

ML.00
Mental Hygiene Administration
Department of Health and Mental Hygiene

Operating Budget Data

(\$ in Thousands)

	FY 00	FY 01	FY 02		% Change
	<u>Actual</u>	<u>Working</u>	<u>Allowance</u>	<u>Change</u>	<u>Prior Year</u>
General Fund	\$446,638	\$466,363	\$505,787	\$39,424	8.5%
Special Fund	2,813	2,511	2,674	163	6.5%
Federal Fund	151,539	164,814	155,950	(8,863)	(5.4%)
Reimbursable Fund	<u>2,450</u>	<u>2,434</u>	<u>2,336</u>	<u>(98)</u>	<u>(4.0%)</u>
Total Funds	\$603,440	\$636,122	\$666,748	\$30,625	4.8%

- The Mental Hygiene Administration (MHA) has accumulated a potential \$23 million general fund liability from fiscal 1998 through 2000. The allowance contains only \$3.1 million in general funds to offset this liability.
- MHA is also undertaking cost containment measures amounting to \$19.5 million to stem a fiscal 2001 budget deficit.
- MHA's fiscal 2002 allowance includes funding for a variety of initiatives including census reduction, services to transitioning youth, and respite care.

Personnel Data

	FY 00	FY 01	FY 02	
	<u>Actual</u>	<u>Working</u>	<u>Allowance</u>	<u>Change</u>
Regular Positions	3,933.55	3,924.55	3,954.15	29.60
Contractual FTEs	<u>180.95</u>	<u>176.46</u>	<u>185.54</u>	<u>9.08</u>
Total Personnel	4,114.50	4,101.01	4,139.69	38.68

Vacancy Data: Regular

Budgeted Turnover: FY 02	245.16	6.20%
Positions Vacant as of 12/31/00	376.75	9.60%

- There are 29.6 full-time equivalent (FTE) new positions in the fiscal 2002 allowance, including 20.6 FTEs at the Eastern Shore Hospital to staff the fourth ward at the new hospital, and 8 FTEs at Spring Grove to support increased office space use at that facility.

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

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Analysis in Brief

Issues

How and Why MHA Accumulated a \$23 Million General Fund Liability from Fiscal 1998 to 2000: In its fiscal 2000 close-out report, the Office of Legislative Audits noted that MHA had reported a \$15 million unprovided for general fund payable to the General Accounting Division. Latest estimates of MHA's general fund liability are closer to \$23 million. **Budget bill language is recommended restricting general funds to reduce prior year payables. A reporting requirement is also recommended.**

The Fiscal 2001 Deficit: On top of an accumulated general fund liability, the Department of Legislative Services (DLS) is projecting a deficit of \$22.5 million for fiscal 2001. MHA has implemented cost containment measures and taken other steps to eliminate this deficit. **Narrative is recommended to request an assessment of the impact of these measures. Language is also recommended adding a reporting requirement.**

Is the Fiscal 2002 Allowance for the Fee-for-service System Adequate?: A brief assessment of the adequacy of the fiscal 2002 allowance for the fee-for-service system is provided. **While DLS is dubious about MHA's ability to achieve the savings needed to make the allowance work, language is recommended restricting any additional savings to reduce prior year payables.**

Despite Poor Fiscal Health, Demands on the Fee-for-service System Continue to Mount: Although faced with severe fiscal problems, demands on the fee-for-service system continue to mount from a variety of sources. Few of these are likely to be met without a significant change in focus for the fee-for-service system or a considerable infusion of funding.

With Fiscal Woes, Downsizing Plans Will Slow: MHA introduced a new downsizing initiative in a 1999 report. That plan was subsequently revised in 2000, and fiscal constraint will result in the need for further revision.

Recommended Actions

1. Add budget bill language restricting \$10.1 million in general funds to be used to reduce reported prior year payables.
2. Add budget bill language restricting any general fund savings that result from overattainment of federal Medicaid funds to be used to reduce reported prior year payables.
3. Add language requiring notification of major changes to the Community Services budget.

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4. Adopt narrative requesting a final accounting of actual fee-for-service expenditures for fiscal 1998 through 2000.
5. Adopt narrative requesting an assessment of the impact of fiscal 2001 cost containment measures.
6. Adopt narrative continuing the Administrative Services Organization quarterly reporting requirement.

Updates

ASO Performance: Since the introduction of the new fee-for-service system for mental health services, the budget committees have required quarterly updates on the performance of the Administrative Services Organizations (ASO). **Narrative continuing those updates is suggested.**

A Building for MPRC?: Beginning in fiscal 2000, the Maryland Psychiatric Research Center (MPRC) received significant grant funding from Novartis AG. That funding required MPRC to develop additional space. Building development was stalled, but now seems to be moving forward.

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Operating Budget Analysis

Program Description

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

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

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

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

As a result of waivers under the authority of Section 1115 of the federal Social Security Act, beginning in fiscal 1998, the State established a program of mandatory managed care for Medicaid recipients. While primary mental health services stayed within the managed care structure, specialty mental health services to Medicaid enrollees were funded through the public mental health system. That system is overseen by MHA, although it contracts with an Administrative Services Organization (ASO), Maryland Health Partners (MHP), to administer the system.

Governor's Proposed Budget

The Governor's fiscal 2002 allowance for MHA shows a \$30.6 million increase over the fiscal 2001 working appropriation (4.8%). **Exhibit 1** details three-year budget data for the four components of MHA's budget: program direction, community services, MPRC, and the State-run psychiatric facilities (facilities). As shown in Exhibit 1:

- Program direction sees the largest percentage increase from fiscal 2001 to 2002 (14.1%). However, program direction remains just 0.9% of the overall MHA budget.
- Community services funding increases by 2.7% from fiscal 2001 to 2002. However, this somewhat masks the extent of change found in the community services budget because a significant increase in general fund expenditures is offset by a large decrease in federal funds, reflecting the mix of clients that MHA has been serving.
- The MPRC contract shows a modest \$68,000 increase in fiscal 2002, 1.8%. This contract remains a very small fraction (0.6%) of MHA's total budget.
- Facilities costs increase by \$19.3 million in fiscal 2002, 8.3%. Most of this increase (82.5%) is due to higher personnel costs. Facilities funding accounts for 37.7% of MHA's total budget.

Exhibit 1

Mental Hygiene Administration
Budget Change -- Fiscal 2000 through 2002
(\$ in Thousands)

	<u>FY 2000</u>	<u>FY 2001</u>	<u>FY 2002</u>	<u>\$ Change FY 01-02</u>	<u>% Change FY 01-02</u>
Program Direction	\$5,095	\$5,279	\$6,022	\$742	14.10%
Community Services	368,503	395,036	405,504	10,469	2.70%
Maryland Psychiatric Research Center	3,824	3,878	3,946	68	1.80%
Facilities	226,017	231,929	251,276	19,346	8.30%
Total	\$603,440	\$636,122	\$666,748	\$30,625	4.80%

Note: Numbers may not sum due to rounding.

Source: Department of Health and Mental Hygiene

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Exhibit 2 details specific components of change in the fiscal 2002 budget from fiscal 2001.

Exhibit 2

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

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimbursable Fund	Total
2001 Working Appropriation	\$466,363	\$2,511	\$164,814	\$2,434	\$636,122
2002 Governor's Allowance	<u>505,787</u>	<u>2,674</u>	<u>155,950</u>	<u>2,336</u>	<u>666,748</u>
Amount Change	\$39,424	\$163	(\$8,863)	(\$98)	\$30,625
Percent Change	8.5%	6.5%	(5.4%)	(4.0%)	4.8%

Where It Goes:

Program Direction	\$742
<i>Personnel Expenses</i>	<i>\$655</i>
Annualization, increments, and other compensation	\$511
General salary increase	106
Employee and retiree health insurance	101
Other fringe benefits	30
Turnover adjustments	(93)
<i>Other Expenses</i>	<i>87</i>
Other Expenses	87
Community Services	10,469
Annualization of initiatives (census reduction, transitioning youth, and respite care)	5,668
Carry over account	5,366
Fiscal 2002 funding of ongoing initiatives (census reduction, transitioning youth, and respite care)	4,435
School-based mental health services	2,000
Cost-of-living increase: fiscal 2001 annualization and fiscal 2002	1,882
Increase in federal mental health block grant	1,240
State-funded inpatient beds purchased when State facilities are full	1,100
Transfer of hot-line funds from the Subcabinet Fund	370
Major fee-for-service program utilization and rate annualization	(9,445)

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Where It Goes:

Grants and contracts cost containment		(3,510)
Other		1,363
Maryland Psychiatric Research Center	68	
Contract Increase		68
State-run Psychiatric Facilities	19,346	
<i>Personnel Expenses</i>		<i>15,954</i>
New positions (29.6 FTEs)		492
Annualization, increments, and other compensation		8,669
General salary increase		3,211
Employee and retiree health insurance		2,955
Other fringe benefits		526
Turnover adjustments		101
<i>Other Expenses</i>		<i>3,392</i>
Fuel and utilities		1,405
Drug costs		852
Building maintenance and repair at Spring Grove		427
Contractual employment expenses		355
Other		353
Total		\$30,625

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

Program Direction

Higher personnel costs account for the bulk of the increase in program direction (\$655,000 or 88%). Most costs relate to annualization of the fiscal 2001 cost-of-living adjustment (COLA) as well as other increments. The general salary increase for fiscal 2002, 4%, effective January 1, 2002, accounts for \$106,000 with employee and retiree health insurance costs another \$101,000 of the overall increase. The remainder of the MHA headquarters budget increases by \$87,000 spread across various items, the most significant increase being the internal Department of Health and Mental Hygiene (DHMH) information systems assessment which increases by \$71,000.

