M00L
Mental Hygiene Administration
Department of Health and Mental Hygiene

Operating Budget Data

($ in Thousands)

	FY 12 Actual	FY 13 Working	FY 14 Allowance	FY 13-14 Change	% Change Prior Year
General Fund	$705,173	$675,453	$702,205	$26,752	4.0%
Contingent & Back of Bill Reductions	0	0	-370	-370	
Adjusted General Fund	**$705,173**	**$675,453**	**$701,835**	**$26,382**	**3.9%**
Special Fund	22,472	35,004	24,381	-10,623	-30.3%
Contingent & Back of Bill Reductions	0	0	-1	-1	
Adjusted Special Fund	**$22,472**	**$35,004**	**$24,380**	**-$10,624**	**-30.4%**
Federal Fund	348,722	353,790	408,049	54,259	15.3%
Contingent & Back of Bill Reductions	0	0	-4	-4	
Adjusted Federal Fund	**$348,722**	**$353,790**	**$408,045**	**$54,255**	**15.3%**
Reimbursable Fund	4,926	4,464	4,415	-49	-1.1%
Adjusted Reimbursable Fund	**$4,926**	**$4,464**	**$4,415**	**-$49**	**-1.1%**
Adjusted Grand Total	**$1,081,293**	**$1,068,711**	**$1,138,675**	**$69,964**	**6.5%**

- The Mental Hygiene Administration (MHA) reported that almost $4.2 million in community mental health service bills from fiscal 2012 were rolled into fiscal 2013. However, favorable enrollment and utilization trends appear to obviate the need for a fiscal 2013 budget deficiency. Indeed, the fiscal 2013 budget appears overfunded.

- The fiscal 2014 community mental health services budget includes funding for the expansion of Medicaid to 138.0% of the federal poverty level, a 2.54% rate increase for community-based providers, and a significant rate increase for specialty physicians (psychiatrists). Funding of the base Medicaid program, based on the continuation of favorable enrollment and utilization trends, appears more than adequate.

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

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Personnel Data

	FY 12 Actual	FY 13 Working	FY 14 Allowance	FY 13-14 Change
Regular Positions	2,824.95	2,854.95	2,854.95	0.00
Contractual FTEs	216.30	188.04	185.56	-2.48
Total Personnel	**3,041.25**	**3,042.99**	**3,040.51**	**-2.48**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	163.30	5.72%
Positions and Percentage Vacant as of 12/31/12	208.35	7.30%

- The fiscal 2014 budget assumes modest savings ($150,000) from a proposed merger of MHA with the Alcohol and Drug Abuse Administration.

- The budget also offers some relief from the high turnover rate built into the fiscal 2013 budget (an artificially high rate based on savings from the closure of assisted living units at Springfield and Spring Grove). However, the assumed turnover rate is still higher than budgeted in recent years.

Analysis in Brief

Major Trends

Community Mental Health Fee-for-service System: Enrollment and Utilization Trends: Enrollment growth in the fee-for-service system has begun to moderate. Utilization of inpatient and Residential Treatment Center (RTC) services slowed markedly in fiscal 2012.

Community Mental Health Fee-for-service System: Expenditure Trends: Expenditure trends broadly mirror enrollment and utilization trends. Growth in expenditures between fiscal 2011 and 2012 is projected at only 3%. Spending patterns between services for adults and the 0 to 21 population show some interesting differences.

Outcomes for Community Mental Health Services: Strong gains in adult functioning were revealed in the most recent Outcomes Measurement System data.

Facility Performance Measures: Readmission rates for the State-run psychiatric facilities continue to be below the national average.

Issues

Residential Treatment Centers: Data submitted on RTCs underscores the issues confronting the youth utilizing these high-intensity services. Interesting differences between RTCs are identified although not always explained. Meaningful outcome measures that are consistently and rigorously collected across all of the RTCs remain elusive.

Future State-run Psychiatric Facility Bed Need: In the 2012 interim, an independent report on projected State-run psychiatric facility bed need was released. The study projected various levels of future demand depending on the extent of community investments made by the department in alternative treatment. The department rejected the bed need projections as premature.

Recommended Actions

		Funds
1.	Reduce funding for emergency admission payments.	$ 50,000
2.	Delete funding for purchase of care beds.	1,250,000
3.	Adopt narrative on the development of outcome measures for Residential Treatment Centers.	
	Total Reductions	**$ 1,300,000**

M00L
Mental Hygiene Administration
Department of Health and Mental Hygiene

Operating Budget Analysis

Program Description

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

- plans and develops comprehensive services for the mentally ill;
- supervises State-run psychiatric facilities for the mentally ill;
- reviews and approves local plans and budgets for mental health programs;
- provides consultation to State agencies concerning mental health services; 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 19 CSAs, some organized as part of local health departments, some as nonprofit agencies, and 2 as multi-county enterprises.
- ***State-run Psychiatric Facilities*** include five hospitals and two Residential Treatment Centers (RTC) – 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.

The carved-out system is overseen by MHA, although it contracts with an administrative services organization (ASO), currently 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. Effective January 1, 2014, Medicaid expansion authorized under the federal Patient Protection and Affordable Care Act of 2010 (ACA) will provide full Medicaid benefits to individuals up to 138% of FPL.

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; anyone discharged from a Maryland psychiatric hospital in the past three months; and anyone within three months of release from a correctional institution.

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

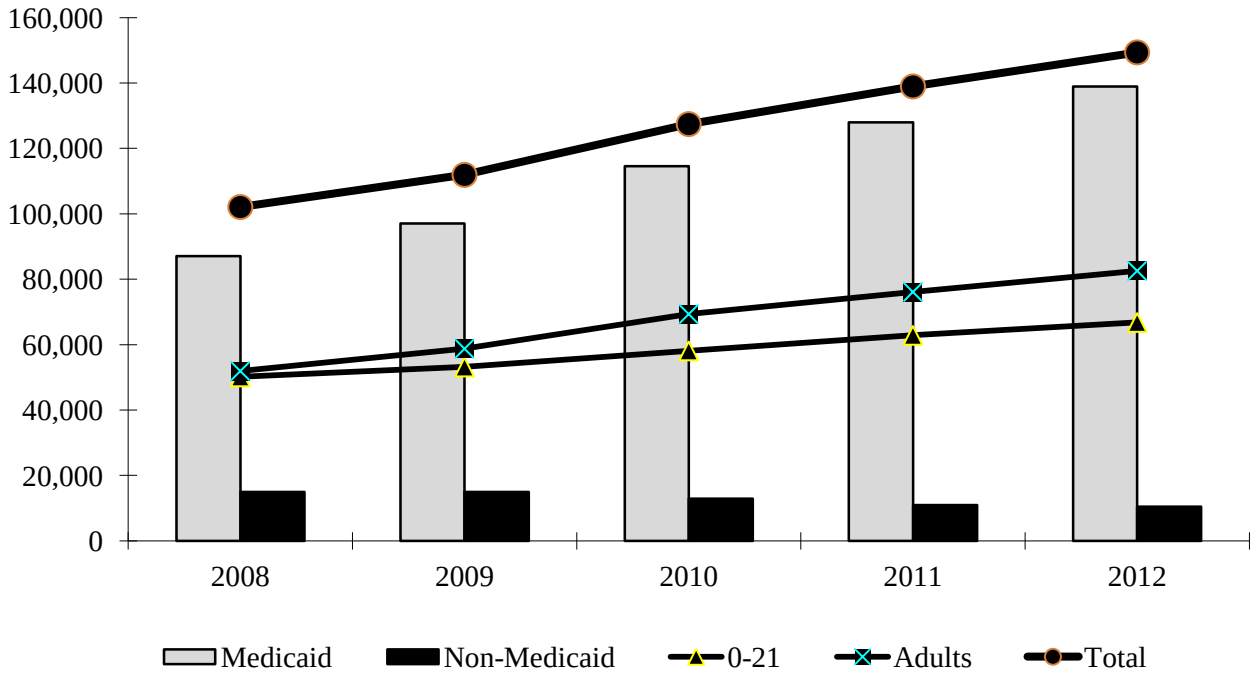
The key goals of the agency include improving the efficacy of community-based care for persons with mental illness and promoting recovery among persons with mental illness in State-run psychiatric facilities so that they may move into less restrictive settings.

Performance Analysis: Managing for Results

1. Community Mental Health Fee-for-service System: Enrollment and Utilization Trends

As shown in **Exhibit 1**, total enrollment in the FFS community mental health system (Medicaid and non-Medicaid) has increased at an average annual rate of 9.0% between fiscal 2008 and 2012. Consistent with the growth in the Medicaid program overall, the recession, as well as Medicaid expansion beginning in fiscal 2009, has resulted in enrollment growth accelerating in recent years, rising by 14.0% between fiscal 2009 and 2010. However, enrollment growth in the FFS community mental health system, as with Medicaid, is beginning to slow with growth of 9.0% between fiscal 2010 and 2011 and 7.5% between fiscal 2011 and 2012.

Exhibit 1
Community Mental Health Services Enrollment Trends
Fiscal 2008-2012



Note: Data for fiscal 2012 is incomplete. Enrollment counts may be duplicated across coverage types. Enrollment in the Baltimore City capitation project is included.

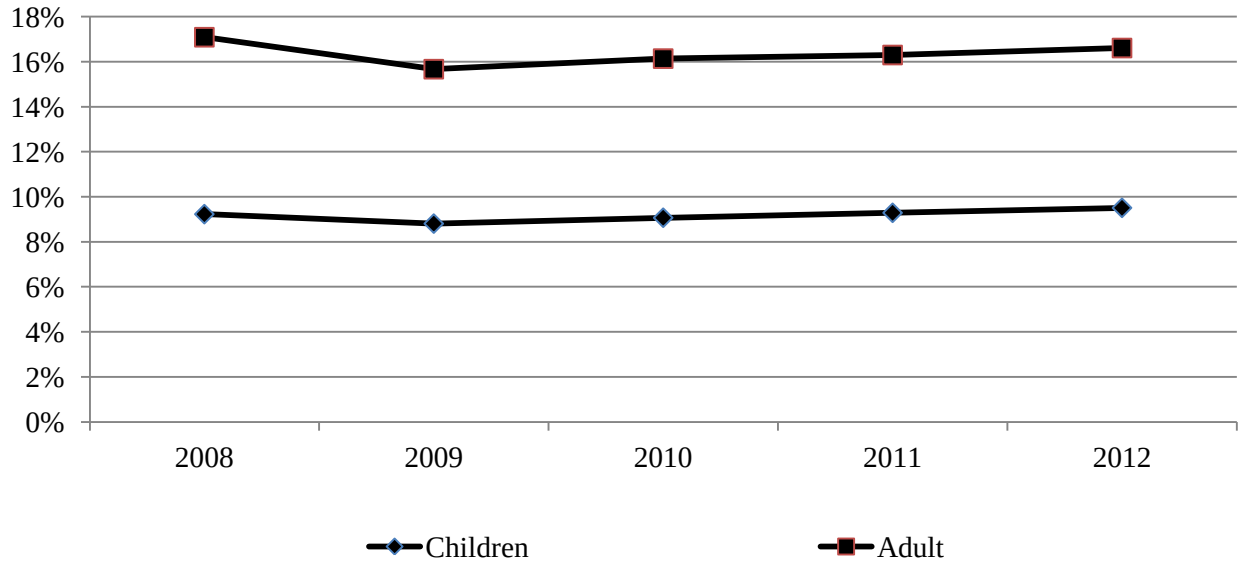
Source: Department of Legislative Services; Department of Health and Mental Hygiene

The exhibit underscores the relative importance of client growth from the Medicaid program over non-Medicaid/uninsured clients. Recent growth is almost exclusively in the Medicaid-eligible category (12% between fiscal 2008 and 2012 and 9% between fiscal 2011 and 2012) with the non-Medicaid population falling for the second year in a row, down 14% between fiscal 2010 and 2011 and a further 5% between fiscal 2011 and 2012. This drop in the non-Medicaid population served reflects a series of efforts to drive down non-Medicaid service spending, which is entirely State funded, for cost containment.

The exhibit also shows that enrollment growth over the period has been driven by adults (12% between fiscal 2008 and 2012) reflecting the Medicaid expansion to parents and also to some extent the recent strong growth in the PAC program. This compares to 7% for children and adolescents. Adults make up 55% of total enrollment in fiscal 2012 compared to just over 50% in fiscal 2008. However, the mix of adults and the 0 to 21 group is the same percentage as in fiscal 2011, reflecting a relative similar growth trend between the two population groups.

The percentage of Medicaid enrollees utilizing FFS community mental health services, the penetration rate, again grew slightly between fiscal 2011 and 2012. The rate grew from 9.3 to 9.5% among children enrolled in Medicaid/Maryland Children's Health Program (MCHP) and from 16.3 to 16.6% among adults. As shown in **Exhibit 2**, the penetration rate in fiscal 2012 for children surpassed the level of fiscal 2008, while the adult rate remains slightly below the fiscal 2008 level. The increase on the adult side is attributed to a larger number of dual-eligible individuals (with substance abuse and mental health issues) becoming eligible for Medicaid or PAC, and this is expected to continue with the proposed Medicaid expansion under ACA.

