services, all at substantially less cost than providing those services in a psychiatric hospital.

The full year cost of this proposal is \$3 million. However, full year expenditures at USCMHC in fiscal 2011 would have been over \$8 million.

While this is the only fiscal 2010 deficiency for MHA, it should be noted that MHA reported a \$6.9 million deficit with the Comptroller at the end of fiscal 2009. According to the Administration, the intent was to generate savings in fiscal 2010 to offset this general fund deficit. However, as will be detailed below, given the extent of program enrollment and fiscal 2010 cost containment, it is unlikely that these savings will be forthcoming.

### **Impact of Cost Containment**

To date, MHA's fiscal 2010 budget has been reduced by almost \$56.9 million through cost containment (just over \$43.7 million general funds, a minimal amount of special funds, and over \$13.1 million in federal funds). In addition to furlough reductions and other personnel actions such as the elimination of the nurse retention bonus, key cost containment actions are shown in **Exhibit 7**.

**Exhibit 7**  
**Mental Hygiene Administration**  
**Major Fiscal 2010 Cost Containment Actions**  
**General Funds Only**

Personnel savings at psychiatric hospitals from facility closure, downsizing, conversion of units to different levels of intensity etc.	\$14,028,039
Utilization review	6,500,000
Utilization review of intensive outpatient services (in lieu of partial year 2% community provider rate cut)	3,600,500
State psychiatric facility operational savings	3,082,674
Elimination of 0.9% inflation adjustment for community providers	2,332,046
Reduction based on RTC utilization	2,306,709
CSA savings	1,300,000
Savings in ASO contract based on most recent award	798,733
Savings in inpatient costs from a lower than budgeted HSCRC update factor	629,924
Spring Grove high-cost atypical antipsychotic drug utilization review	400,000

ASO: Administrative Services Organization  
CSA: Community Services Administration  
HSCRC: Health Services Cost Review Commission  
RTC: Residential Treatment Center

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

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Two observations can be made about these reductions:

- The majority of reductions have come from the State-run psychiatric facilities, certainly disproportionate to their share of the MHA budget, especially when personnel reductions are included in the overall cost containment. Facilities have received an estimated 70% of the general fund reductions yet comprise only 40% of the general fund budget. This reflects MHA's philosophy of utilizing, to the maximum extent possible, community services over institutional placement.
- A reduction of \$3.6 million was taken to the Board of Public Works (BPW) in August and advertised as a 2% community provider rate reduction. This reduction was not imposed. Instead, based on a review of service utilization, MHA decided to clamp down on the use of intensive outpatient and partial hospitalization services to generate the same amount of savings. MHA indicates that it is generating savings, although it is not clear if the amount of

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savings will match the reduction taken. Further, it is unclear if individuals that had been receiving these services will instead move to other services, such as outpatient. While cheaper, it offsets the potential savings.

While sympathetic to MHA's desire not to cut community provider rates, DLS would note that this also has the impact of increasing the base for future growth. DLS also notes that this action calls into question the validity of the information presented to BPW when it considers cost containment actions. While it is unknown that the Board would have decided differently on this particular action since it was part of a much larger cost containment package, the action presented to the Board was clearly different from the action taken.

## **Proposed Budget**

As shown in **Exhibit 8**, the Governor's fiscal 2011 allowance increases just over \$30.4 million, or 3.2%, from the fiscal 2010 working appropriation. This change reflects DLS' estimates of several across-the-board actions to be allocated by the Administration including a combination of employee furloughs and government shut-down days similar to the plan adopted in fiscal 2010; a reduction in overtime based on accident leave management; a change in the injured workers' settlement policy and administrative costs; and a savings in health insurance to reflect a balance in that account. Savings from other across-the-board actions, the streamlining of State operations and hiring freeze and attrition savings, cannot be attributed at the agency level at this time and are not included in the discussion of budget changes.

## **Personnel Changes**

Across the Administration, personnel expenses fall by just over \$1.1 million. The largest increase is a positive turnover adjustment, which primarily reflects how facility position changes were budgeted in the fiscal 2010 working appropriation. The large drop in regular salaries relates to the annualization of facility closures and downsizing and the proposed fiscal 2011 furlough. The allowance abolishes 7.5 full-time equivalent (FTE) regular positions (all vacant) at the Eastern Shore Hospital Center. This reduction is related to the fiscal 2010 cost containment action that converted some beds at that hospital to lower intensity assisted living beds.

**Exhibit 8**  
**Proposed Budget**  
**DHMH – Mental Hygiene Administration**  
**(\$ in Thousands)**

<b>How Much It Grows:</b>	<b><u>General</u> <u>Fund</u></b>	<b><u>Special</u> <u>Fund</u></b>	<b><u>Federal</u> <u>Fund</u></b>	<b><u>Reimb.</u> <u>Fund</u></b>	<b><u>Total</u></b>
2010 Working Appropriation	\$621,597	\$23,122	\$299,403	\$8,295	\$952,417
2011 Allowance	<u>636,273</u>	<u>23,384</u>	<u>321,933</u>	<u>5,784</u>	<u>987,373</u>
Amount Change	\$14,675	\$262	\$22,530	-\$2,511	\$34,956
Percent Change	2.4%	1.1%	7.5%	-30.3%	3.7%
 Contingent Reduction	 -\$4,392	 -\$2	 -\$115	 -\$14	 -\$4,522
Adjusted Change	\$10,283	\$260	\$22,415	-\$2,524	\$30,433
Adjusted Percent Change	1.7%	1.1%	7.5%	-30.4%	3.2%
 <b>Where It Goes:</b>					
<b>Personnel Expenses</b>				<b>-\$1,128</b>	
Turnover adjustments .....					\$7,133
November 2008 BPW personnel-related cost containment adjustment.....					2,077
Retirement contributions.....					1,572
Employee and retiree health insurance (including Section 19 reduction).....					1,298
Other fringe benefit adjustments.....					428
Workers' compensation premium assessment (including Sections 21 and 23 reductions).....					-412
Abolished positions (7.5 FTEs) .....					-421
Social security contributions.....					-633
Overtime .....					-1,495
Regular salaries (including Section 18 reductions).....					-10,675
<b>Community Mental Health Services</b>				<b>\$36,829</b>	
<b>Fee-for-service expenditures</b>				<b>\$38,197</b>	
Enrollment and utilization.....					35,197
Eastern Shore community service expansion .....					3,000
<b>Grants and Contracts</b>				<b>-\$1,368</b>	
Increase to offset one-time fiscal 2010 cost containment .....					1,500
Baltimore City capitation project.....					1,058
Shelter Plus Care grant (federal funds).....					577
Youth suicide prevention grant (federal funds) .....					500