While there is little of note budgetarily in program direction, it should be noted that the vacancy rate in program direction on December 31, 2000, was 13.2%, or 12.5 FTEs. The Department of Legislative Services (DLS) was concerned about the vacancy rate at the end of 1999, reporting a 17.2% vacancy rate (15.5 FTEs) in last year's budget analysis. Indeed, the General Assembly reduced authorized positions in

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program direction in fiscal 2001 by 2 FTEs because of long-term vacancy rates. DHMH has actually added 7 FTE positions in program direction compared to the fiscal 2001 legislative appropriation (transferred from Perkins Hospital), but these were filled positions and do not explain the vacancy rate.

Community Services

The Community Services budget contains numerous significant changes over fiscal 2001 including:

- In fiscal 2000 MHA began three initiatives: strengthening institutional downsizing efforts; providing additional case management, supported employment, residential services, and mental health treatment for youth transitioning from adolescence to adulthood; and respite care for caregivers of children with serious emotional disturbances. The fiscal 2002 budget includes funding for the annualization of services begun in fiscal 2001 (\$5.7 million) as well as new funding (\$4.4 million).
- The establishment of a carry over account to support the payment of bills accrued from previous years (\$5.4 million), something which is discussed further below.
- \$2 million for school-based mental health services. This initiative builds upon the expansion of school-based health care centers funded through the Subcabinet Fund in fiscal 2001. The initiative is designed to offer grant support to local jurisdictions to implement practices recognized as being effective in promoting positive mental health and preventing violence, substance abuse, suicide, and other destructive behaviors. Practices must also be integrated with mental health treatment services as well as juvenile justice and social service interventions available to students inside and outside of targeted schools.
- \$1.9 million for the annualization of the fiscal 2001 COLA on grants and contracts and a fiscal 2002 COLA. These grants and contracts include payments to CSAs as well as other services which continue to be provided through grants as they do not easily fit into the fee-for-service system.
- \$1.1 million to purchase private hospital beds when State facilities are full;
- A \$9.4 million decline in the major fee-for-service programs based on a combination of utilization and the annualization of a rate increase that went into effect in March 2000. **Exhibit 3** details spending in these programs for fiscal 2000 through 2002. As shown in Exhibit 3, for the most part the changes from fiscal 2001 to 2002 represent a realignment of expenditures based on the most recent experience. Specific program changes include:
 - Reduced inpatient payments based on a combination of factors including Health Services Cost Review Commission (HSCRC) incentives to move people out of hospital settings quickly resulting in lower overall reimbursement in inpatient settings.
 - Reduced utilization of outpatient services. Reasons for this include more people accessing psychiatric rehabilitation services and also a reflection of some of the cost containment measures currently being undertaken by MHA in fiscal 2001 which carry over into fiscal 2002.

Exhibit 3

**Community Services
Major Fee-for-service Program Changes
Fiscal 2000 through 2002
(\$ in Thousands)**

	FY 2000 Actual	FY 2001 Approp.	FY 2002 Allowance	\$ Change FY 01 - 02	Change Due to Utilization/ Rates
Inpatient	\$113,197	\$122,016	\$116,159	(\$5,857)	(\$9,629)
Outpatient	82,773	90,570	75,007	(15,563)	(16,190)
Psychiatric Rehab. Service	118,611	100,576	123,667	23,091	16,143
Targeted Case Management	5,571	5,654	6,483	829	231
Total	\$320,152	\$318,815	\$321,316	\$2,501	(\$9,445)

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

Source: MHA/Maryland Health Partners

- Growth in psychiatric rehabilitation service expenditures reflecting, for example, MHA's efforts at facility census reduction which typically result in placement with a psychiatric rehabilitation provider, the acuity of patient problems, and the establishment of community wrap-around services for children coming out of residential treatment facilities.
- There is also a \$3.5 million reduction in the grants and contracts program that relate to cost containment measures being introduced in fiscal 2001 carried over into fiscal 2002. The reason for these cost containment measure will be discussed further below.

State-run Psychiatric Facilities

As noted above, personnel costs account for 82.5% of the overall increase in facilities budgets. The budget includes \$492,000 for 29.6 FTE new positions. These positions include:

- 1.0 FTE contractual conversion at the Carter center.
- 20.6 FTE positions at the Eastern Shore Hospital (a combination of direct care workers, nurses, and therapists) to staff the fourth ward at the new hospital. MHA hopes to open the new hospital in March and open the fourth ward in July. However, DLS would note that the new positions have a 50% turnover rate which is going to make this difficult and will also create short-term strains on Crownsville and Springfield hospitals which were budgeted for lower populations based on that ward opening in July.

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- 8 FTE positions at Spring Grove Hospital. These are maintenance and guard positions and reflect increased utilization of renovated Spring Grove buildings for office space. These positions are funded with reimbursable funds and are supported through rents charged to tenants (such as the Office of Health Care Quality, various health occupations boards, and other DHMH headquarters staff).

Other major increases include almost \$8.7 million for annualization of the fiscal 2001 COLA as well as increments and other salary adjustments, \$3.2 million for the fiscal 2002 general salary increase, and almost \$3 million in higher employee and retiree health insurance costs.

The extent of personnel costs as a portion of overall budget increase at the facilities mirrors the fact that a significant proportion of the total expenditures at the facilities are in personnel. For example, over 81% of total expenditures at the facilities are for regular or contractual personnel. This reflects both the personnel-intensive nature of the care and supervision provided in the facilities, and also the level of training and expertise required of much of the facilities workforce. Given this personnel-intensive service provision, **Exhibit 4** presents some disturbing data:

- Overall, the vacancy rate at the facilities is high, 9.5%.
- Some of the facilities have vacancy rates significantly higher than the overall average: Crownsville, 11.1%; Springfield, 12.8%; and RICA-Southern Maryland, 15.6%.
- Nursing positions appear particularly hard to fill, not surprising given the statewide nursing shortage. Nursing positions represent just over half (50.5%) of total vacancies.
- Statewide, 18.3% of all nursing positions at the facilities were vacant as of December 31, 2000. Shortages are particularly marked at Springfield and Spring Grove where a quarter of all nursing positions are vacant.

It should be noted that there is a two-grade annual salary review (ASR) increase for nurses budgeted in the Department of Budget and Management. This increase allows for a one-grade increase effective July 1, 2001, and a further one-grade increase effective January 1, 2002. Further, there are legislative efforts (for example, HB 316) to ease the nursing shortage at the State facilities by encouraging retired nurses to return to work on a contractual basis without negatively impacting their retirement benefits.

In terms of other major expenditure increases at the facilities:

- The most significant is rising fuel and utility rates, a little over \$1.4 million. Included in this is a \$715,000 increase in the overall Maryland Environmental Service charge for the facilities, as well as significant increases in anticipated natural gas costs (\$424,000).
- Drug costs continue to rise, \$852,000 above fiscal 2001 expenditures. Rising drug prices have been a particular problem at the facilities. However, since this increase is over and above the significant increase that was eventually included in the fiscal 2001 budget, it is probably close to adequate.

Exhibit 4

**MHA Facilities -- Various Personnel Data
Fiscal 2001**

	<u>Auth. FTEs</u>	<u>Vacancies</u>	<u>Vacancy Rate</u>	<u>Nursing Vacancies</u>	<u>Nursing Vacancies as % of Total Vacancies</u>	<u>Nursing Vacancies as % of Nursing Positions</u>
Carter	148.3	11.0	7.4%	7.0	63.6%	14.6%
Finan	227.0	7.0	3.1%	2.0	28.6%	3.3%
RICA Baltimore	136.5	9.6	7.0%	5.0	52.1%	16.4%
Crownsville	535.3	59.5	11.1%	37.5	63.0%	27.3%
Eastern Shore	220.0	8.0	3.6%	2.0	25.0%	2.6%
Springfield	884.5	114.5	12.9%	66.0	57.6%	24.3%
Spring Grove	774.5	72.7	9.4%	34.0	46.8%	15.3%
Clifton Perkins	521.5	47.5	9.1%	17.5	36.8%	20.6%
RICA Montgomery	179.6	8.5	4.7%	1.0	11.8%	5.6%
Upper Shore	114.0	12.5	11.0%	9.5	76.0%	20.0%
RICA So. MD	86.5	13.5	15.6%	2.5	18.5%	25.0%
Total	3,827.7	364.3	9.5%	184.0	50.5%	18.3%

Note: Long-term vacancies are those vacant over 12 months.

