
**Department of Health and
Mental Hygiene
Fiscal 2008 Budget Overview**

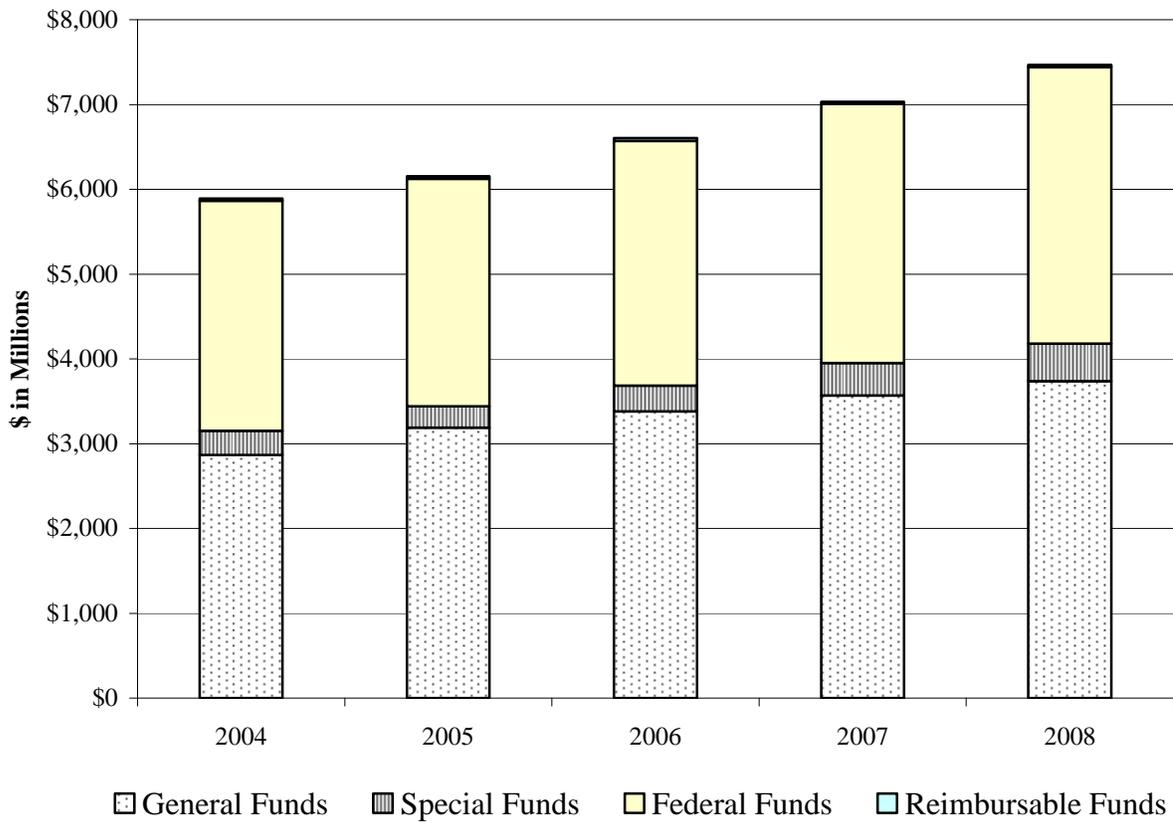
**Department of Legislative Services
Office of Policy Analysis
Annapolis, Maryland**

January 2007

M00 – DHMH – Fiscal 2008 Budget Overview

M00
Department of Health and Mental Hygiene
Fiscal 2008 Budget Overview

Department of Health and Mental Hygiene
Five-year Funding Trends
Fiscal 2004-2008
(\$ in Millions)



M00 – DHMH – Fiscal 2008 Budget Overview

**Department of Health and Mental Hygiene
Budget Overview: Expenditure Growth Moderates?
Fiscal 2004-2008
(\$ in Millions)**

	<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>Change 2007-08</u>
Operations	\$521	\$540	\$566	\$632	\$627	-\$5
Contractual Services	5,271	5,518	5,943	6,278	6,725	447
Grants	99	96	95	120	115	-5
Total	\$5,890	\$6,154	\$6,604	\$7,031	\$7,467	\$437
General Fund	\$2,865	\$3,191	\$3,382	\$3,567	\$3,738	\$171
Special Fund	\$289	\$248	\$303	\$386	\$440	\$55
Federal Funds	\$2,712	\$2,686	\$2,884	\$3,055	\$3,262	\$206
Reimbursable Funds	\$24	\$29	\$36	\$23	\$27	\$5
Total	\$5,890	\$6,154	\$6,604	\$7,031	\$7,467	\$437
Annual % Change from Prior Year	8.1%	4.5%	7.3%	6.5%	6.2%	
Underlying Change Excluding One-time Health Cost Savings				-\$28		
Total				\$7,002	\$7,467	\$465
Adjusted Annual % Change from Prior Year					6.6%	

Note: Excludes fiscal 2007 deficiencies and fiscal 2008 contingent reductions.

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

M00 – DHMH – Fiscal 2008 Budget Overview

**Department of Health and Mental Hygiene
Fiscal 2007 Deficiencies, Planned Reversions, and
Fiscal 2008 Contingent Reductions**

Fiscal 2007 Deficiencies		General Funds	Total Funds
Medicaid	Funding to replace unavailable Cigarette Restitution Funds as restricted by Section 19 of the fiscal 2007 budget bill	\$26,000,000	\$26,000,000
Medicaid	Supplemental funding for the purchase of birth certificates and other Vital Records to comply with new federal mandates regarding citizenship and identification verification	5,724,000	11,448,000
Medicaid	Supplemental funding for Medical Assistance services to legal immigrants ineligible for the federal Medicaid program	5,000,000	5,000,000
Health Regulatory Commissions	Special funds for additional payments from the Maryland Trauma Physician Services Fund per Chapter 484 of 2006	0	3,300,000
Fiscal 2007 Deficiencies Total		\$36,724,000	\$45,748,000
Fiscal 2007 Planned Reversions			
Medicaid	Excess fiscal 2006 funds	10,000,000	20,000,000
Fiscal 2008 Contingent Reductions			
Administration	Reduction contingent on legislation authorizing the assessment of indirect costs on the health regulatory commissions	\$1,250,000	\$0

Source: Department of Legislative Services; Governor's Budget Books, Fiscal 2008

M00 – DHMH – Fiscal 2008 Budget Overview

**Department of Health and Mental Hygiene
Fiscal 2007 and 2008 Revenue Adjustments**

<u>Item</u>	<u>2007</u>	<u>2008</u>
Fees collected by Vital Records for birth certificates required by Medicaid to comply with new federal mandates regarding citizenship and identification verification	\$10,048,000	\$1,560,000
Fees collected by the Office of Health Care Quality		683,750
Medicare Part D reimbursement of outreach costs and other expenses	3,655,658	
Deer's Head: Services to Veterans		600,000
Fiscal 2007 and 2008 Revenue Adjustments Total	\$13,703,658	\$2,843,750

Source: Department of Legislative Services; Governor's Budget Books, Fiscal 2008

M00 – DHMH – Fiscal 2008 Budget Overview

**Department of Health and Mental Hygiene
Budget Overview: All Funding Sources
Fiscal 2006-2008
(\$ in Thousands)**

	<u>Actual 2006</u>	<u>Working 2007</u>	<u>Allowance 2008</u>	<u>\$ Change 2007-08</u>	<u>% Change 2007-08</u>
Medical Programs/Medicaid	\$4,449,957	\$4,684,381	\$4,983,959	\$299,578	6.4%
Provider Reimbursements	4,222,238	4,441,074	4,727,576	286,502	6.5%
Maryland Children's Health Program	161,370	177,163	190,217	13,054	7.4%
Other	66,349	66,144	66,165	21	0.0%
Mental Hygiene	\$809,996	\$864,250	\$902,966	\$38,716	4.5%
Program Direction	6,671	7,615	7,421	-194	-2.5%
Community Services	537,639	576,736	615,406	38,670	6.7%
Facilities	265,686	279,899	280,139	240	0.1%
Developmental Disabilities	\$641,846	\$693,738	\$742,865	\$49,127	7.1%
Program Direction	5,229	5,742	5,890	148	2.6%
Community Services	564,516	612,987	662,180	49,193	8.0%
Facilities	72,101	75,010	74,795	-215	-0.3%
Community and Family Health	\$257,210	\$280,319	\$275,795	-\$4,524	-1.6%
Targeted Local Health	66,352	68,161	71,050	2,889	4.2%
Women, Infants, and Children	65,035	62,819	68,948	6,129	9.8%
Cigarette Restitution Fund	33,464	47,494	47,477	-18	0.0%
Other	92,359	101,846	88,321	-13,525	-13.3%
Alcohol and Drug Abuse	\$131,885	\$137,561	\$143,298	\$5,737	4.2%
Other Budget Areas	\$313,595	\$370,435	\$418,535	\$48,100	13.0%
DHMH Administration	40,936	49,352	88,782	39,430	79.9%
Office of Health Care Quality	14,089	15,378	15,736	358	2.3%
Health Occupations Boards	19,602	23,427	24,141	714	3.0%
Chronic Disease Hospitals	41,843	44,919	44,244	-675	-1.5%
AIDS Administration	54,443	73,612	72,592	-1,020	-1.4%
Chief Medical Examiner	8,228	8,205	8,516	311	3.8%
Preparedness and Response	22,376	23,731	23,847	117	0.5%
Laboratories Administration	22,371	21,820	22,438	618	2.8%
Health Regulatory Commissions	89,707	109,991	118,239	8,248	7.5%
Total Funding	\$6,604,489	\$7,030,684	\$7,467,419	\$436,734	6.2%

DHMH: Department of Health and Mental Hygiene

Notes: Numbers may not sum to total due to rounding.
Excludes fiscal 2007 deficiencies.