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**Where It Goes:**

Healthy Transitions initiative grant (federal funds).....	480
Veteran's Behavioral Health Program.....	447
Maryland CARES grant (federal funds) .....	385
Mental Health Transformation grant (federal funds).....	254
Traumatic Brain Injury grant (federal funds).....	-115
Data Infrastructure grant (federal funds) .....	-142
RTC Diversion project (technical change).....	-1,661
Child and adolescent services delivered via the CSAs .....	-1,829
Lower ASO contract .....	-2,822
<b>Facilities</b>	<b>-\$5,087</b>
Savings in nonpersonnel costs from the closure of the Carter and USCMH centers .....	-5,087
Other .....	-181
<b>Total</b>	<b>\$30,433</b>

ASO: Administrative Services Organization  
 CSA: Core Service Agencies  
 RTC: Residential Treatment Center  
 USCMH: Upper Shore Community Mental Health Center

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

## **Community Mental Health Services**

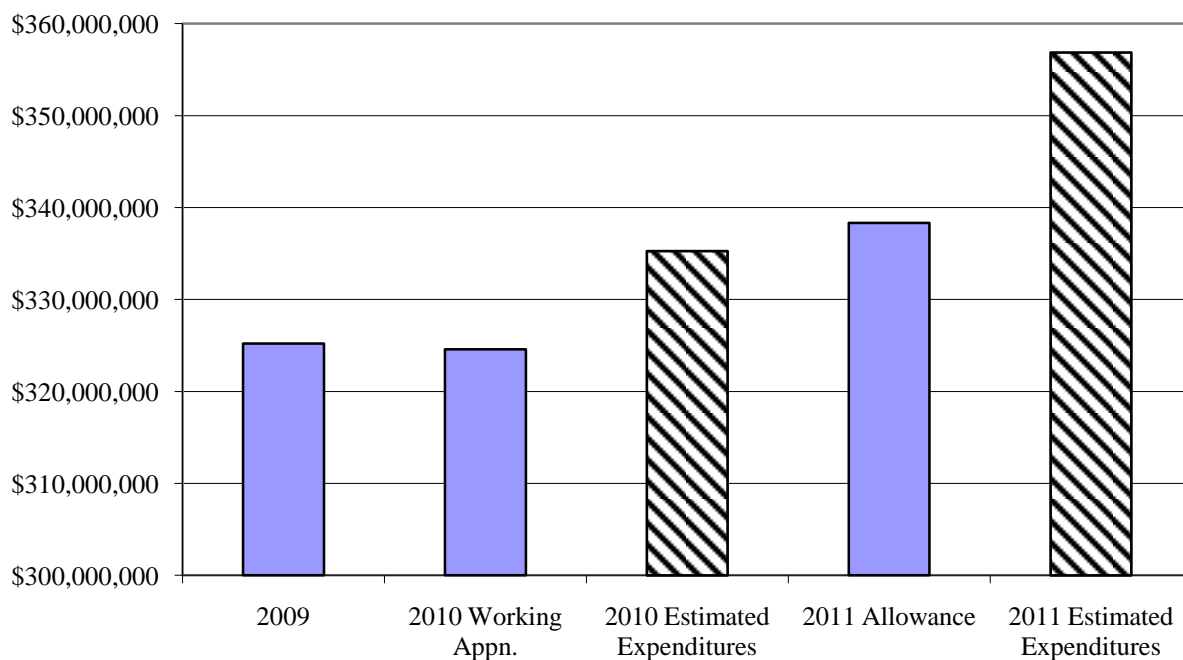
### **Fee-for-service expenditures**

The funding available for fee-for-service community mental health expenditures (Medicaid and non-Medicaid) increases by just under \$38.2 million in the fiscal 2011 allowance. However, \$3.0 million of this increase (all general funds) is for the expansion of community-based services on the Eastern Shore as part of the agreement to close the USCMHC. Other than enrollment growth, the remaining \$35.2 million is intended to support rate increases of 2.84% for HSCRC-regulated services, and 4.3% for Residential Treatment Centers (RTCs), but no rate adjustment is included for other providers. The available funding represents a 6.0% total increase over fiscal 2010.

The adequacy of this funding is questionable. Based on the most recent data of spending in fiscal 2009, even after accounting for cost containment made by BPW, the fiscal 2010 working appropriation appears inadequate. Indeed, that data indicates that fiscal 2010 expenditures could be greater than the fiscal 2011 allowance, which bodes ill for fiscal 2011.

**Exhibit 9** provides an analysis of State fund adequacy in the fee-for-service system (recognizing the availability of special funds from the Health Care Coverage Fund available to support the Medicaid expansion population). The assumptions underpinning the DLS estimates relate to the most recent estimate of fiscal 2009 expenditures, enrollment growth of 7% in fiscal 2010 and 6% in fiscal 2011 (both of which are below the 9% experienced between fiscal 2008 and 2009), the full realization of cost containment in fiscal 2010 carried forward into fiscal 2011, and rate adjustments for HSCRC-regulated services and RTCs only. Based on this analysis, DLS estimates that community mental health fee-for-service budget has a State fund deficit of almost \$11.0 million in fiscal 2010 and \$18.5 million in fiscal 2011. This is in addition to the almost \$6.9 million problem rolled over from fiscal 2009 to 2010.

**Exhibit 9**  
**Community Mental Health Services Fee-for-service Funding**  
**State Funds Adequacy**  
**Fiscal 2009-2011**  
**(\$ in Millions)**



Note: See text for assumptions. Fiscal 2009 funding includes unfunded deficit.

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

## **Grants and Contracts**

The fiscal 2011 budget for mental health services delivered through grants and contracts falls by almost \$1.4 million from fiscal 2010. The most significant increase is \$1.5 million to offset what has been described as one-time fiscal 2010 cost containment. According to MHA, rather than reduce services, the cost containment will be attained by clawing-back CSA carryover funds. Unlike other grant programs, Health General Article Section 10-203(c)(3) allows the CSAs to retain unspent year-end funds. **The committees may wish to consider deleting that provision through the Budget Reconciliation and Financing Act of 2010 at least for fiscal 2010, 2011 and 2012, and requiring all unexpended State funds to revert to the general fund.**

Other increases include a net increase in funding for a variety of federal grants (\$1.939 million), the Baltimore City Capitation project (\$1.058 million), and the Veterans Behavioral Health Program (\$447,000). Total funding for the Veteran's Behavioral Health Program in fiscal 2011 is almost \$1.3 million which, based on expenditure data, appears reasonable.

These increases are more than offset by three major reductions:

- \$1.661 million in funding for the RTC diversion project. However, according to the department this is a technical change, based on how the administration was funding this project in fiscal 2010 using reimbursable funds. The total available funding remains unchanged.
- \$1.829 million in funding for child and adolescent services delivered via CSAs. Virtually all of this reduction is in reimbursable funding derived from the Department of Juvenile Services (DJS) for family intervention specialists. DJS reduced this funding in fiscal 2010 as both an internal cost containment measure (in response to its own budget issues not a BPW reduction) and also because it is shifting its funding into evidence-based services.
- \$2.822 million due to the lower ASO contract price under the most recent contract award.