Nursing vacancies include LPN and RN and supervisor positions.

Source: Mental Hygiene Administration

- Building maintenance and repair work continues at Spring Grove, much of it associated with increasing the availability of office space on the hospital campus. According to DHMH, the following buildings are, or will be shortly, utilized as office space:
 - **Vocational Rehabilitation Building:** Alcohol and Drug Abuse Administration (ADAA) staff, to be occupied March 2001;
 - **Ben Rush Building:** Health Occupation Boards including Dentistry and Occupational Therapy,

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- currently occupied;
- ***Bland Bryant Building:*** Office of Health Care Quality (OHCQ), currently occupies first, second, and part of the third floor, and the remaining building space is to be filled with OHCQ staff;
- ***Dix Building:*** MHA staff, to be occupied summer 2001; and
- ***Mitchell Building:*** Renovation work yet to be done.

Once again, the fiscal 2002 budget for the facilities is predicated on falling average daily populations (ADP), although as shown in **Exhibit 5** the reduction from fiscal 2001 is slight (0.6%). The significant increase in ADP at the Eastern Shore Hospital represents the full opening of that hospital. Small reductions are shown at Finan, Crownsville, and Springfield. It is also interesting to note that statewide, admissions are estimated to be at the same level as in fiscal 1999.

Performance Analysis: Managing for Results

Community Services

MHA's Managing for Results (MFR) submission for community service expenditures focuses on the consumer satisfaction survey that the ASO is required to undertake in order to evaluate consumer satisfaction with the new fee-for-service system. Data is collected through telephone interviews. While there are limitations to this kind of survey (for example, obtaining information for individuals on Medicaid and for individuals who are uninsured or underinsured often presents challenges, and consumer satisfaction surveys typically result in the expression of high levels of satisfaction), it is the only quality measure available to MHA.

The most recent satisfaction surveys indicated:

- The level of satisfaction with mental health services received overall remains high (89% of respondents were satisfied with services received).
- Of those who had direct contact with the CSAs or ASO, most express satisfaction with that contact (78.3% for CSAs, 82.6% for the ASO).
- For those persons receiving substance abuse services, 84.6% reported satisfaction with those services.
- The major area of concern remains satisfaction with the choice respondents felt they had in selecting their service provider. It has been noted that limited clinical resources in some areas (for example, more rural areas) may well contribute to a sense of restricted choice.
- A second area of concern appears when you look at specific services, for example, satisfaction with inpatient services is relatively low.

Exhibit 5

**Mental Hygiene Administration Facilities
Average Daily Population
Fiscal 1999 through 2002**

	<u>FY 99 Actual</u>	<u>FY 00 Actual</u>	<u>FY 01 Est.</u>	<u>FY 02 Est.</u>	<u>% Change FY 99 - 02</u>	<u>% Change FY 01 - 02</u>
Carter	43	47	45	45	1.5%	0.0%
Finan	89	86	90	85	(1.5)%	(5.6)%
RICA Baltimore	42	42	43	43	0.8%	0.0%
Crownsville	208	203	190	185	(3.8)%	(2.6)%
Eastern Shore	45	48	55	72	17.0%	30.9%
Springfield	400	363	335	320	(7.2)%	(4.5)%
Spring Grove	347	330	310	310	(3.7)%	0.0%
Clifton Perkins	200	214	205	205	0.8%	0.0%
RICA Montgomery	71	71	76	76	2.3%	0.0%
Upper Shore	35	28	38	38	2.8%	0.0%
RICA Southern Maryland	32	27	34	34	2.0%	0.0%
State Totals						
Admissions	4,264	3,878	4,475	4,261	0.0%	(4.8)%
Operated Beds	1,723	1,684	1,619	1,614	(2.2)%	0.0%
ADP	1,512	1,459	1,421	1,413	(2.2)%	(0.6)%

Source: Mental Hygiene Administration

DLS notes that it would be useful to develop other outcome measures in the community services areas. For example, ongoing provider concern about the administration of the fee-for-service system warrants some measure of the performance of the ASO. Similarly, it would be useful to know the impact of community programs. This could be done, for example, through measuring if a client is admitted to a State facility within 30, 60, or 90 days of ending services with a private provider or while services are being provided.

State Facilities

DLS was somewhat critical of the MFRs developed by the State facilities in fiscal 2001. In addition to a lack of consistency between goals and objectives, the department noted a general inconsistency between the various MFR submissions. While recognizing that institutions have different priorities and different missions, there is room in an MFR to reflect some measure which are universal or near universal objectives (for example, the Joint Commission on the Accreditation of Health Care Organizations (JCAHCO) accreditation scores, readmission rates within 30 days, and the use of seclusion and restraints), as well as those suited to the individual mission of the facility.

DLS would note that the fiscal 2002 MFR submissions goes a considerable way towards this balance of commonality and individualism. However, as shown in **Exhibit 6**, there is still some room for improvement. For example, it is particularly frustrating when most of the facilities have as part of their MFR some objective relating to the use of seclusion and restraints, but the specific outcome measure chosen by the facility varies: Crownsville shows the seclusion rate per 1,000 patient days for adults only; Finan Center uses the number of incidents of seclusion; RICA Baltimore uses the number of seclusion incidents for the same client in a month; the Upper Shore and Eastern Shore Hospital use the rate of seclusion hours per 1,000 patient days; Springfield uses the percentage of time in seclusion and compares it to the national average; and Spring Grove and RICA Southern Maryland use a measure which combines seclusion with restraint.

MHA should continue to work to meld common goals and objectives into the MFR submissions of the State facilities, including comparable outcome measures, while allowing other goals and objectives to reflect the individual missions of the facilities.

Exhibit 6

State Facilities -- Selected Outcome Measures Fiscal 1999 through 2002

	JCAHO Accreditation Survey Score				Readmission within 30 days (%)				Seclusion Incidents (rates per 100)			
	<u>FY 99</u>	<u>FY 00</u>	<u>FY 01</u>	<u>FY 02</u>	<u>FY 99</u>	<u>FY 00</u>	<u>FY 01</u>	<u>FY 02</u>	<u>FY 99</u>	<u>FY 00</u>	<u>FY 01</u>	<u>FY 02</u>
Carter	Yes	Yes	Yes	Yes								
Finan									3.3	2.1	1.8	1.9
RICA Baltimore		99.0	99.0	99.0								
Crowsville					4.0	5.0	5.0	5.0	87.8	84.0	82.0	79.0
Eastern Shore				Yes	5.7	3.6	4.6	4.0				
Springfield						9.4	7.9	6.5				
Spring Grove					3.2	5.8	5.0	3.0				
Clifton Perkins												
RICA												
Montgomery					0.0	0.0	1.0	2.0				
Upper Shore					9.0	6.2	5.0	4.6				
RICA So. MD						0.0	15.0	15.0				

Note: Crowsville seclusion rate data is for adult population only.
 RICA Southern Maryland readmission rate is within 60 days.
 No JCAHO numeric score given for Carter or Eastern Shore.

Source: Department of Health and Mental Hygiene

Issues

1. How and Why MHA Accumulated a \$23 Million General Fund Liability from Fiscal 1998 to 2000

In its fiscal 2000 close-out report, the Office of Legislative Audits (OLA) reported that MHA had reported a \$15 million unprovided for general fund payable to the General Accounting Division. This payable represents mental health services delivered between fiscal 1998 and 2000 that will be charged to the fiscal 2001 general fund appropriation due to the lack of available funds in fiscal 2000. OLA, in its report, noted that the actual extent of the payable was in fact closer to \$25 million.

The How

As noted in **Exhibit 7**, according to the most recent data from MHA and MHP, the actual total of general fund overexpenditures for fiscal 1998 through 2000 was \$30.7 million. As shown in Exhibit 7:

- MHA reported expenditures that are different than actual expenditures documented by MHP.
- In fiscal 1998 MHA actually reported spending more general funds than they actually did (\$616,000) while reporting receiving almost \$4.8 million less in federal funds than they actually did.
- However, in fiscal 1999 and 2000, MHA reported spending \$31.4 million less in general funds than they actually did. Thus, for the period fiscal 1998 through 2000, general fund expenditures were \$30.7 million more than reported.
- Offsetting this liability is fiscal 1998 through 2000 interest earned by MHP on funds held in their account prior to bill payment and the \$4.8 million overattainment in federal funds in 1998, for a total liability of \$22.9 million.