Source: Department of Legislative Services; Governor's Budget Books, Fiscal 2008

M00 – DHMH – Fiscal 2008 Budget Overview

**Department of Health and Mental Hygiene
Budget Overview: General Funds Only**

Fiscal 2006-2008

(\$ in Thousands)

	<u>Actual 2006</u>	<u>Working 2007</u>	<u>Allowance 2008</u>	<u>\$ Change 2007-08</u>	<u>% Change 2007-08</u>
Medical Programs/Medicaid	\$2,085,217	\$2,195,457	\$2,301,621	\$106,164	4.8%
Provider Reimbursements	1,996,171	2,103,119	2,202,097	98,978	4.7%
Maryland Children's Health Program	54,987	59,086	65,859	6,773	11.5%
Other	34,059	33,252	33,665	413	1.2%
Mental Hygiene	\$581,172	\$602,449	\$628,746	\$26,297	4.4%
Program Direction	4,936	6,020	5,829	-191	-3.2%
Community Services	317,282	323,602	350,175	26,573	8.2%
Facilities	258,954	272,827	272,742	-85	0.0%
Developmental Disabilities	\$418,371	\$451,310	\$472,982	\$21,672	4.8%
Program Direction	3,759	4,795	4,369	-426	-8.9%
Community Services	342,920	371,924	394,230	22,306	6.0%
Facilities	71,692	74,591	74,383	-208	-0.3%
Community and Family Health	\$120,216	\$122,336	\$116,881	-\$5,455	-4.5%
Targeted Local Health	61,487	63,668	66,557	2,889	4.5%
Women, Infants, and Children	250	250	250	0	0.0%
Cigarette Restitution Fund	0	0	0	0	0.0%
Other	58,479	58,418	50,073	-8,344	-14.3%
Alcohol and Drug Abuse	\$78,082	\$84,881	\$90,746	\$5,865	6.9%
Other Budget Areas	\$98,539	\$110,702	\$126,909	\$16,207	14.6%
DHMH Administration	22,965	31,355	46,763	15,408	49.1%
Office of Health Care Quality	8,439	9,570	9,781	211	2.2%
Health Occupations Boards	198	241	205	-36	-14.9%
Chronic Disease Hospitals	36,853	38,977	38,987	10	0.0%
AIDS Administration	4,941	4,664	4,703	39	0.8%
Chief Medical Examiner	8,005	7,951	8,239	288	3.6%
Preparedness and Response	280	374	0	-374	-100.0%
Laboratories Administration	16,858	17,570	18,231	661	3.8%
Health Regulatory Commissions	0	0	0	0	0/0%
Total Funding	\$3,381,597	\$3,567,135	\$3,737,885	\$170,750	4.8%

DHMH: Department of Health and Mental Hygiene

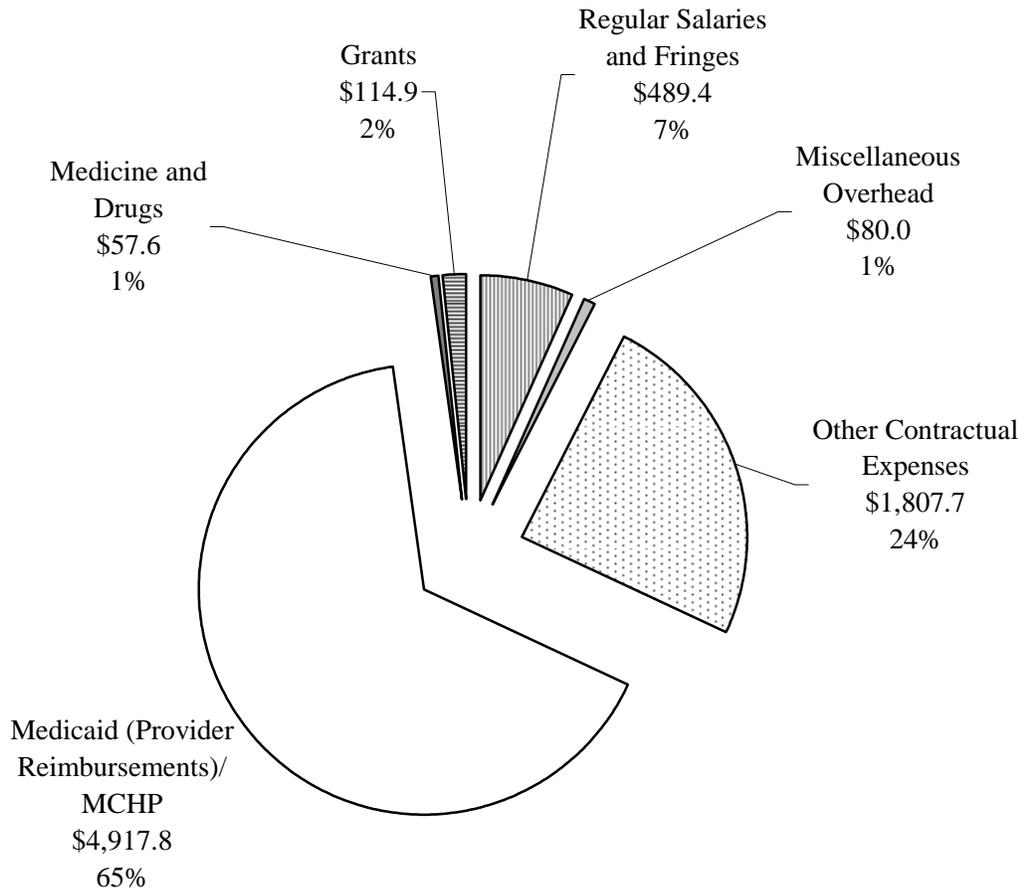
Notes: Numbers may not sum to total due to rounding.

Excludes fiscal 2007 deficiencies and fiscal 2008 contingent reductions.

Source: Department of Legislative Services; Governor's Budget Books, Fiscal 2008

M00 – DHMH – Fiscal 2008 Budget Overview

**Department of Health and Mental Hygiene
Functional Breakdown of Spending
Fiscal 2008 Allowance
(\$ in Millions)**



MCHP: Maryland Children's Health Program

M00 – DHMH – Fiscal 2008 Budget Overview

**Governor’s Proposed Budget Changes
Department of Health and Mental Hygiene
(\$ in Thousands)**

	<u>General Fund</u>	<u>Special Fund</u>	<u>Federal Fund</u>	<u>Reimb. Fund</u>	<u>Total</u>
2007 Working Appropriation	\$3,567,135	\$385,558	\$3,055,489	\$22,503	\$7,030,685
2008 Governor's Allowance	<u>3,737,884</u>	<u>440,363</u>	<u>\$3,261,850</u>	<u>27,321</u>	<u>7,467,419</u>
Amount Change	\$170,750	\$54,805	\$206,361	\$4,818	436,734
Percent Change	4.8%	14.2%	6.8%	21.4%	6.2%

Where It Goes:

Major Personnel Expense Changes	-\$6,096
Retirement contributions	\$7,729
Regular Earnings (increments and new positions offset by position abolitions).....	5,962
Turnover expectancy	1,170
Social Security contributions.....	835
Overtime	799
Other adjustments.....	134
Employee and retiree health insurance costs decline due to one-time savings	-22,203
Reclassifications	-523
Major Programmatic Changes (Exc. Medicaid)	\$95,574
Alcohol and Drug Abuse Administration	
Expansion of Buprenorphine Therapy	5,000
Mental Hygiene Administration	
Medicaid-eligible community mental health fee-for-service 2% rate increase	13,097
End hospital day limits.....	12,000
Medicaid-eligible community mental health fee-for-service enrollment and utilization	11,896
Funding for mental health services at the Hickey School (Reimbursable Funds).....	1,135
Core Service Agency services 2% rate increase	1,100
Developmental Disabilities Administration	
Annualization of prior year community placements	24,457
Provider 2% rate increase.....	12,037
Transitioning youth initiative	7,560
Emergency placements (services to 76 clients).....	3,120
Waiting List Equity Fund (services to 40 clients).....	1,953
Community and Family Health Administrations	
WIC (supplemental nutrition grants and counseling).....	6,129
Targeted local health formula	2,889
Operating subsidy to Prince George’s Hospital Center.....	-10,000
Health care for immigrants.....	-3,000
Pfiesteria Surveillance Program.....	-1,039

M00 – DHMH – Fiscal 2008 Budget Overview

Where It Goes:

AIDS Administration	
Additional case management	1,169
Maryland AIDS Drug Assistance Program drug funding	-2,043
Office of Preparedness and Response	
CDC Pandemic Influenza grant.....	1,837
CDC City Readiness Initiative (Anthrax response)	1,103
Reduction to the CDC Emergency Preparedness Base Grant and the HRSA Hospital Preparedness grant.....	-2,720
End of the federal Department of Justice security and technology infrastructure improvement grant	-1,033
Other Programs	
Health Regulatory Commissions: Increase in Uncompensated Care Fund.....	4,000
Health Regulatory Commissions: Special fund payments from the Maryland Trauma Physician Services Fund per Chapter 484 of 2006.....	3,100
DHMH Administration: Utility costs (to be re-allocated among the DHMH institutions).....	1,827
Medicaid/Medical Care Programs Administration	\$333,676
Medical inflation and utilization changes increase 4.1% – does not include MCO rate increase for calendar 2008.....	187,532
Enrollment growth of about 2% – primarily children	60,647
Enhance physician rates with HMO premium tax revenues/federal matching funds.....	40,000
End hospital day limits.....	40,000
Local and federal dollars for Healthy Start Program will now pass through the budget	6,063
Restore coverage for legal immigrant children and pregnant women who have resided in the United States for less than five years - 100% general funds	6,000
Ongoing cost of verifying citizenship for new applicants.....	2,900
Apply 1% cost containment against calendar 2008 MCO rates – similar action was taken in calendar 2006	-9,466
Other	13,580
Total Change	\$436,734

WIC: Women, Infants, and Children Food Program
 CDC: Centers for Disease Control
 HRSA: Health Resources and Services Administration
 DHMH: Department of Health and Mental Hygiene
 MCO: Managed Care Organization
 HMO: Health Maintenance Organization

Numbers may not sum to total due to rounding.

M00 – DHMH – Fiscal 2008 Budget Overview

**Department of Health and Mental Hygiene
Regular Employees (FTEs)
Fiscal 2006-2008**

	<u>Actual 2006</u>	<u>Working 2007</u>	<u>Allowance 2008</u>	<u>Change 2007-08</u>	<u>% Change 2007-08</u>
DHMH Administration	457.1	462.1	477.1	15.0	3.2%
Office of Health Care Quality	187.4	194.4	194.4	0.0	0.0%
Health Occupations Boards	200.0	216.0	229.0	13.0	6.0%
Community and Family Health Administrations	319.7	316.7	314.7	-2.0	-0.6%
AIDS Administration	132.0	124.0	121.0	-3.0	-2.4%
Chief Medical Examiner	76.0	76.0	76.0	0.0	0.0%
Office of Preparedness and Response	31.0	35.0	35.0	0.0	0.0%
Chronic Hospitals	569.8	568.3	568.3	0.0	0.0%
Laboratories Administration	272.5	271.5	269.5	-2.0	-0.7%
Alcohol and Drug Abuse Administration	64.0	65.0	64.0	-1.0	-1.5%
Mental Hygiene Administration	3,385.1	3,389.1	3,385.6	-3.5	-0.1%
Developmental Disabilities Administration	1,228.2	1,232.2	1,231.2	-1.0	-0.1%
Medical Care Programs Administration	618.7	632.7	608.7	-24.0	-3.8%
Health Regulatory Commissions	89.6	96.9	99.4	2.5	2.6%
Total Regular Positions	7,631.0	7,679.8	7,673.8	-6.0	-0.1%

Source: Governor's Budget Books, Fiscal 2008

- The vacancy rate of the department as of December 28, 2006, was 9.7%, or 747.5 vacancies.

M00 – DHMH – Fiscal 2008 Budget Overview

**Department of Health and Mental Hygiene
Regular Employees (FTEs) – Vacancy Rates
December 28, 2006**

	<u>FTE Positions</u>	<u>FTE Vacancies</u>	<u>Vacancy Rate</u>
DHMH Administration	462.1	40.8	8.8%
Office of Health Care Quality	194.4	24.8	12.8%
Health Occupations Boards	216.0	25.0	11.6%
Community and Family Health Administrations	316.7	36.3	11.5%
AIDS Administration	124.0	20.0	16.1%
Chief Medical Examiner	76.0	0.0	0.0%
Office of Preparedness and Response	35.0	14.0	40.0%
Chronic Hospitals	568.3	51.0	9.0%
Laboratories Administration	271.5	30.5	11.2%
Alcohol and Drug Abuse Administration	65.0	9.5	14.6%
Mental Hygiene Administration	3,389.1	277.8	8.2%
Developmental Disabilities Administration	1,232.2	138.5	11.2%
Medical Care Programs Administration	632.7	61.3	9.7%
Health Regulatory Commissions	96.9	18.0	18.6%
Total	7,679.8	747.5	9.7%

Source: Governor's Budget Books, Fiscal 2008

M00 – DHMH – Fiscal 2008 Budget Overview

**Department of Health and Mental Hygiene
Contractual Employees (FTEs)
Fiscal 2006-2008**

	<u>Actual 2006</u>	<u>Working 2007</u>	<u>Allowance 2008</u>	<u>Change 2007-08</u>	<u>% Change 2007-08</u>
DHMH Administration	12.0	13.8	14.7	0.9	6.4%
Office of Health Care Quality	5.7	5.4	5.4	0.0	0.0%
Health Occupations Boards	29.1	30.1	20.4	-9.8	-32.4%
Community and Family Health Administrations	11.8	18.2	18.8	0.7	3.7%
AIDS Administration	0.0	0.0	0.0	0.0	0.0%
Chief Medical Examiner	4.5	6.0	6.8	0.8	12.5%
Office of Preparedness and Response	0.0	2.5	0.0	-2.5	-100.0%
Chronic Hospitals	18.5	21.6	19.2	-2.3	-10.8%
Laboratories Administration	2.3	2.8	2.8	0.0	0.0%
Alcohol and Drug Abuse Administration	2.4	3.2	4.5	1.3	42.0%
Mental Hygiene Administration	243.6	210.1	235.2	25.1	12.0%
Developmental Disabilities Administration	85.6	75.1	75.1	0.0	0.0%
Medical Care Programs Administration	45.4	66.1	72.8	6.7	10.2%
Health Regulatory Commissions	0.8	3.0	3.0	0.0	0.0%
Total Contractual Positions	461.5	457.8	478.7	20.9	4.6%

Source: Governor's Budget Books, Fiscal 2008

M00 – DHMH – Fiscal 2008 Budget Overview

**Department of Health and Mental Hygiene
Budget Overview: Selected Caseload Measures
Fiscal 2005-2008**

	<u>Actual</u> <u>2005</u>	<u>Actual</u> <u>2006</u>	<u>Working</u> <u>2007</u>	<u>Allowance</u> <u>2008</u>	<u>Change</u> <u>2007-08</u>	<u>% Change</u> <u>2007-08</u>
Medical Programs/Medicaid						
Medicaid Enrollees	522,138	525,997	526,446	534,210	7,764	1.5%
Maryland Children's Healthcare Program	95,019	103,260	108,813	116,500	7,687	7.1%
Developmental Disabilities Administration						
Residential Services	4,770	4,888	5,219	5,287	68	1.3%
Day Services	9,049	9,335	9,765	10,637	872	8.9%
In-home support services	8,120	7,846	8,413	8,962	549	6.5%
Average daily census at institutions	380	358	361	354	-7	-1.9%
Mental Hygiene Administration						
Average daily populations at State-run psychiatric hospitals:						
Hospitals excluding RICAs and Assisted Living	1,187	1,177	1,208	1,207	-1	-0.1%
RICAs	114	107	144	144	0	0.0%
Assisted Living	89	91	105	98	-7	-6.7%
Total	1,390	1,375	1,457	1,449	-8	-0.5%
Number receiving community mental health services:						
Medicaid eligible	75,503	74,821 *	80,430	83,750	3,320	4.1%
Medicaid-ineligible	16,574	17,894	12,870	11,970	-900	-7.0%
Total	92,077	92,715	93,300	95,720	2,420	2.6%

RICAs: Regional Institutes for Children and Adolescents

*In 2006 a change was made to the definition of Medicaid-eligible clients to exclude clients receiving assistance to pay Medicare premiums. This change masks what would have been a small increase in the Medicaid-eligible population and a drop in the Medicaid-ineligible population.

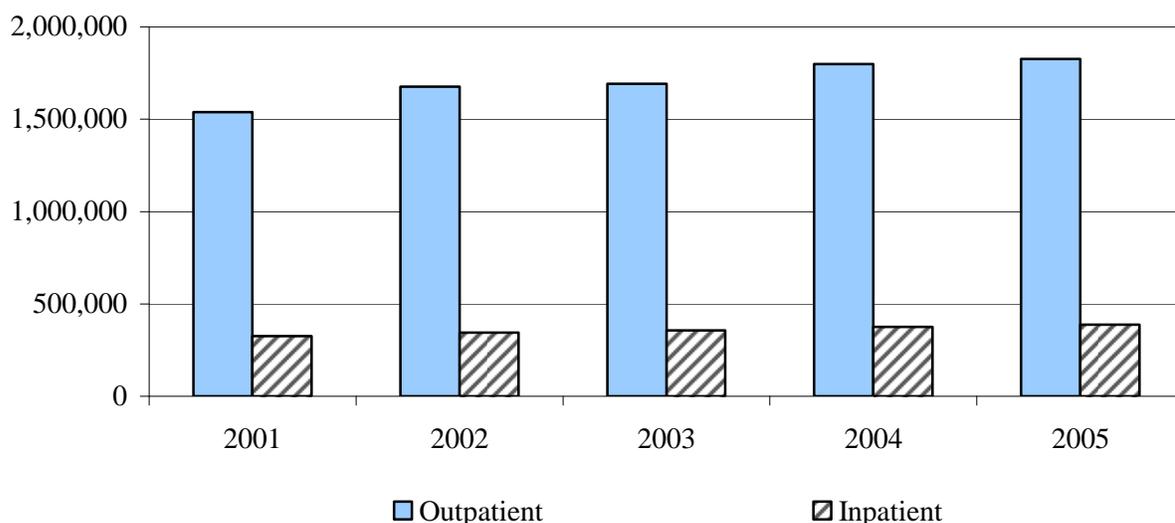
Source: Department of Legislative Services; Department of Health and Mental Hygiene

Issues

1. Emergency Department Overcrowding

During the 2006 session, the issue of emergency department overcrowding was raised in various budget analyses. Evidence of increased use of emergency departments is plentiful both nationally and statewide. Emergency department visits in Maryland increased by an average 4% per year between fiscal 2001 and 2005, although that growth appears to be almost twice the rate of increase in emergency department visits nationwide. As shown in **Exhibit 1**, using data from the Health Services Cost Review Commission (HSCRC), growth occurred in both emergency department cases that resulted in inpatient admissions and those treated on an outpatient basis.

