

M00L
Mental Hygiene Administration
Department of Health and Mental Hygiene

Operating Budget Data

(\$ in Thousands)

	FY 07	FY 08	FY 09	FY 08-09	% Change
	<u>Actual</u>	<u>Working</u>	<u>Allowance</u>	<u>Change</u>	<u>Prior Year</u>
General Fund	\$594,784	\$623,262	\$653,369	\$30,107	4.8%
Special Fund	4,761	5,000	5,280	280	5.6%
Federal Fund	253,320	259,459	271,993	12,533	4.8%
Reimbursable Fund	<u>5,472</u>	<u>5,917</u>	<u>8,773</u>	<u>2,856</u>	<u>48.3%</u>
Total Funds	\$858,338	\$893,638	\$939,415	\$45,776	5.1%

- The Governor's fiscal 2009 allowance adds almost \$46.0 million to the Mental Hygiene Administration (MHA) budget compared to the fiscal 2008 working appropriation (5.1%). However, this increase is distorted by changes in employee and retiree health insurance and Other Post Employment Benefits funding. Adjusting for these factors, growth is \$30.9 million (3.6%).
- Funding for the community mental health fee-for-service system includes funding for rate increases and a 1.5% provider cost-of-living adjustment. However, little remains to address enrollment and utilization growth.
- The major new initiative is almost \$3.5 million to provide mental health and substance abuse gap services to veterans.

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

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Personnel Data

	<u>FY 07 Actual</u>	<u>FY 08 Working</u>	<u>FY 09 Allowance</u>	<u>FY 08-09 Change</u>
Regular Positions	3,389.05	3,357.25	3,333.70	-23.55
Contractual FTEs	<u>237.96</u>	<u>242.77</u>	<u>230.75</u>	<u>-12.02</u>
Total Personnel	3,627.01	3,600.02	3,564.45	-35.57

Vacancy Data: Regular Positions

Turnover, Excluding New Positions	194.35	5.83%
Positions Vacant as of 12/31/07	247.55	7.37%

- The budget includes six new full-time equivalent positions for the veteran’s mental health initiative.
- However, these new positions are more than offset by abolitions (both those anticipated at the Board of Public Works in January 2008 as well as additional abolitions for fiscal 2009).
- Personnel reductions are having an impact on the ability to maintain capacity at State-run psychiatric facilities.

Analysis in Brief

Major Trends

Community Mental Health Fee-for-service System: Enrollment and utilization appear to be increasing.

Outcomes Measurement System: After a long wait, initial outcomes are being generated for the community mental health fee-for-service system. The initial data provides interesting insight into the characteristics of the population using the system.

State-run Psychiatric Facility Staffing Levels: A recent staffing study pointed to significant understaffing at the State-run psychiatric facilities. MHA has responded to the study by closing some beds, but understaffing remains a chronic problem.

Issues

Utilization of Perkins Hospital in the Rosewood Closure Plan: The Department of Health and Mental Hygiene anticipates using a currently vacant ward at Perkins for evaluation of up to 15 developmentally disabled individuals as part of the plan to close Rosewood. A key concern of this proposal is the department’s difficulty in transferring developmentally disabled eligible individuals from State-run psychiatric hospitals.

RTC Capacity: Residential Treatment Centers (RTC) vacancy levels are high, and vacancies reported by the State-run RTCs are rising.

Integration of Care: Despite advances in the treatment of mental illness, persons with serious mental illnesses have much lower life expectancy rates than persons in their age cohort. Many persons with serious mental illnesses have other chronic health care issues which go undetected or untreated. States are looking to integrate physical and mental health care for high-cost users of public health services in order to improve outcomes and potentially reap savings.

Recommended Actions

	<u>Funds</u>	<u>Positions</u>
1. Add language requiring notification of significant deviations from proposed budget spending in the community mental health budget.		
2. Reduce five new positions and associated office costs for the Veterans Mental Health Initiative.	\$ 273,123	5.0
3. Reduce funding for gap services to veterans.	1,400,000	
4. Reduce general funds based on sharing maintenance and related costs with tenants at the Carter Center.	330,000	
5. Reduce funds for Maryland Environmental Service charges.	280,000	
6. Adopt narrative requiring the Mental Hygiene Administration to report on the implementation and utilization of new services to veterans.		
7. Adopt narrative requesting the Department of Health and Mental Hygiene to develop a transition plan to facilitate the movement of developmentally disabled-eligible or pending eligibility individuals out of State-run psychiatric facilities.		

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8. Adopt narrative requesting the Department of Health and Mental Hygiene develop a pilot integrated care management program for persons with serious mental illnesses and chronic physical health issues.
9. Add language reducing funds and positions for the Regional Institute of Children and Adolescents-Southern Maryland.

Total Reductions	\$ 2,283,123	5.0
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Updates

Mental Health Transformation Grant: The State is moving forward with a variety of initiatives funded through its federal mental health transformation grant.

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Mental Hygiene Administration
Department of Health and Mental Hygiene

Operating Budget Analysis

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

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

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

- ***MHA Headquarters*** coordinates mental health services throughout the State according to the populations served, whether in an institutional or community setting.
- ***Core Service Agencies (CSA)*** work with MHA, through signed agreements, to coordinate and deliver mental health services in the counties. There are currently 20 CSAs, some organized as part of local health departments, some as nonprofit agencies, and 1 as a multi-county enterprise.
- ***State-run Psychiatric Facilities*** include seven hospitals and three residential treatment centers – Regional Institutions for Children and Adolescents (RICA) – for the mentally ill.

As a result of waivers under the authority of Section 1115 of the federal Social Security Act, beginning in fiscal 1998, the State established a program of mandatory managed care for Medicaid recipients. While primary mental health services stayed within the managed care structure, specialty mental health services to Medicaid enrollees were carved out and funded through the public mental health system. Specialty mental health services are defined as meeting certain medical necessity criteria utilizing accepted diagnostic tools.

The carved-out system is overseen by MHA, although it contracts with an Administrative Services Organization (ASO), APS Healthcare Inc. (APS), to administer the system. Services are also available to non-Medicaid clients. Prior to fiscal 2003, eligibility for non-Medicaid clients was

up to 300% of the federal poverty level (FPL), with services provided on a sliding-fee scale. After fiscal 2003, eligibility for new clients was limited to 116% of FPL. With the development of the Maryland Primary Adult Care (PAC) program beginning in fiscal 2007, persons with severe mental illnesses with incomes up to 116% of FPL were transitioned to the Medicaid program for the purposes of reimbursement of mental health services. However, a significant pool of non-Medicaid clients who do not meet the eligibility criteria for PAC continues to be served by MHA.