Is this \$22.9 million figure likely to change? There are three factors which might impact that figure:

- The number may rise because additional claims against fiscal 2000 may be filed through March 2001 (up to nine months after services have been provided).
- MHA is still seeking federal fund reimbursements for an estimated \$11 million in claims incurred during fiscal 1998 and 1999. Those claims have been booked as federal funds, but if the claims are denied for any reason, those claims will become general fund payables thus again adding to the total payable number.

Exhibit 7

**How MHA Accumulated a \$23 Million Liability in Its Fee-for-service System
Fiscal 1998 through 2000**

	<u>FY 98</u>	<u>FY 99</u>	<u>FY 00</u>
Reported Expenditures			
General Funds	\$161,598,421	\$163,882,100	\$169,259,688
Federal Funds	111,436,404	134,300,784	134,873,146
Actual Expenditures MHP			
General Funds	160,982,344	177,392,852	187,105,206
Federal Funds	116,243,912	132,463,701	133,046,355
Difference			
General Funds	616,077	(13,510,752)	(17,845,518)
Federal	(4,807,508)	1,837,083	1,826,791

Combined General Fund Overexpenditures Fiscal 1998 through 2000	(\$30,740,193)
Fiscal 1998 through 2000 Interest Income	3,030,583
Overattained Fiscal 1998 Federal Funds	4,807,508
Fiscal 1998 through 2000 Liability	(22,902,102)

Source: Mental Hygiene Administration; Department of Legislative Services

- However, MHA is hoping to reduce the deficit by retroactively attempting to establish Medicaid eligibility for some of the claims thereby offsetting some general fund expenditures with increased federal fund income. However, while this may be possible for fiscal 2000 claims, it will be extremely difficult for claims filed in fiscal 1998 and 1999.

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The Why

There are a number of reasons why MHA has accumulated such a significant deficit:

- The growth of non-Medicaid (grey zone) expenditures in fiscal 1999 and 2000. As shown in **Exhibit 8** actual non-Medicaid expenditures in fiscal 1999 and 2000 were significantly above reported non-Medicaid expenditures. In addition to Medicaid enrollees, MHA serves the uninsured and the underinsured. Eligibility is based on the federal poverty level and also by type of service received, and also involves a complex array of copayments again depending on income and service provided.

Exhibit 8

**Medicaid and non-Medicaid Expenditures
Fiscal 1998 through 2000**

	<u>FY 98</u>	<u>FY 99</u>	<u>FY 00</u>
Reported Expenditures			
Medicaid	\$222,872,808	\$268,601,568	\$269,746,292
Non-Medicaid	50,162,017	29,581,316	34,386,542
Non-Medicaid as a % of Total	18.4	9.9	11.3
Actual Expenditures MHP			
Medicaid	232,487,824	264,927,402	266,092,710
Non-Medicaid	44,738,432	44,929,151	54,058,851
Non-Medicaid as a % of Total	16.1	14.5	16.9

Source: Mental Hygiene Administration

According to MHA, the growth in non-Medicaid expenditures is due to such factors such as the growth of psychiatric rehabilitation services to children that are not covered by private insurance, a growth in service utilization among adults, and a lack of incentive on the part of providers to assist in maximizing Medicaid recoveries.

- MHA allowed claims to be filed and re-filed in fiscal 1998 and 1999 beyond the normal nine-month window because of problems with billings. These issues have been well-documented and include: problems with software compatibility, provider data entry errors as they struggle to move from a grants-based to fee-for-service system, and difficulty in determining Medicaid eligibility. Thus, bills continued to be paid and were charged against subsequent fiscal years.
- The difficulty MHA has had in making the transition from a grants-based to fee-for-service system.

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In looking at many of the actions MHA has taken in the first years of the fee-for-service system, it is clear that their priority, understandably, has been maintaining continuity and quality of care during the transition period. Consumer satisfaction data presented in the MFR discussion would indicate that they were successful in achieving that priority. Where MHA was less successful was understanding what was happening within the system and developing an adequate methodology for estimating expenditures for claims incurred but not reported.

MHA's difficulty in predicting what was happening in the system is ultimately reflected in the data shown in Exhibit 8 in terms of reported and actual expenditures. Consider also data presented in the Governor's operating budget books which show estimated and actual individuals served in the fee-for-service system. As shown in **Exhibit 9**, for example, MHA's original fiscal 1998 estimates of individuals to be served were substantially above the individuals actually served. In fiscal 1999 the number of people served was very close to the estimate, but the mix of people served was very different from the estimate. In fiscal 2000 the estimate of individuals served was slightly overestimated and while the Medicaid population served number was reasonably accurate, estimates of the non-Medicaid population served were again significantly inaccurate.

The inability to produce accurate data about actual expenditures has been amply documented in numerous OLA audit reports over the past several years. Unfortunately, this lack of accurate financial information contributed to other actions taken which contributed to the deficit MHA is facing. For example, **Exhibit 10** details various actions which have been taken to reduce general funds support for the fee-for-service program between fiscal 1998 and 2000 on the basis of financial data available at that time. These actions include:

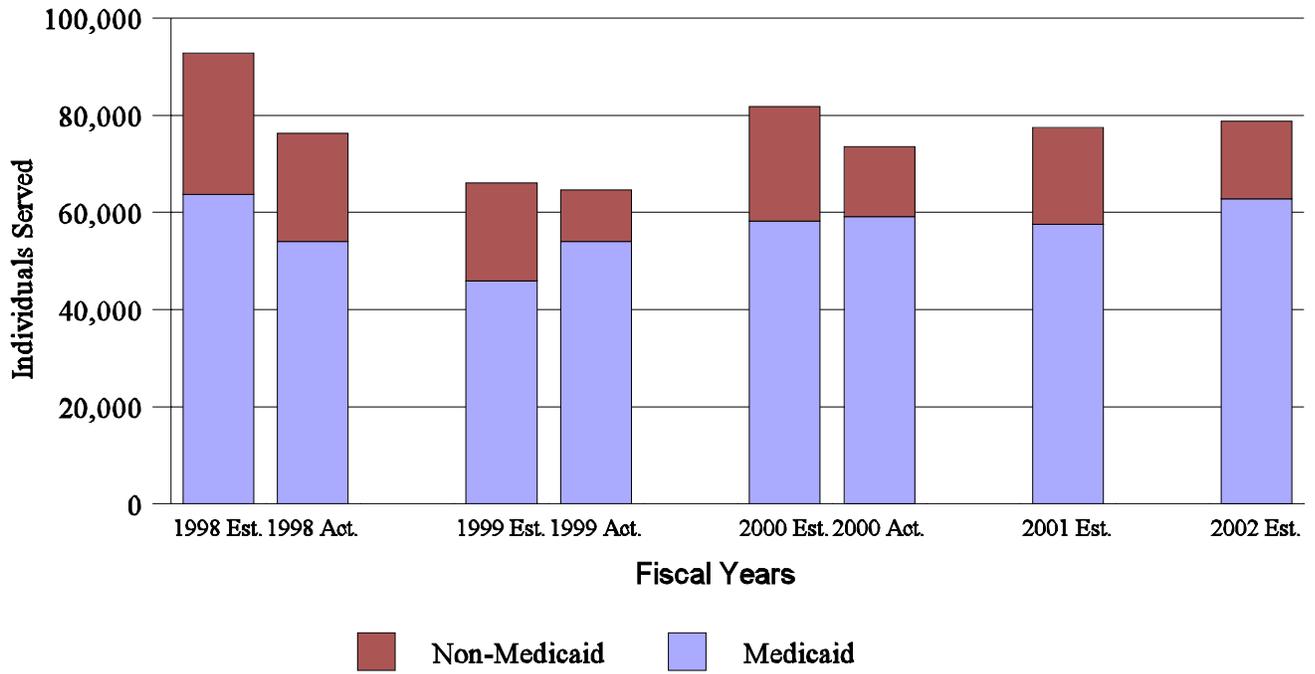
- transferring general funds to cover deficiencies at the State facilities (\$5.5 million) and in Medicaid (\$5.8 million); and
- reductions made to the proposed budget by the executive (\$6.3 million) and the legislature (\$1.3 million).

What to Do About the Problem

To date, the accumulated fiscal 1998 through 2000 deficit has been managed by rolling-over the deficit into fiscal 2001, i.e., using fiscal 2001 dollars to cover the fiscal 1998 through 2000 deficiency. However, at some point this deficit has to be resolved. Indeed, MHA has indicated that, given the deficit it faces in its fiscal 2001 budget, it may have to suspend bill payments in the last months of fiscal 2001 until the fiscal 2002 appropriation becomes available.