Exhibit 1
Emergency Department Usage
Total Cases
Fiscal 2001-2005



Source: Health Services Cost Review Commission; Department of Legislative Services

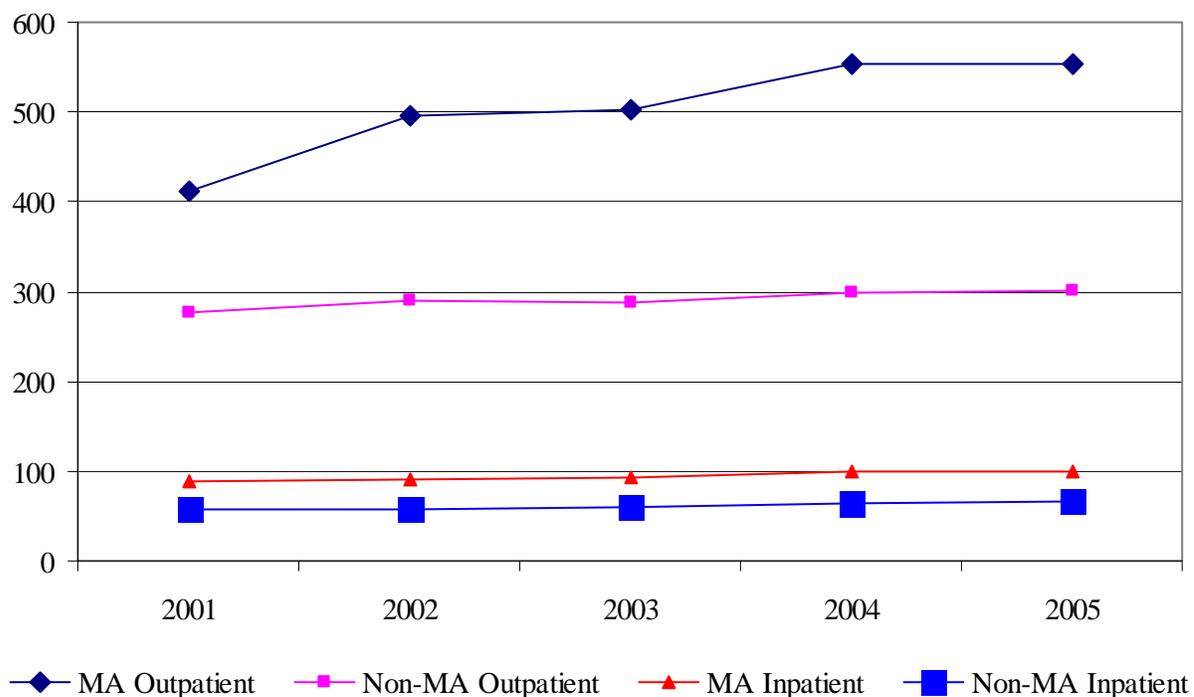
There are numerous factors that influence the utilization of emergency departments. A 2002 Maryland Health Care Commission and HSCRC study of emergency room utilization noted a variety of factors including increased demand for emergency room services, how emergency room patients are managed, and issues concerning hospital and community health system capacity.

As one of the major health care insurers in Maryland, it is interesting to examine the use of the emergency department by enrollees in the Medicaid program.

The Use of the Emergency Department by Medicaid Enrollees

Medicaid spending for emergency departments increased at an average annual rate of 14% over the last five years. As depicted in **Exhibit 2**, Medicaid enrollees are far more likely than other Maryland residents to utilize the emergency department on an outpatient basis, but no more likely to make an emergency department visit that results in an inpatient hospital stay. The exhibit also demonstrates that Medicaid enrollee use of the emergency department on an outpatient basis is not only higher but growing faster than the usage by other citizens.

Exhibit 2
Emergency Department Usage – Medicaid Compared to Rest of Population
Per 1,000 People
Fiscal 2001-2005



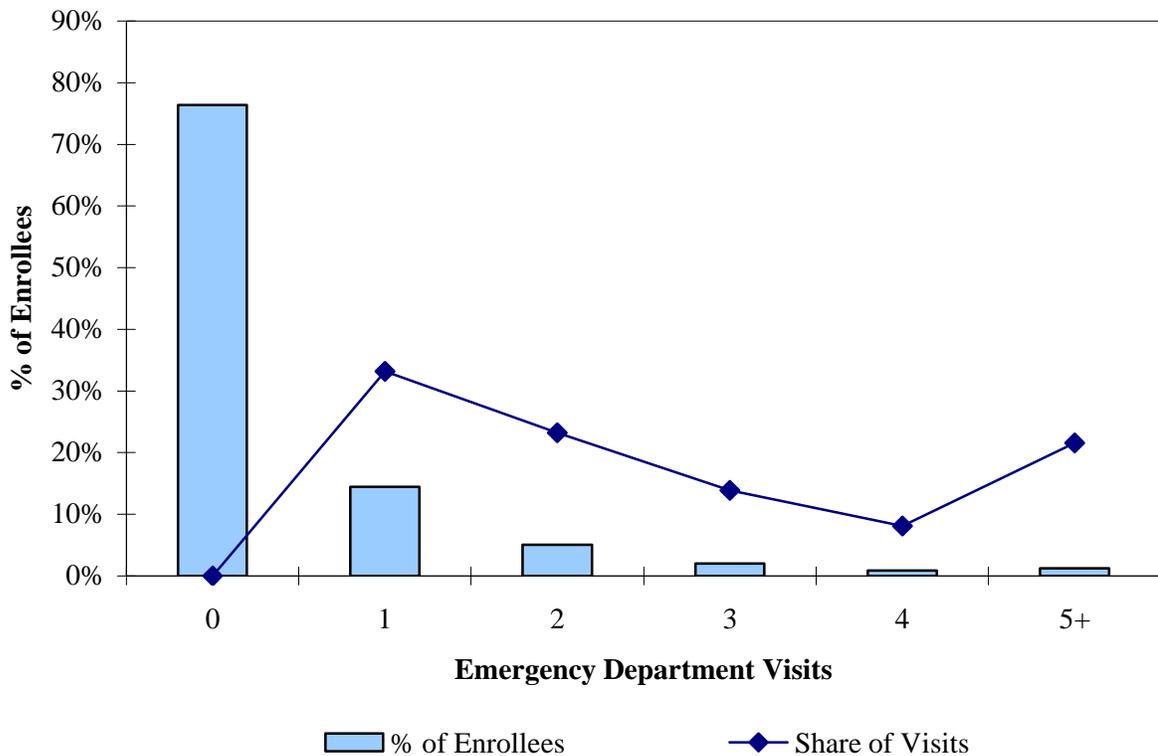
MA: Medicaid

Source: Department of Legislative Services

Why are Medicaid enrollees more likely to use the emergency department on an outpatient basis than other citizens? Potential explanations include a lack of access to primary care, successful marketing by the hospitals, and differences in health status. **Exhibit 3** provides information on the frequency of emergency room usage by Medicaid enrollees while **Exhibit 4** compares the frequency of the emergency room and ambulatory care visits. A number of points can be made from the exhibits:

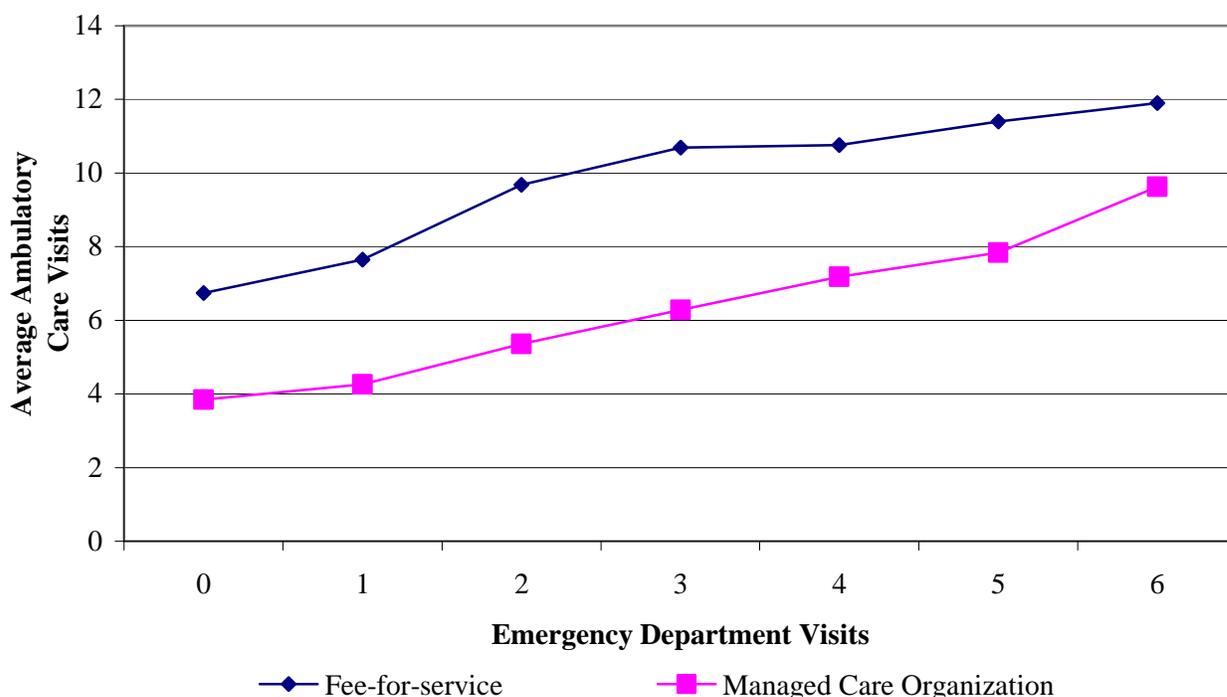
- Most Medicaid recipients make little or no use of the emergency department. More than three-quarters of Medicaid enrollees did not visit the emergency department in calendar 2005, and more than half of those with an emergency department visit made only a single visit. The figures suggest that access to primary care is not a systemic issue for the Medicaid population.

Exhibit 3
Medicaid/MCHP Emergency Department Usage
Calendar 2006



Source: Department of Health and Mental Hygiene

Exhibit 4
Frequency of Medicaid Ambulatory Care and Emergency Room Visits



Source: Department of Health and Mental Hygiene

- A small cadre of Medicaid enrollees (about 1%) made five or more emergency department visits during the year, and these enrollees account for about 22% of all Medicaid funded visits.
- Approximately 85% of Medicaid enrollees with an emergency department visit in calendar 2005 also made at least one ambulatory care visit during the year.
- Ambulatory care visits were far more common among fee-for-service recipients than managed care enrollees. This differential is not unexpected as fee-for-service enrollees are composed largely of populations with high acuity including the elderly, institutionalized, and children with rare and expensive conditions.
- Frequent emergency department visitors received more ambulatory care than individuals with one or fewer emergency department visits. However, the ratio of ambulatory care to emergency department visits shrinks as the number of emergency department visits rises. For example, the ratio of ambulatory care to emergency department visit was 4.3:1 for Managed Care Organization.

M00 – DHMH – Fiscal 2008 Budget Overview

Care Organization (MCO) enrollees with one emergency department visit during the year and 1.6:1 for MCO patients with five emergency department visits.

While not conclusive, the data suggest that the disproportionate use of the emergency department on an outpatient basis is due to a handful of people who are frequent users of both the emergency department and other forms of care. These individuals may at times substitute the emergency department for specialty or primary care, but their frequent use of a variety of health care options suggests they are also very ill.

To reduce State expenditures for inappropriate use of the emergency department, the Department of Health and Mental Hygiene (DHMH) recently instituted a policy of limiting payments to hospitals for non-emergency care to triage and ancillary costs. Case management programs may be the best option for addressing the frequent emergency department visits by clients with chronic illnesses. **DHMH should discuss what if any steps they plan to take to identify common diagnoses for frequent emergency room visitors and develop case management programs that seek to control the acuity of such illnesses.**

The Use of the Emergency Department by Medicaid Enrollees Presenting with Psychiatric Symptoms

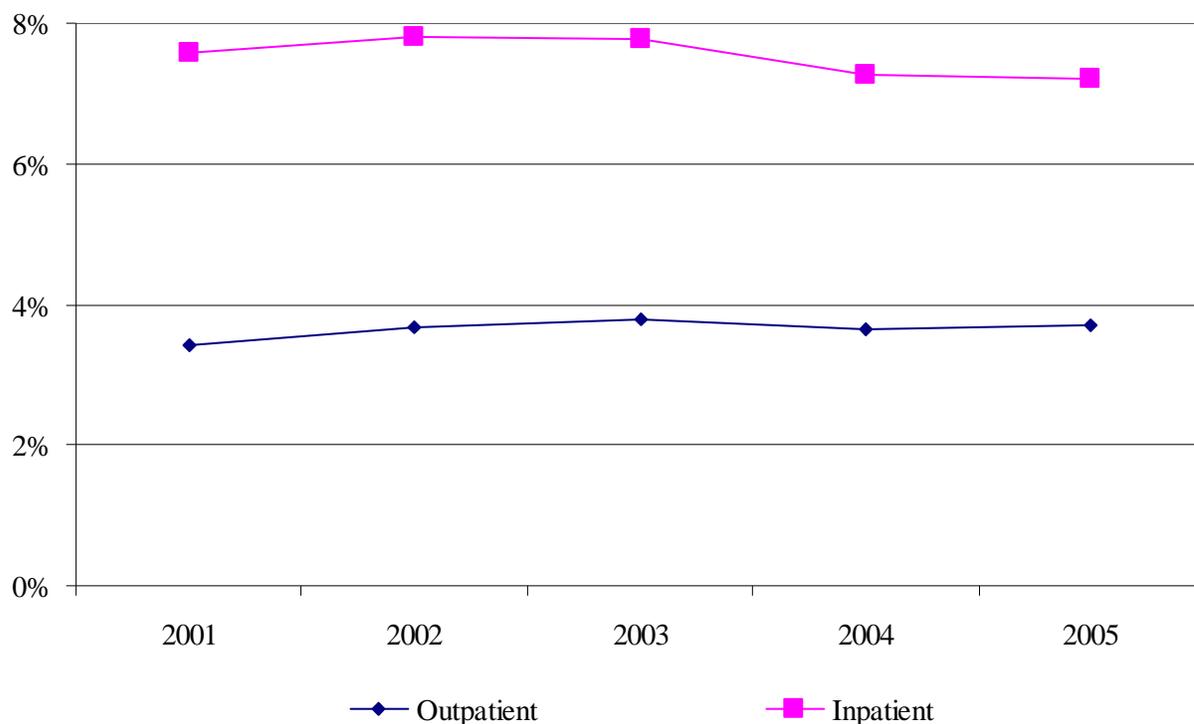
In fiscal 2005, 4.3% of all emergency department cases were persons presenting with psychiatric symptoms, up slightly since fiscal 2001 (4.1%). Amongst the Medicaid population, 6.2% of all emergency department cases were persons with psychiatric symptoms, a level that is unchanged since fiscal 2001.

As shown in **Exhibit 5**, outpatient use of emergency departments by all persons presenting with psychiatric symptoms in fiscal 2005 represented 3.7% of all outpatient cases, up from 3.4% in fiscal 2001. For patients subsequently admitted to inpatient care from the emergency department, persons with psychiatric symptoms represented a much higher share of total inpatient admissions, 7.2% in fiscal 2005, although this was down from 7.6% in fiscal 2001. Almost 30% of all emergency department visits by persons with psychiatric symptoms result in an admission for inpatient care compared with 18% for emergency department visits overall.

As shown in **Exhibit 6**, more striking is the use of the emergency department by persons with psychiatric symptoms who are Medicaid-enrollees compared to the rest of the population:

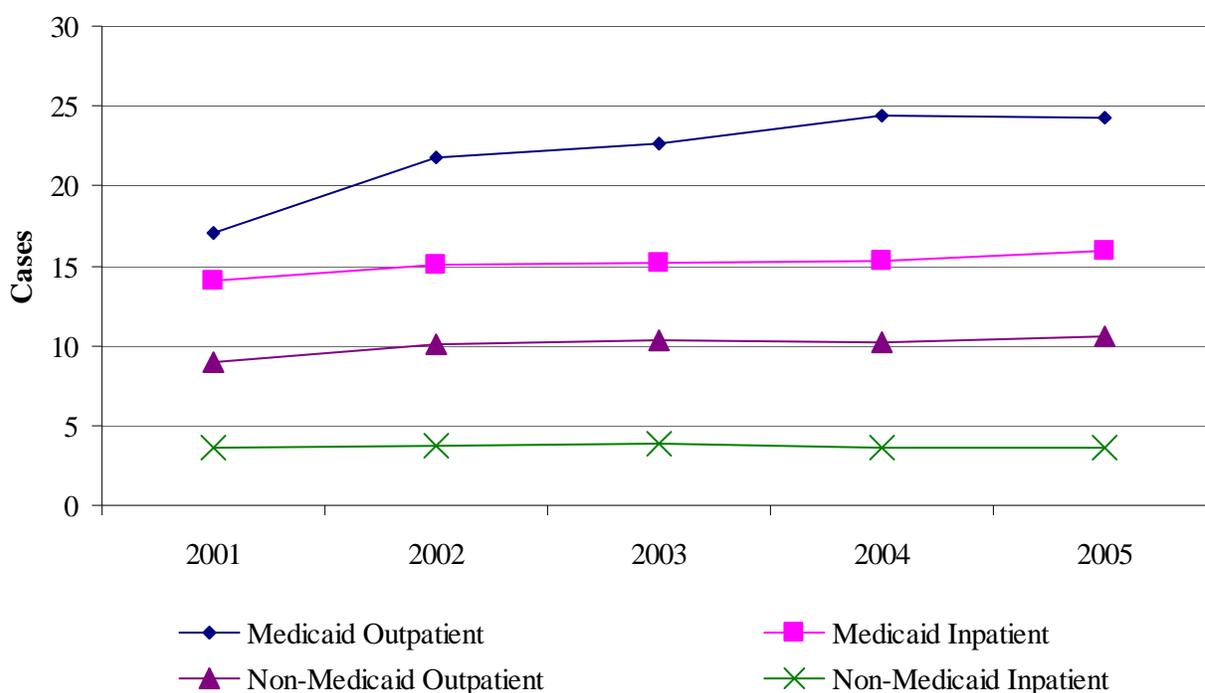
- Medicaid enrollees with psychiatric symptoms are more likely to use the emergency department than non-Medicaid enrollees. This applies both to outpatient visits and, unlike the use of emergency department by Medicaid enrollees generally, also visits that result in an admission to inpatient care.