Exhibit 2
Community Mental Health Services Penetration Rate
Fiscal 2008-2012

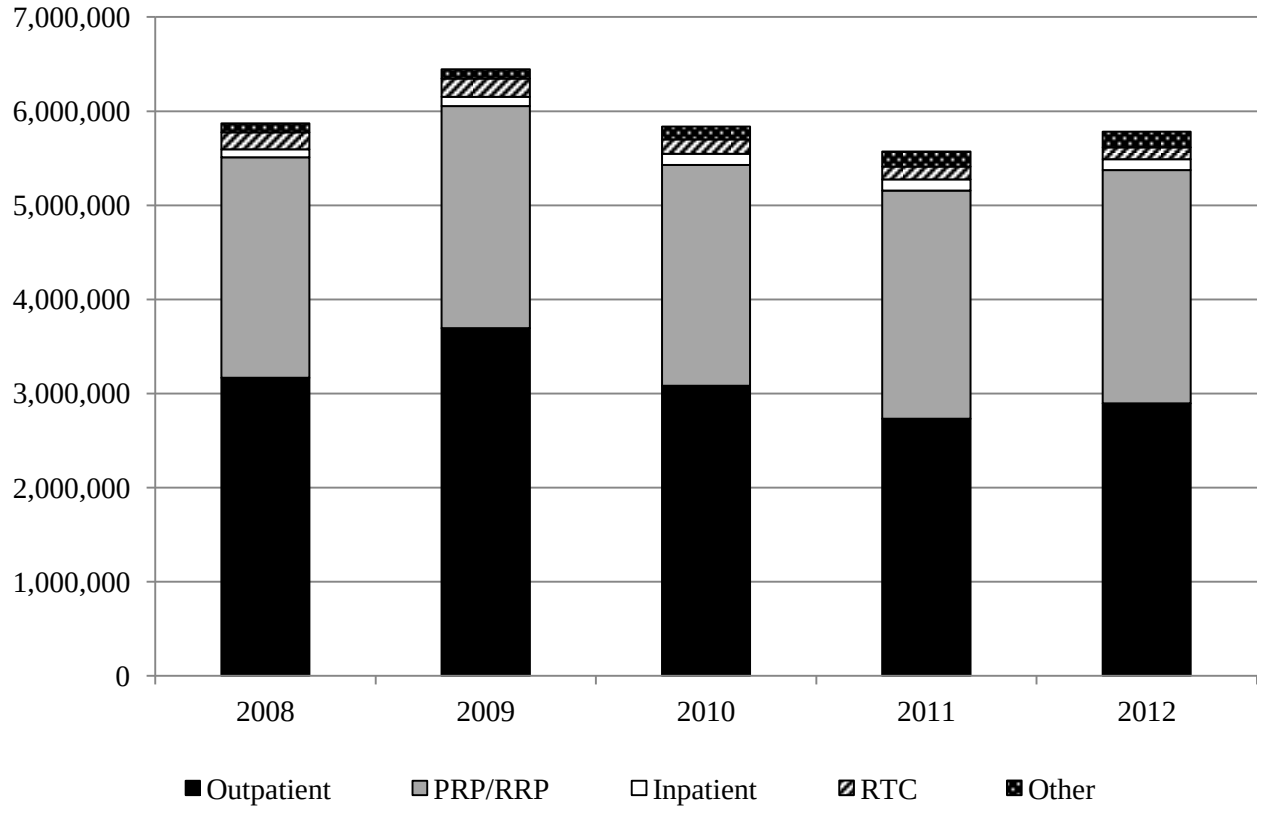


Note: Data for fiscal 2012 is incomplete.

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

In terms of utilization of services, trends are shown in **Exhibit 3**. The exhibit shows a sharp jump in total service units between fiscal 2008 and 2009, a jump that correlates with Medicaid expansion in fiscal 2009. Interestingly, total service units provided fell in fiscal 2010 and 2011 driven largely by a decline in outpatient service units in both years. This decline related to MHA's decision to reduce what it saw as overutilization of intensive outpatient services. In addition to utilization review, it ended intensive outpatient services as a benefit for the uninsured. The number of service units delivered began to grow again in fiscal 2012 although not in inpatient or RTCs.

Exhibit 3
Community Mental Health
Fee-for-service Service Utilization Trends (Units of Service)
Fiscal 2008-2012



PRP: Psychiatric Rehabilitation Program
RRP: Resident Rehabilitation Program
RTC: Residential Treatment Center

Note: Data for fiscal 2012 is incomplete. Total service unit data includes service units for the Baltimore City capitation project.

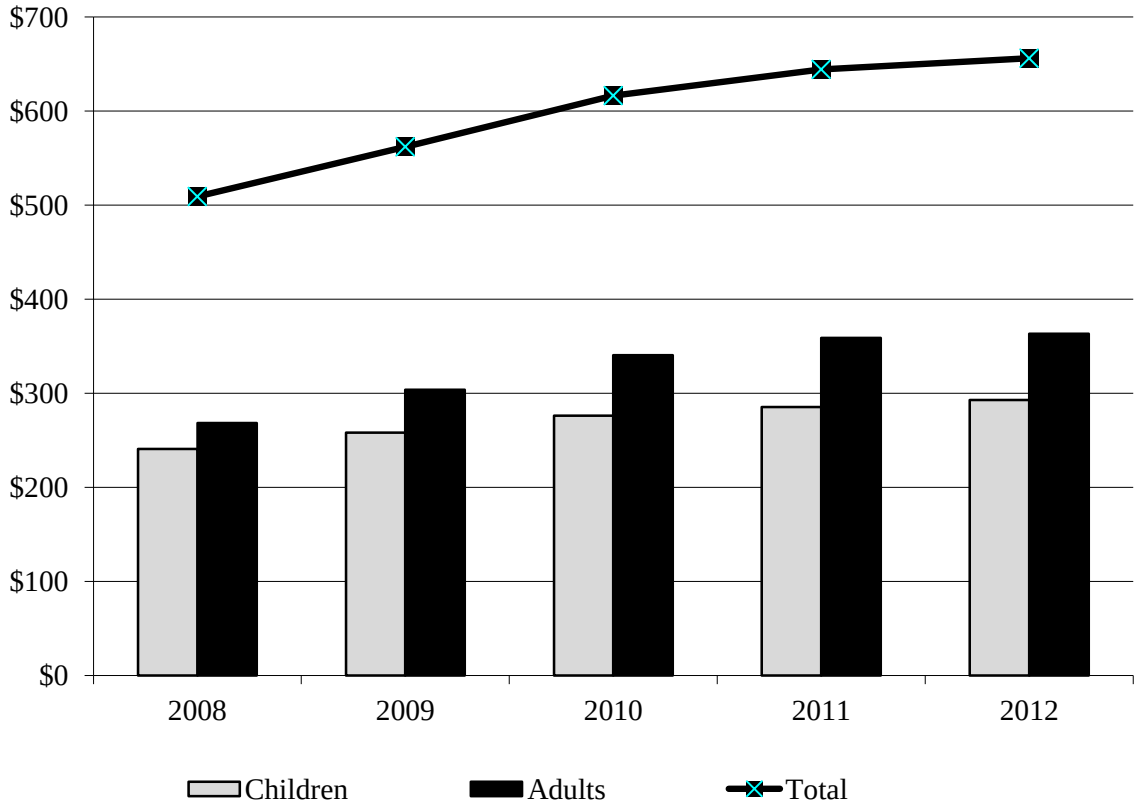
Source: Department of Legislative Services; Department of Health and Mental Hygiene

The growth between fiscal 2011 and 2012 appears to be driven mostly by enrollment. Average per capita service utilization in the major service utilization categories (outpatient and psychiatric rehabilitation) remains largely unchanged between fiscal 2011 and 2012 beyond a small drop in psychiatric rehabilitation services.

2. Community Mental Health Fee-for-service System: Expenditure Trends

Expenditure patterns broadly mirror enrollment growth (**Exhibit 4**). Expenditure growth over the period fiscal 2008 to 2012 is 6.6%. In the middle of the period, growth was somewhat higher (8.0% between fiscal 2009 and 2010) but has begun to slow (4.5% between fiscal 2010 and 2011 and projected at 3.0% between fiscal 2011 and 2012).

Exhibit 4
Community Mental Health
Fee-for-service Expenditures
Fiscal 2008-2012
($ in Millions)

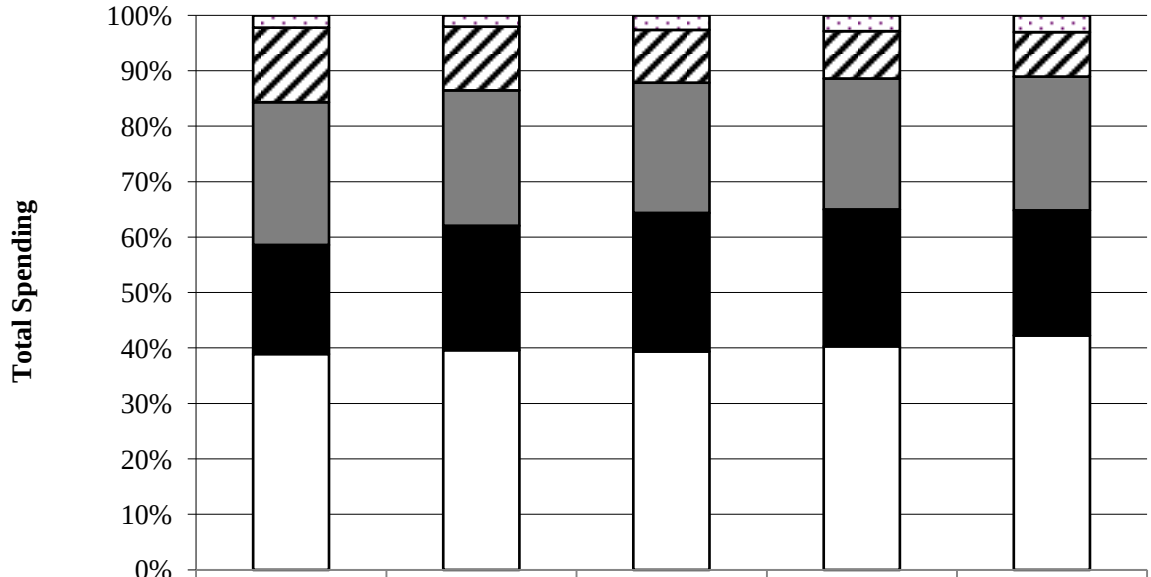


Note: Data for fiscal 2012 is incomplete. Total expenditures exclude funding for the Baltimore City capitation project.

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

In addition to slowing expenditure growth, there has been a change in expenditure patterns between different services. The decline in inpatient and RTC service units provided shown in Exhibit 3 is reflected in the expenditure data shown in **Exhibit 5**.

Exhibit 5
Community Mental Health Service Expenditures by Service Type
Fiscal 2008-2012



	2008	2009	2010	2011	2012
Other	$11,122,399	$11,532,624	$16,174,567	$18,331,147	$19,658,091
RTC	$68,559,249	$64,348,547	$58,430,907	$55,042,932	$52,542,979
PRP and RRP	$131,043,095	$137,319,566	$144,957,126	$152,070,664	$158,254,813
Inpatient	$100,019,339	$126,137,700	$154,084,557	$158,903,478	$148,269,523
Outpatient	$198,314,678	$222,649,404	$242,696,022	$259,860,083	$277,301,361

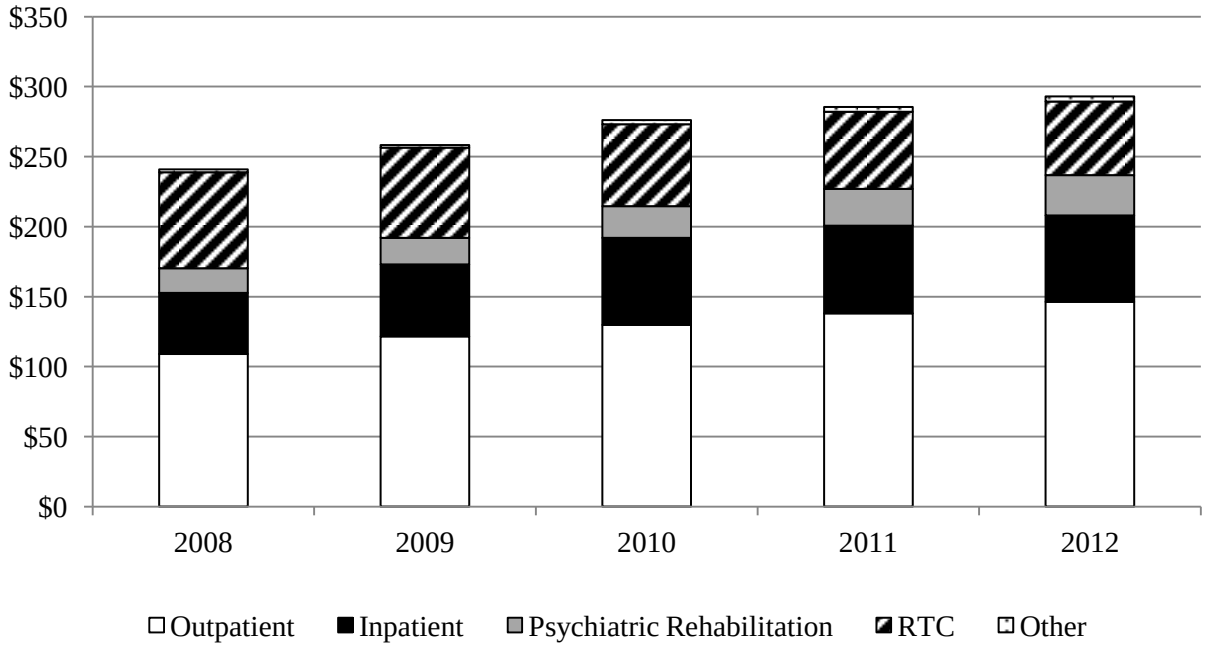
PRP: Psychiatric Rehabilitation Program
RRP: Resident Rehabilitation Program
RTC: Residential Treatment Center

Note: Data for fiscal 2012 is incomplete.

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

There is some significant difference in spending patterns between children and adult services (see **Exhibits 6** and **7)**.