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

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

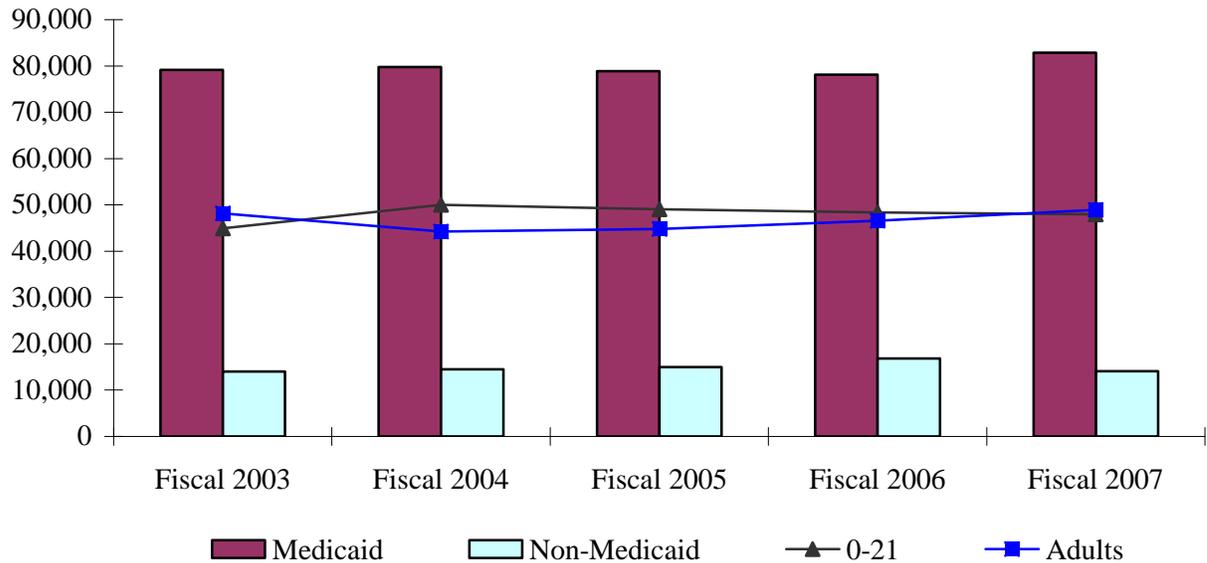
Performance Analysis: Managing for Results

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

As shown in **Exhibit 1**, total enrollment in the fee-for-service community mental health system (Medicaid and non-Medicaid) has increased by an average annual rate of 1% between fiscal 2003 and 2007. Looking at the total population served:

- Enrollment growth among children (aged 0-21), which through fiscal 2004 had been driving enrollment trends, has leveled off considerably in recent years. At this point, it is enrollment among adults that is the main driver, with a growth of 5.0% between fiscal 2006 and 2007 compared to a decline of 1% for children in the same period. For children, while Medicaid enrollment of children has grown, the penetration rate (the proportion of Medicaid enrollees that are served in the public mental health system) into the public mental health system has declined from 9.50% in fiscal 2004 to 8.67% in fiscal 2007.
- The growth in adult enrollment has been evident since fiscal 2005. The decline in the number of adults served prior to fiscal 2005 was due to a change in categorization rather than a drop in actual enrollment. Specifically, beginning in fiscal 2004, claims for dually eligible Medicaid and Medicare clients were moved from the ASO process to Medicaid.

Exhibit 1
Community Mental Health Services Enrollment Trends
Fiscal 2003-2007



Note: Data for fiscal 2007 is incomplete. Enrollment counts may be duplicated across coverage types. Includes enrollment in the Baltimore City capitation project which serves approximately 350 individuals.

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

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

- Two definitional changes have limited the growth in the Medicaid population: in fiscal 2004, the transfer of claims for dually eligible Medicaid and Medicare clients to Medicaid; and between fiscal 2005 and 2006, the exclusion of clients receiving assistance to pay Medicare premiums (this assistance totaled some 2,265 clients in fiscal 2006). This change masks what would have been a small increase in Medicaid clients and a drop in the Medicaid-ineligible population.
- Beginning in fiscal 2007, with the start of the PAC program, non-Medicaid enrollment falls. Under that program, among other benefits, persons with incomes up to 116% of FPL are eligible for specialty mental health services and the State can claim Medicaid reimbursement for those expenditures.

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The issue of how many individuals served in MHA’s “safety-net” program for persons with severe mental illness that could be enrolled in PAC (and thus eligible for federal fund attainment) was one that the legislature sought to address in the 2007 session by asking MHA to clarify its eligibility criteria for its non-Medicaid eligible population and to develop strategies to maximize the enrollment of this population in PAC.

MHA did report on the use of the safety-net program, identifying six categories of persons served:

- Those who have received services within the public mental health system in the past two years (alleviating continuity of care issues for those who occasionally lose Medicaid coverage). Most persons served in the safety-net program fall into this category.
- The homeless.
- People who received Social Security Disability Insurance due to psychiatric impairment and are eligible for Medicare (excluding them from PAC) but who need services beyond those covered by Medicare.
- People who are on court-ordered conditional releases from a State-run psychiatric hospital.
- Anybody discharged from a Maryland psychiatric hospital in the past three months.
- Anybody within three months of release from a correctional institution.

However, the report did not specifically identify barriers to enrollment in PAC and thus strategies to overcome these barriers although it did note that MHA is “striving to maximize enrollment efforts (in PAC).” Two points immediately spring to mind:

- Although the report notes that there is an incentive on the part of the provider to ensure clients have applied for PAC benefits (which not only cover mental health services but also primary care and medications), one would have to question that statement. Although the report also notes that Medicaid funding is more secure, the provider gets paid regardless of coverage, and the client receives services (although some providers note that getting authorizations for services to this population is burdensome).
- Obtaining Medicaid coverage is difficult, especially for a population that often does not have the required documentation. Anecdotally, some CSAs note the difficulty in dealing with local Departments of Social Services and the need to dedicate staff resources just to assist in obtaining coverage.

In either case, the report offers little in the way of remedy.

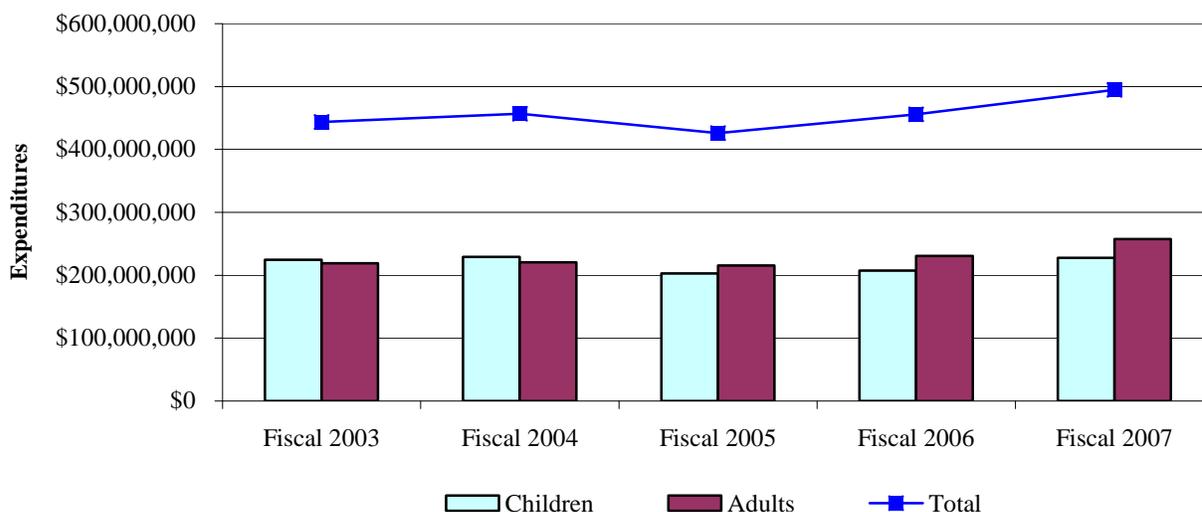
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Spending patterns broadly mirror enrollment growth (**Exhibit 2**), although cost containment actions taken in late fiscal 2004 are easy to identify. That cost containment slows the overall rate of growth during the period to 3% (driven by spending on adults, increasing 4% while spending on children was essentially flat). However, beginning in fiscal 2006, spending picked up and accelerated in fiscal 2007: growth between fiscal 2006 and 2007 was 10% for children, 12% for adults, and 9% overall. This reflects a combination of:

- increased enrollment;
- higher service utilization again reflecting increased enrollment rather than a significant change in average service utilization (See **Exhibit 3**); and
- rate increases (in addition to the Health Services Cost Review Commission and cost-based rates increases, provider rates were increased on average by 2% in each of fiscal 2007 and 2008).