## **Facilities**

Although there are a number of changes in nonpersonnel costs at the facilities, the key change is the annualized saving of almost \$5.1 in nonpersonnel costs from the closure of the Carter and Upper Shore Community Mental Health centers.

## ***Issues***

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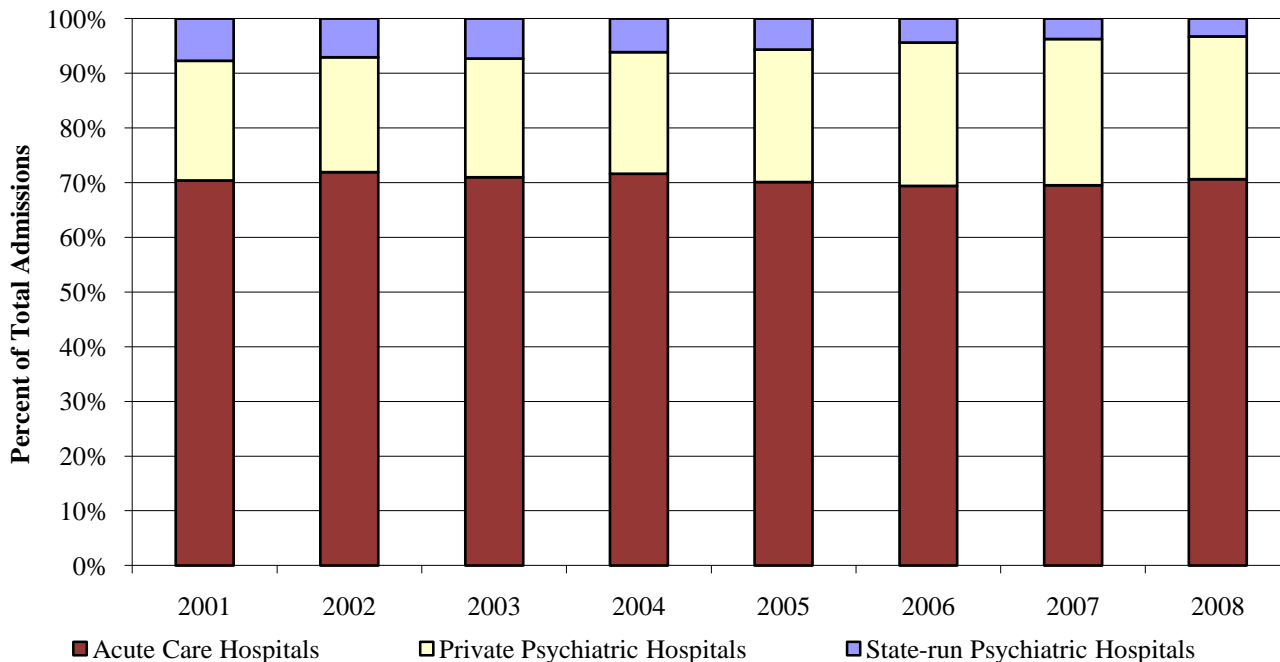
### **1. The Reconfiguration of the State-run Psychiatric Hospitals**

#### **Historic Trends in State-run Psychiatric Hospital Care in Maryland**

A review of historical data reveals the following trends in capacity, facility closure, admissions, and patient mix in Maryland.

- In 1956, the average daily population (ADP) at the State-run psychiatric hospitals was 9,500. This number fell to just above 8,000 in 1967, before falling dramatically over the following 15 years to under 3,000 in 1983. After appearing to stabilize for several years, ADP dropped steadily from 3,000 to 1,500 in 1998. That decline has continued in recent years to a little over 1,000.
- The decline in the number of State-run psychiatric hospital beds mirrors the ADP decline. Aside from 1985 when over 1,000 beds were closed, the decline in capacity has been gradual.
- Despite the overall drop in ADP, prior to 2004, only one facility was closed, Highland Health in 1998. However, like most other states, as noted above, Maryland has recently closed facilities – Crownsville, the Carter Center, RICA Southern Maryland, as well as the proposal to close USCMHC – and reduced capacity at others (for example, Spring Grove and Springfield).
- At the same time, the total number of inpatient psychiatric admissions has increased in Maryland, almost doubling from 24,000 in 1982 to just over 47,000 in 2008. However, by 2008 State-run psychiatric hospital admissions amounted to only 6% of total admissions. As shown in **Exhibit 10**, most admissions are to acute general hospitals, although the private psychiatric hospitals' share of admissions has actually grown larger in recent years.

**Exhibit 10**  
**Inpatient Psychiatric Admission Data by Facility Type**  
**Calendar 2001-2008**

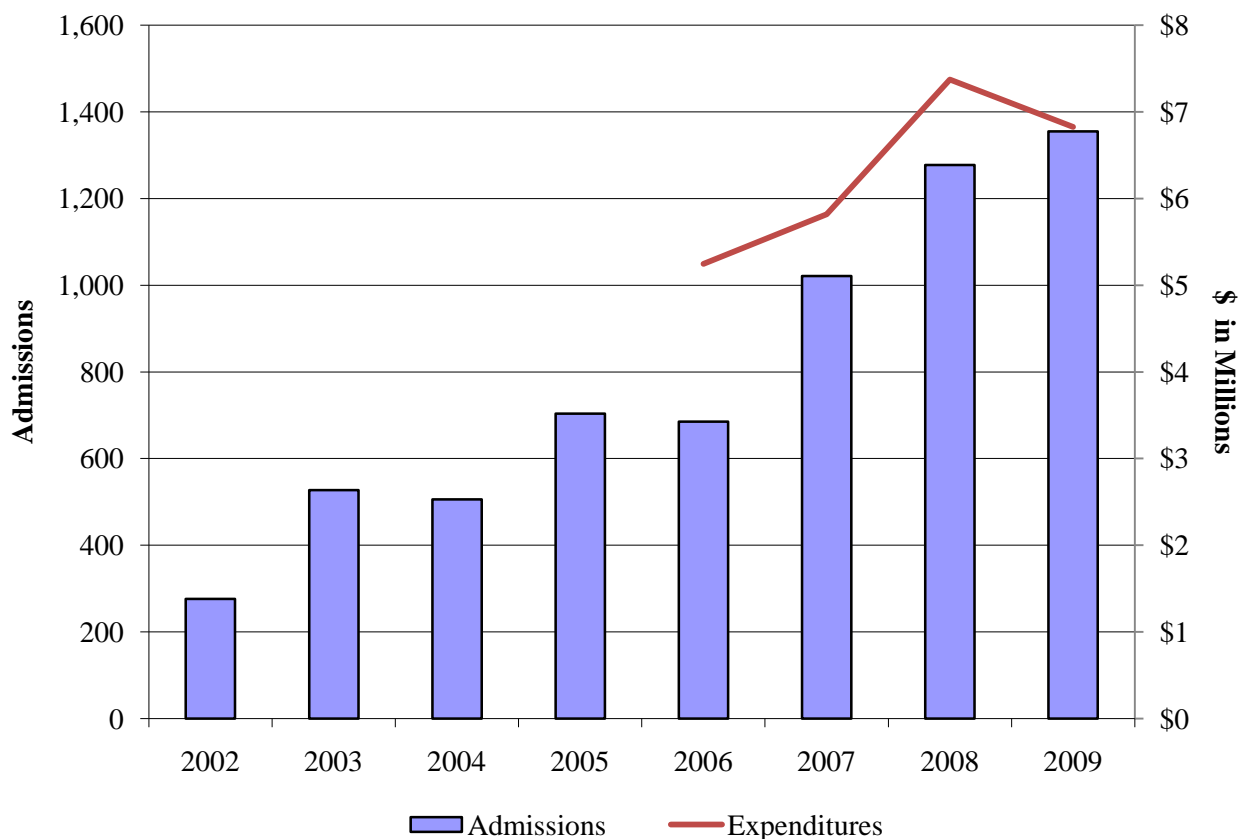


Note: Admission data for State-run psychiatric hospitals is for the fiscal year that begins in the calendar year shown. Calendar year data for those facilities was not available.