Exhibit 6
Children's Community Mental Health Service Expenditures by Service Type
Fiscal 2008-2012
($ in Millions)

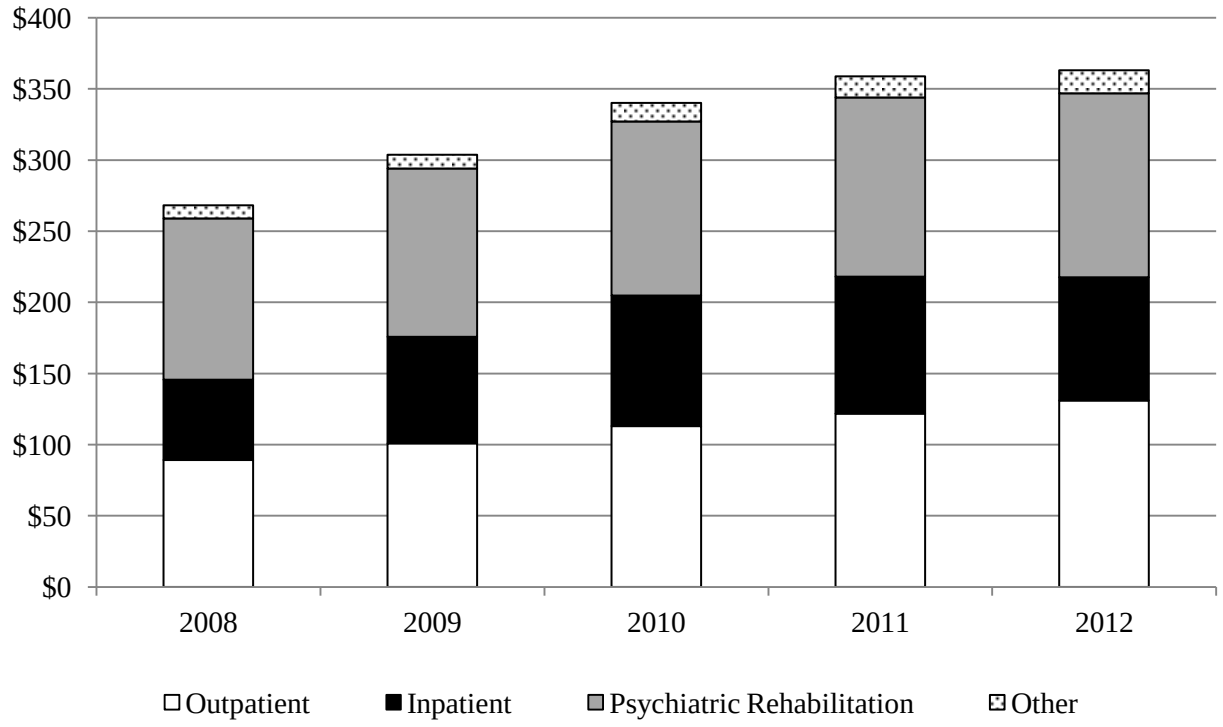


RTC: Residential Treatment Center

Note: Data for fiscal 2012 is incomplete.

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

Exhibit 7
Adult Community Mental Health Service Expenditures by Service Type
Fiscal 2008-2012
($ in Millions)



Note: Data for fiscal 2012 is incomplete.

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

Overall these exhibits show that:

- Spending on children's services increased by 5% between fiscal 2008 and 2012, compared to almost 7.9% for adult services. Spending growth between fiscal 2011 and 2012 in both segments is much lower, although the rate of growth for children's services is twice the amount of growth for adult services.

- For children, since RTC programming is available only for individuals 0 to 21, the decline in those expenditures impacts this segment only. This decline reflects consistently declining utilization, with RTC beds increasingly used for short-term diagnostic and evaluation services rather than longer treatment stays, plus the impact of the roll-out of community slots under the RTC Alternatives demonstration waiver.

- Although spending on psychiatric/residential rehabilitation programming for children is a relatively small part of the total spending on children's mental health services, it has grown sharply in recent years, 13.3% between fiscal 2008 and 2012 compared to 3.3% for adults. Again, MHA attributes this increase to efforts to treat children in the community rather than in institutional care.

- Inpatient spending on children and adults grew at similar rates between fiscal 2008 and 2012, although between fiscal 2011 and 2012, the rate of spending on adult inpatient services has dropped dramatically (10.0%) compared to inpatient children's services which remains relatively flat (down 1.6%).

  This decline in adult inpatient expenditures is attributed to a variety of efforts:

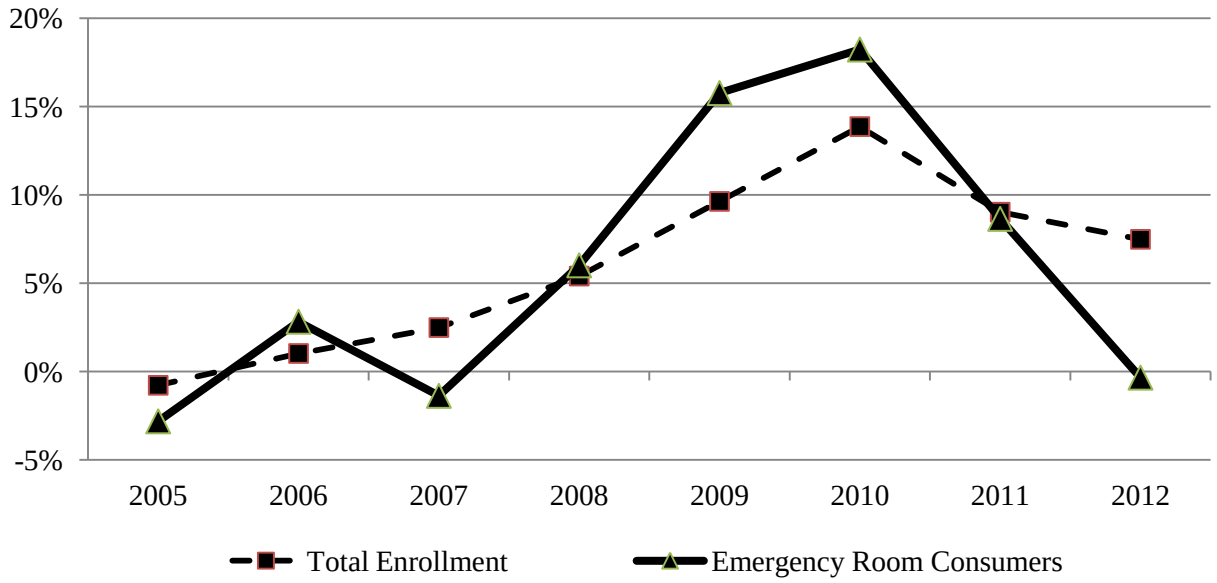
  - ASO management efforts to limit lengths-of-stay;

  - strengthening diversion efforts including ensuring that appropriate contact is made with available crisis services; and

  - connecting high-cost users to appropriate outpatient care at discharge.

Another sense of MHA's efforts to both divert patients from inpatient care and connect them to community-based care at discharge can be seen in **Exhibit 8,** which tracks year-over-year total enrollment growth in the public mental health system with emergency department usage (the emergency room being the gateway to inpatient care). Clearly, there is a change in the number of consumers using emergency rooms in fiscal 2012 compared to fiscal 2011. Other data confirms that the number of service units is also declining.

Exhibit 8
Total Public Mental Health Service Enrollment and Emergency Department Utilization (Unduplicated Consumer Count)
Fiscal 2005-2012 Year-over-year Growth



Note: Data for fiscal 2012 is incomplete.

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

Even given this success in curtailing emergency room utilization, as noted in the fiscal 2013 MHA analysis, additional savings in this area may be possible. This is because Medicaid individuals presenting at emergency rooms with mental illness are much more likely to be admitted to inpatient care than individuals with somatic issues (25% of the time versus 10% of the time with data just for individuals in the Public Mental Health System indicating admissions from emergency rooms at 45%).

3. Outcomes for Community Mental Health Services

Outcome data from MHA's Outcomes Measurement System continues to be limited to outpatient clinics. The data presented in **Exhibit 9** is restricted to clients with at least two data points (generally six months but up to several years apart) and with the same questionnaire type (*i.e.*, the same age group) for those responses. The data compares the initial interview with the most recent interview and compares results from the fiscal 2008, 2009, 2010, 2011, and 2012 cohorts. While this is not an unduplicated sample, there are strong gains in improved functioning for adults. While net improvement in functioning for children was not as high in fiscal 2012 as in fiscal 2011, it was still higher than at any other time. Data on adult employment, while still better than in fiscal 2011, remains a concern.

Exhibit 9
Community Mental Health Services
Outpatient Fee-for-service Selected Outcomes
Fiscal 2008-2012

	Reported in 2008	Reported in 2009	Reported in 2010	Reported in 2011	Reported in 2012
Adult Outcomes					
Net Improvement in Functioning (% of Total Observations)	8.0%	10.2%	12.0%	13.8%	21.8%
Increase in Employment Between Observations (%)	-1.0%	-4.1%	-5.5%	-2.2%	-1.7%
Persons Unemployed in Both Observations (%)	58.0%	59.5%	61.4%	74.0%	63.5%
Homelessness in Both Observations (%)	5.3%	5.3%	6.6%	5.5%	5.5%
Children and Adolescents Outcomes					
Net Improvement in Functioning (% of Total Observations)	9.0%	8.8%	14.3%	16.0%	15.3%

Source: Department of Legislative Services; Mental Hygiene Administration

4. Facility Performance Measures

Data presented in **Exhibit 10** examines readmission trends at the State-run psychiatric hospitals. For the purposes of this discussion, Clifton T. Perkins Hospital (Perkins) is excluded given the nature of programming at that facility.

Exhibit 10
State-run Psychiatric Hospitals: Readmissions within 30 Days of Discharge
(Percent of Total Admissions)
Fiscal 2008-2012

	2008	2009	2010	2011	2012	Trend 2008-2012	Trend 2011-2012
Eastern Shore	5.8%	10.5%	4.0%	3.0%	2.1%	√	√
Finan Center	5.3%	2.7%	1.8%	4.4%	3.4%	√	√
Spring Grove	5.0%	4.0%	4.0%	1.1%	2.4%	√	X
Springfield	8.8%	4.6%	3.4%	4.7%	4.4%	√	√

X: worsened
√: improved

Note: Data excludes assisted living patients

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

As shown in the exhibit, long- and short-term readmission trends are almost universally positive outside a slight increase in the fiscal 2011 to 2012 readmission rate at Spring Grove. Even here, the fiscal 2012 rate remains relatively low. In all cases, State-run psychiatric hospital readmission rates are still significantly below the latest national readmission rate for state-run hospitals of 9%.

Fiscal 2013 Actions

Personnel Actions

Section 25 of Chapter 1 of the First Special Session of 2012 – the Budget Reconciliation and Financing Act (BRFA) of 2012 – required the Governor to abolish at least 100 vacant positions as of January 1, 2013, saving at least $6 million in general funds. MHA saw a position reduction of 55 positions – 34 full-time equivalents (FTE) at Springfield and 21 FTEs at Spring Grove. Many of these positions were vacated as a result of the closure of assisted living units (ALU) that was included in the fiscal 2013 budget. It should be noted that in addition to these 55 abolished positions, 6 other positions associated with the ALU closure were transferred to other parts of the department.

Proposed Deficiency

There is one fiscal 2013 deficiency for MHA, $2,386,986 in federal funds for a variety of program activities including:

- $250,000 for the Maryland Launching Individual Futures Together (LIFT) targeted at youth ages 13 to 17 in Baltimore County with serious emotional disturbances and co-occurring substance abuse needs.

- $250,000 for the Maryland Linking Actions for Unmet Needs in Children's Health Project (LAUNCH) to promote the wellness of young children from birth to 8 years in Prince George's County by addressing physical, social, emotional, cognitive, and behavioral aspects of development.

- $1,377,216 in block grant funds to provide mental health services to dually diagnosed individuals in community services ($924,655) and to provide short-term intensive mental health crisis services for children, adolescents, and adults in community settings ($452,561).

- $509,770 in federal funds will be utilized by CSAs and the University of Maryland to develop and implement a statewide system of care that meets the co-occurring substance abuse and mental health needs of Maryland's children and their families.

General Fund Unprovided for Payables

Exhibit 11 details the fiscal 2012 schedule of general fund unprovided for payables in MHA. These amounts represent bills from fiscal 2012 that were rolled into fiscal 2013 because the agency had insufficient funds to pay those bills in fiscal 2012. None of these items were provided a deficiency appropriation in the fiscal 2014 budget.

Exhibit 11
Fiscal 2012 General Fund Unprovided for Payables
Mental Hygiene Administration

Program	Unprovided for Payable
Community mental health services for the uninsured	$2,396,647
Community mental health services for Medicaid recipients	1,760,280
Spring Grove Hospital Center: various operating expenses	353,834
RICA-Gildner: various operating expenses	48,570
Total	**$4,559,511**

RICA: Regional Institutes for Children and Adolescents

Source: Department of Legislative Services

The deficits reported at the two facilities are of a magnitude that a deficiency appropriation was unlikely. Those facilities will be expected to manage those payables with their fiscal 2013 appropriation. As for the community mental health services deficits, it should be noted that the levels noted in the exhibit are significantly lower than reported in prior years. The department indicates that based on current spending trends, the actual level of unprovided for payables may be less than reported because of available accruals. In any event, as is discussed below in more detail, an analysis of fiscal 2013 spending trends indicates that the fiscal 2013 appropriation is more than adequate to take care of these deficits without the need for a deficiency appropriation.