Exhibit 5
Emergency Department Usage – Psychiatric Cases as a
Percentage of Total Cases
Fiscal 2001-2005



Source: Health Services Cost Review Commission; Department of Legislative Services

Exhibit 6
Emergency Department Usage with Psychiatric Symptoms as Principal Diagnosis –
Medicaid Compared to the Rest of Population
(Cases Per 1,000 Persons)
Fiscal 2001-2005



Source: Health Services Cost Review Commission; Department of Legislative Services

- The growth in the outpatient use of emergency departments by persons with psychiatric symptoms who were also Medicaid enrollees averaged 9% between fiscal 2001 and 2005, more than double that of the rest of the population (4%). Indeed, but for a leveling off between fiscal 2004 and 2005 for Medicaid enrollees, this difference would have been much more stark.
- The growth in emergency department use by persons with psychiatric symptoms that result in an inpatient admission also grew more strongly amongst Medicaid enrollees (3% between fiscal 2001 and 2005) compared to the rest of the population (1%).

Interestingly, data from the Mental Hygiene Administration (MHA) for emergency room services paid for via the fee-for-service public mental health system shows relatively little change in emergency room utilization. (These payments are for emergency department visits where a specialty

M00 – DHMH – Fiscal 2008 Budget Overview

mental health diagnosis is made.) These data are apparently at odds with data showing use of emergency departments by Medicaid enrollees generally. MHA currently has no firm explanation for this apparent discrepancy, although MHA speculates that this may be a reflection of the broad definition of “psychiatric symptoms” used in the HSCRC data.

Indeed, MHA’s efforts to reduce utilization of emergency departments by persons with psychiatric symptoms have typically focused on the uninsured rather than the Medicaid population. For example, the fiscal 2008 budget continues funding for the purchase of acute care beds in private psychiatric hospitals for uninsured persons in emergency departments who need that level of care and where no inpatient beds are available to that individual in that acute general hospital. MHA financed 672 such admissions in fiscal 2006. Another example is the funding of residential crisis beds which continues in the fiscal 2008 budget. These beds often provide a short-term intervention for persons in crisis, potentially diverting them from emergency department visits.

A more recent intervention, and one that appears promising, has been developed in Montgomery County through its Core Service Agency (CSA). This program, the Crisis Center, is funded by recycling existing grant funds provided to the CSA by MHA for purchase of care beds, residential crisis services, and forensic evaluations. Under this program, qualified licensed mental health professionals screen uninsured individuals who present for psychiatric admission at the emergency department of Shady Grove Hospital (available 16 hours a day 7 days a week) and who are likely to be an inpatient admission. The center also provides telephone screening of similar individuals who present at all other Montgomery County emergency departments. The intent of the program is to reduce the amount of time spent in the emergency department and also to place them in appropriate levels of care. If the program is successful in diverting individuals from inpatient care, savings will be used to develop more alternatives to hospitalization.

In the first three months of the initiative, results are encouraging. Looking specifically at Shade Grove Hospital, the Crisis Center handled 159 cases and was able to divert 59 individuals, 37%, into community-based alternatives to hospital care. Interestingly, just under half of these community-based interventions were primarily for addictions treatment.

2. The State of the State’s Health – 2006

One of the more comprehensive nationwide health rankings is developed by the United Health Foundation (a nonprofit, private foundation established by UnitedHealth Group), the American Public Health Association (an organization representing public health professionals), and Partnership for Prevention (a national nonprofit organization dedicated to health improvement). Since 1990 in a publication entitled *America’s Health: State Health Rankings*, individual state rankings have been produced using data that represent a broad range of issues affecting a population’s health, that are available at a state level, and that are current. Data and the ranking methodology are regularly reviewed by a large panel of public health experts and can change from year-to-year.

M00 – DHMH – Fiscal 2008 Budget Overview

The purpose of these rankings is two-fold: to stimulate public conversation concerning health in the states and to provide information to facilitate citizen participation in discussions about health policy.

Data are collected in two broad categories:

- Risk factors which are in turn broken into four groupings:
 - Personal behaviors (prevalence of smoking, motor vehicle deaths, prevalence of obesity, and high school graduation);
 - Community environment (violent crime offenses, infectious disease, children in poverty, and occupational fatalities);
 - Public and Health policies (lack of health insurance, per capita public health spending, and immunization coverage); and
 - Health Services (adequacy of prenatal care, and two measures under development [quality of care and cost efficiency]).
- Outcomes (poor mental health days, poor physical health days, cardiovascular deaths, cancer deaths, infant mortality, and premature death).

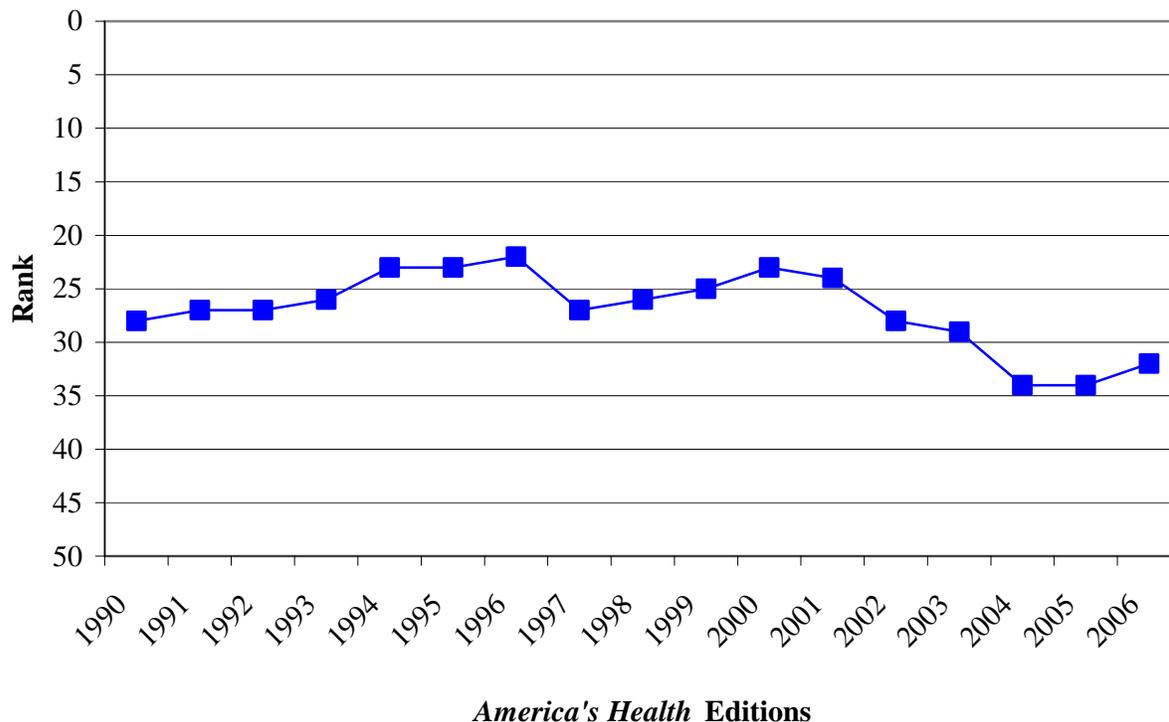
Data for each component is appropriately adjusted and weighted and combined into a single State overall health score. Risk factors ultimately contribute 60% of a State's overall score, with outcomes 40%.

As shown in **Exhibit 7**, in the 2006 edition of *America's Health*, Maryland's overall ranking based on this combined health score is thirty-second, a slight improvement over 2005.