Source: Mental Hygiene Administration; Health Services Cost Review Commission; Department of Legislative Services

- In recent years, MHA has reinforced this trend by further diverting admissions to State-run psychiatric hospitals through the use of POC beds at private hospitals *i.e.*, paying for hospital admissions in the private sector, rather than admitting patients to State-run psychiatric hospitals. As shown in **Exhibit 11**, this practice has grown significantly in recent years, with 1,355 admissions diverted in fiscal 2009. MHA notes that this generally results in significant savings to the State, with a cost per admission less than half of that to a State-run psychiatric hospital.

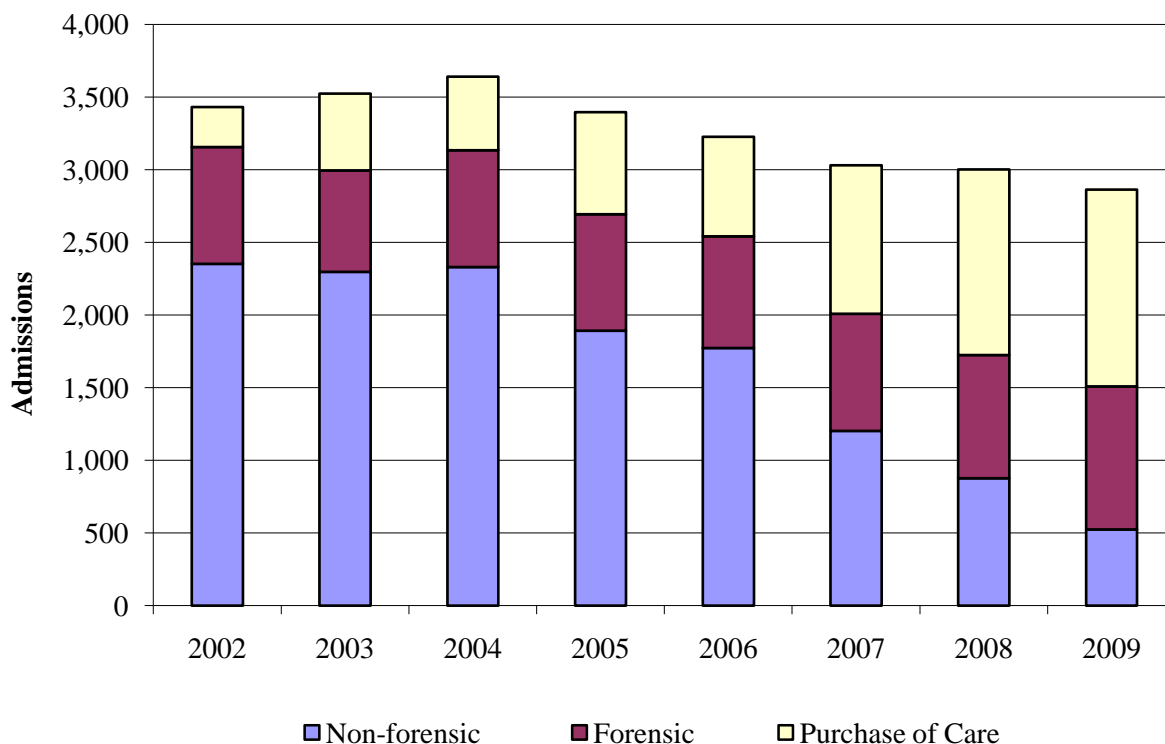
**Exhibit 11**  
**Purchase of Care Admissions and Expenditures**  
**Fiscal 2002-2009**



Source: Mental Hygiene Administration; Department of Legislative Services

- The patients being treated by the State-run psychiatric hospitals are increasingly forensic. Maryland has one maximum security psychiatric hospital, Perkins, but a significant number of forensic patients are also served at other State-run psychiatric hospitals. As shown in **Exhibit 12**, which details all admissions to the State-run psychiatric hospitals as well as the POC admissions between fiscal 2002 and 2009, only 25% of the admissions to State hospital hospitals in fiscal 2002 were forensic compared to 65% in fiscal 2009 (a figure that rises to over 70% if admissions to the USCMHC are excluded since that facility had virtually no forensic admissions). This increase is despite the number of forensic admissions to State hospitals being relatively flat over the period. Again, MHA’s use of POC beds, for what otherwise would have been civil admissions to the State-run psychiatric hospitals, largely explains this change.

**Exhibit 12  
Admission Data  
Fiscal 2002-2009**



Note: Excludes admissions for Regional Institutions for Children and Adolescents.

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

In summary, trends in State-run hospital care in Maryland reveal fewer beds, fewer admissions, greater emphasis on a difficult to serve populations, with some element of facility consolidation, closure, and downsizing. In this regard, the experience in Maryland is little different than that of the nation as a whole.

**The Pace of Change Accelerates in Fiscal 2010**

The State's fiscal situation has accelerated the change in the operational capacity of the State-run psychiatric hospitals. Excluded from this particular discussion are the changes that have also been made to reduce capacity at both RICA-Baltimore and RICA-Gildner. While the State is actually opening new space in fiscal 2010, a 48-bed wing at Perkins hospital (one ward is anticipated to open in February, the second in May), more than offsetting this additional capacity are a number of facility closures and downsizing initiatives:

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- The closure of the Carter Center and USCMHC. These closures underscore MHA’s policy of utilizing State-run psychiatric hospitals to serve patients requiring long-term hospitalization and forensic admissions, and specifically, moving away from acute care and civil admissions.
- The closure of beds at Springfield because of budget reductions and a policy decision to reduce capacity as a result of a change in the treatment of individuals with mental illness and development disabilities. Beginning in fiscal 2010, the department has been moving to serve these individuals in an appropriate community or institutional placement (by adding capacity at the Potomac Center). Budget constraints initially delayed this initiative but there has been significant progress in moving this population from the State-run psychiatric hospitals since the beginning of calendar 2010.
- The closure of beds at Spring Grove effective January 1, 2010, although the number of beds closed may be moderated by the development of additional forensic assisted living beds.