This spending pattern is problematic because, as will be discussed below, budgeted funding is not growing at the same rate (only an annual average increase of 4% from fiscal 2007 to 2009).

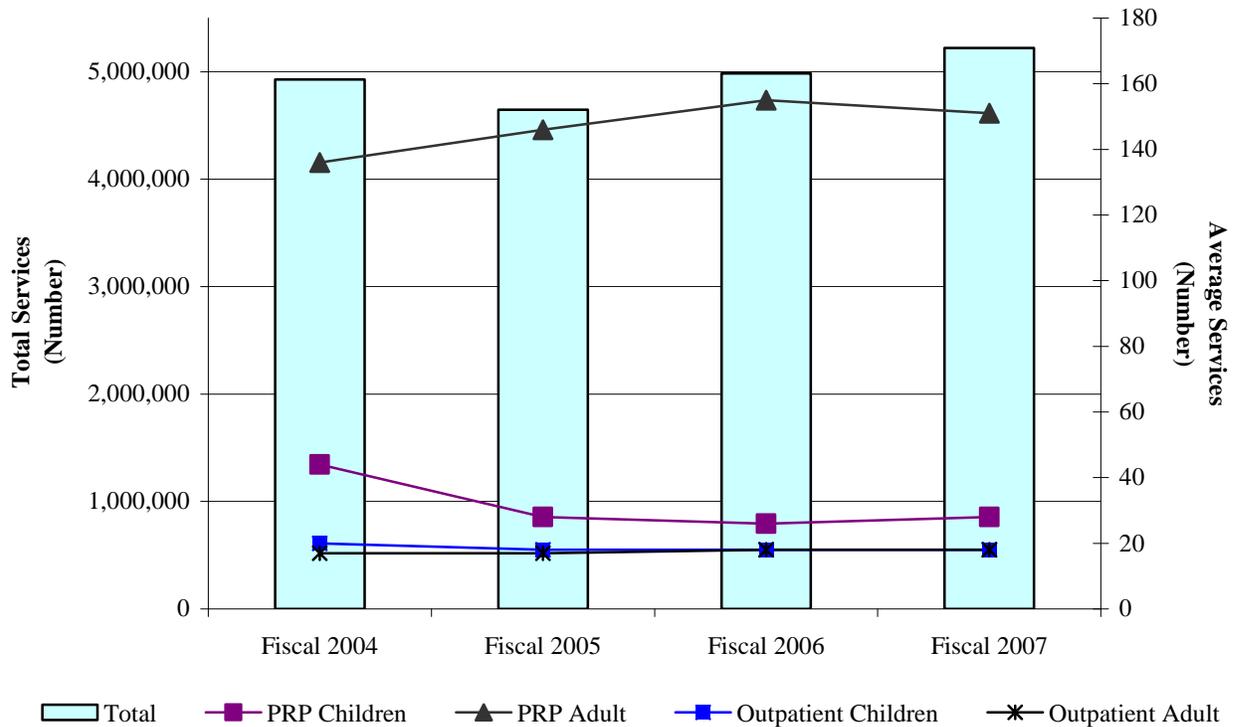
Exhibit 2
Community Mental Hygiene
Fee-for-service Expenditures
Fiscal 2003-2007



Note: Data for fiscal 2007 is incomplete. It includes funding for the Baltimore City Capitation project at approximately \$10 million per year.

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

Exhibit 3
Various Service Utilization Measures
Fiscal 2004-2007



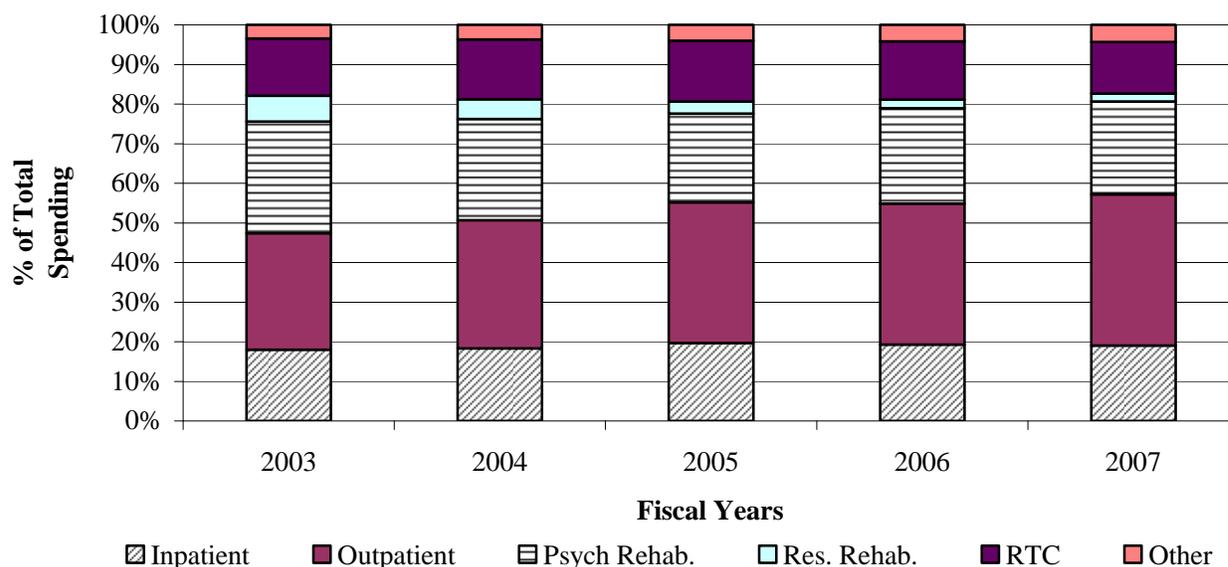
PRP: Psychiatric Rehabilitation Programs

Note: Data for fiscal 2007 is incomplete.

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

Which mental health services are experiencing the most rapid growth? While the fiscal 2007 data is incomplete, as shown in **Exhibit 4**, it confirms the trends from the prior years. Namely, with the imposition of a case rate in February 2004 as well as stronger enforcement of medical necessity criteria, there has been a shift away from psychiatric rehabilitation services to outpatient services. Outpatient services now consume 38% of fee-for-service spending up from 29% in fiscal 2003, while psychiatric rehabilitation service spending is down over the same period from 28% to 23%. Other service areas are relatively stable although Residential Treatment Centers (RTC) expenditures, which remain flat in dollar terms, are consuming less of the total expenditure, down to 13% in fiscal 2007 from 15% only the year before.

**Exhibit 4
Community Mental Health Services Expenditures by Service Type
Fiscal 2003-2007**



RTC: Residential Treatment Centers

Note: Data for fiscal 2007 is incomplete.