Proposed Budget: Funding for Community Mental Health Medicaid Expansion and Rate Increases Spur Budget

As shown in **Exhibit 12**, the Governor's fiscal 2014 allowance for MHA is just under $70.0 million (6.5%) above the fiscal 2013 working appropriation. As also shown in the exhibit, there are some significant fund changes in the 2014 budget compared to the fiscal 2013 working appropriation. Notably, special funds fall by $10.6 million, $10.5 million (99.0%) of which relates to Budget Restoration Fund support in the fiscal 2013 working appropriation (for salary increases, community provider rate adjustments, and operations at the two RICAs) that is replaced by general funds in fiscal 2014. Federal fund growth of almost $54.3 million (15.3%) is primarily related to the January 1, 2014 expansion of Medicaid to 138.0% of FPL.

Exhibit 12
Proposed Budget
DHMH – Mental Hygiene Administration
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
2013 Working Appropriation	$675,453	$35,004	$353,790	$4,464	$1,068,711
2014 Allowance	702,205	24,381	408,049	4,415	1,139,050
Amount Change	$26,752	-$10,623	$54,259	-$49	$70,339
Percent Change	4.0%	-30.3%	15.3%	-1.1%	6.6%
Contingent Reduction	-$370	-$1	-$4	$0	-$375
Adjusted Change	$26,382	-$10,624	$54,255	-$49	$69,964
Adjusted Percent Change	3.9%	-30.4%	15.3%	-1.1%	6.5%

Where It Goes:

Personnel Expenses	**$6,235**	
Retirement contributions		$3,536
Employee and retiree health insurance		2,052
Annualization of fiscal 2013 2% cost-of-living adjustment		1,626
Workers' compensation premium assessment		1,027
Turnover adjustments		830
Other fringe benefit adjustments		24
Accrued leave payout		-105
Social Security contributions		-189
Regular salaries (savings from positions abolished in fiscal 2013)		-2,566
Community Mental Health Services	**$64,135**	
Fee-for-service Expenditures	***$56,018***	
Medicaid expansion effective January 1, 2014		28,258
Provider rate adjustment (2.54% for non-regulated services)		13,018
Specialty physician rate increase to Medicare rates		8,007
Non-Medicaid expansion enrollment and utilization		6,735
Grants and Contracts	***$8,117***	
Alternative placements to Residential Treatment Centers		4,107
Grants and contracts provider rate adjustment		1,200
Maryland LIFT (federal funds)		1,000
Maryland LAUNCH (federal funds)		839
Community mental health service block grant funding (federal funds)		655
Shelter care (federal funds)		353
Administrative Services Organization contractual fee		343
Emergency admissions		102
Maryland CARES (federal funds)		-482
Facilities (Excluding Personnel)	**-$500**	
Contractual employment		205
Vehicle costs		165
Food		105
Fuel and utilities		-446
Medical care (Spring Grove and Springfield)		-529
Other		94
Total		**$69,964**

CARES: Community Action and Referral Effort
LAUNCH: Linking Actions for Unmet Needs in Children's Health Project
LIFT: Launching Individual Futures Together

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

Personnel and Facility Expenditures

Personnel expenditures, 96% of which are at the State-operated psychiatric facilities, increase by just over $6.2 million. Significant increases include the following: over $3.5 million in retirement contributions (attributable to underattaining investment returns, adjusting actuarial assumptions, and increasing the reinvestment of savings achieved in the 2011 pension reform); almost $2.1 million in higher health insurance costs; over $1.6 million to support the annualization of the fiscal 2013 2% cost-of-living adjustment (COLA) that was effective January 1, 2013; and just over $1.0 million for increased workers' compensations premiums.

Another interesting increase is $830,000 in turnover adjustments (*i.e.*, reducing the amount of budgeted turnover from fiscal 2013 to 2014). This increase is noteworthy for several reasons:

- According to the department, the fiscal 2014 budget for MHA includes a turnover adjustment increasing turnover by $150,000 to reflect savings that will result from the integration of the Alcohol and Drug Abuse Administration (ADAA) and MHA. This administrative integration together with a discussion of wider service delivery and financing integration and workforce regulatory changes is discussed in detail in the ADAA analysis. As a result, the actual turnover adjustment for regular operations is closer to $1 million.

- The number of vacant positions required to meet turnover requirements in the fiscal 2014 budget is 163.3 FTEs (5.72%), well below the 208.35 FTE vacant positions as of December 31, 2012. This is even after the 55.0 FTE positions abolished at Springfield (34.0 FTEs) and Spring Grove (21.0 FTEs) by the Board of Public Works (BPW) on January 2, 2013.

- The turnover adjustment in the fiscal 2013 working appropriation was artificially high because savings in personnel costs as a result of the ALU units at Springfield and Spring Grove were taken as turnover adjustments. Thus, an increase in funding to reduce budgeted turnover would be expected. However, the turnover adjustment that remains in the budget is still significantly higher than traditionally used for MHA (generally between 4.0 and 5.0%). While the facilities often have higher vacancy rates than needed to meet turnover, the funding not used for salaries is instead used for overtime and contractual support.

It has long been an issue that staffing ratios at the State-run psychiatric facilities do not meet the department's own standards. Despite the adjustment made to turnover, the fiscal 2014 budget will not improve that situation. While staffing levels at Perkins are improved, given the additional resources provided to that facility in fiscal 2012 and 2013 in the wake of two fatal patient-on-patient attacks, staffing at other facilities remains a problem. For example, the vacancy rates as of December 31, 2012, at two of the facilities are quite notable: Spring Grove at 8.7% and the Eastern Shore at 16.7%. Issues include recruiting to the field generally, low salaries, and an aging workforce.

The largest decline in personnel expenses is almost $2.6 million in regular salary savings, primarily savings from the positions abolished by BPW on January 2, 2014.

Other than personnel costs, there are no significant increases in other facility costs.

Community Mental Health Fee-for-service Expenditures

As shown in Exhibit 12, community mental health fee-for-service expenditures increase by over $56.0 million in fiscal 2014. The largest increase is an estimated $28.3 million to support the expansion of Medicaid to 138% of FPL, effective January 1, 2014. The budget estimate is based on an estimate of total increased Medicaid enrollment (adjusted for the Medicaid mental health adult penetration rate) and estimated fiscal 2014 provider rates and utilization. Although most of the fiscal 2014 cost of expansion is covered by the federal government, some portion of the expansion population is expected to utilize Medicaid-ineligible services that will be 100% funded with State funding. The fiscal 2014 estimate for those State-only services is approximately $3.3 million.

The fiscal 2014 budget includes two rate adjustments:

- A 2.54% provider rate adjustment for non-rate regulated providers per Chapters 497 and 498 of 2010. The total cost of this adjustment in the fee-for-service system is just over $13 million.

- An increase in specialty physician evaluation and management rates to the 2013 Medicare rate, effective July 1, 2014. The total cost of this adjustment is just over $8 million. Rate increases will vary depending on the service provided but range from 26 to 58%.

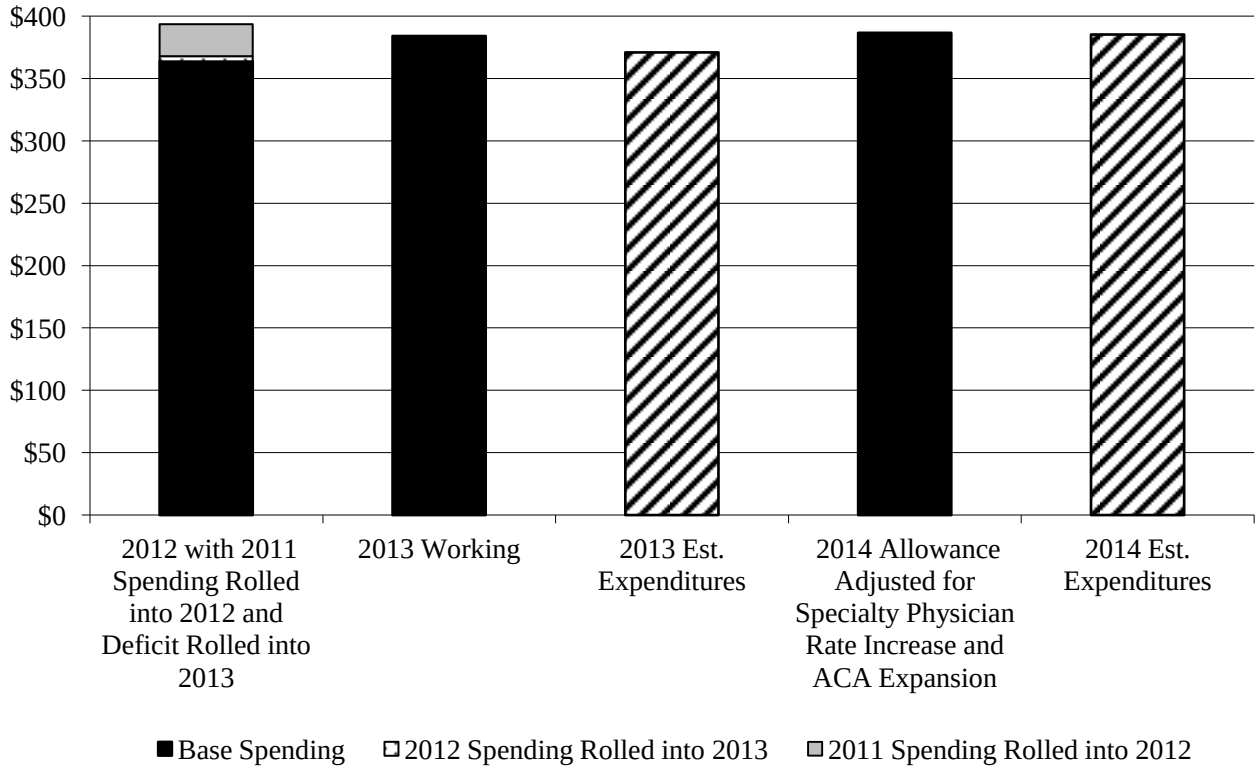
  The increase in specialty physician evaluation and management rates was discussed extensively in the fiscal 2013 budget analysis for Medicaid. Under the ACA, for calendar 2013 and 2014 only, the federal government pays 100% of the difference between State rates in effect on July 1, 2009, and Medicare rates for primary care physician evaluation and management fees. The intent behind the increase is to improve access to primary care physicians when the Medicaid program expands eligibility to 138% of the FPL on January 1, 2014. In the fiscal 2013 budget, the administration decided to increase the evaluation and management fees for all physicians not just primary care. It argued that this increase would also facilitate access to specialty care under Medicaid expansion and also noted concern about the ability of the Maryland's Medicaid Management Information System to readily identify primary care physicians from other physician specialties. Funding for specialty physician rate increases is at the traditional Medicaid matching rate.

  At the time, there was no discussion about extending the specialty rate increase to psychiatrists, and no funding was provided in the fiscal 2013 budget. The reason given for this apparent discrepancy was that the diagnostic codes used by psychiatrists did not have a separate evaluation and management services code; rather these services were integrated with psychotherapy. However, effective January 1, 2013, the code set for psychiatry services has been overhauled, and evaluation and management codes used by psychiatrists will be similar to those used by other health care professionals. Although the rate increase is optional and does bear an increased cost, it is consistent with the increase provided to other specialty

physicians in the fiscal 2013 budget that was proposed by the Governor and approved by the General Assembly.

The budget also includes $6.7 million for enrollment and utilization growth in the base Medicaid/Uninsured program. This represents 1% growth over the fiscal 2013 base budget. As shown in **Exhibit 13**, this limited budget growth is possible because the fiscal 2013 budget appears overfunded. Based on the most recent expenditure data for fiscal 2012 and 2013, the Department of Legislative Services (DLS) estimate of expenditure growth for fiscal 2013 is 2.0% compared to the 5.5% budgeted growth. As has been discussed above, this is almost entirely driven by declining expenditures on inpatient care. The trends identified that were in fiscal 2011 and 2012 appear to be continuing into fiscal 2013. Modest savings are also being seen in lower residential treatment utilization, a longer term trend. These savings more than offset increases in outpatient and other community-based settings.

Exhibit 13
State Support for Community Fee-for-service Mental Health Services
Fiscal 2012-2014
($ in Millions)



ACA: Affordable Care Act of 2010

Source: Department of Legislative Services

Interestingly, to date is not possible to see any impact in mental health outpatient expenditures from the adoption of outpatient tiered rates. This action was taken as part of the fiscal 2013 Medicaid budget. The idea was that by allowing hospitals to have differential clinic rates, rates for certain services like mental health that are more utilized by Medicaid patients would tend to be lower than more specialized outpatient services, and that would result in savings to the Medicaid program. Approximately one-third of MHA's outpatient expenditures are derived from rate-regulated providers. However, these savings have been difficult to discern in both Medicaid and MHA.

Compared to fiscal 2013 anticipated expenditures (rather than fiscal 2013 budgeted expenditures), budgeted growth in the fiscal 2014 base program is a reasonable 4.0%. DLS' projection of fiscal 2014 expenditures is that the fiscal 2014 allowance appears slightly overfunded. This projection is based on modest enrollment increases in the base program consistent with growth in the overall Medicaid program (2.4%), limited utilization growth, and the 2.54% provider rate adjustment for non-rate regulated community providers.

As the projected surplus is slight, DLS does not recommend any reduction to the fiscal 2014 base. **However, DLS does recommend the adoption of Budget Reconciliation and Financing Act language to:**

- **restrict $2.1 million of the fiscal 2013 community mental health budget to allow for the increase in specialty physician rates effective January 1, 2013, as is being provided in the Medicaid budget for other specialty providers;**

- **restrict $4.2 million of the fiscal 2013 community mental health budget to be used only to eliminate the fiscal 2012 unprovided for general fund payables rolled into fiscal 2013. Any funding not required based on available accruals shall revert to the general fund; and**

- **reduce the fiscal 2013 community mental health budget by $5 million.**

Community Mental Health Grants and Contracts Expenditures

Compared to the fiscal 2013 working appropriation, funding in the fiscal 2014 budget for mental health grants and contracts increases by $8.1 million. This growth is somewhat overstated; however, fiscal 2013 deficiencies increase some of this spending in the current year, making the change $5.7 million.