Exhibit 9

**Individuals Served -- Fee-for-service System
Fiscal 1998 through 2002**



Source: Governor's Operating Budget Books 1998 through 2002

Exhibit 10

**Various Alterations to the Fee-for-service System -- General Funds
Fiscal 1999 through 2000**

	<u>FY 1999</u>	<u>FY 2000</u>	<u>Total</u>
Transfer to cover deficiencies at State facilities	\$3,485,542	\$2,018,726	\$5,504,268
Transfer to cover deficiencies in Medicaid	5,820,873	0	5,820,873
Reduction to current services budget (Executive)	0	6,300,000	6,300,000
Reduction to allowance (General Assembly)	0	1,286,955	1,286,955
Total	\$9,306,415	\$9,605,681	\$18,912,096

Source: Department of Health and Mental Hygiene

The fiscal 2002 allowance does include a \$5.3 million (\$3.1 million in general funds) carry over account which is designed to offset over-expenditures in prior years. Clearly this amount is inadequate to meet the deficit that MHA has accumulated from fiscal 1998 through 2000.

Thus, DLS recommends that budget bill language be added to restrict the use of \$10.1 million in general funds in the fiscal 2002 allowance to pay for unprovided for payables reported to the General Accounting Division. This \$10.1 million is derived as follows:

- **\$3.1 million from the carry over account;**
- **\$1.7 million which represents half of the new funding designated for census reduction, transitioning youth, and respite care initiatives;**
- **\$1.8 million which represents half of the annualization funding for these same initiatives in fiscal 2001, since MHA has delayed these initiatives in fiscal 2001 in order to resolve their fiscal 2001 deficit;**
- **\$2 million for school-based mental health services; and**
- **\$1.5 million for the grants and contracts COLA, mirroring the action MHA has already taken in fiscal 2001 in order to resolve their fiscal 2001 deficit.**

Even this action does not resolve MHA's problem. At some point an appropriation sufficient to resolve these overexpenditures will have to be provided and/or even greater limitations on non-Medicaid services than those currently proposed will have to be imposed.

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DLS further recommends that MHA report back to the budget committees on July 1, 2001, with a final accounting of reported and actual expenditures for fiscal 1998 through 2000. That report should include actions taken and further recommendations for improving financial oversight of the fee-for-service system as well as an implementation plan for any recommendations made. In developing these recommendations, MHA should work together with OLA.

2. The Fiscal 2001 Deficit

In addition to the deficit accumulated from fiscal 1998 through 2000, DLS is also projecting a deficit in the fee-for-service system in the current year of almost \$22.5 million (see **Exhibit 11**). The projected \$22.5 deficit is offset by \$3 million in surplus block grant dollars as well as the right-sizing of other contracts plus \$250,000 in estimated fiscal 2001 interest income earned by MHP on funds held in their account prior to bill payment. This deficit is basically an extension of the problems MHA has had in developing accurate financial projections since their fiscal 2001 appropriation was based on previously reported inaccurate expenditures. However, MHA exacerbated the problem by increasing a variety of rates in March 2000, an increase which the fiscal 2001 budget did not anticipate nor could support.

In order to manage this projected deficit, MHA has proposed and implemented a variety of cost containment measures shown in **Exhibit 12**.

Exhibit 11

Components of a Fiscal 2001 Deficit in the Fee-for-service System

Original Estimate of Expenditures Based on Appropriation

Medicaid	\$290,450,188
Non-Medicaid	28,364,752

Revised Estimate of Expenditures Based on Claims Data

Medicaid	278,970,720
Non-Medicaid	56,588,800

Estimated General Fund Deficiency **\$22,484,314**

Funds Available from Non Fee-for-service Programs **(\$3,000,000)**

Fiscal 2001 Interest Income **(\$250,000)**

Necessary Cost Containment **\$19,234,314**

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

Exhibit 12

**Mental Hygiene Administration
Fiscal 2001 Cost Containment Actions**

<u>Cost Containment Measure</u>	<u>Projected Cost Savings</u>	<u>Implementation Status</u>
Delay initiatives	\$1,500,000	Complete
Take back one-time funds from CSAs	1,500,000	Complete
Freeze CSA budget modifications	500,000	Complete
Enforce claims time limits	1,000,000	In effect
Reduce payments for non-Medicaid services	2,000,000	Proposed
Cap non-Medicaid enrollment growth:		
• Enforce rules on Medicaid applications	1,500,000	In effect
• Limit non-Medicaid enrollment	1,500,000	In effect
Seek Medicaid eligibility for non-Medicaid clients	6,000,000	In effect
Reduce services to non-Medicaid clients	2,000,000	In effect
Stop HSCRC non-Medicaid payments	1,000,000	Proposed
Bill laboratory work to Medicaid	1,000,000	In process
All Cost Containment Measures	\$19,500,000	

Source: Mental Hygiene Administration

Specifics on the cost containment measures are as follows:

- A delay in the ongoing census reduction, transitioning youth, and respite care initiatives.
- MHA currently allows the CSAs to retain any funds that are unspent from their grant awards at the end of the fiscal year. These funds are used to support a variety of one-time programming. MHA has taken all prior year unspent funds back from the CSAs.
- The fiscal 2001 budget provided for increases in the grants awarded to the CSAs. MHA has frozen those increases.
- In theory, providers have nine months to submit claims to MHP for payment. However, in practice MHA has not enforced this time limit. It is now doing so.

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- MHA is proposing to reduce payments for a variety of on-site and off-site services performed by psychiatric rehabilitation providers.
- MHA is proposing to cap the growth in non-Medicaid expenditures by enforcing provisions that require providers to be proactive in terms of getting clients to seek Medicaid eligibility, for example by actually taking clients to the local department of social services where eligibility determination occurs. MHA is also limiting non-Medicaid services to "priority populations." MHA's definition of "priority population" is provided in **Appendix 1**.
- The most significant cost containment measure is to maximize federal reimbursement through increasing the proportion of the served population that is enrolled in Medicaid.
- MHA is also capping benefits for non-Medicaid clients in a variety of ways. For example, MHA is limiting the number of services that can be provided in a week. MHA is also refusing to provide any payment for residential crisis services if a client has private insurance, requiring providers to seek reimbursement from the private insurance company. MHA is also trying to limit stays in residential crisis services to 30 days. Finally, MHA is clamping down on the copayment and income eligibility waivers that have been granted by CSAs.
- Those outpatient clinics which are governed by HSCRC rates (typically those outpatient clinics which are attached to, or on the grounds of, a hospital) are currently reimbursed for services provided to non-Medicaid as well as Medicaid clients. However, since the HSCRC rate includes an allowance for uncompensated care, MHA feels that they should not have to pay for services delivered at these clinics to non-Medicaid clients.
- Currently, private laboratories are unable to submit laboratory bills through the Medicaid Management Information System II. MHA is working with the Medical Care Programs Administration to allow such claims to be processed so that appropriate federal reimbursement can be attained.

Unless these cost containment measures are effective, MHA's fiscal situation will be even worse than it already is. **DLS recommends that the committees adopt narrative requiring MHA to report to them by December 1, 2001, on their projected fiscal 2001 expenditures in the fee-for-service system. The report shall include an assessment of the impact of each of the cost containment measures proposed by MHA to resolve the fiscal 2001 deficit on providers, clients, and MHA's fiscal situation. The report shall also include an assessment of the adequacy of MHA's fiscal 2002 appropriation based on the most recent claims data and detail any additional cost containment measures required for fiscal 2002.**

Further, given the significant changes being made to the Community Services budget, DLS recommends adding language which requires DHMH to notify the budget committees of any regulatory, policy, or procedural changes which increase or decrease that budget by more than \$500,000. This is similar to language traditionally included in the budget for Medicaid.

3. Is the Fiscal 2002 Allowance for the Fee-for-service System Adequate?

As shown in Exhibit 3, the fiscal 2002 allowance for the fee-for-service system parts of the public mental health system provides for a modest 0.8% overall growth over fiscal 2001. Is this growth sufficient? While predicting anything about the fee-for service system has proven difficult, it is reasonably safe to assume that the allowance continues to place the system under financial pressure.

Consider, for example, **Exhibit 13**. This exhibit shows: the general funds that MHA needs for fiscal 2001 based on its latest projections; general fund expenditures based on estimated cost containment plus one-time additions to the appropriation; general funds in the fiscal 2002 allowance; and general fund requirements based on normal growth. As shown in Exhibit 13:

- based on normal growth in Medicaid and non-Medicaid expenditures, the 2002 allowance could be \$16 million short in required general funds;
- the effectiveness of fiscal 2001 cost containment measures are the key to solvency in fiscal 2002 in that those hoped-for savings in fiscal 2001 need to continue in fiscal 2002;
- if fiscal 2001 cost containment measures are ineffective (and to date MHA's ability to contain growth in non-Medicaid expenditures and increase federal fund attainment is unproven), not only does this result in a fiscal 2001 deficit to add to accumulated fiscal 1998 to 2000 debts, it casts into doubt the ability of MHA to achieve solvency in fiscal 2002.