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

Outcomes for Community Mental Health Services

Outcome data from MHA’s Outcomes Measurement System (OMS) that MHA has been developing over several years is finally, if slowly, becoming available. Initial data from outpatient clinics is restricted to patients with at least two data points (generally six months apart), the same questionnaire type, and treatment during that period from the same provider. For adults the total number of clients involved is an estimate 10,000; for children and adolescents, just over 11,000. Other data is based on information from 28,000 adults and 24,000 children. The following observations are found as shown in **Exhibit 5**.

Exhibit 5
Community Mental Health Services
Outpatient Fee-for-service Selected Outcomes

Adult Outcomes	
Net improvement in functioning (% of total observations)	6.4
Increase in employment between observations (%)	1.8
Persons unemployed in both observations (%)	70.8
Homelessness in the past six months/since last interview (%)	16.0
Of those homeless:	
African American males	23.1
White males	23.7
African American females	29.4
White females	22.3
Arrests in the past 12 months (%)	15.0
Of those arrested:	
African American males	24.4
White males	30.0
African American females	18.5
White females	25.3
Children and Adolescents Outcomes	
Net improvement in functioning (% of total observations)	8.7
School suspensions in past six months (%)	12.0
Arrests in past 12 months (%)	8.0
Of those arrested:	
African American males	41.0
White males	25.1
African American females	17.7
White females	13.1

Source: Department of Legislative Services; Mental Hygiene Administration

The data is encouraging in that looking at improvement for the group of clients overall there are gains for example in functioning and employment. However, the data also provide insight into the multiple issues faced by this population including high levels of homelessness; significant criminal justice involvement; employment issues; and for children and adolescents, high suspension rates.

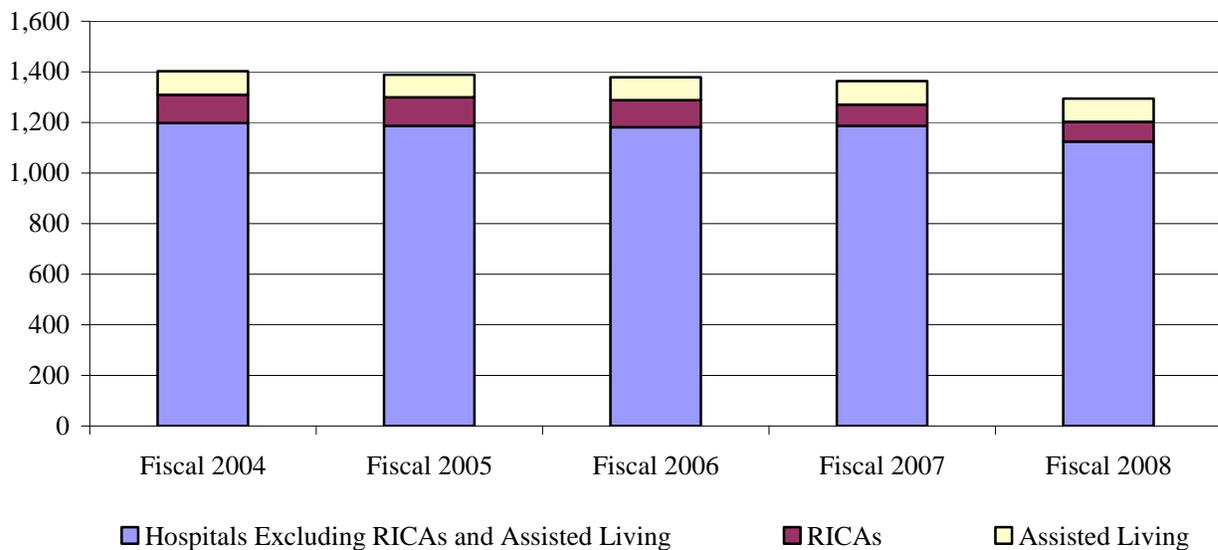
State-run Psychiatric Facilities: Population and Outcome Trends

Average Daily Populations

As shown in **Exhibit 6**, the average daily population (ADP) at the State-run psychiatric facilities continues to show a steady decline. The most significant declines include:

- One unit at the Carter Center was closed in 2006 because the State has been unable to procure sufficient contract psychiatrists from the University of Maryland, Baltimore to keep all of the units open. ADP at the Carter Center continues to decline in fiscal 2008 although the facility is now handling forensic patients from Baltimore City, and the population is expected to stabilize at current levels.
- Wards at Springfield and Spring Grove were cut to respond to a 2007 staffing study that indicated serious shortfalls in staffing (discussed further below).

Exhibit 6
State-run Psychiatric Facilities: Average Daily Population Trends
Fiscal 2004-2008



RICA: Regional Institutions for Children and Adolescents

Note: Fiscal 2008 data is through November 2007.

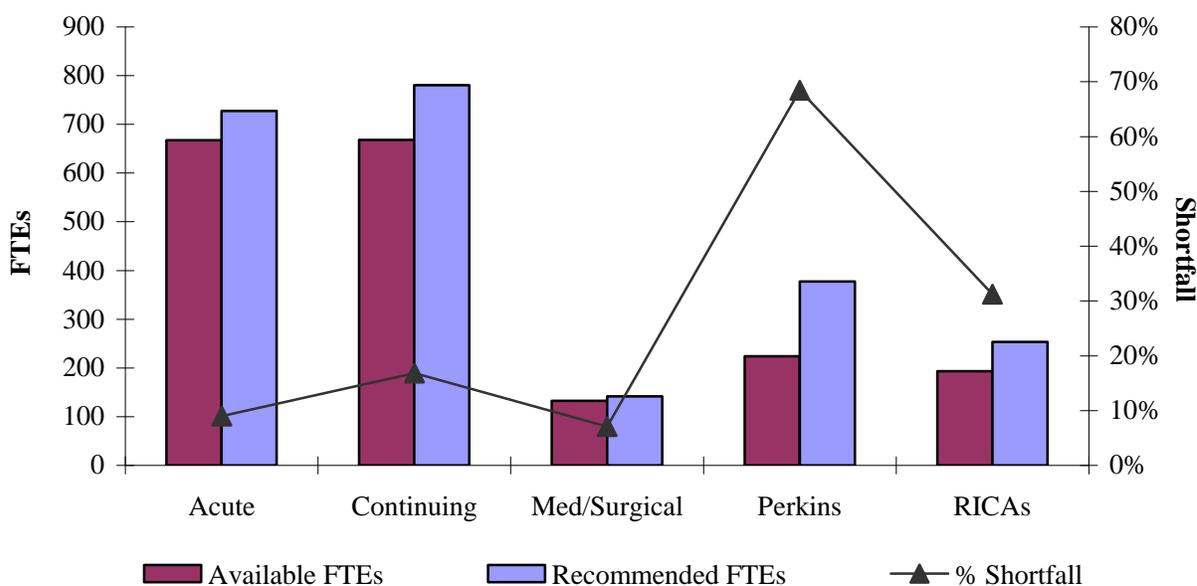
Source: Department of Legislative Services; Department of Health and Mental Hygiene

- Populations at the three RICAs also continue to shrink. As noted last year, part of this relates to data issues concerning MHA’s methodology for calculating ADP at the RICAs, although it should also be noted that one unit at RICA-Gildner was closed in 2006, and according to MHA, 23 additional beds were cut for budget reasons in fiscal 2008 (8 each at RICA-Montgomery and RICA-Baltimore and 7 at RICA-Southern Maryland).

Staffing Study

In 2007, MHA received a staffing study that looked at patient needs as well as current staffing levels at the facilities. The analysis was based on staffing standards initially developed in 1986 (standards reviewed and modified by an outside panel of national experts), subsequently updated in 1998, and reviewed again for the purposes of the new study. The report compared available direct care positions to recommended levels by service type, distinguishing Perkins and the RICAs. The results are detailed in **Exhibit 7**.