Taken together, as shown in **Exhibit 13**, the State is proposing to operate a system with 1,103 beds. This represents a decline of 137 beds from fiscal 2009 and 216 from the recent high of 1,319 in fiscal 2007.

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**Exhibit 13**  
**State-run Psychiatric Hospitals: Facility Operating Capacity**  
**Fiscal 2004-2010**

	<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>2010</u>
Crownsville	202	0	0	0	0	0	0
Eastern Shore	78	80	80	80	80	80	80
Upper Shore	37	40	40	40	40	40	0
Springfield	328	405	405	405	355	355	270
Spring Grove	330	441	441	445	425	425	403
Perkins	206	218	218	218	218	218	262
Finan	80	80	80	80	88	88	88
Carter	49	51	51	51	34	34	0
<b>Total</b>	<b>1,310</b>	<b>1,315</b>	<b>1,315</b>	<b>1,319</b>	<b>1,240</b>	<b>1,240</b>	<b>1,103</b>

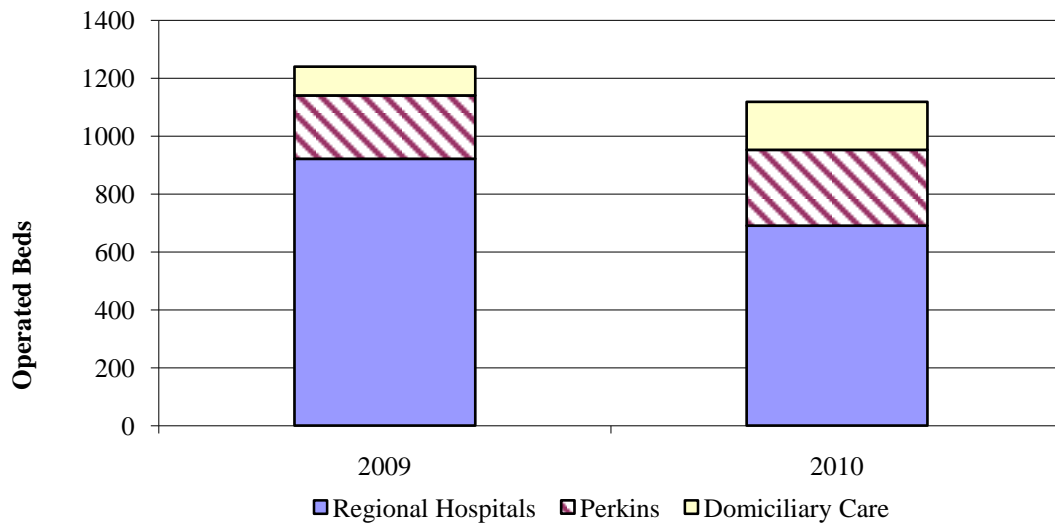
Note: Based on full implementation of fiscal 2010 proposals, including July, August, and November Board of Public Works actions plus full capacity at Perkins.

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

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At the same time that MHA is revising overall capacity at the State-run psychiatric hospitals and moving away from acute care services, as shown in **Exhibit 14**, it is also changing the mix of beds by increasing the number of lower intensity (and less costly) assisted living beds. These beds are for patients who no longer require the level of supervision that would normally be provided in a hospital setting, but still require a residential placement either because they are not yet ready for discharge to the community and/or because they are difficult to discharge. In fiscal 2010, for example, assisted living capacity has been expanded at Spring Grove (a secure post evaluation forensic unit) and the Eastern Shore Hospital.

**Exhibit 14**  
**State-run Psychiatric Hospitals: Changing Bed Mix**  
**Fiscal 2009-2010**



Note: Based on full implementation of fiscal 2010 proposals, including July, August, and November Board of Public Works actions plus full capacity at Perkins.

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

### **Have Capacity Changes Ameliorated Staffing Concerns?**

Staffing levels at MHA’s facilities have been a problem for some time. A 2007 staffing study revealed that the facilities were staffed at almost 400 FTEs below that required to meet MHA’s own standards. MHA responded to that staffing study by closing down a number of wards.

An updated staffing study was requested given all the proposed changes to bed capacity made in the original 2010 budget. That study was subsequently delayed to account for the additional changes made by BPW reductions and includes data on the two RICAs.

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The study makes a number of important points about staffing levels at the State facilities, again using MHA’s own standards as a benchmark (which are based on a literature review and considered appropriate):

- Staff availability and bed capacity have declined almost equally since the last study, allowing the maintenance of staff-to-patient ratios but preventing any real progress in meeting staffing standards.
- Based on staff need and direct care staff availability (available positions offset by vacancies and employees on long term leave), there is a 25% shortage in direct care staff, primarily nurses (see **Exhibit 15**).

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**Exhibit 15**  
**State-run Psychiatric Facilities: Direct Care Staff Deficits by Facility and Staff Type**

<u>Facility/Staff Type</u>	<u>Needed</u>	<u>Available</u>	<u>Difference</u>
<b>Facility</b>			
Eastern Shore	109.28	90.68	-18.60
Finan	139.04	109.37	-29.67
Springfield	414.12	381.20	-32.92
Spring Grove	586.22	427.80	-158.42
Perkins	454.92	267.00	-187.92
RICA Baltimore	66.88	47.00	-19.88
RICA Gildner	56.32	44.50	-11.82
<b>Total</b>	<b>1826.78</b>	<b>1367.55</b>	<b>-459.23</b>
<b>Staff Type</b>			
Nursing	1420.40	1058.9	-361.50
Psychiatrist	82.94	70.58	-12.36
Psychologist	50.66	38.15	-12.51
Rehabilitation	188.92	116.37	-72.55
Social Worker	83.86	83.55	-00.31
<b>Total</b>	<b>1826.78</b>	<b>1367.55</b>	<b>-459.23</b>

RICA: Regional Institute for Children and Adolescents

Note: Based on full implementation of fiscal 2010 proposals plus full capacity at Perkins.

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

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- Not only is there a significant shortfall of nursing staff, the study goes on to note that, compared to best practices, within the nursing staff, there is an overreliance on less skilled staff (certified assistants or aides) as opposed to Registered Nurses or Licensed Practical Nurses (or their equivalent).

- Staffing shortages are filled by extensive use of overtime.

### The Impact on Quality

It is not yet possible to know if or how the rapid changes in capacity in recent months have impacted the quality of service delivery. Similarly it remains difficult to infer just from data whether quality of care has been compromised as a result of ongoing staffing shortages. Nonetheless, data presented in Exhibits 16, 17, and 18 examines 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.