Aside from the 2.54% rate adjustment that is also applied to various grants and contracts in the MHA budget, most of the increase in funding relates to federal grants. Specific increases include:

- Just over $4.1 million in additional funding through the alternative placements to residential treatment demonstration waiver program. The program serves children and young adults under 22 years of age with care management and a variety of community-based services not traditionally provided through the Medicaid program, with the intent of limiting entry into institutional care. Most of the additional funding in fiscal 2014 is federal funds and relates to

one-time spending that either begins in the middle of fiscal 2013 or the beginning of fiscal 2014. Specifically:

- A $3.2 million contract for the period December 2012 through September 2014 with the University of Maryland School of Medicine for ongoing project management of youth and families served under the waiver; to undertake an assessment of Maryland's workforce capacity to serve larger numbers of youth in community alternative placements; and to work on other workforce issues.

- A $7.0 million contract for the period December 2012 through September 2014 with the University of Maryland School of Social Work for technical assistance (with other academic partners) to the states that participated in the waiver; the development of a practice model for social workers aimed at reducing psychiatric placements; and supporting MHA in sustaining approaches developed under the original demonstration project.

- A $1.5 million contract for the period July 1, 2013 through September 2014 to continue funding for a psychiatric consultation with a pediatrician project at the University of Maryland School of Medicine and at Salisbury University.

Fiscal 2014 is anticipated to be the final full year of funding under this particular waiver. The waiver officially ended September 30, 2012, and new enrollment under the program is closed. Clients receiving services through the waiver are eligible for continued services for up to two years from date of entry. The department is hoping to replace the services provided under the demonstration waiver with another waiver, a 1915(i) waiver.

The 1915(i) waiver was first enacted in 2005 and was intended to increase community-based services instead of Medicaid institutional services. For a number of reasons, few states took advantage of this waiver option. The ACA made a number of changes to the 1915(i) waiver to encourage its use, including removing the requirement that an individual had to meet an institutional level of care in order to qualify for home- and community-based services; expanding its use to include chronic mental illness and/or substance abuse; adding the ability to target to certain populations; and adding the ability to narrowly tailor services.

MHA has been pursuing a 1915(i) waiver for some time. At this point, the administration is still refining what population it will be targeting in the waiver application. Medicaid indicates that it is still hoping to submit the waiver (as a State Plan amendment) on July 1, 2013. There is currently no funding in the fiscal 2014 budget for services if the waiver is approved. However, given the length of time taken for approval, MHA is hoping that general funds currently used for the demonstration waiver can be subsequently allocated to the 1915(i) waiver in fiscal 2015.

- $1.0 million in federal funds for the LIFT project targeted at youth ages 13 to 17 in Baltimore County with serious emotional disturbances and co-occurring substance abuse needs. This is a four-year federal grant that began in September 2012.

- $839,000 in federal funds for the LAUNCH project to promote the wellness of young children from birth to 8 years in Prince George's County by addressing physical, social, emotional, cognitive and behavioral aspects of development. This is a five-year federal grant that also began in September 2012.

Issues

1. Residential Treatment Centers

Chapter 148 of 2012 (the fiscal 2013 budget bill) included language withholding funds pending the receipt of a report providing a variety of information on RTCs. Specifically, the language was intended to provide the budget committees with comparative data between public and private RTCs.

This information was considered to be pertinent at a time of surplus capacity in the RTC system as a whole, a situation which prompts the policy question of the role of the public RTC facilities vis-à-vis the private facilities. Typically, the public sector's role in Maryland is as a provider of last resort when appropriate private capacity for whatever reason is unavailable or inadequate.

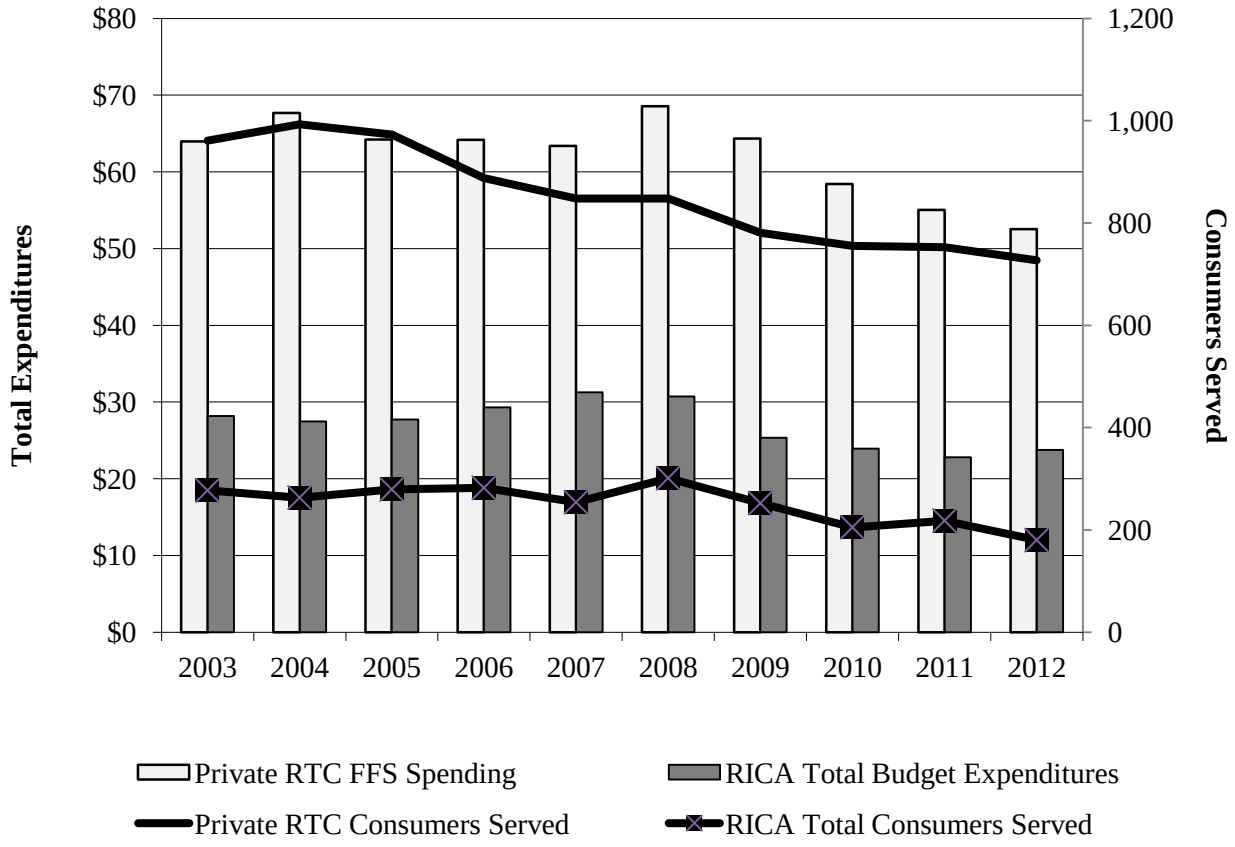
In response to the fiscal 2013 budget bill, the Department of Health and Mental Hygiene submitted a report to the budget committees in November 2012. For many of the data elements included in the report there was not facility-specific data, limiting the ability to make comparisons between RTCs generally and between the public and private RTCs. However, in response to a request by DLS for additional data, MHA agreed to provide facility-specific data concerning length-of-stay; the home jurisdiction of youth; the use of high-intensity and community-based psychiatric services prior to admission; the use of high-intensity psychiatric services received after discharge from an RTC placement; and cost data. This information was received at the end of January 2013. The follow-up report also noted that the methodology used in the original report for calculating admissions had been revised slightly. Although it does not materially impact the broad conclusions drawn in the original report, the revised methodology occasionally changes data. This write-up will use the data from the original report unless otherwise specified.

Background

In recent budgets, primarily due to the availability of federal funds, there has been increased emphasis and funding for alternatives to institutional placements for children and youth with serious mental illness. Accordingly, institutional placements for children and youth with serious mental illness both in privately operated RTCs and at publicly operated RTCs, RICAs, have fallen in recent years.

As shown in **Exhibit 14**, after peaking in fiscal 2008 at just over $68.5 million, spending at private RTCs through the fee-for-service public mental health system steadily declined in each of the next four fiscal years, falling to just over $52.5 million in fiscal 2012. This spending trend reflects a similar drop in consumers served at those RTCs from just under 1,000 in fiscal 2004 to 727 in fiscal 2012 (24%). Likewise, total spending at RICAs also fell from a peak of $31.3 million in fiscal 2007 down to just over $22.8 million in fiscal 2011 before increasing slightly to just over $23.7 million in fiscal 2012. Consumers served at RICAs have also fallen, peaking at 301 in fiscal 2008 and falling to 180 in fiscal 2012 (40%). In both the public and private systems, there have been facility and bed

Exhibit 14
Expenditure Data and Consumers Served
Fiscal 2003-2012
($ in Millions)



FFS: fee-for-service
RICA: Regional Institutes for Children and Adolescents
RTC: Residential Treatment Center

Note: Fiscal 2012 data is incomplete.

Source: Department of Legislative Services; Governor's Operating Budget; Department of Health and Mental Hygiene

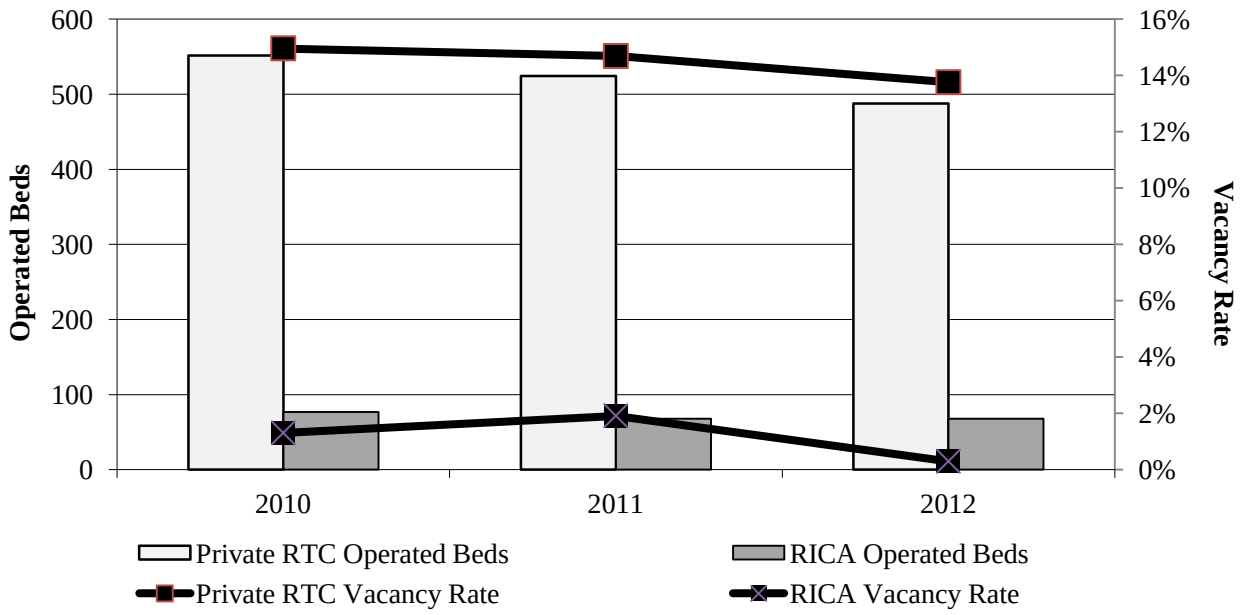
closures. For example, a review of public and private RTC capacity conducted in 2001 indicated that there were 748 licensed beds at 11 private and 3 public facilities; by July 2012, there were only 642 licensed beds at 8 private and 2 public facilities. Furthermore, total operational capacity was even lower, at 519 beds.

RTC Report

Placement Trends

The department's report confirmed the trends in utilization noted above and noted a vacancy rate in the RTC system as a whole of 12.1% in fiscal 2012. This represents a slightly lower rate than in fiscal 2010 and 2011 of 13.3 and 13.2%, respectively. This drop in vacancy rates does not reflect increased demand for residential placements (which as noted above is falling), but rather the continued reduction in operational capacity. This reduction is shown in **Exhibit 15**, with both private and public operational capacity reduced by 11.5% between fiscal 2010 and 2012.

Exhibit 15
Operated Beds and Vacancy Rates
Fiscal 2010-2012



RICA: Regional Institutes for Children and Adolescents
RTC: Residential Treatment Center

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

However, as Exhibit 15 also illustrates, while operational capacity in both private and public RTCs is falling, the vacancy rate is almost exclusively in private sector beds. In fiscal 2012, for example, the vacancy rate in the private RTCs was 13.8% compared to 0.3% at RICAs. While the report notes the varied services offered by different RTC programs (for example, respite care, substance abuse treatment, case management, and mentoring), there is no identification of these

services by facility. Thus, it is impossible to determine if the vacancy rates at RICAs are lower because they treat consumers that cannot be treated at private RTCs. However, the report specified that even if a facility does not indicate that it offers a specific service, that does not mean a youth in need of a particular set of services could not, in fact, have those services provided at that facility. In that regard, service availability should not explain this difference in vacancy rates.

It is also interesting to note that referrals to RTCs have, on average, increased in recent years (from an average of 121 referrals to each RTC in fiscal 2009 to 151 in fiscal 2012). However, as the report notes, again this is not because of increased demand. Rather, there are a variety of possible explanations: an individual consumer can be referred to multiple RTCs; the number of beds overall has reduced which may be driving up the number of referrals received by an individual RTC; and an effort has been made to limit the number of youth placed in out-of-state RTCs. Again, the report did not provide detail on an individual facility basis, so drawing conclusions between public and private RTCs was not possible.