Exhibit 7
State-run Psychiatric Facilities
Staffing Shortfalls
Fiscal 2007



RICAs: Regional Institutions for Children and Adolescents
 FTEs: full-time equivalent positions

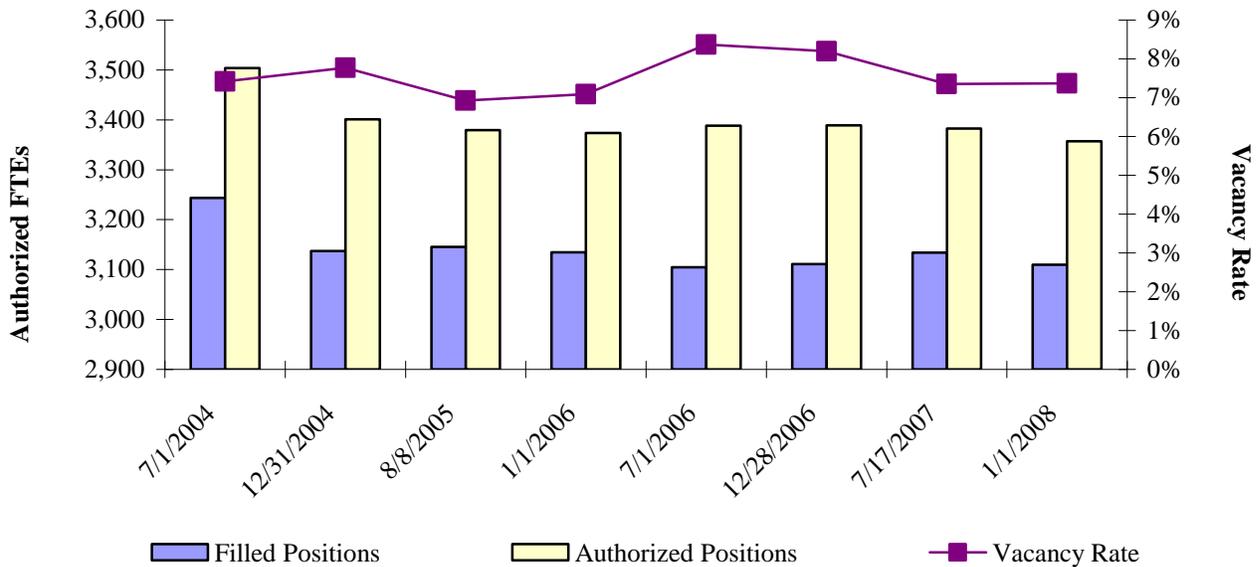
Source: Mental Hygiene Administration Staffing Study 2007

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As shown in the exhibit, there are shortfalls (some extremely significant) throughout the facilities in terms of available staff. Total staff shortfalls reach almost 400 full-time equivalent positions (FTEs). Further, as the report notes, lack of information about current vacancy levels, understates the staffing shortfall.

The data provided in **Exhibits 8 and 9** underscores this. While, as shown in Exhibit 8, MHA’s vacancy rate since the beginning of fiscal 2005 (after the closure of Crownsville) is relatively unchanged compared to the beginning of fiscal 2008, in those three-and-a-half years MHA has lost 146.2 FTE authorized positions and, more importantly, has 133.8 FTE fewer filled positions. Similarly, Exhibit 9 provides vacancy (end of calendar year vacancy rates) and turnover (the number of separations during the calendar year compared to authorized positions) data for Registered Nurses (RN) and Licensed Practical Nurses (LPN) for the past three calendar years. Vacancy rates among nurses (RN and LPN) are higher than for the agency as a whole, and employee churn is significant. Improvement in RN vacancy rates from calendar 2006 to 2007 is derived only from a drop in authorized positions (45 FTEs). Constant turnover not only adds the burden of ongoing training, it also inhibits consistency in the provision of care and requires the extensive use of overtime (which long-term can be a problem) as well as contract staffing.

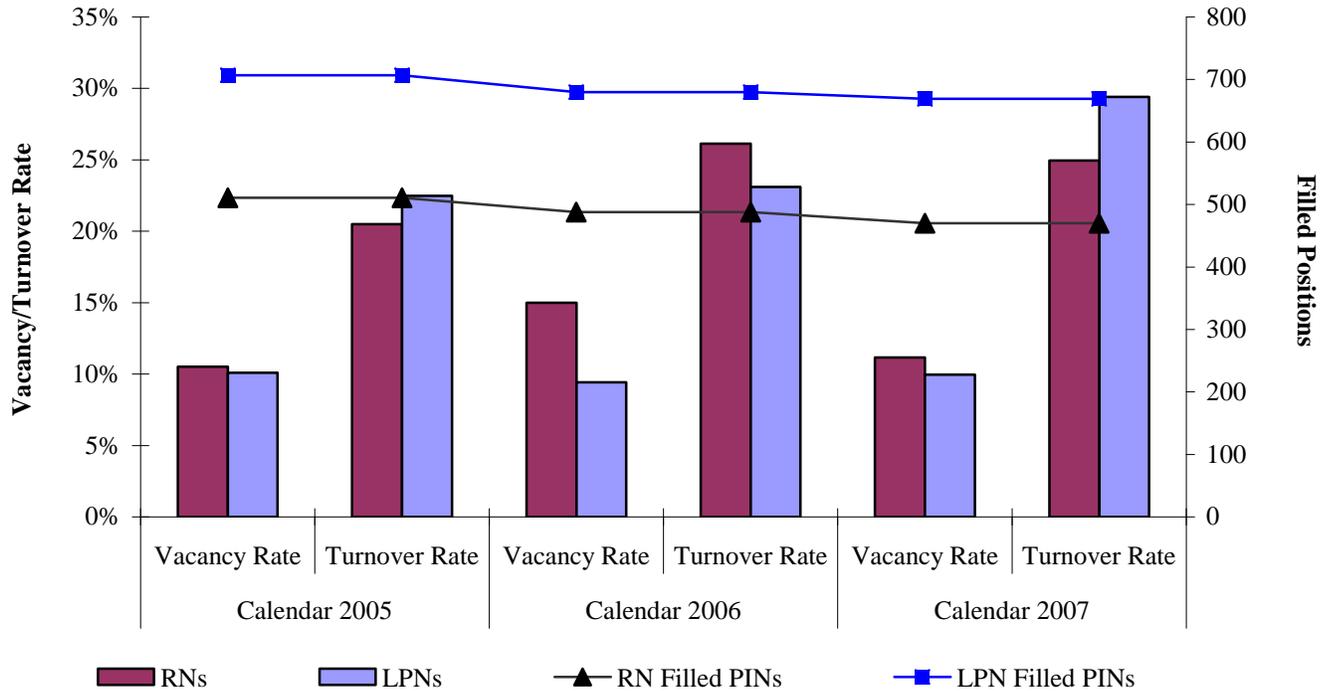
**Exhibit 8
Mental Hygiene Administration Vacancy Rate
Fiscal 2004-2008**



FTEs: full-time equivalent positions

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

**Exhibit 9
MHA Nurse Vacancy and Turnover Rates
Calendar 2005-2007**



MHA: Mental Hygiene Administration
 RN: Registered Nurses
 LPN: Licensed Practical Nurses

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

It should also be noted that this most recent staffing analysis was done prior to the reductions made by the Board of Public Works (BPW) in July 2007, those expected by BPW in January 2008, and those contained in the proposed budget. These actions combine to cut an additional 18.5 FTE direct care positions (direct care assistants, nurses, and other health care professionals). Rather than adding staff, staffing levels are actually going in the opposition direction. The report noted that it would require the closure of 248 beds systemwide to meet recommended staffing levels absent adding additional staff. As noted above, some reductions in capacity have taken place, but reductions of the magnitude recommended by the report are unlikely given current demand for inpatient care. Thus, understaffing of State-run psychiatric facilities will continue, most especially at Springfield, Spring Grove, and Perkins.