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**Exhibit 16**  
**State-run Psychiatric Hospitals: Readmissions within 30 Days of Discharge**  
**(Percent of Total Admissions)**  
**Fiscal 2005-2009**

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>Trend</u> <u>2005-2009</u>	<u>Trend</u> <u>2008-2009</u>
Carter	1.7%	4.0%	5.1%	8.5%	3.42%	X	√
Eastern Shore	2.0%	5.9%	7.5%	5.8%	10.5%	X	X
Finan	2.3%	2.2%	0.0%	5.3%	2.7%	X	√
Spring Grove	3.5%	3.6%	3.6%	5.0%	4.0%	X	√
Springfield	4.6%	4.2%	6.0%	8.8%	5.69%	X	√
Upper Shore	1.3%	2.6%	5.7%	7.6%	5.1%	X	√

X: worsened

√: improved

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

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**Exhibit 17**  
**State-run Psychiatric Hospitals: Use of Seclusion**  
 (Rate per 1,000 Patient Hours)  
 Fiscal 2005-2009

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>	<b>Trend 2005-2009</b>	<b>Trend 2008-2009</b>
Carter	0.62	0.25	0.40	0.83	0.36	√	√
Eastern Shore	2.77	0.55	0.32	0.28	0.26	√	√
Finan	0.15	0.08	0.03	0.25	0.03	√	√
Spring Grove	0.29	0.10	0.05	0.02	0.02	√	No change
Springfield	0.29	0.29	0.19	0.18	0.10	√	√
Upper Shore	0.79	1.45	0.02	0.15	0.15	√	No change

X: worsened  
 √: improved

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

**Exhibit 18**  
**State-run Psychiatric Hospitals: Elopements**  
 (Number per 1,000 Patient Days)  
 Fiscal 2005-2009

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>	<b>Trend 2005-2009</b>	<b>Trend 2008-2009</b>
Carter	0.05	0.28	0.46	0.29	0.42	X	X
Eastern Shore	0.21	0.11	0.04	0.14	0.15	√	X
Finan	0.18	0.15	0.23	0.38	0.27	X	√
Spring Grove	0.35	0.32	0.20	0.26	0.29	√	X
Springfield	0.63	0.51	0.32	0.27	0.09	√	√
Upper Shore	0.41	0.92	0.50	0.65	0.08	√	√

X: worsened  
 √: improved

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

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Mindful of the different resource and patient factors that apply to different facilities when making comparisons, two points can be made from these exhibits.

- The long-term trend in readmissions within 30 days continues to show readmission rates higher in fiscal 2009 than 2005, although all facilities except for the Eastern Shore Hospital remain below the latest available national benchmark for readmission rates (9%). However, for the most part, short-term readmission rates (again with the exception of the Eastern Shore Hospital) show improvement.
- Trends in the use of seclusion remain favorable. Elopement data is more mixed but tends to represent minimal change

One area of potential concern that bears watching concerns the number of staff hours lost due to injury. The largest three hospitals, Spring Grove, Springfield, and Perkins, all experienced an increase in the number and rate of staff hours lost due to injury. This may be a reflection of the more difficult population being served in these facilities with limited staff. Interestingly, as shown in the most recent staffing study, Spring Grove and Perkins face the largest deficit of staff, and all three facilities have high levels of overtime.

### **Summary**

Although the recent changes in State-run psychiatric hospital capacity are being made at a pace not previously seen, they are consistent with the policy direction that MHA has been pointing the State-run psychiatric hospitals in recent years. Specifically, these hospitals have moved away from the treatment of civil and acute care admissions, toward that of serving patients with more difficult and complex conditions often requiring longer-term hospital care and forensic admissions.

However, this changing capacity will require MHA:

- To continue to manage the population at its State-run psychiatric hospitals through diversion projects (which have proved successful in diverting individuals from emergency departments and subsequent potential placement in a State-run psychiatric bed) as well as maintaining the policy of purchasing psychiatric bed capacity in private psychiatric hospitals and acute general hospitals. This, in turn, means that MHA must ensure that this mix of public and private psychiatric beds remains available.
- To manage the forensic population. This is a population for which control over admissions lies primarily with the judicial branch.
- To address, at some point, staffing issues. In addition to vacancy issues, the staffing study pointed to the fact that the hospitals' workforce tend to be longer-service employees. Even in the current economic climate, hiring, especially for skilled positions, has been problematic. There is nothing to indicate that the demand for the types of skilled health care staff that the State-run psychiatric hospitals need will change to the State's benefit in the near future.

## ***Recommended Actions***

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1. Add the following language:

Provided that a total of \$2,436,959 in general funds and 76 full-time equivalent regular positions shall be reduced from the budgets of the Regional Institute for Children and Adolescents – Baltimore and the John L. Gildner Regional Institute for Children and Adolescents by reducing residential capacity at each facility to 16 beds. Further provided that a total of \$2,323,225 in general funds appropriated for the operation of the Regional Institute for Children and Adolescents – Baltimore and the John L. Gildner Regional Institute for Children and Adolescents may not be used for that purpose and instead may only be used to support residential services in private residential treatment centers or community-based residential treatment diversion programming.

**Explanation:**

The language reduces operational support for residential placements at the Regional Institute for Children and Adolescents (RICA) – Baltimore and RICA Gildner by reducing residential capacity to 16 beds at each facility. A portion of the savings, as well as 76 positions, is cut. The remainder is allocated for treating youth in private residential treatment centers (RTCs) or in community-based RTC diversion programming. According to the Mental Hygiene Administration, there is sufficient private RTC capacity to accommodate this reduction. At the same time, the reduction will not impact day programming that occurs at RICA-Baltimore and RICA-Gildner.

	<b><u>Amount Reduction</u></b>
2. Reduce grant funding by \$1.5 million. In order to stay within its fiscal 2010 budget for community mental health grant funding, rather than making ongoing program reductions the Mental Hygiene Administration (MHA) intends to claw-back carryover funding from the Core Service Agencies as a one-time cost containment measure. The fiscal 2011 budget provides additional funding to allow MHA to make this a one-time action in fiscal 2010. An alternative would be for MHA to make a structural change to its fiscal 2010 grants budget and produce ongoing savings of \$1.5 million.	\$ 1,500,000 GF
<b>Total General Fund Reductions</b>	<b>\$ 1,500,000</b>

## ***Updates***

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### **1. The Closure of the Walter P. Carter Center**

Chapter 484 of 2009 (Fiscal 2010 Budget Bill) including language withholding funds until the Department of Health and Mental Hygiene (DHMH) submitted a report on the status of the closure of the Carter Center. The department submitted the required report on December 14, 2009.