Exhibit 8 groups states into four categories based on the individual state combined health scores used in the *America's Health* rankings relative to the national norm. As shown:

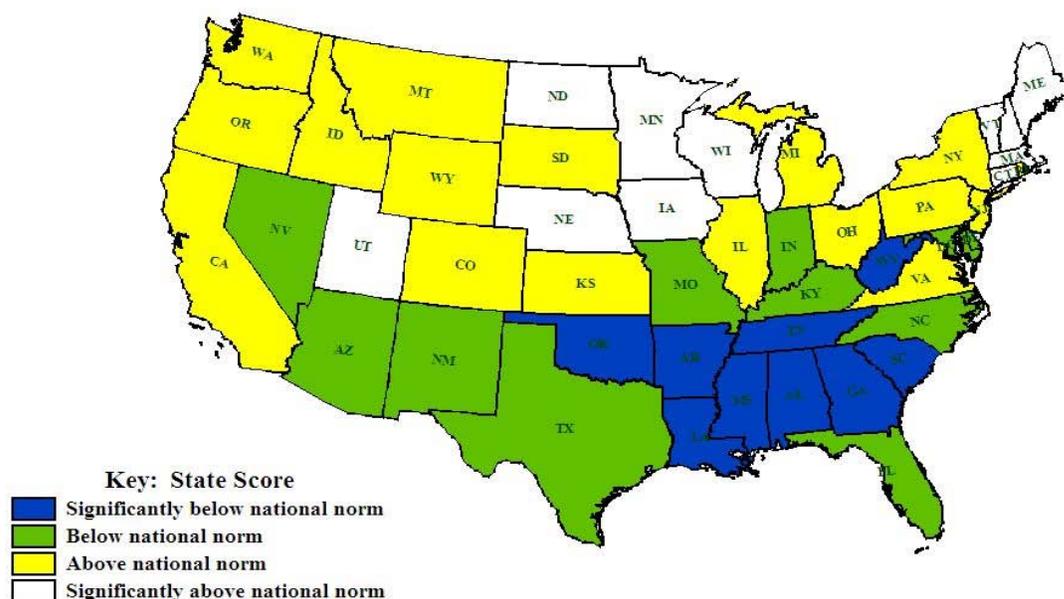
- southern states have markedly poorer scores than those in the north.
- states with significantly higher scores are clustered in the upper midwest and northeast.
- on the basis of this grouping methodology, Maryland is more aligned with the southern states than the northern states.

Exhibit 7
America's Health: State Health Rankings
1990-2006
Maryland



Source: *America's Health*, State Health Rankings, 2006 Edition

Exhibit 8
America's Health: State Health Rankings – 2006



Note: Alaska's state score was below the national norm; Hawaii had a state score significantly above the national norm.

Source: *America's Health*, State Health Rankings, 2006 Edition

Maryland Data in Detail

Looking at the detail behind Maryland's combined health score, as shown in **Exhibit 9**, short-term data trends for health outcomes between 2005 and 2006 are mostly positive. However, looking only at risk factors, short-term data trends are more mixed.

- Significant improvement in performance is shown in terms of prevalence of smoking, infectious disease rates, cardiovascular deaths, and infectious diseases.
- Significantly poorer performance is shown in terms of occupational fatalities and the number of children in poverty.

Available long-term trends (1990 to 2006) in all health outcomes are positive. Similarly, long-term trends for risk factors are positive with the exception of prevalence of obesity and a lack of health insurance. These two risk factors have long been identified as measures that should challenge policymakers nationally.

**Exhibit 9
Various Health Outcomes and Risk Factors
U.S. and Maryland: 1990, 2005, and 2006**

<u>Outcome</u>	<u>1990</u>		<u>2005</u>		<u>2006</u>		<u>Long-term Trend</u>	<u>Short-term Trend</u>
	<u>Maryland</u>	<u>Maryland Rank</u>	<u>Maryland</u>	<u>Maryland Rank</u>	<u>Maryland</u>	<u>Maryland Rank</u>		
Cardiovascular Deaths (Deaths Per 100,000 Population)	409	28	324.1	29	314.9	27	✓	✓
Cancer Deaths (Deaths Per 100,000 Population)	219.7	49	207.2	32	203.9	29	✓	✓
Infant Mortality (Deaths Per 1,000 Live Births)	11.6	41	8.7	46	8.4	44	✓	✓
Premature Death (Years Lost Per 100,000 Population)	9,145	36	8,014	33	8,117	35	✓	×
Poor Mental Health Days (Days in Previous 30 Days)		n/a	3.3	19	3.2	23		✓
Poor Physical Health Days (Days in Previous 30 Days)		n/a	3.2	14	3.1	7		✓
<u>Risk Factor</u>								
Prevalence of Smoking (% of Population)	29.7	26	19.5	10	18.9	11	✓	✓
Motor Vehicle Deaths (Deaths Per 100 Million Miles Driven)	2.0	11	1.2	10	1.1	8	✓	✓
Prevalence of Obesity (% of Population)	12.0	29	23.9	32	24.4	25	×	×
High School Graduation (% of Incoming 9th Graders)	76.5	25	74.1	11	79.2	15	✓	✓
Violent Crime (Offenses Per 100,000 Population)	768.0	45	701.0	48	703.0	47	✓	×
Lack of Health Insurance (% without Coverage)	8.9	11	14.6	30	14.2	24	×	✓
Infectious Disease (Cases Per 100,000 Population)	41.1	38	40.3	48	36.5	48	✓	✓
Children in Poverty (% of Persons Under 18)	16.4	17	11.0	8	13.3	13	✓	×
Occupational Fatalities (Deaths Per 100,000 Workers)	5.7	5	4.2	12	5.0	20	✓	×
Per capita Public Health Spending (\$ Per Person)		n/a	189.0	14	189.0	14		No Change
Immunization Coverage (% of Children 19-35 Months Receiving Selected Vaccines)		n/a	80.0	34	82.3	23		✓
Adequacy of Prenatal Care (% of Pregnant Women Receiving Adequate Care)			70.9	38	70.1	38		×

Note: Year refers to year that the ranking is made. The data used to make that ranking are the most current available.

Source: *America's Health*, State Health Rankings, 2006 Edition

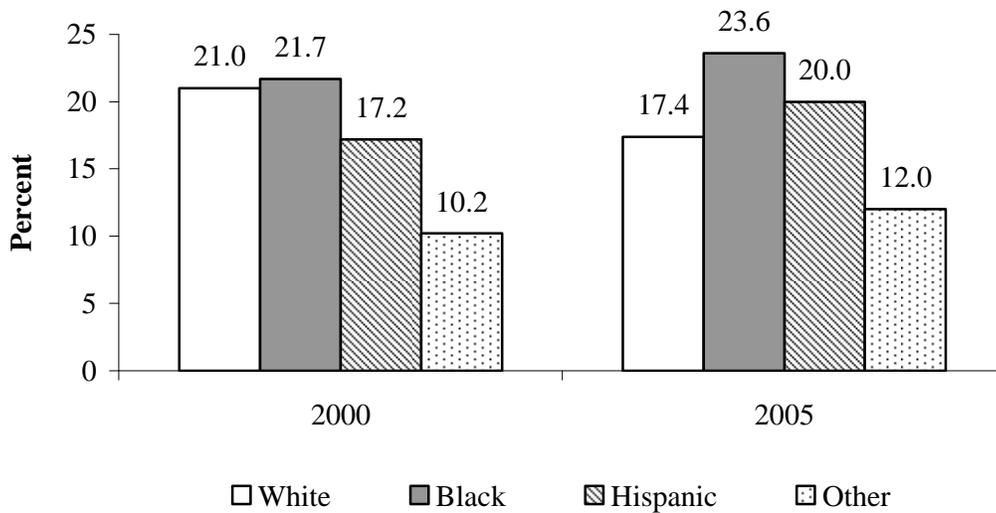
Health disparities

Looking further at the Maryland data, it is apparent that there are significant differences in the risk factors and health outcomes when evaluated by racial and ethnic status. Indeed, given that in 2005, minorities account for just over 40% of Maryland’s population and that this percentage is growing quickly, addressing these differences is particularly important in improving the State’s overall health.

Consider, for example, the data for two of the risk factors (prevalence of smoking and lack of health insurance) and two health outcomes (infant mortality and cancer deaths) used to develop the *America’s Health* ranking:

Prevalence of Smoking: As noted above, in the 2006 *America’s Health* ranking, an important area of improvement for Maryland was the decline in the overall smoking rate. Smoking is linked to higher rates of mortality and morbidity for such things as heart disease, stroke, and smoking-related cancers. However, as shown in **Exhibit 10**, between 2000 and 2005 while smoking amongst Whites fell, the trend in smoking for racial and ethnic minorities between 2000 and 2005 actually increased.