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The report's analysis of understaffing at Perkins is notable because there has been a steady increase in forensic patients entering the State-run psychiatric hospital system in recent years. The department has acknowledged the need for more forensic beds at Perkins and an additional maximum security wing is being constructed. Having secured the funding for the capital construction, the department will need to work to staff the new beds.

The Department of Health and Mental Hygiene (DHMH) is obviously aware of the need to recruit and retain direct care staff. Although direct care positions have been generally exempted from the State's recent hiring freeze, facilities have struggled to hire direct care workers in what is a competitive marketplace despite recent annual salary review (ASR) increases and other initiatives. A more thorough review of staffing recruitment and retention issues is merited. **The Department of Legislative Services (DLS) recommends incorporating State-run psychiatric facility staffing issues into the work of the Maryland Health Care Commission-convened (MHCC) task force that is developing a plan for the appropriate continuum of mental health services in Maryland.**

Facility Outcomes

Has quality of care been compromised as a result of staffing shortages? If so, it should be reflected in such things as loss of the Joint Commission on Accreditation of Healthcare Organizations accreditation, higher rates of readmissions, greater use of seclusion and restraint, higher numbers of incidents of aggression, and so forth. In terms of outcomes, **Exhibits 10, 11, and 12** examine trends in three outcomes at the State-run psychiatric hospitals. For the purposes of this discussion, Perkins is excluded given the nature of programming at that facility.

Exhibit 10
State-run Psychiatric Hospitals Readmissions within 30 Days of Discharge
(Percent of Total Admissions)
Fiscal 2003-2007

	<u>2003</u>	<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>Trend</u> <u>2003-2007</u>	<u>Trend</u> <u>2006-2007</u>
Carter	3.9%	2.3%	1.7%	4.0%	5.1%	X	X
Eastern Shore	6.5%	5.8%	2.0%	5.9%	7.5%	X	X
Finan	1.7%	1.5%	2.3%	2.2%	0.0%	√	√
Spring Grove	4.2%	3.6%	3.5%	3.6%	3.6%	√	No change
Springfield	5.5%	4.4%	4.6%	4.2%	7.5%	X	X
Upper Shore	5.0%	4.0%	1.3%	2.6%	5.7%	X	X

X: worsened

√: improved

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

Exhibit 11
State-run Psychiatric Hospitals: Use of Seclusion
(Rate Per 1,000 Patient Hours)
Fiscal 2003-2007

	<u>2003</u>	<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	Trend <u>2003-2007</u>	Trend <u>2006-2007</u>
Carter	0.48	1.16	0.62	0.25	0.40	√	X
Eastern Shore	0.76	1.58	2.77	0.55	0.32	√	√
Finan	0.17	0.17	0.15	0.08	0.03	√	√
Spring Grove	0.33	0.42	0.29	0.10	0.05	√	√
Springfield	0.38	0.38	0.29	0.29	0.19	√	√
Upper Shore	1.18	0.97	0.79	1.45	0.02	√	√

X: worsened

√: improved

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

Exhibit 12
State-run Psychiatric Hospitals: Elopements
(Number Per 1,000 Patient Days)
Fiscal 2003-2007

	<u>2003</u>	<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	Trend <u>2002-2006</u>	Trend <u>2005-2006</u>
Carter	0.39	0.50	0.05	0.28	0.46	X	X
Eastern Shore	0.22	0.36	0.21	0.11	0.04	√	√
Finan	0.34	0.25	0.18	0.15	0.23	√	X
Spring Grove	0.58	0.30	0.35	0.32	0.20	√	√
Springfield	0.47	0.64	0.63	0.51	0.32	X	√
Upper Shore	1.25	0.85	0.41	0.92	0.50	√	√

X: worsened

√: improved

Note: Elopement is generally considered as a client who is absent, unaccounted for, not found on the grounds, or has left the grounds without permission.

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

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

- The most disturbing trends concern readmissions within 30 days. Both long- and short-term trends are generally worsening although all facilities remain below the national benchmark for readmission rates. The change is particularly noticeable compared to fiscal 2005 when most facilities achieved their lowest readmission rates. According to the most recent Substance Abuse and Mental Health Services Administration (SAMHSA) data, for 45 reporting states and jurisdictions (including Maryland), 8% of patients returned to a state hospital within 30 days of discharge. MHA has concerns about readmissions as a measure on the grounds that patients admitted to an acute general hospital psychiatric unit within 30 days of discharge will not be captured in the data while areas without such units would more likely see readmissions to the State facility. **If MHA does not like this measure, it should suggest alternative measures to be used in the Managing for Results to indicate performance at its State-run psychiatric facilities.**
- Trends in the use of seclusion and elopements are generally favorable. In terms of seclusion, all facilities fall below the national benchmark of 0.6 per 1,000 patient hours.

Fiscal 2008 Actions

Impact of Cost Containment

BPW actions in July 2007 reduced MHA's fiscal 2008 budget by almost \$7.5 million. Of this amount, \$6.0 million (\$3.0 million general funds and \$3.0 million federal funds) represented the imposition of hospital day limits for the whole of the fiscal year. The fiscal 2008 allowance removed hospital day limit cost containment that had been in place for several years. During budget deliberations, the legislature re-imposed partial cost containment (for seven months of fiscal 2008). BPW action implements that cost containment for the whole of fiscal 2008. The fiscal 2009 budget continues the cost containment through the first half of fiscal 2009.

Other July 2007 cost containment actions saw the abolition of positions including six at Spring Grove Hospital as well as operating reductions (travel, turnover, fleet vehicles, etc.) across the State-run psychiatric facilities.

Additional cost containment action taken by the legislature during the 2007 special session will result in the abolition of an additional 13.55 FTE positions (2.5 FTEs in headquarters, with the remainder spread between Carter, Springfield, Spring Grove, and Perkins).

Governor’s Proposed Budget

As shown in **Exhibit 13**, the Governor’s fiscal 2009 allowance for MHA shows an increase of almost \$46 million (5.1%). Absent the distortion caused by the disparate funding of employee and retiree health insurance and the Other Post Employment Benefits (OPEB) liability, growth is much lower at almost \$30.9 million (3.6%). Key budget changes are detailed below.

Personnel Changes

In addition to changes driven by employee and retiree health insurance and OPEB liability funding, the fiscal 2009 budget includes just over \$2.1 million to offset one-time fiscal 2008 hiring freeze savings and \$889,000 in increased overtime to better reflect actual utilization. The budget also includes 6 FTE new positions to support a Veteran’s Mental Health initiative (discussed further below). However, these new positions are more than offset by 29.55 FTE abolitions, primarily from the facilities. As noted above, 13.55 FTE positions are expected to be abolished by BPW in January 2008. An additional 16 FTE positions are abolished as part of the fiscal 2009 budget (from Carter, Finan, Spring Grove, and Perkins). While not all of these positions are direct care staff, given the prior discussion about staffing levels, these reductions seem likely to exacerbate an already difficult situation. MHA has indicated that additional bed cuts are possible although no specifics are currently available.