Originally slated to close October 1, 2009, the last patient left the facility September 3, 2009. The department's work in closing the facility can be summarized as follows:

- Patient transfers were accommodated at Spring Grove Hospital.
- DHMH offered a wide range of assistance to employees displaced by the closure (for example, resume and job application assistance, receiving hiring freeze exemptions from the Department of Budget and Management (DBM) for any State agency willing to hire a Carter Center employee, and bus trips to Perkins to apply for positions at that facility). Of the 119 active employees at Carter January 21, 2009, employment status was as follows:
  - 5 remain at Carter (maintenance staff);
  - 23 retired/resigned/otherwise separated;
  - 9 transferred to other State agencies;
  - 38 transferred to other positions within DHMH (excluding Perkins);
  - 25 transferred to Perkins;
  - 5 elected to exercise displacement rights; and
  - 14 were laid off.
- Tenant status was as follows:
  - Baltimore Crisis Response Incorporated has acquired a new location and was planning to move at the end of December 2009;
  - The University of Maryland's Fayette Street Clinic relocated to 701 Pratt Street on August 21, 2009 (that building has also been renamed in honor of Walter P. Carter);
  - Programs of Assertive Community Treatment also moved to 701 Pratt Street on August 21, 2009;

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- The Behavioral Pediatrics Clinic relocated to 22 S. Greene Street on June 18, 2009;
- The Methadone Clinic was remaining on-site until the end of fiscal 2010 and is working on plans to find a new building; and
- Upton School is in the process of relocating to 500 Orchard Street but is no longer in operation at the Carter Center. The report indicated that there was no definitive start date at the new location.

The department intends to declare the building surplus and refer it to the Department of Planning for disposition through the clearinghouse process.

**The report satisfies the reporting requirement included in Chapter 484, and DLS recommends releasing the withheld funds. A letter to that effect will be drafted after the budget hearings unless concerns are raised at those hearings which require additional action by the department.** DLS would note, however, that the substantial amount of funding being withheld (\$10 million) means that some degree of urgency needs to be attached to releasing these funds.

## **2. Cost of Somatic Care**

During the 2009 session, the MHA budget analysis noted the significant increase in the cost of off-grounds outpatient and inpatient somatic medical costs. DLS recommended some cost sharing of somatic costs for forensic patients transferred from local correctional facilities to the State-run psychiatric facilities. Specifically, DLS recommended seeking reimbursement from the county of origin for somatic costs over \$25,000 for any transferred individual forensic patient.

The budget committees declined to impose such cost-sharing but did ask for additional data. DHMH submitted a report and noted that total off-grounds somatic care for forensic patients in fiscal 2009 amounted to almost \$2.5 million for over 600 patients. Of this, \$857,402 was the amount of funding over \$25,000 per individual, for just 15 forensic patients. Expenditures over \$25,000 per individual for those transferred from local correctional facilities was \$383,790, representing just 5 patients (3 from Baltimore City, and 1 each from Baltimore and Queen Anne's counties).

## ***Current and Prior Year Budgets***

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

	<b><u>General Fund</u></b>	<b><u>Special Fund</u></b>	<b><u>Federal Fund</u></b>	<b><u>Reimb. Fund</u></b>	<b><u>Total</u></b>
<b>Fiscal 2009</b>					
Legislative Appropriation	\$641,369	\$5,272	\$271,902	\$8,773	\$927,315
Deficiency Appropriation	10,000	326	11,796	0	22,122
Budget Amendments	10,563	5,557	8,004	456	24,581
Cost Containment	-23,954	-2	-1,504	0	-25,459
Reversions and Cancellations	-29	-1,186	-1,669	-1,508	-4,392
<b>Actual Expenditures</b>	<b>\$637,949</b>	<b>\$9,967</b>	<b>\$288,529</b>	<b>\$7,721</b>	<b>\$944,166</b>
<b>Fiscal 2010</b>					
Legislative Appropriation	\$665,285	\$8,636	\$296,285	\$8,295	\$978,500
Cost Containment	-43,743	-8	-13,125	0	-56,876
Budget Amendments	55	14,494	16,244	0	30,793
<b>Working Appropriation</b>	<b>\$621,597</b>	<b>\$23,122</b>	<b>\$299,403</b>	<b>\$8,295</b>	<b>\$952,417</b>

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

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## **Fiscal 2009**

The fiscal 2009 legislative appropriation for MHA was increased by just over \$16.9 million. This increase was derived as follows:

- Deficiency appropriations added just over \$22.1 million. Most of this amount, just under \$20.0 million (\$10.0 million in each of general and federal funds) was based on demand for the fee-for-service community mental health system. The remainder was almost \$1.8 million in federal funds to cover costs associated with the development of a statewide framework for early childhood mental health, the Baltimore City capitation project, and the ASO contract and \$326,000 in special funds from increased tenant collections at Carter and collections from shared services at Finan.
- An increase of almost \$25.0 million through budget amendments. Specifically:
  - General fund budget amendments increased the legislative appropriation by almost \$10.6 million. Significant additions included just over \$3.3 million representing MHA's share of the fiscal 2009 cost-of-living adjustment originally budgeted in DBM; almost \$2.9 million for a provider rate adjustment derived from fiscal 2008 lottery overattainment (Chapters 335 and 589 of 2008 directed these overattained funds to provide the rate adjustment); and almost \$4.5 million transferred into MHA from other parts of DHMH as part of the close-out process.
  - Special fund budget amendments increased the legislative appropriation by almost \$5.6 million. The three major increases in special funds were almost \$2.7 million in funding from the Health Care Coverage Fund to effectively eliminate Medicaid Day Limit cost containment in fiscal 2009; just over \$2.2 million in similar funding for costs associated with the State's expansion of Medicaid to eligible parents; and \$653,000 from additional tenant collections at the Carter Center and RICA Southern Maryland.
  - Federal fund budget amendments added just over \$8.0 million to the legislative appropriation. Almost \$6.9 million represented the federal matching funds for the provider rate adjustment, ending Medicaid day limit cost containment, and Medicaid expansion increases noted above. The remainder, just over \$1.1 million, was based on underestimated Medicaid attainment for administrative costs.
  - Reimbursable budget amendments added \$456,000 to the legislative appropriation. The largest transfer was \$356,000 from the Developmental Disabilities Administration related to costs associated with the newly opened forensic units for developmentally disabled patients at Perkins and Springfield.
- The increase to the legislative appropriation derived from deficiencies and budget amendments was partially offset by almost \$25.5 million in fiscal 2009 cost containment

*M00L – DHMH – Mental Hygiene Administration*

actions taken by BPW. Most of the cost containment related to personnel expenditures from abolishing vacant positions, deleting funding for Other Post Employment Benefits, reducing budgeted funding for health insurance costs based on the use of statewide health insurance balances, and employee furloughs.

However, MHA has also experienced specific reductions to programs, including reductions in provider rates, a 1% reduction in fee-for-service community mental health general fund support tightening inpatient and RTC admissions and length of stay while leaving medical necessity criteria unchanged, a 1% across-the-board reduction in general fund support for CSA grant awards (\$630,000), savings from the fiscal 2009 Veterans Behavioral Health initiative based on start-up and implementation delays, lowering reimbursements to RTCs, operational savings across the State-run psychiatric facilities, as well as a reduction at Springfield related to the repayment of an energy loan contract to be back-filled by special funds from the Strategic Energy Investment fund.

- The legislative appropriation was further reduced by \$29,000 in general fund reversions and just under \$4.4 million in cancellations spread across special, federal, and reimbursable funds.