Exhibit 10
Adult Smoking Prevalence by Race and Ethnicity, Maryland
2000 and 2005

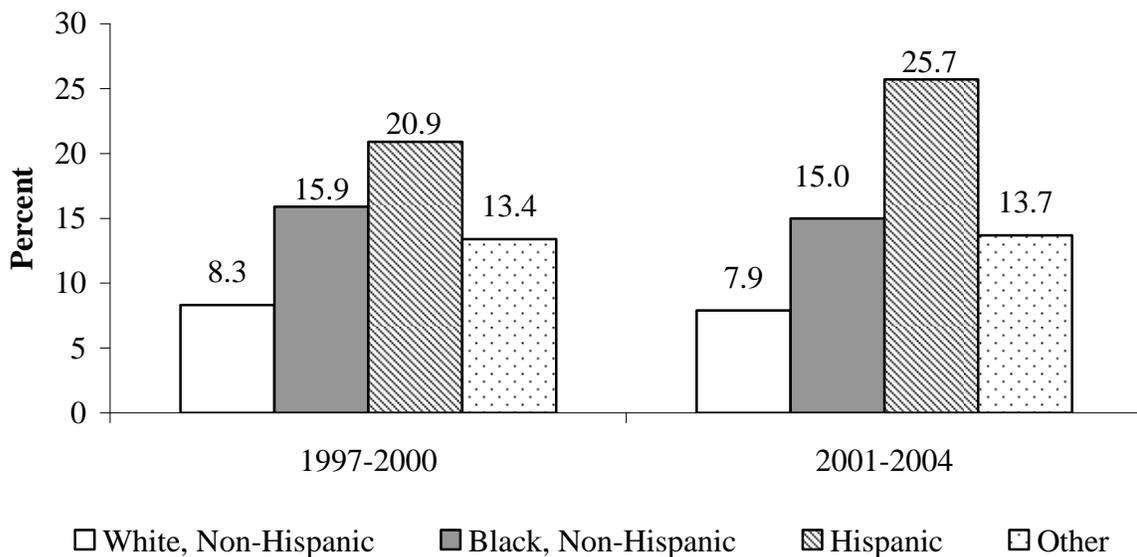


*The Behavioral Risk Factor Surveillance System is an ongoing, state-based telephone surveillance system supported by the Centers for Disease Control and Prevention. Through a series of telephone interviews, states uniformly collect data on behaviors and conditions that affect adult health.

Source: Behavioral Risk Factor Surveillance System* Survey Data, 2000 and 2005

Lack of Health Insurance: Lack of health insurance coverage is a major factor in access to health care. While the percentage of people without health insurance in Maryland fell in the latest *America's Health* rankings, as shown in **Exhibit 11**, there is a significant gap in coverage by race and ethnicity. In the period 2001 to 2004, the Black, Non-Hispanic population in Maryland was almost twice as likely to be uninsured as the White, Non-Hispanic population. The Hispanic population was over three times as likely to be uninsured as the White, Non-Hispanic population.

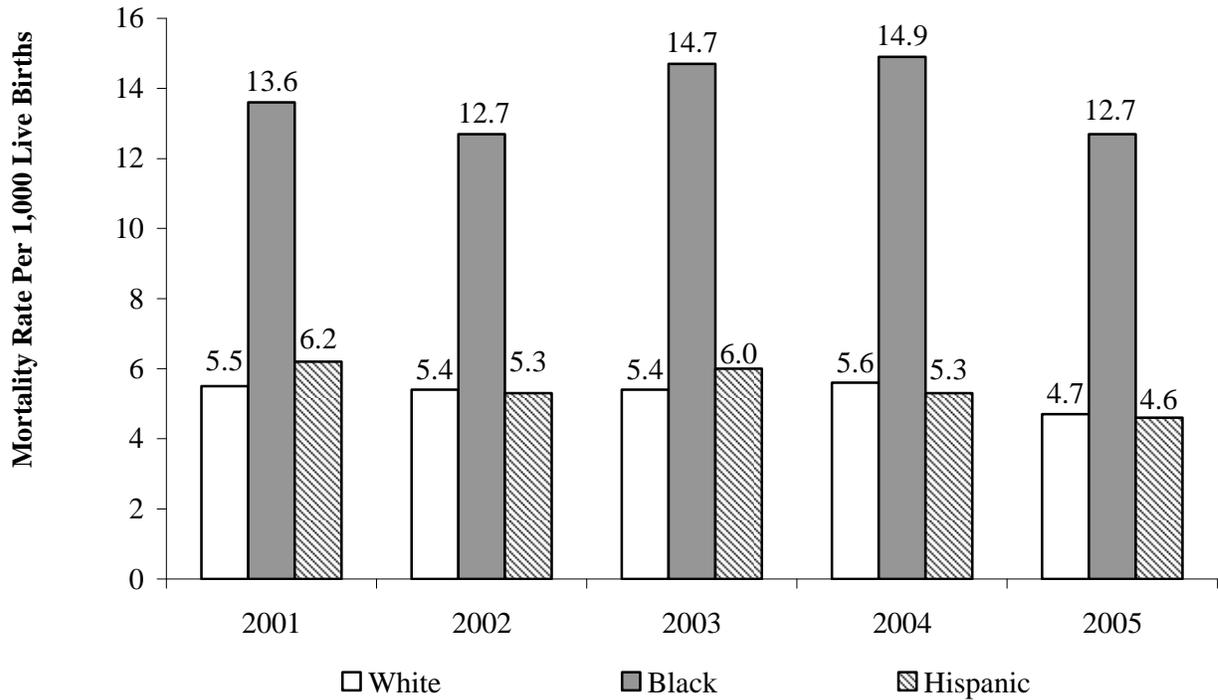
Exhibit 11
Percent of Marylanders by Race and Ethnicity
Who Do Not Have Health Insurance Coverage
1997-2000 and 2001-2004



Source: Maryland Behavioral Risk Factor Surveillance System interactive web site: <http://marylandbrfss.org/> 2000-2004

Infant Mortality: Despite the improvement in Maryland's infant mortality rate in the 2006 *America's Health* rankings, the State's infant mortality rate has for many years been among the worst in the nation. As shown in **Exhibit 12**, infant mortality rates statewide were just under three times higher in 2005 for Black infants than White and Hispanic infants. Over the five-year period from 2001 to 2005, the infant mortality rate for Blacks has fluctuated, most recently showing some improvement after two years of worsening outcomes, but it still remains much higher than the rates for Whites and Hispanics.

Exhibit 12
Infant Mortality Rates in Maryland by Race and Hispanic Origin
2001-2005

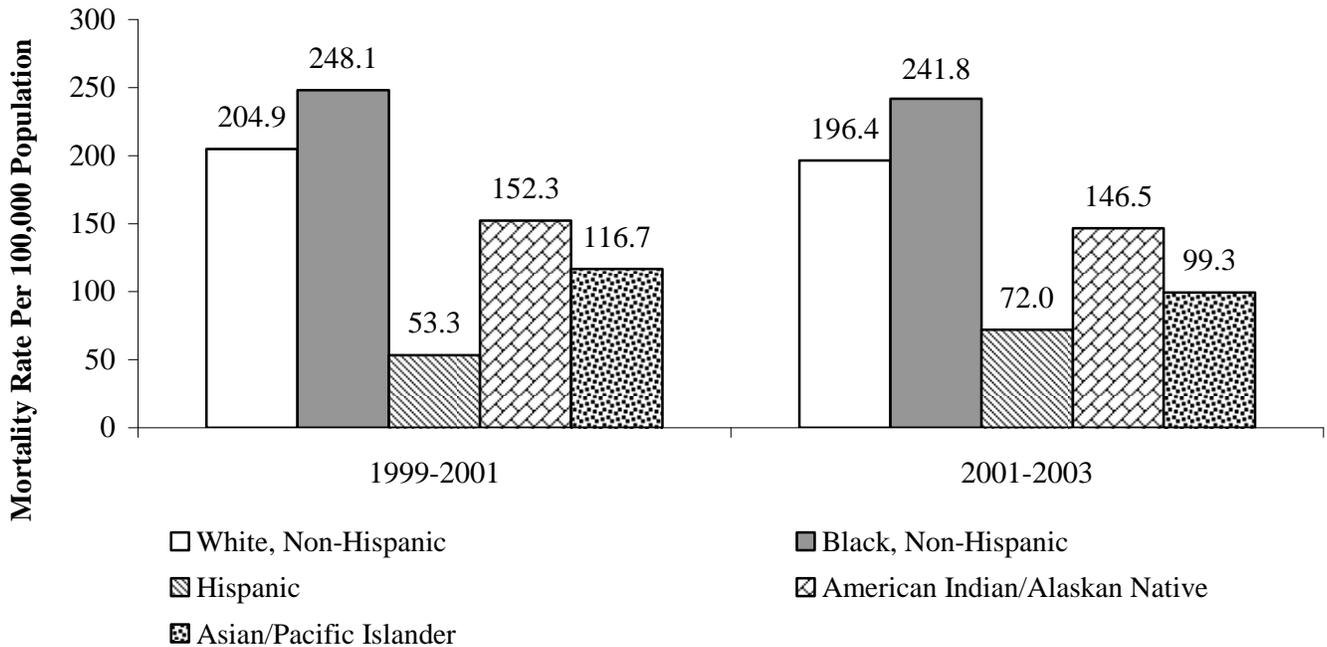


Note: Data for Hispanics are included in the data for each race. The Hispanic infant mortality rate includes all deaths to Hispanics of any race.

Source: *Maryland Vital Statistics Preliminary Report, 2005*

Cancer Deaths: Maryland continued to show improvement in terms of the rate of cancer deaths in the *America's Health* rankings (in 1990 Maryland ranked almost dead last nationwide in this category). As shown in **Exhibit 13**, between 1999 to 2001 and 2001 to 2003, this improvement was felt by most, but not all populations. However, Blacks continue to have a higher rate of deaths compared to every other ethnic group.

Exhibit 13
Adult All Cancer Age-adjusted Mortality Rate in Maryland by Race and Ethnicity



Source: Adult mortality by cause: United States/State, 1999-2003 National Vital Statistics System, Centers for Disease Control and Prevention/National Center for Health Statistics