The additional data provided did provide some interesting information on length of stay, revealing some notable differences between facilities. However, the follow-up commentary also noted that this data warranted further investigation before any conclusions can be drawn.

Patient Acuity

The report provided insight into patient acuity by using service utilization data prior to an RTC admission, as well as data derived from an acuity survey completed by RTCs. The acuity survey was undertaken because the service utilization data was available only for youth receiving services through Medicaid or MCHP. Services provided through private insurance, other State programs (for example, through the Department of Juvenile Services (DJS) and the Department of Human Resources, which together provide 84% of total RTC referrals and may offer treatment to clients paid for through those systems as well as potentially through Medicaid and MCHP), or other means were not readily available.

That caveat aside, the service utilization data (as revised in the follow-up report) revealed that in fiscal 2011, 3% of youth had received inpatient psychiatric treatment within 90 days of an RTC admission, 14% had a psychiatric emergency room (ER) visit within 90 days of an admission, and 5% had been discharged from an RTC within 90 days of an admission to a new RTC. In all cases, these represent duplicative counts, *i.e.*, an individual youth could have both an ER visit and an inpatient stay. Similarly, some 14% of youth entering an RTC had received a community-based psychiatric service (*e.g.*, outpatient therapy, medication management, and psychiatric rehabilitation services) within 90 days of an RTC admission.

As shown in **Exhibit 16,** there is some interesting variation between RTCs in terms of the percent of admissions with some level of high-intensity or community-based psychiatric services within 90 days of admission. MHA concurred that this variation was interesting without having any specific conclusions as to why the variation occurred. However, it should be noted that at this point, this is data only for one year, and relatively small changes in utilization in any given year could significantly change a facility's data.

Exhibit 16
Youth Receiving High Intensity and Community-based Services
90 Days Prior to Admission
Fiscal 2011

	IP	ED	RTC	CBS
Adventist Rockville	2.0%	7.8%	21.6%	9.8%
Adventist AA	2.2%	15.6%	8.9%	15.6%
Sheppard Pratt	1.9%	16.0%	0.9%	12.3%
Chesapeake Treatment Center	4.3%	4.3%	0.0%	4.3%
Good Shepherd	2.2%	22.1%	2.9%	18.4%
Adventist ES	7.7%	4.6%	1.5%	10.8%
Villa Marie	2.8%	21.1%	3.5%	18.3%
RICA Rockville	3.3%	8.2%	6.6%	9.8%
RICA Baltimore	1.4%	8.5%	4.2%	4.2%
Woodbourne	1.4%	7.0%	5.6%	18.3%
Jefferson School	1.2%	11.8%	4.7%	11.8%
Statewide Average	**2.6%**	**13.8%**	**4.8%**	**13.6%**

AA: Anne Arundel
CBS: Community-based Services
ED: Emergency Department
ES: Eastern Shore
IP: Inpatient
RICA: Regional Institutes for Children and Adolescents
RTC: Residential Treatment Center

Note: See text for additional information. Data is based on a duplicated count, *i.e.*, a single admission could have both high-intensity (all types) and/or community-based services.

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

The acuity survey adds more detail in terms of length of stay; diagnosis; medication usage; and history of trauma, aggression, victimization, and delinquent behavior. However, at this point, that data was not available by facility.

Outcomes

With the same caveat about data limitations already noted, data was provided on reentry to RTCs and psychiatric hospitalizations after discharge; although again, the data was limited to services provided through Medicaid and MCHP. In fiscal 2011, for example, 14.2% of youth discharged from an RTC were readmitted to an RTC within 6 to 12 months of discharge or were admitted for an inpatient psychiatric hospital stay within 3 months of discharge.

As shown in **Exhibit 17**, again there was some considerable variation between facilities and at the same facility from year to year (although the statewide average readmission rate was reasonably consistent). Some of this variation may be explained by the nature of the clients served at the different RTCs. For example, Villa Marie serves younger children and that may lead to disproportionately more subsequent contacts. Conversely, the Chesapeake Treatment Center, located within the secure grounds of the DJS Hickey School, sees no subsequent readmissions perhaps because many of the children in the facility tend to age-out. Again, MHA indicated that there was no simple explanation for this variation.

Exhibit 17

Readmission to an RTC within 6 to 12 Months of Discharge or Admission to an Inpatient Psychiatric Hospital within 3 Months of Discharge

Fiscal 2009-2011

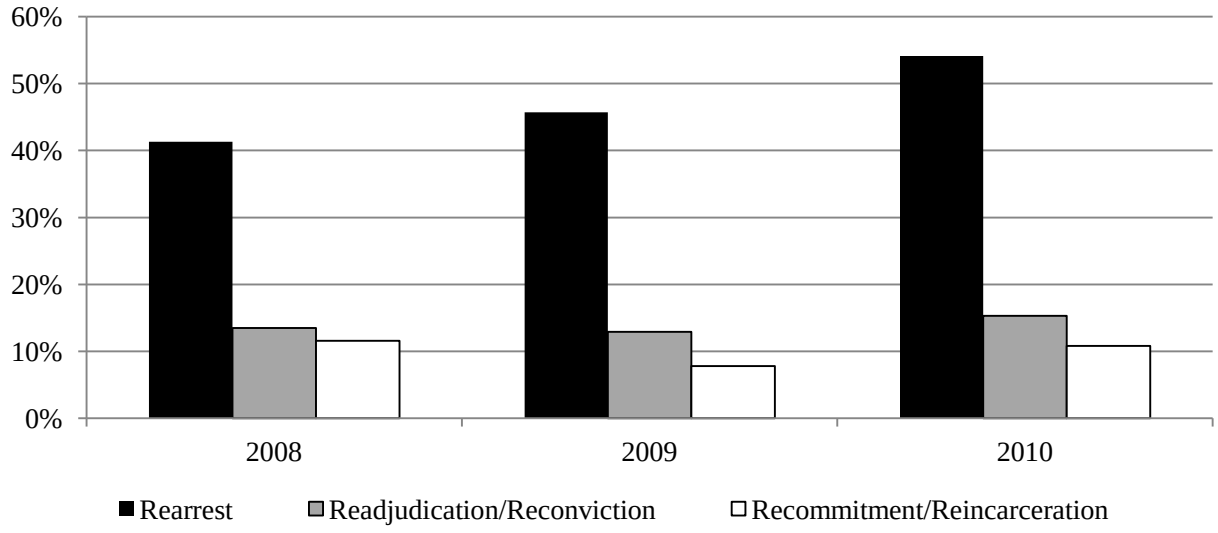
	2009	2010	2011
Adventist Rockville	23.4%	3.3%	7.9%
Adventist AA	7.7%	27.6%	15.0%
Sheppard Pratt	2.6%	3.0%	0.0%
Chesapeake Treatment Center	0.0%	0.0%	0.0%
Good Shepherd	10.2%	18.8%	14.5%
Adventist ES	12.5%	6.9%	17.4%
Villa Marie	11.1%	23.2%	28.2%
RICA Rockville	15.1%	12.1%	10.8%
RICA Baltimore	12.1%	17.1%	25.6%
Woodbourne	0.0%	18.2%	9.1%
Jefferson School	17.1%	12.5%	14.6%
Statewide Average	**11.8%**	**14.7%**	**14.2%**

AA: Anne Arundel
ES: Eastern Shore
RICA: Regional Institute for Children and Adolescents
RTC: Residential Treatment Center

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

The report also provided data on recidivism for DJS-referred RTC youth. As noted above, DJS is a major source of referrals for RTCs, and recidivism is a traditional outcome measure used by DJS. The data shown in **Exhibit 18** reports recidivism within one year of release from an RTC for three fiscal year cohorts, noting subsequent penetration into either the juvenile justice or criminal justice systems (with the deepest level of penetration chosen for any given individual). As shown in the exhibit, for the fiscal 2010 cohort, for example, 54% of the DJS youth released from an RTC were rearrested within one year of release, 15% were readjudicated or convicted, and 11% were recommitted or incarcerated. These numbers are better than for DJS youth as a whole, but only marginally so.

Exhibit 18
Department of Juvenile Services Youth Released from RTCs
Various Recidivism Data
Fiscal 2008-2010



RTC: Residential Treatment Center

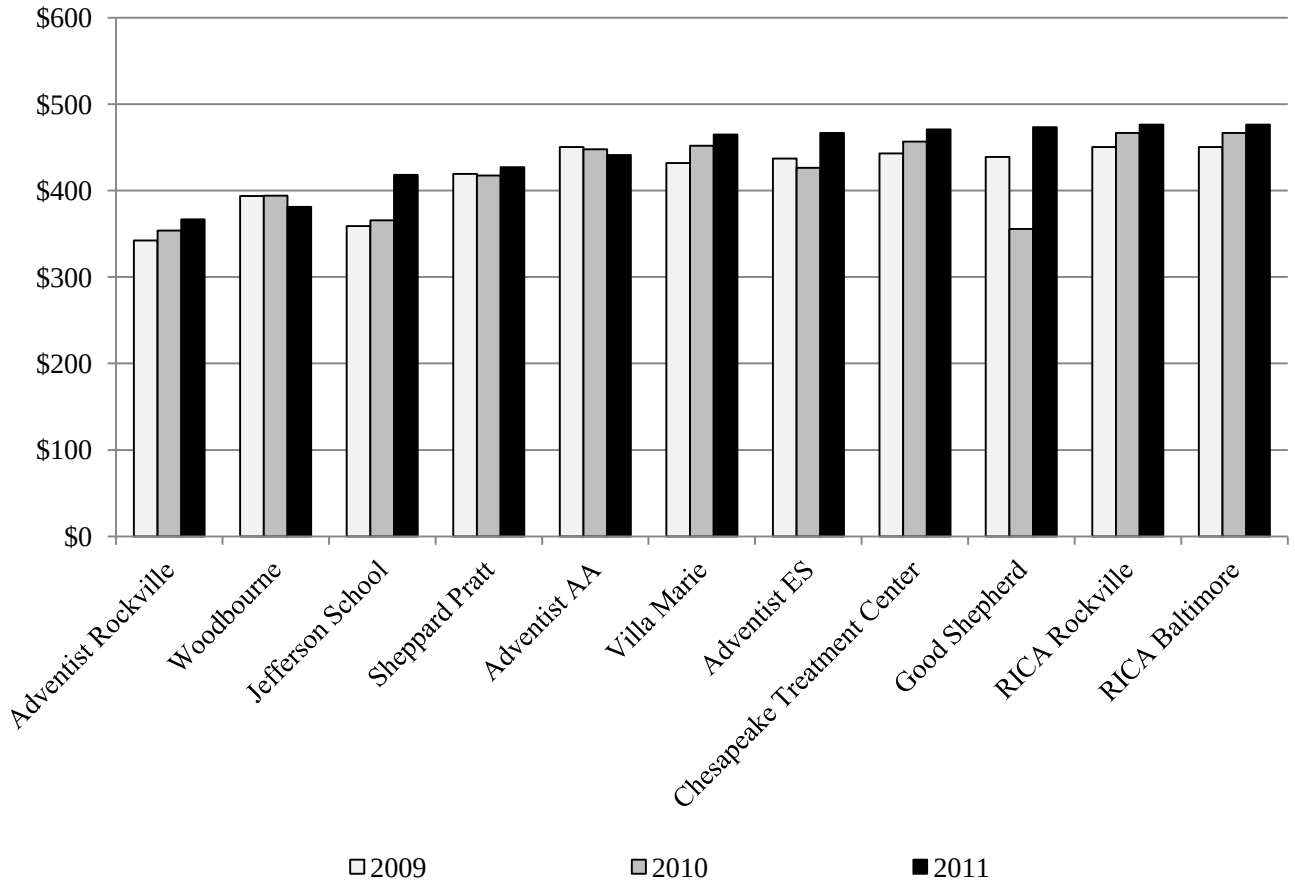
Source: Department of Legislative Services; Department of Health and Mental Hygiene

In terms of other outcomes, the report notes that facilities track a variety of process and outcome measures both during a youth's stay at the facility and at discharge. However, there is no uniformity in the data collected, thus precluding any meaningful comparison between facilities. The stakeholder group that was consulted during the development of the report agreed that meaningful outcome and process measures need to be developed for RTCs that are both measurable and valid. **DLS concurs with this recommendation and recommends the adoption of narrative to request the results of those efforts.**

Cost Data

The report also included data on RTC costs. As updated by the follow-up information, the range of rates paid to RTCs through the Medicaid program for fiscal 2011 was $367 to $476 per day (see **Exhibit 19**) as the final rate for fiscal 2011. As anticipated, the daily rates for the two public RTCs are the highest shown in each fiscal year.

Exhibit 19
RTC Medicaid Final Daily Rate
Fiscal 2009-2011



AA: Anne Arundel
ES: Eastern Shore
RICA: Regional Institutes for Children and Adolescents
RTC: Residential Treatment Center

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

Conclusion

The submitted report on RTCs provides interesting and useful data about the youth served in RTCs in Maryland. Notably, the data provides a good overview of the overall challenges confronting these youth and their facilities. Similarly, the report provides a good overview of the structure of the RTC system in terms of capacity and vacancy rates.

Nonetheless, the report falls short in terms of outcomes. The lack of uniformity in reporting effectively limits insight into how well these facilities are treating the youth placed in them. While it is a positive step that stakeholders have agreed to come together to develop measurable and valid outcome measures, it is unfortunate that such outcomes have not been in place and collected to this point.