## **Fiscal 2010**

To date, the fiscal 2010 legislative appropriation has been reduced by almost \$26.1 million. This change reflects:

- Cost containment taken by BPW in July, August, and November 2009 totaling just under \$56.9 million. For details see the body of the analysis.
- Cost containment reductions have been partially offset by almost \$30.8 million in budget amendments. Specifically:
  - General fund budget amendments have increased the appropriation by \$55,000 based on internal reorganization.
  - Special fund budget amendments have increased the appropriation by just over \$14.5 million, again based on transfers from the Health Care Coverage Fund to cover expenditures derived from the Medicaid expansion to eligible parents.
  - Federal funds have increased by just over \$16.2 million, \$14.5 million representing the federal fund match to the Medicaid expansion funding noted above, as well as \$1.75 million in Medicaid funds as a result of the State resuming federal fund claims for Targeted Case Management.

## ***Audit Findings***

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Unit Audited	Springfield Hospital Center
Audit Period for Last Audit:	December 1, 2005 – September 30, 2008
Issue Date:	April 2009
Number of Findings:	2
Number of Repeat Findings:	1
% of Repeat Findings:	50%
Rating: (if applicable)	

***Finding 1:*** **Springfield Hospital Center had not established adequate controls over pharmaceutical and dietary inventories. The department agreed with the finding and recommendations although notes that this is an issue at every facility and may be difficult to rectify.**

***Finding 2:*** **Controls over patient and welfare funds were inadequate. The department agreed with the finding and recommendations.**

\*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>FY09 Actual</u>	<u>FY10 Working Appropriation</u>	<u>FY11 Allowance</u>	<u>FY10 - FY11 Amount Change</u>	<u>Percent Change</u>
<b>Positions</b>					
01 Regular	3,182.20	2,914.05	2,906.55	-7.50	-0.3%
02 Contractual	215.91	203.04	187.84	-15.20	-7.5%
<b>Total Positions</b>	<b>3398.11</b>	<b>3117.09</b>	<b>3094.39</b>	<b>-22.70</b>	<b>-0.7%</b>
<b>Objects</b>					
01 Salaries and Wages	\$ 218,059,878	\$ 195,013,073	\$ 211,516,305	\$ 16,503,232	8.5%
02 Technical and Spec. Fees	10,551,653	8,444,294	8,706,858	262,564	3.1%
03 Communication	848,240	824,914	729,858	-95,056	-11.5%
04 Travel	171,869	189,297	149,751	-39,546	-20.9%
06 Fuel and Utilities	11,179,072	13,625,934	11,756,496	-1,869,438	-13.7%
07 Motor Vehicles	737,856	833,267	648,426	-184,841	-22.2%
08 Contractual Services	683,012,820	715,054,595	736,357,577	21,302,982	3.0%
09 Supplies and Materials	17,952,415	17,002,979	16,290,526	-712,453	-4.2%
10 Equipment – Replacement	688,166	447,442	325,553	-121,889	-27.2%
11 Equipment – Additional	74,207	101,544	300	-101,244	-99.7%
12 Grants, Subsidies, and Contributions	235,729	353,734	331,553	-22,181	-6.3%
13 Fixed Charges	654,206	526,248	560,020	33,772	6.4%
<b>Total Objects</b>	<b>\$ 944,166,111</b>	<b>\$ 952,417,321</b>	<b>\$ 987,373,223</b>	<b>\$ 34,955,902</b>	<b>3.7%</b>
<b>Funds</b>					
01 General Fund	\$ 637,949,178	\$ 621,597,413	\$ 636,272,551	\$ 14,675,138	2.4%
03 Special Fund	9,967,097	23,121,830	23,383,835	262,005	1.1%
05 Federal Fund	288,528,896	299,403,365	321,933,089	22,529,724	7.5%
09 Reimbursable Fund	7,720,940	8,294,713	5,783,748	-2,510,965	-30.3%
<b>Total Funds</b>	<b>\$ 944,166,111</b>	<b>\$ 952,417,321</b>	<b>\$ 987,373,223</b>	<b>\$ 34,955,902</b>	<b>3.7%</b>

Note: The fiscal 2010 appropriation does not include deficiencies.

**Fiscal Summary**  
**DHMH – Mental Hygiene Administration**

<u>Program/Unit</u>	<u>FY09 Actual</u>	<u>FY10 Wrk Approp</u>	<u>FY11 Allowance</u>	<u>Change</u>	<u>FY10 - FY11 % Change</u>
01 Mental Hygiene Administration	\$ 666,240,028	\$ 685,158,134	\$ 722,796,392	\$ 37,638,258	5.5%
03 Walter P. Carter Community Mental Health Center	13,607,277	6,293,336	925,799	-5,367,537	-85.3%
04 Thomas B. Finan Hospital Center	18,149,462	18,315,467	18,435,745	120,278	0.7%
05 Regional Institute for Children and Adolescents - Baltimore City	12,493,819	12,539,425	12,645,931	106,506	0.8%
06 Crownsville Hospital Center	1,532,081	1,504,798	1,424,248	-80,550	-5.4%
07 Eastern Shore Hospital Center	17,750,500	17,888,073	18,218,953	330,880	1.8%
08 Springfield Hospital Center	72,319,766	71,114,533	73,724,277	2,609,744	3.7%
09 Spring Grove Hospital Center	76,348,471	73,696,616	77,230,800	3,534,184	4.8%
10 Clifton T. Perkins Hospital Center	43,752,614	47,344,309	49,958,757	2,614,448	5.5%
11 John L. Gildner Reg. Institute for Children and Adolescents	12,864,969	11,554,331	10,933,124	-621,207	-5.4%
12 Upper Shore Community Mental Health Center	8,963,703	6,542,486	1,017,768	-5,524,718	-84.4%
14 Regional Institute for Children and Adolescents – South Maryland	143,421	465,813	61,429	-404,384	-86.8%
<b>Total Expenditures</b>	<b>\$ 944,166,111</b>	<b>\$ 952,417,321</b>	<b>\$ 987,373,223</b>	<b>\$ 34,955,902</b>	<b>3.7%</b>
General Fund	\$ 637,949,178	\$ 621,597,413	\$ 636,272,551	\$ 14,675,138	2.4%
Special Fund	9,967,097	23,121,830	23,383,835	262,005	1.1%
Federal Fund	288,528,896	299,403,365	321,933,089	22,529,724	7.5%
<b>Total Appropriations</b>	<b>\$ 936,445,171</b>	<b>\$ 944,122,608</b>	<b>\$ 981,589,475</b>	<b>\$ 37,466,867</b>	<b>4.0%</b>
Reimbursable Fund	\$ 7,720,940	\$ 8,294,713	\$ 5,783,748	-\$ 2,510,965	-30.3%
<b>Total Funds</b>	<b>\$ 944,166,111</b>	<b>\$ 952,417,321</b>	<b>\$ 987,373,223</b>	<b>\$ 34,955,902</b>	<b>3.7%</b>

Note: The fiscal 2010 appropriation does not include deficiencies.