The key to MHA's financial solvency in the upcoming year is shifting non-Medicaid cases to Medicaid and generating general fund savings by reducing non-Medicaid expenditures. DLS's concern with this strategy has been the weakness of MHA's performance to date in this area. **DLS recommends that language be adopted requiring that, should MHA be able to generate general funds savings as a result of increasing federal fund attainment, those savings be used only to pay for prior fiscal year unprovided for payables recorded with the General Accounting Division.**

Exhibit 13

**Does MHA Have the Necessary General Funds for Fiscal 2002?
(\$ in Millions)**

	FY 01 Projected	FY 01 with Cost Cont.	FY 02 Allowance	Projected FY 02 Growth?
Medicaid	\$139	\$147	\$132	\$145
Non-Medicaid	57	35	62	60
Fiscal 2002 Initiatives	0	0	(5)	0
Total	\$196	\$182	\$189	\$205

Source: Department of Legislative Services

4. Despite Poor Fiscal Health, Demands on the Fee-for-service System Continue to Mount

While it might be sensible to think that fiscal 2002 should be a year when MHA tries to concentrate on stabilizing its financial situation, that would ignore the demands that continue to mount on the fee-for-service system. These demands include:

- ***A Growth in the Acuity of Client Problems, Most Notably the Increase of Clients with Cooccurring Substance Abuse and Mental Health Disorders:*** Cooccurring disorders worsen outcomes for individuals with mental disorders in a variety of ways, including: symptom exacerbation; treatment noncompliance; more frequent hospitalization; and greater depression and likelihood of suicide. It is estimated that 80% of individuals with mental illness and substance abuse are served through the mental health system. Further, persons with primarily substance abuse issues often access substance abuse through the mental health system, exacerbating demands on the system. While it is impossible to know exactly how much substance abuse treatment is provided through the fee-for-service mental health system, we do know that expenditures on persons with a dual diagnosis code in fiscal 2000 based on actual claims data was just over \$70 million, \$61 million Medicaid expenditures, and \$9.7 million on non-Medicaid expenditures. Spending on persons with a dual diagnosis appears to be growing at 10%+ annually (see DLS's report *Substance Abuse Treatment: Understanding the Publicly-Funded System In Maryland* for further details).
- ***Fiscal Problems for the State's Freestanding Psychiatric Hospitals:*** The State's free-standing psychiatric hospitals are reported to be facing significant fiscal problems. Indeed, in the past several years, one hospital, Gundry Glass, has closed and another, Chestnut Lodge, has declared bankruptcy. There are a number of reasons for the problems faced by these institutions, some of which may relate to the way the institutions operate (for example, average length of stays, per diem costs, and average

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costs per discharge are significantly above the national average for private psychiatric hospitals). However, the most pressing problem appears to be the changing funding mix of patients served by these institutions.

In prior years, an estimated 70% of the patients served in these hospitals were covered by private insurance, with 30% Medicaid/Medicare (excluding uncompensated care). That ratio has shifted closer to 50:50. Because of the different reimbursement levels received for private and Medicare/Medicaid patients, hospital revenues have thus declined. Private insurance rates are regulated by HSCRC. However, because these facilities are not part of the Medicare waiver, Medicare and Medicaid patients are not subject to HSCRC rate-setting authority. These rates are determined by Medicare (and utilized by Medicaid) on the basis of allowable costs and ultimately reconciled on a cost based, retroactive audit basis. It is estimated that the State reimburses at approximately 60% of the HSCRC rate. Further, the cost settlement process can take many years to resolve, and can result in hospitals often being owed or owing significant sums. MHA estimates that free-standing psychiatric hospitals are currently owed \$8.8 million in cost settlements. These cost settlement payments begin in fiscal 2003 and are over and above deficits noted above.

It has been proposed that the State begin to reimburse these hospitals, like other providers, on a prospective basis: that is they will pay a certain rate for a service, and there will be no subsequent cost settlements. This action requires an amendment to the State Medicaid plan to be submitted to the Health Care Financing Administration. However, while such a move will reduce problems associated with cost settlements, moving to a prospective payment system in and of itself does nothing to change reimbursement rates for Medicaid patients. However, the hospitals are also asking for an increase over the current reimbursement rate, either to the HSCRC rate or some proportion higher than the current 60%. No funds for this increase are included in the fiscal 2002 allowance, nor has MHA submitted a State plan amendment.

- ***Community Mental Health Clinics Have Asked for Higher Rates and Regulatory Relief:*** The State's community health clinics have asked MHA to increase Medicaid reimbursement from 25% to 100% for co-payments from dually eligible Medicare/Medicaid clients. Currently, the Medicare program reimburses outpatient mental health services at 50% of the Medicare allowable rate. For dually eligible clients, Medicaid will reimburse clinics for one-quarter of the difference. The clinics have asked for Medicaid to reimburse all of the difference. This also requires the submission of a State Medicaid plan amendment as well as additional funding. MHA has not submitted a plan amendment and the fiscal 2002 allowance contains no funds for an increase.

The clinics have also asked for rate increases for certain services, for example, child and adolescent individual and family therapy services. According to the clinics, these are services for which current rates are significantly inadequate. Again no funds for this kind of rate increase are contained in the budget. The clinics have also called for MHA to offer regulatory relief for requirements imposed on them when they were funded under the old grants-based system but which make little sense now.

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- ***Community Providers Have Called for the Indexing of Rates to the Medical Portion of the CPI:*** Community providers have sought to get regular rate increases by linking rate increases to the medical portion of the Consumer Price Index (CPI) (see SB 328 of 2001). SB 328 would not be effective until the fiscal 2003 budget, but there is no requirement for the Governor to fund the increase. Without sufficient funding, additional service reductions to non-Medicaid clients will be required.
- ***Awareness of Mental Health Issues Has Heightened, but Increases in Treatment Dollars Have Failed to Follow:*** The State is undertaking many issues around screening for mental health illness, recognizing that this is an area that has perhaps been neglected in the past. For example, MHA is working closely with the Department of Juvenile Justice to ensure mental health and substance abuse screening for juvenile delinquents. The addition of \$2 million for school-based mental health services in the fiscal 2002 allowance is another example of the State trying to make sure children access mental health services. However, while such programming has the benefit of early intervention and may ultimately save the State money; in the short-term it is likely to generate even more demand for treatment. The fiscal 2002 allowance contains little provision to support anything other than current demand let alone any potential increase in demand for treatment.

5. With Fiscal Woes, Downsizing Plans Will Slow

Beginning in the late 1950s, prompted by the development of new and effective psychotropic medications and a growing dissatisfaction with the limitations of long-term institutional care, the United States has been gradually deinstitutionalizing care for persons with severe mental illness. Maryland's deinstitutionalization experience roughly parallels the national experience: bed numbers in State facilities have fallen from as many as 10,000 in the 1950s to a little over 1,600 projected for fiscal 2002.

The most recent report on downsizing State psychiatric facilities was released in August 1999. That report called for a gradual lowering of ADP at State facilities at the same time additional State dollars (from both increased appropriations and cost savings at the facilities from lower ADPs) were allocated to the development of community resources. The report established a plan for fiscal 2000 through 2004, building on initiatives begun in fiscal 1999. However, based on demand for hospital beds as well as the funding available in the fiscal 2001 budget, MHA revised its plan, essentially spreading the plan over an additional three years through fiscal 2007. The revised plan is detailed in **Exhibit 14**.

As shown in Exhibit 14, actual general fund support for the downsizing plan has been somewhat below the level required to support the implementation of the plan. Specifically:

- MHA has had to defer support in fiscal 2001 because of its operating budget deficit;
- the fiscal 2002 allowance provided for slightly less (\$3.7 million) than the \$4.3 million anticipated in the plan, and given MHA's fiscal situation, it is likely that the actual funding devoted to the initiative in fiscal 2002 will fall; and
- since fiscal 2001 and 2002 funding is likely to be lower than expected, the anticipated savings from the various State facilities anticipated in fiscal 2004 and beyond are also unlikely to be realized.

Exhibit 14

**Mental Hygiene Administration
Facility Downsizing -- Revised Plan
Fiscal 1999 through 2007**

	<u>FY 1999</u>	<u>FY 2000</u>	<u>FY 2001</u>	<u>FY 2002</u>	<u>FY 2003</u>	<u>FY 2004</u>	<u>FY 2005</u>	<u>FY 2006</u>	<u>FY 2007</u>
ADP	1,396	1,322	1,273	1,223	1,173	1,123	1,073	1,029	1,005
Regular Employees (FTEs)	3,884	3,841	3,841	3,841	3,841	3,731	3,631	3,531	3,431
Staff:Patient Ratio	2.78	2.91	3.02	3.14	3.27	3.32	3.38	3.43	3.41
General Funds Needed (\$ in Millions)		\$3.8	\$2.5	\$4.3	\$7.8	\$5.2	\$3.2	\$0.8	\$0.0
Hospital Savings (\$ in Millions)		\$0.2	\$0.2	\$0.2	\$0.2	\$6.2	\$5.5	\$5.7	\$0.0
Actual General Fund Spending (\$ in Millions)		\$3.8	\$1.3*	\$3.7					

*Fiscal problems in fiscal 2001 will delay implementation of the initiative. This figure is an estimate of revised spending. The fiscal 2002 spending figure is also likely to be revised downward.