Community Mental Health Services Fee-for-service Expenditures: *Déjà Vu* All Over Again?

The funding available for the fee-for-service component of the public mental health system increases by just over \$20.0 million (this represents funding for both Medicaid-eligible and Medicaid-ineligible clients). Based on current estimates of fiscal 2008 expenditures in the fee-for-service system, DLS estimates that the cost of providing rate increases for rate-regulated and cost-settled services as well as a 1.5% cost-of-living adjustment (COLA) for all other services is \$11.7 million. After adding in the funding to eliminate hospital day limit cost containment measures effective January 1, 2009, there is only \$2.8 million remaining for increased enrollment and utilization. Given current enrollment and utilization trends (discussed above), it is highly unlikely that this funding will be adequate to avoid deficits, albeit small, in fiscal 2009.

Exhibit 13
Governor’s Proposed Budget
DHMH – Mental Hygiene Administration
(\$ in Thousands)

How Much It Grows:	<u>General Fund</u>	<u>Special Fund</u>	<u>Federal Fund</u>	<u>Reimb. Fund</u>	<u>Total</u>
2008 Working Appropriation	\$623,262	\$5,000	\$259,459	\$5,917	\$893,638
2009 Governor’s Allowance	<u>653,369</u>	<u>5,280</u>	<u>271,993</u>	<u>8,773</u>	<u>939,415</u>
Amount Change	\$30,107	\$280	\$12,533	\$2,856	\$45,776
Percent Change	4.8%	5.6%	4.8%	48.3%	5.1%

Where It Goes:

Personnel Expenses	\$17,072
Health insurance: reduce long-term Other Post Employment Benefits liability.....	\$11,008
Employee and retiree health insurance pay-as-you-go costs	4,172
Fiscal 2008 Budget Section 45 one-time hiring freeze savings	2,129
Increments and other compensation.....	1,509
Overtime	889
New positions for Veterans Mental Health Initiative (6 full-time equivalent (FTE))	367
Other fringe benefit adjustments.....	-37
Workers’ compensation premium assessment	-413
Turnover adjustment	-1,087
Abolitions (29.55 FTE: 2.5 FTE headquarters and 27.05 FTE facilities).....	-1,465
Community Mental Health Services	\$27,897
<i>Fee-for-service Expenditures</i>	
Rate increase/provider cost-of-living-adjustment (varies by service)	11,694
Elimination of hospital day limit cost containment effective 1/1/2009	5,625
Enrollment and utilization	2,809
<i>Grants and Contracts</i>	
Residential Treatment Center Diversion Waiver Demonstration Project (federal and reimbursable funds)	5,608
Veterans Mental Health Initiative (excluding personnel costs).....	3,085
Grants and contracts provider cost-of-living-adjustment.....	743
Baltimore City peer support and advocacy (federal funds)	252
Community Mental Health Services Block Grant (federal funds).....	-1,919

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Where It Goes:

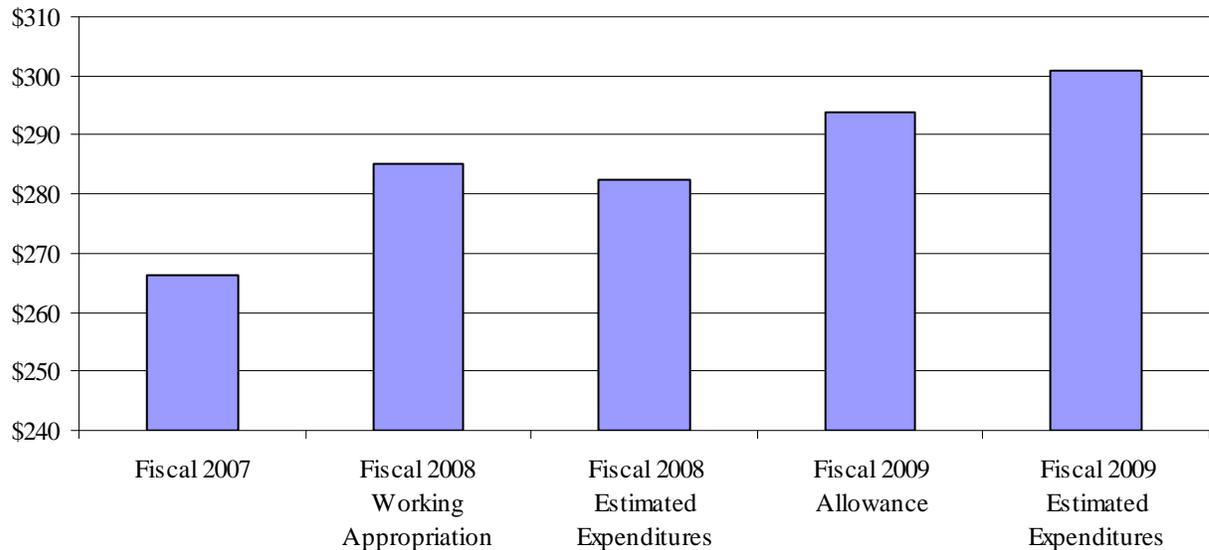
State-run Psychiatric Facilities	\$900
Medical contracts.....	644
Maryland Environmental Service charges.....	388
Out-sourcing laboratory testing at Spring Grove Hospital.....	242
Medical contractual support.....	239
Housekeeping contract at Carter.....	171
Food and dietary costs.....	141
Office supplies.....	139
Building repairs and maintenance across the facilities.....	114
Contractual employment and turnover adjustments.....	-363
Fuel and utilities.....	-815
Other	
Other.....	-93
Total	\$45,776

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

Exhibit 14 provides an analysis of general fund adequacy in the fee-for-service system. In the exhibit, fiscal 2008 expenditures are estimated based on the most recent estimates of expenditures for fiscal 2007 adjusted for rate increases, provider COLAs, and enrollment/utilization increases of 2% in the Medicaid-eligible population and no growth in the Medicaid-ineligible population. As shown in the exhibit, under these assumptions, the fiscal 2008 appropriation appears adequate; indeed there is potentially a small surplus. However, in a cautionary note, weekly and monthly expenditure data from fiscal 2008 would indicate that MHA will do well to stay within budget.

Looking specifically at the fiscal 2009 budget, building off estimated fiscal 2008 expenditures and assuming rate increases, provider COLAs, and enrollment/utilization increases of 3.5% in the Medicaid-eligible population and no growth in the Medicaid-ineligible population, the general fund appropriation appears slightly below (\$7 million) what appears to be required for fiscal 2009.

Exhibit 14
Community Mental Health Services Fee-for-service Funding
General Fund Adequacy
Fiscal 2007-2008
(\$ in Millions)



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

Three other points need to be made about the fiscal 2009 community mental health fee-for-service budget:

- Beginning in fiscal 2008 and fully-implemented in fiscal 2009, MHA has stopped seeking federal fund participation for targeted case management services (a variety of services that seek to coordinate the delivery of Medicaid and non-Medicaid services). This change was prompted by a decision by the federal Centers for Medicare and Medicaid Services (CMS) to change the reimbursement for case management from a monthly rate to a rate based on 15-minute service times. According to MHA, this change would have resulted in a 30% to 50% reduction in the compensation rate to providers. Thus, MHA decided to withdraw mental health case management services from the Medicaid State Plan. Case management services will continue to be provided, but through State funds only.