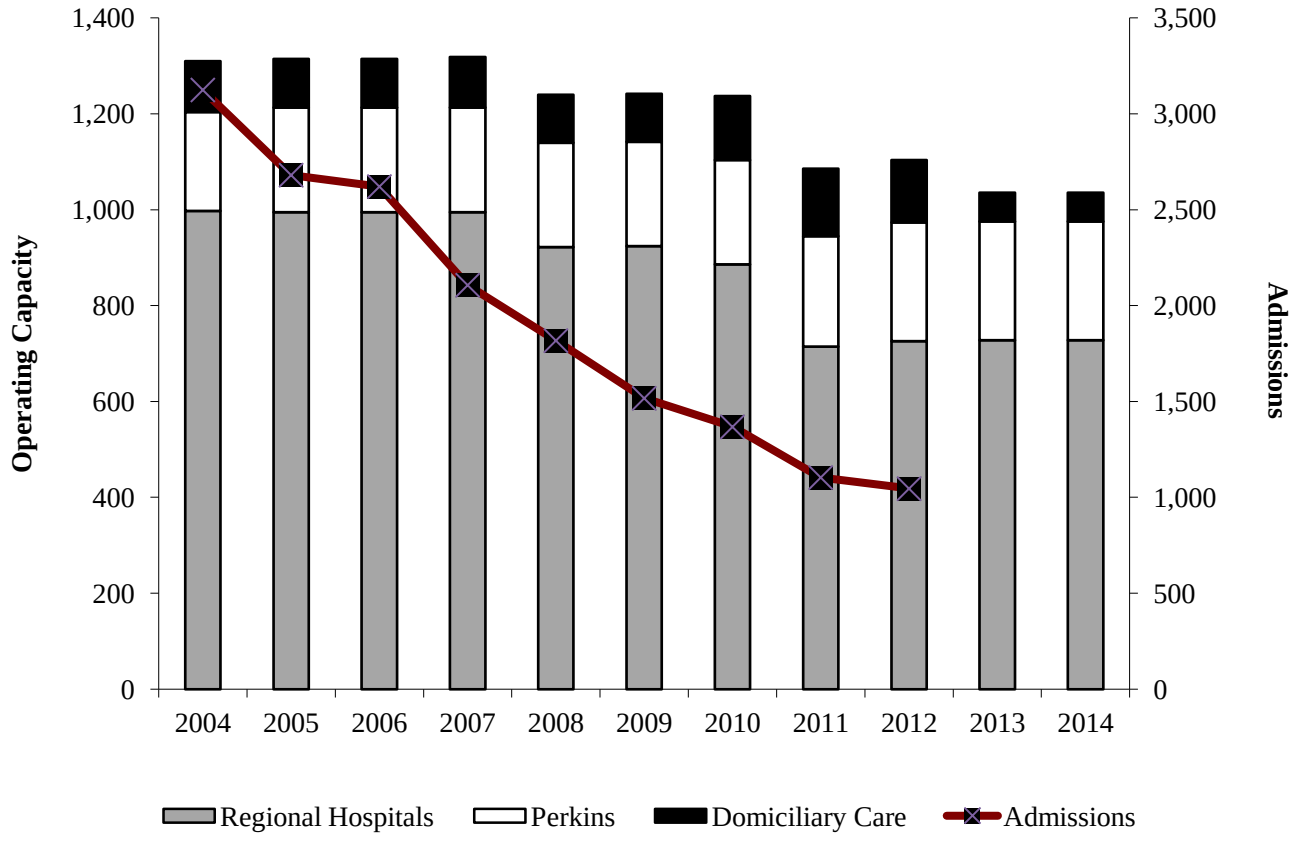
2. Future State-run Psychiatric Facility Bed Need

Chapter 395 of 2011 (the fiscal 2012 budget bill) included language restricting a total of $200,000 in the budgets of the State-run psychiatric hospitals for the purpose of conducting an independent analysis of population and placement trends at those hospitals. The report was due to the legislature by December 1, 2011. However, the Secretary of Health and Mental Hygiene requested that the report deadline be extended to September 1, 2012, and the budget committees approved the request for an extension. The report was submitted in September 2012.

The report was intended to be a starting point in the assembling of data necessary to properly plan future capacity at the State-run psychiatric hospitals. Legislative interest in this issue stemmed from the knowledge that the physical plant of the current facilities systemwide is inadequate as well as the potential re-use of current State-run psychiatric facility sites. Of the five facilities, the Eastern Shore is the newest facility, built in the past 15 years. The facility plant at Finan and Perkins, while older, is generally considered reasonable, and Perkins, in particular, has seen considerable capital improvements in recent years and is scheduled for more in the *Capital Improvement Program*. Springfield and Spring Grove are both facilities set on sprawling campuses that were designed to hold thousands of patients and are now serving just over 600 combined.

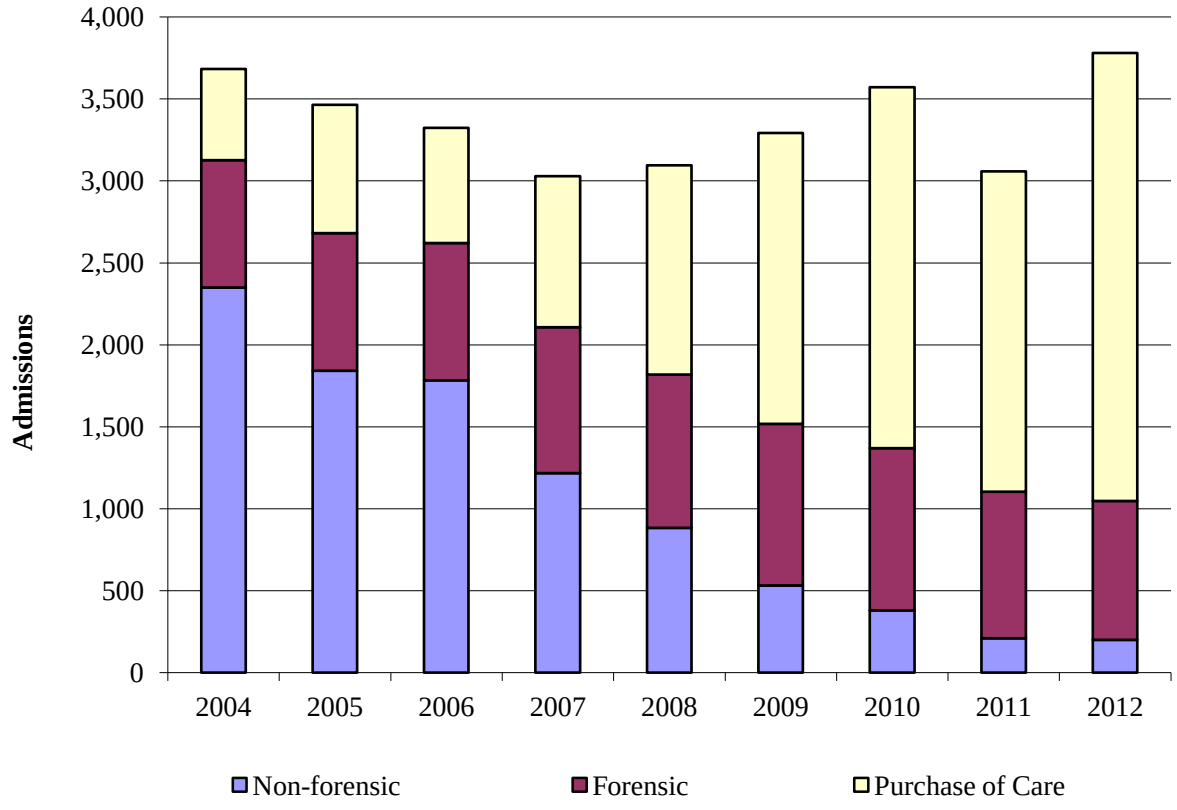
As shown in **Exhibit 20**, even in the past several years, operating capacity at, and admissions to, the facilities has fallen significantly. Additionally, as noted in **Exhibit 21**, the mix of admission has also changed significantly. In fiscal 2012, non-forensic admissions now form only 20% of total State-run psychiatric facility admissions as MHA has sought new ways to serve these patients in alternative inpatient settings, as well as where possible from serving patients in non-institutional settings, down from 75% in fiscal 2004.

Exhibit 20
State-run Psychiatric Hospital Operating Capacity and Admissions
Fiscal 2004-2014



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

Exhibit 21
State-run Psychiatric Hospital Admissions, Admission Mix, and Purchase of Care Admissions
Fiscal 2004-2012



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

Against this backdrop, the independent analysis projected bed need over the next decade using four different scenarios:

- **Status Quo:** This scenario assumes current policies and investments stay constant over the next decade, with demand driven by demographic shifts and normal utilization trends.

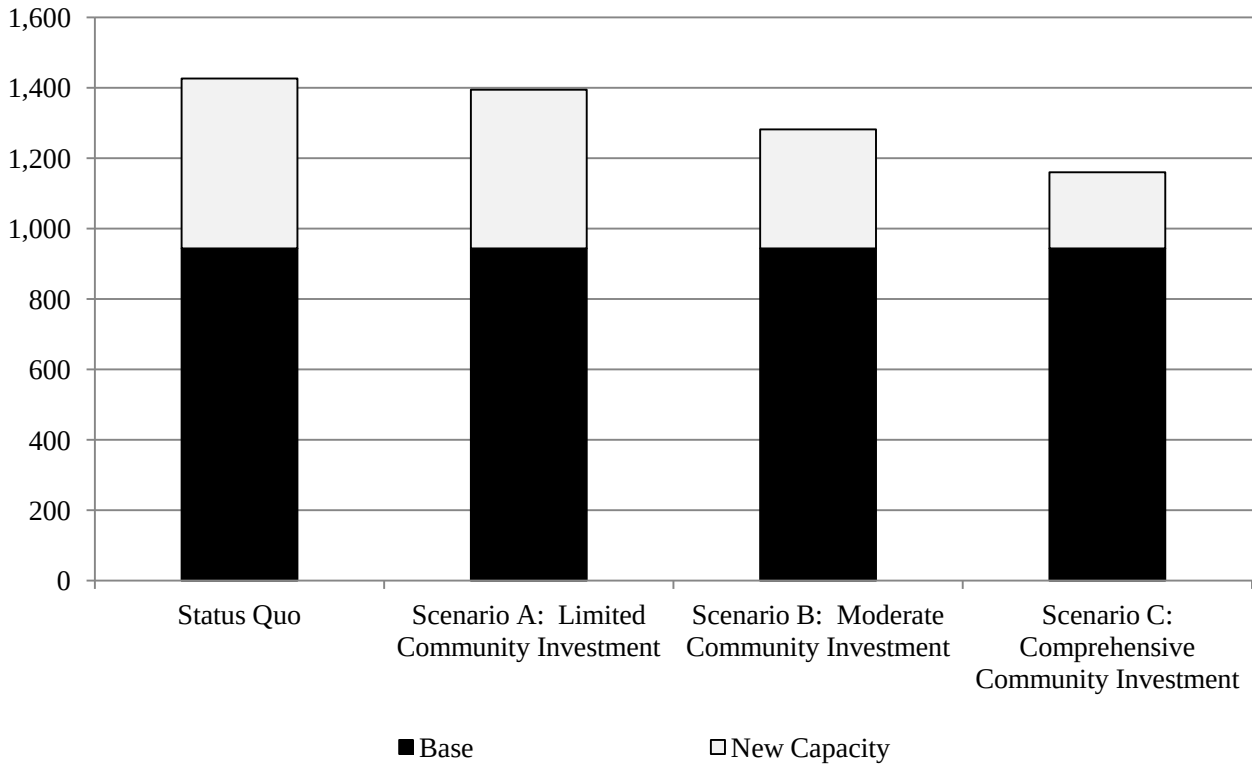
- **Scenario A:** Conservative. Under this scenario, a number of community strategies are assumed to be implemented which will reduce admissions. Specifically, the assumption is that strategies that are easy to implement and of low cost will be adopted: peer-support networks and expanded use of telepsychiatry.

- **Scenario B:** Moderate. Under this scenario, a number of community strategies with moderate ease of implementation and capital requirements are implemented including peer-support networks, expanded telepsychiatry, alternative community beds, and forensic monitoring.

- **Scenario C:** Comprehensive. Under this scenario, all the community strategies included in Scenario B are added through diversion programming, as well as payment changes that facilitate the development of additional community programming that would reduce State-run psychiatric hospital admissions.

The different bed scenarios are illustrated in **Exhibit 22**.

Exhibit 22
State-run Psychiatric Hospital Projected Bed Need



Note: The report uses as its base 944 beds. This number differs from that presented in the Governor's budget books and used in Exhibit 20.

Source: Cannon Design, *Independent Study on Future Demand for State-operated Psychiatric Hospital Capacity*

The department's response to the report was to support the need for additional community investments but to reject the need for additional beds as being premature. On the one hand, this is not an unreasonable conclusion given that the department has closed three facilities (Carter, Crownsville, and the Upper Shore Community Health Center) and significantly reduced operating capacity at others in the past decade and has transformed the nature of the State-run psychiatric facilities in terms of patient mix. At this point, for example, the department's relationship with the Judiciary is perhaps the key one in immediate initiatives around hospital capacity. The report notes, for example, the length of stay at the facilities is increasing. The ability to move forensic patients through the psychiatric hospitals more quickly could have a significant impact on bed utilization and thereby change need. Similarly, the emphasis on community-based interventions rather than institutional treatment is the approach that is considered best for the patient and could further depress demand for those beds.

On the other hand, much of the psychiatric bed capacity that the State does operate is antiquated, inefficient, and programmatically inadequate. Having an assessment of demand for these facilities is the *prima facie* requirement to begin a conversation about facility improvement for those patients that require that level of care. As the department correctly notes in its response, there is plenty of spare capacity scattered across the facilities. However short- and long-term, this capacity shares the same limitations of much of the existing capacity noted above.