Fiscal 2000 through 2002 ADP numbers may not reflect numbers used elsewhere in the analysis based on the exclusion of domiciliary care and the way MHA calculates ADP at RICAs for the budget versus the report.

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

In addition to the underfunding of the revised plan, demand for State facility beds continues to be high because of:

- the closure of private psychiatric hospitals;
- the acuity of patient problems: based on a survey of patients admitted to State facilities between August 1999 and 2000, 38.4% had substance abuse problems;
- the actions of private insurance companies to limit stays in non-State facilities;
- incentives offered to hospitals regulated by HSCRC to limit average length-of-stays; and
- the issue of forensic patients being sent to State facilities for psychiatric screening but not being able to return to jails until their hearing date, therefore taking up bed space.

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The demand for State facility beds continues to have ripple effects throughout the mental health system, particularly in emergency rooms. MHA has taken a variety of steps to resolve this problem including: the purchase of crisis beds in private hospitals; the funding of crisis intervention programs; developing an automated system (operated from the Carter Center) to determine capacity and bed availability at State facilities; and establishing a diversion program in conjunction with The Johns Hopkins Hospital. The impact of the steps is not yet readily apparent and providers indicate that some actions may be more successful than others.

As DHMH works to develop updated deinstitutionalization plans across the department in the wake of the Olmstead Supreme Court decision, it should ensure that MHA's downsizing plan is updated to recognize the realities of underfunding and continuing demand for facility beds.

Recommended Actions

1. Add the following language:

. provided that \$10,100,000 of this appropriation may only be used to pay for unprovided for general fund payables reported to the General Accounting Division.

Further provided that it is the intent of the General Assembly that this \$10,100,000 be derived from the following programs: \$3,100,000 from the carry over account; \$2,000,000 targeted for school-based mental health services; \$3,500,000 from funding for the annualization and expansion of census reduction, transitioning youth, and respite care initiatives; and \$1,500,000 from the grants and contracts program.

Explanation: At the close of fiscal 2000, the Mental Hygiene Administration (MHA) reported \$15 million in unprovided for general fund payables to the General Accounting Division. The Office of Legislative Audits noted that this figure may be underreported by at least \$10 million. The MHA fiscal 2002 allowance includes only \$3.1 million in general funds to be used to pay for these unprovided for payables. The language restricts that \$3.1 million and an additional \$7 million to pay for these unprovided for payables and also expresses legislative intent as to the programs from where those funds are derived.

2. Add the following language:

Further provided that, to the extent the Mental Hygiene Administration attains additional federal Medicaid reimbursement by increasing the level of Medicaid enrollment among its population served, any general fund savings that result from that overattainment of federal Medicaid dollars shall be used to pay for unprovided for general fund payables reported to the General Accounting Division.

Explanation: At the close of fiscal 2000, the Mental Hygiene Administration (MHA) reported \$15 million in unprovided for general fund payables to the General Accounting Division. The Office of Legislative Audits noted that this figure may be underreported by at least \$10 million. MHA is trying to reduce general fund only payment for services by maximizing Medicaid enrollment. To the extent that this results in additional Medicaid reimbursement, the language expresses the intent of the General Assembly that any overattainment of federal Medicaid dollars be used to pay unprovided for payables.

3. Add the following language:

Further, it is the intent of the General Assembly that the Community Services budget be reimbursed in accordance with the budget detail presented to and approved by the General Assembly. Should the department wish to make a regulatory, policy, or procedural change which increases or decreases the budget by a sum greater than \$500,000, it shall inform the committees of the change and the committees shall have 45 days to review and consider it before it becomes effective.

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Explanation: The language requires the Department of Health and Mental Hygiene (DHMH) to notify the budget committees of any regulatory, policy, or procedural changes which increase or decrease the Community Services budget by more than \$500,000.

Information Request	Authors	Due Date
Notification of regulatory, policy, or procedural changes of \$500,000 or more	DHMH	As needed, with 45 day review

4. Adopt the following narrative:

Final Accounting of Actual Expenditures for Fiscal 1998 through 2000: The Mental Hygiene Administration (MHA) is requested to report back to the committees on a final accounting of actual fee-for-service expenditures. The report should also include details on the actions taken by MHA, as well as further recommendations for improving financial oversight of the fee-for-system. The report should establish a time-frame for implementing any recommendations made in the report. In developing these recommendations, MHA should consult with the Office of Legislative Audits.

Information Request	Author	Due Date
Final accounting of fee-for-service expenditures in fiscal 1998 through 2000	MHA	July 1, 2001

5. Adopt the following narrative:

Impact of Fiscal 2001 Cost Containment Measures: In order to balance its fiscal 2001 budget, the Mental Hygiene Administration (MHA) is undertaking significant cost containment measures. The committees request MHA to report back to them with an assessment of fiscal 2001 actual expenditures as well as the impact of the cost containment measures on clients, providers, and MHA's fiscal situation. The report shall also include an assessment of the adequacy of MHA's fiscal 2002 appropriation based on the most recent claims data and detail any further cost containment measures that may be required.

Information Request	Author	Due Date
Impact of fiscal 2001 cost containment measures	MHA	December 1, 2001

6. Adopt the following narrative:

Quarterly Performance Reports on the Administrative Services Organization: For the past three fiscal years the committees have adopted narrative concerning the performance of the Administrative Services Organization (ASO). Given the financial situation of the fee-for-service system and the important role that the ASO plays in this system, the Mental Hygiene

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Administration is requested to continue its quarterly reporting on the performance of the ASO. Each report is due within six weeks of the preceding quarter and should detail performance requirements and fulfilment of those requirements for the preceding quarter, as well as what changes have been made to those performance requirements for the upcoming quarter.

Information Request	Author	Due Date
Quarterly ASO performance reports	MHA	Within six weeks of the close of each quarter

Updates

1. ASO Performance

Since the introduction of the new fee-for-service system for mental health services, the budget committees have required quarterly updates on the performance of the ASO. The ASO acts as the gatekeeper and administrator of the fee-for-service system for MHA. The quarterly updates provide detail on efforts to address some of the billing issues which continue to occur in the fee-for-service system, as well as responsiveness to consumers. The ASO also underwent an independent audit in 2000.

Given the ongoing concerns about the performance of the fee-for-service system and the role of the ASO in that system DLS recommends that quarterly reporting on the performance of the ASO which is currently provided to the budget committees be continued in fiscal 2002.

2. A Building for MPRC?

The primary mission of MPRC is the study of schizophrenia, although research is also conducted on the origins of neurodegenerative diseases such as Huntington's and Parkinson's diseases. MPRC is State-funded through a contract paid by DHMH but is part of the University of Maryland, Baltimore (UMB) School of Medicine. In addition to federal grant and contract awards, MPRC also does research under private contracts. Beginning in fiscal 2000, the amount of private dollars garnered by MPRC increased significantly (\$2.5 million over fiscal 1999) through an agreement made with Novartis AG, a major pharmaceutical company.

The only hurdle to be overcome for the full benefit of the Novartis contract to be realized as reported in last year's budget analysis was a lack of building-space, specifically for laboratories and animal facilities. According to MPRC, the cost for this space (to be located next to their existing building at Spring Grove) is now \$5 million, down from \$7 million. MPRC has agreed to provide \$3.75 million of this cost from the first three years' funding of the Novartis contract. MPRC has also applied to the National Institutes of Health for a \$1 million facility grant, and UMB has guaranteed the other \$250,000.

Mental Hygiene Administration Priority Populations

“Priority population” means those children, adolescents, and adults for whom, because of the seriousness of their mental illness, extent of functional disability, and financial need, the department has declared priority for publicly-funded services.

Priority population includes:

A child or adolescent, younger than 18 years old, with serious emotional disturbance, which is a condition that is:

- Diagnosed with a mental health diagnosis, according to a current diagnostic and statistical manual of the American Psychiatric Association; and
- Characterized by a functional impairment that substantially interferes with or limits the child’s role or functioning in the family, school, or community activities.