At this point, the department is unwilling to indicate what it believes future bed needs are and does not want to undertake the expense of building a new facility. While that is perhaps understandable, especially given the demands on the capital budget, there are other options that the State could consider. For example, the State could work with other facilities to house forensic patients, look to partner with existing hospital systems and/or academic health centers to develop alternative inpatient capacity, and look at alternative financing mechanisms to replace existing State capacity, all while developing community capacity. **The department should indicate how it intends to move to a system that serves those individuals that need the level of care currently provided in State-run psychiatric hospital beds without the shortcomings of the current system capacity.**

Recommended Actions

		Amount Reduction	
1.	Reduce funding for emergency admission payments. The department pays for certain expenses related to emergency psychiatric evaluation admissions for the uninsured. The fiscal 2014 allowance is based on a two-year average. However, fiscal 2011 expenses were abnormally high. The reduction aligns funding to the most recent actual.	$ 50,000	GF
2.	Delete funding for purchase of care beds. Purchase of care beds are beds at private hospitals to treat uninsured individuals in need of inpatient care. These beds are used as an alternative to treatment in State-run psychiatric facilities. The fiscal 2013 budget reduced funding for these beds because under federal law hospitals are required to treat or appropriately transfer patients that require inpatient care. Uninsured patients still receive care and reimbursement for higher levels of uncompensated care is ultimately made through hospital rates. This action deletes all remaining funding.	1,250,000	GF

3. Adopt the following narrative:

Residential Treatment Centers Outcomes: The committees are interested that consistent and meaningful outcome measures are adopted by all public and private Residential Treatment Centers (RTC) in Maryland. The Mental Hygiene Administration (MHA) has indicated that it will be convening a stakeholder group to develop such measures. The committees request that MHA submit a report by November 1, 2013, on the results of that stakeholder process. The report should also include any available facility-specific outcome data for outcome measures that will be adopted for RTCs even if the data is not available for every facility.

Information Request	Author	Due Date
RTC outcomes	MHA	November 1, 2013

Total General Fund Reductions **$ 1,300,000**

Appendix 1

Current and Prior Year Budgets

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

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2012					
Legislative Appropriation	$675,077	$23,283	$356,974	$5,734	$1,061,068
Deficiency Appropriation	19,100	0	3,157	0	22,257
Budget Amendments	11,044	31	1,618	49	12,742
Reversions and Cancellations	-48	-841	-13,027	-857	-14,774
Actual Expenditures	**$705,173**	**$22,472**	**$348,722**	**$4,926**	**$1,081,293**
Fiscal 2013					
Legislative Appropriation	$675,562	$27,814	$353,769	$4,464	$1,061,609
Budget Amendments	-109	7,191	21	0	7,102
Working Appropriation	**$675,453**	**$35,004**	**$353,790**	**$4,464**	**$1,068,711**

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

Fiscal 2012

The fiscal 2012 legislative appropriation for MHA was increased by $20.225 million. This change is derived as follows:

- Deficiency appropriations added almost $22.3 million including:
  - just under $3.2 million in federal funds for Maryland Mental Health Transformation activities and community alternatives to institutionalization for children and youth with mental illness; and
  - $19.1 million in general funds to cover deficits in the community mental health FFS system.
- Budget amendments added $12.7 million. Specifically:
  - General fund amendments added $11.0 million. Significant increases included $3.2 million to cover increased overtime expenditures at Perkins Hospital after two incidents that resulted in patient deaths (funded through the transfer of surplus funds in MCHP), $2.3 million to cover deficits throughout MHA as part of the fiscal 2012 closeout process, $2.2 million to fund the cost of the fiscal 2012 one-time $750 bonus, $2.1 million from the Medical Care Programs Administration (MCPA) to cover the cost of an assessment that was imposed on State-operated hospitals in Chapter 397 of 2011 (BRFA of 2011) with these funds subsequently returned to MCPA in a reimbursable fund amendment in the same amount, and just over $2.0 million transferred from the budget of the Department of Budget and Management (DBM) to support a rate adjustment for community mental health service providers. These increases were partially offset by a reduction of $800,000 in a fiscal 2012 closeout amendment re-aligning State employee health care premium subsidy funding.
  - Special fund amendments added $31,000.
  - An increase in federal funds of just over $1.6 million, over $1.5 million of which was federal funds transferred from the budget of DBM to support a rate adjustment for community mental health service providers.
  - Reimbursable fund amendments of $49,000.
- The budget increases from deficiency appropriations and budget amendments were partially offset by reversions and cancellations of almost $14.8 million. Specifically:
  - General fund reversions of $48,000.
  - Special fund cancellations of $841,000 derived from a variety of special fund sources.

- Federal fund cancellations of just over $13 million. The bulk of this was lower than expected federal fund Medicaid and MCHP attainment plus lower than anticipated expenditures from a number of federal grant sources.

- Reimbursable fund cancellations of $857,000.

Fiscal 2013

To date, MHA's fiscal 2013 appropriation has been increased by just over $7.1 million. This increase is primarily derived from three amendments:

- Just under $6.25 million in special funds derived from revenue generated from the CareFirst premium tax exemption to support community mental health services as authorized by Chapter 1 of the 2012 First Special Session, the BRFA of 2012.

- $944,000 in special funds and $21,000 in federal funds to support the fiscal 2013 COLA.

- An offset of $109,000 in general funds primarily related to the transfer of funds to MCPA as part of the creation of a Division of Behavioral Health in that agency.

Appendix 2

Audit Findings

Facility	Springfield Hospital Center
Audit Period for Last Audit:	October 1, 2008 – July 28, 2011
Issue Date:	February 2012
Number of Findings:	1
Number of Repeat Findings:	0
% of Repeat Findings:	n/a
Rating: (if applicable)	n/a

Finding 1: Springfield had not established adequate controls and recordkeeping for pharmaceutical drugs. The hospital concurred with the finding and related recommendations regarding inventory responsibilities and recordkeeping involving returned and unused drugs.

Facility	Finan Hospital Center and Brandenburg Center*
Audit Period for Last Audit:	July 1, 2008 – June 30, 2011
Issue Date:	May 2012
Number of Findings:	2
Number of Repeat Findings:	0
% of Repeat Findings:	n/a
Rating: (if applicable)	n/a

*The Brandenburg Center is located next to the Finan Center and served individuals with developmental disabilities. The Finan Center provided Brandenburg with a variety of support services (*e.g.*, payroll). Brandenburg was closed during fiscal 2011.

Finding 1: Finan lacked documentation in certain instances to support its compliance with State procurement regulations. The hospital concurred with the finding and corresponding recommendations.

Finding 2: Corporate purchasing cards were not promptly cancelled for terminated employees, although records indicated that no purchases were made on these accounts subsequent to termination. The hospital concurred with the finding and corresponding recommendations.

Facility	Spring Grove Hospital Center
Audit Period for Last Audit:	June 1, 2009 – January 17, 2012
Issue Date:	November 2012
Number of Findings:	4
Number of Repeat Findings:	1
% of Repeat Findings:	25%
Rating: (if applicable)	n/a

Finding 1: Proper internal controls were not established over cash receipts. The hospital concurred with the finding and corresponding recommendations.

Finding 2: Certain employees were paid overtime compensation even though they were ineligible based on their employment classifications. The hospital concurred with the finding and corresponding recommendations including consulting with the Office of the Attorney General concerning the recovery of inappropriate overtime payments.

Finding 3: **Equipment inventory was not properly accounted for and controlled. The hospital concurred with the finding and corresponding recommendations.**

Finding 4: Current formal agreements were not always executed for the hospital's leased properties, nor could the hospital document how lease payment amounts were calculated. The hospital concurred with the finding and corresponding recommendations.

Note: Finding highlighted in bold indicates repeat finding from the prior audit.

Facility	Clifton T. Perkins Hospital Center
Audit Period for Last Audit:	August 31, 2009 – February 16, 2012
Issue Date:	December 2012
Number of Findings:	4
Number of Repeat Findings:	1
% of Repeat Findings:	25%
Rating: (if applicable)	n/a

Finding 1: Certain employees were paid overtime compensation even though they were ineligible based on their employment classifications. The hospital concurred with the finding and corresponding recommendations including consulting with the Office of the Attorney General concerning the recovery of inappropriate overtime payments. Additionally, DBM has subsequently determined that the employment classifications involved will be eligible for overtime payments.

Finding 2: **The propriety of billings for pharmacy and laboratory testing services was not adequately verified. The hospital concurred with the finding and corresponding recommendations.**

Finding 3: State procurement regulations were not complied with when purchasing dietary items. The hospital concurred with the finding and corresponding recommendations.

Finding 4: Internal controls over cash receipts were inadequate. The hospital concurred with the finding and corresponding recommendations

Note: Finding highlighted in bold indicates repeat finding from the prior audit.

Object/Fund Difference Report
DHMH – Mental Hygiene Administration

Object/Fund	FY 12 Actual	FY 13 Working Appropriation	FY 14 Allowance	FY 13 - FY 14 Amount Change	Percent Change
Positions					
01 Regular	2,824.95	2,854.95	2,854.95	0.00	0%
02 Contractual	216.30	188.04	185.56	-2.48	-1.3%
Total Positions	**3,041.25**	**3,042.99**	**3,040.51**	**-2.48**	**-0.1%**
Objects					
01 Salaries and Wages	$ 210,683,178	$ 212,858,581	$ 219,468,670	$ 6,610,089	3.1%
02 Technical and Spec. Fees	10,677,972	8,337,496	8,542,541	205,045	2.5%
03 Communication	466,459	467,353	478,381	11,028	2.4%
04 Travel	141,665	123,007	121,356	-1,651	-1.3%
06 Fuel and Utilities	10,258,616	10,440,743	9,994,246	-446,497	-4.3%
07 Motor Vehicles	733,215	644,006	809,442	165,436	25.7%
08 Contractual Services	831,111,304	820,526,880	884,068,281	63,541,401	7.7%
09 Supplies and Materials	15,606,688	14,232,013	14,402,094	170,081	1.2%
10 Equipment – Replacement	512,039	250,684	249,820	-864	-0.3%
11 Equipment – Additional	169,484	0	0	0	0.0%
12 Grants, Subsidies, and Contributions	357,670	336,655	411,885	75,230	22.3%
13 Fixed Charges	537,725	493,583	503,075	9,492	1.9%
14 Land and Structures	37,195	0	0	0	0.0%
Total Objects	**$ 1,081,293,210**	**$ 1,068,711,001**	**$ 1,139,049,791**	**$ 70,338,790**	**6.6%**
Funds					
01 General Fund	$ 705,173,030	$ 675,452,676	$ 702,204,993	$ 26,752,317	4.0%
03 Special Fund	22,472,008	35,004,083	24,380,935	-10,623,148	-30.3%
05 Federal Fund	348,721,807	353,790,294	408,049,091	54,258,797	15.3%
09 Reimbursable Fund	4,926,365	4,463,948	4,414,772	-49,176	-1.1%
Total Funds	**$ 1,081,293,210**	**$ 1,068,711,001**	**$ 1,139,049,791**	**$ 70,338,790**	**6.6%**

Note: The fiscal 2013 appropriation does not include deficiencies. The fiscal 2014 allowance does not include contingent reductions.

Fiscal Summary
DHMH – Mental Hygiene Administration

Program/Unit	FY 12 Actual	FY 13 Wrk Approp	FY 14 Allowance	Change	FY 13 - FY 14 % Change
01 Mental Hygiene Administration	$ 814,652,222	$ 805,367,089	$ 869,769,968	$ 64,402,879	8.0%
03 Walter P. Carter Community Mental Health Center	146,456	154,377	51,090	-103,287	-66.9%
04 Thomas B. Finan Hospital Center	18,255,323	18,187,338	18,853,725	666,387	3.7%
05 Regional Institute for Children and Adolescents – Baltimore City	12,862,145	12,674,192	13,015,710	341,518	2.7%
06 Crownsville Hospital Center	1,295,507	954,956	854,961	-99,995	-10.5%
07 Eastern Shore Hospital Center	18,322,236	18,090,088	18,641,647	551,559	3.0%
08 Springfield Hospital Center	71,254,195	70,518,527	71,233,429	714,902	1.0%
09 Spring Grove Hospital Center	79,942,596	77,216,233	78,892,672	1,676,439	2.2%
10 Clifton T. Perkins Hospital Center	52,848,877	54,047,477	55,737,970	1,690,493	3.1%
11 John L. Gildner Reg. Institute for Children and Adolescents	10,881,702	10,746,669	11,253,225	506,556	4.7%
12 Upper Shore Community Mental Health Center	792,817	750,752	740,178	-10,574	-1.4%
14 Regional Institute for Children and Adolescents – S. Maryland	39,134	3,303	5,216	1,913	57.9%
Total Expenditures	**$ 1,081,293,210**	**$ 1,068,711,001**	**$ 1,139,049,791**	**$ 70,338,790**	**6.6%**
General Fund	$ 705,173,030	$ 675,452,676	$ 702,204,993	$ 26,752,317	4.0%
Special Fund	22,472,008	35,004,083	24,380,935	-10,623,148	-30.3%
Federal Fund	348,721,807	353,790,294	408,049,091	54,258,797	15.3%
Total Appropriations	**$ 1,076,366,845**	**$ 1,064,247,053**	**$ 1,134,635,019**	**$ 70,387,966**	**6.6%**
Reimbursable Fund	$ 4,926,365	$ 4,463,948	$ 4,414,772	-$ 49,176	-1.1%
Total Funds	**$ 1,081,293,210**	**$ 1,068,711,001**	**$ 1,139,049,791**	**$ 70,338,790**	**6.6%**

Note: The fiscal 2013 appropriation does not include deficiencies. The fiscal 2014 allowance does not include contingent reductions.