An adult, aged 18 to 64, with a serious and persistent mental disorder, which is a disorder that is:

Diagnosed, according to a current diagnostic and statistical manual of the American Psychiatric Association as:

- Schizophrenic disorder,
- Major affective disorder,
- Other psychotic disorder, or
- Borderline or schizotypal personality disorders, with the exclusion of an abnormality that is manifested only by repeated criminal or otherwise antisocial conduct; and

Characterized by impaired role functioning, on a continuing or intermittent basis, for at least two years, including at least three of the following:

- Inability to maintain independent employment,
- Social behavior that results in intervention by the mental health system,
- Inability, due to cognitive disorganization, to procure financial assistance to support living in the community,
- Severe inability to establish or maintain a personal social support system, and
- Need for assistance with basic living skills.

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Appendix 1 (Cont.)

An elderly adult, aged 65 or over, who:

Is diagnosed, according to a current diagnostic and statistical manual of the American Psychiatric Association as:

- Schizophrenic disorder,
- Major affective disorder,
- Other psychotic disorder, or
- Borderline or schizotypal personality disorders, with the exclusion of an abnormality that is manifested only by repeated criminal or otherwise antisocial conduct; or

Who experiences one of the following:

- Early stages of serious mental illness, with symptoms that have been exacerbated by the onset of age-related changes,
- Severe functional deficits due to cognitive disorders and/or acute episodes of mental illness, or
- Psychiatric disability coupled with a secondary diagnosis, such as alcohol or drug abuse, developmental disability, physical disability, or serious medical problem.

An individual committed as not criminally responsible who is conditionally released from a Mental Hygiene Administration facility, according to the provisions of Health-General Article. Title 12, Annotated Code of Maryland.

Current and Prior Year Budgets

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

	<u>General Fund</u>	<u>Special Fund</u>	<u>Federal Fund</u>	<u>Reimb. Fund</u>	<u>Total</u>
Fiscal 2000					
Legislative Appropriation	\$454,253	\$2,468	\$175,389	\$2,711	\$634,821
Deficiency Appropriation	1,257	0	0	0	1,257
Budget Amendments	(8,859)	731	(10,873)	502	(18,499)
Reversions and Cancellations	(13)	(386)	(12,977)	(763)	(14,139)
Actual Expenditures	\$446,638	\$2,813	\$151,539	\$2,450	\$603,440
Fiscal 2001					
Legislative Appropriation	\$466,363	\$2,511	\$164,814	\$2,434	\$636,122
Budget Amendments	0	0	0	0	0
Working Appropriation	\$466,363	\$2,511	\$164,814	\$2,434	\$636,122

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

There were a variety of significant changes to the fiscal 2000 legislative appropriation:

- A \$1.257 million **general fund deficiency** to cover the rising cost of anti-psychotic drugs used in State-run psychiatric facilities.

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- **General fund budget amendments** which in aggregate reduced the appropriation by \$8.859 million. This was largely due to the transfer of \$12.86 million in general funds from Mental Health Pharmacy Services to the Medicaid program for provider pharmacy reimbursements offset most significantly by a \$2.8 million general fund increase to cover the cost of implementing the new State pay plan, and \$400,000 in transfers from other parts of DHMH as part of the fiscal 2000 close-out amendment to cover a variety of higher than expected costs across most of the State-run psychiatric facilities.
- **Federal fund budget amendments** which in aggregate reduced the appropriation by \$10.873 million. This was largely due to the corresponding federal fund transfer of \$12.86 million from Mental Health Pharmacy Services to the Medicaid program for provider pharmacy reimbursement offset by miscellaneous smaller federal grant awards.
- **Federal fund cancellations** of \$12.977 million, primarily of Medicaid funds in the Community Services program.

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

Positions	Object/Fund	FY00	FY01	FY02	FY01 - FY02	Percent
		Actual	Working Appropriation	Allowance	Amount Change	Change
01	Regular	3933.55	3924.55	3954.15	29.60	0.8%
02	Contractual	180.95	176.46	185.54	9.08	5.1%
	Total Positions	4114.50	4101.01	4139.69	38.68	0.9%
Objects						
01	Salaries and Wages	\$ 178,893,851	\$ 184,799,379	\$ 201,408,663	\$ 16,609,284	9.0%
02	Technical & Spec Fees	7,350,917	7,098,391	7,453,071	354,680	5.0%
03	Communication	1,181,570	1,377,831	1,522,252	144,421	10.5%
04	Travel	158,781	169,037	169,446	409	0.2%
06	Fuel & Utilities	7,995,422	7,454,801	8,859,645	1,404,844	18.8%
07	Motor Vehicles	695,568	783,026	669,820	(113,206)	(14.5%)
08	Contractual Services	391,896,597	418,220,970	429,502,029	11,281,059	2.7%
09	Supplies & Materials	13,046,772	14,239,678	14,942,265	702,587	4.9%
10	Equip - Replacement	753,878	624,276	786,713	162,437	26.0%
11	Equip - Additional	356,530	231,102	348,658	117,556	50.9%
12	Grants, Subsidies, Contracts	420,203	408,064	428,910	20,846	5.1%
13	Fixed Charges	573,443	599,754	565,128	(34,626)	(5.8%)
14	Land & Structures	116,196	115,959	91,000	(24,959)	(21.5%)
	Total Objects	\$ 603,439,728	\$ 636,122,268	\$ 666,747,600	\$ 30,625,332	4.8%
Funds						
01	General Fund	\$ 446,637,702	\$ 466,363,399	\$ 505,787,156	\$ 39,423,757	8.5%
03	Special Fund	2,812,877	2,511,400	2,674,401	163,001	6.5%
05	Federal Fund	151,538,949	164,813,527	155,950,377	(8,863,150)	(5.4%)
09	Reimbursable Fund	2,450,200	2,433,942	2,335,666	(98,276)	(4.0%)
	Total Funds	\$ 603,439,728	\$ 636,122,268	\$ 666,747,600	\$ 30,625,332	4.8%

Note: Full-time and contractual positions and salaries are reflected for operating budget programs only.

Fiscal Summary
DHMH - Mental Hygiene Administration

<u>Unit/Program</u>	FY00	FY01	FY01	FY00 - FY01	FY02	FY01 - FY02
	<u>Actual</u>	<u>Legislative Appropriation</u>	<u>Working Appropriation</u>	<u>% Change</u>	<u>Allowance</u>	<u>% Change</u>
01 Mental Hygiene Administration	\$ 373,598,464	\$ 400,315,106	\$ 400,315,106	7.2%	\$ 411,526,027	2.8%
02 Maryland Psychiatric Research Center	3,823,891	3,877,863	3,877,863	1.4%	3,946,062	1.8%
03 Walter P. Carter Community Mental Health Center	11,439,572	11,680,005	11,692,871	2.2%	12,421,232	6.2%
04 Thomas B. Finan Hospital Center	13,087,638	13,729,221	13,746,231	5.0%	14,732,542	7.2%
05 Regional Institute for Children & Adolescents-Balt	8,811,444	9,048,784	9,061,169	2.8%	9,751,137	7.6%
06 Croftsville Hospital Center	30,360,373	30,967,264	30,967,264	2.0%	33,865,503	9.4%
07 Eastern Shore Hospital Center	12,137,220	13,046,413	13,128,367	8.2%	14,546,624	10.8%
08 Springfield Hospital Center	49,965,059	51,344,787	50,894,194	1.9%	56,200,113	10.4%
09 Spring Grove Hospital Center	48,017,153	47,935,998	47,991,757	(0.1%)	51,885,748	8.1%
10 Clifton T. Perkins Hospital Center	29,625,262	30,926,304	31,026,790	4.7%	32,657,007	5.3%
11 Regional Institute for Children & Adolescents-Mont	10,419,202	10,824,645	10,831,470	4.0%	11,544,702	6.6%
12 Upper Shore Community Mental Health Center	6,518,363	6,824,179	6,939,191	6.5%	7,375,571	6.3%
14 Regional Institute For Children & Adolescents-S.Md	5,636,087	5,601,699	5,649,995	0.2%	6,295,332	11.4%
Total Expenditures	\$ 603,439,728	\$ 636,122,268	\$ 636,122,268	5.4%	\$ 666,747,600	4.8%
General Fund	\$ 446,637,702	\$ 466,363,399	\$ 466,363,399	4.4%	\$ 505,787,156	8.5%
Special Fund	2,812,877	2,511,400	2,511,400	(10.7%)	2,674,401	6.5%
Federal Fund	151,538,949	164,813,527	164,813,527	8.8%	155,950,377	(5.4%)
Total Appropriations	\$ 600,989,528	\$ 633,688,326	\$ 633,688,326	5.4%	\$ 664,411,934	4.8%
Reimbursable Fund	\$ 2,450,200	\$ 2,433,942	\$ 2,433,942	(0.7%)	\$ 2,335,666	(4.0%)
Total Funds	\$ 603,439,728	\$ 636,122,268	\$ 636,122,268	5.4%	\$ 666,747,600	4.8%

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