However, it should be noted that the general funds available to back fill the loss of federal funds falls below the actual level of spending on targeted case management in fiscal 2007. Overall, this reduction represents a loss of between 20% to 30% of available funding, and MHA has imposed spending cuts on providers.

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- There is no funding specifically in the MHA budget for Medicaid expansion as authorized by Chapter 7 of the 2007 special session. DHMH indicates that at this point all expenses related to the expansion (including specialty mental health expenditures) are being budgeted in the Medical Care Programs Administration in order to determine actual experience.
- As noted above, in addition to cost-settled and regulated rate increases, the allowance includes funding for a 1.5% COLA for other providers. In fiscal 2007, the first year that MHA had been able to provide a COLA for several years, MHA implemented differential rate increases for certain services (family psychoeducation, assertive community treatment, and supported employment) that were utilizing evidence-based practices (EBPs). Those differential rates continue and the University of Maryland, Baltimore annually monitors those programs receiving the EBP rate to ensure fidelity to the EBP model. Indeed, MHA won a national award from the federal SAMHSA for its supported employment EBP.

The literature notes the importance of using EBPs for treatment efficacy. Additionally, as noted in last year's analysis, at this point EBPs are a proxy for performance in these services until the OMS can provide more concrete provider performance data. In fiscal 2008, MHA indicated that it was contemplating adding other differential rates for EBPs, specifically for children's respite services and co-occurring substance abuse/mental illness. Ultimately, MHA chose not to do this. However, in a report requested by the committees on the expansion of EBPs, DHMH indicated that it anticipated implementation of these enhanced rates in fiscal 2009.

Implementing EBPs for persons with co-occurring substance abuse/mental illness would appear to be an important advance for MHA. The legislature, through the Joint Committee on Access to Mental Health Services, encouraged this in its 2007 interim report. Conversations with CSAs indicate that this is a population that is imposing the most demand on their resources. The treatment of this population, according to SAMHSA, is a relatively new field, and the development and testing of a large number of EBPs for this population has not been possible. However, SAMHSA does provide certain treatment and program elements that show success for co-occurring substance abuse and mental illness.

Unfortunately, MHA indicates that it does not believe that there is sufficient funding available in the fiscal 2009 budget to implement differential rates for co-occurring substance abuse/mental illness services. Thus, the State finds itself unable to fund practices which are clinically shown to be successful.

Community Mental Health Services Grants and Contracts

RTC Waiver Demonstration Project

The largest increase in community mental health grants and contracts is \$5.6 million in a combination of reimbursable and federal funds for the RTC Waiver demonstration project. The reimbursable funds (representing the State match) are Rehabilitation Option funds (pursuant to Chapter 428 of 2003) from the Interagency Fund. The waiver was officially approved by CMS in later December 2007.

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To date, expenditures have focused on making computer changes and recruiting providers and youth. It is unlikely that all of the funding provided in fiscal 2008 will be required as the program will not begin to serve youth until the end of the fiscal year at the earliest. Initially, services will be offered to 50 youth in Baltimore City and Montgomery, St. Mary’s, and Wicomico counties, although it is hoped that 87 youth will be served for much of fiscal 2009. DLS would note that the MHA budget assumes that all of the services offered under this waiver project will be eligible for federal funds. However, discussion with MHA indicates that about 20% of per youth costs are ineligible for federal fund attainment.

Veterans Mental Health

The major new initiative in the MHA budget is an effort to improve access to mental health services for veterans (separate legislation (SB 210/HB 372) to establish the program has also been introduced). Personnel and service funding for this initiative is just under \$3.5 million. The intent of the program is two-fold: to link veterans to mental health services provided by the U.S. Department of Veterans Affairs (VA) through the employment of six FTE resource coordinators; and providing gap services if there is delay in service provision from the VA. MHA envisages providing a wide array of services: crisis intervention, individual, group, and family therapy, substance abuse early intervention and detoxification services, and medications until a veteran can access VA care.

Specific spending components of the plan are shown in **Exhibit 15**.

Exhibit 15
Veterans Mental Health Initiative
Proposed Program Components and Funding

<u>Item</u>	<u>Funding Level</u>
Salary and fringe benefits (six full-time equivalent positions)	\$386,655
Various contract expenses (Administrative Services Organization computer configurations, web-based resource site, transportation, and medication)	400,000
Crisis services	1,600,000
<i>Crisis Hotline</i>	100,000
<i>Residential Crisis Services</i>	750,000
<i>In-home Support Services</i>	750,000
Short-term mental health and substance abuse evaluation and treatment services	1,000,000
Miscellaneous office and equipment costs and other contract expenditures	84,820
Total	\$3,471,475

Source: Department of Legislative Services; Mental Hygiene Administration

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Three aspects of this initiative merit comment.

- There is little argument that significant numbers of military personnel returning from recent overseas operations in Iraq and Afghanistan have mental disorders. The VA's web site identifies one-third of all combat veterans as having a mental disorder. Data indicates that 10% to 15% of combat veterans have post-traumatic stress disorder (PTSD) and another 10% have signs of PTSD, depression or anxiety and may benefit from some type of care. Co-occurring substance abuse problems are also common among this population as are high suicide rates and levels of homelessness.

There is also no dispute that all military personnel returning from Iraq and Afghanistan are eligible for VA services. The VA has responded to growing concerns about PTSD and other mental disorders among this population by establishing dozens of PTSD programs as well as counseling centers. They also offer pre- and post-deployment health assessment programs that seek to destigmatize mental health treatment and have simplified access to VA care for combat veterans after discharge. The VA notes that these additional efforts should lower the high rates of PTSD noted above.

Inevitably, there are tragic cases (including cases in Maryland) of veterans who, for whatever reason, do not get the care they are entitled to from the VA. The VA has responded with aggressive outreach programs to ensure veterans understand the benefits they are entitled to, and the federal government is adding funds to provide behavioral health service to veterans.

However, there is evidence to suggest that the VA has not responded adequately to the demand for services. The Government Accountability Office for example, has been critical of VA's spending of mental health earmarks. In 2006 alone, the VA allegedly did not allocate \$42 million available for mental health spending and of the amount allocated did not spend \$46 million. One alternative for states may be simply to seek federal grants from Congress to provide the services for which the VA has the funding but apparently cannot spend.

Despite the documented need for mental health services that combat veterans are likely to require, it is difficult given the state's own financial issues to contemplate using state dollars to provide services to a population that should be accessing those services through the VA. Even DHMH concedes that it is the responsibility of the VA to provide necessary mental health services to eligible individuals.

- MHA has indicated that the intent of this program is to transition veterans to VA services. They intend to do this in a number of ways: developing a hot-line, providing web-based resources, and adding regional coordinators to determine a veteran's needs, provide gap services, and link the client to VA services. While there may be merit in adding a hot-line and web-based resource guide, it is unclear why an additional layer of bureaucracy needs to be added to the existing state and federal infrastructure for accessing mental health services.

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Specifically, Maryland has a statewide CSA system. In addition to its own web-based resource guide, the VA has a network of facilities including:

- two medical centers (Baltimore and Perry Point, with Baltimore as one of the VA's designated PTSD centers);
- nine outpatient clinics (Loch Raven, Cambridge, Charlotte Hall, Cumberland, Fort Howard, Glen Burnie, Greenbelt, Hagerstown, and Pocomoke); and
- five Vet Centers offering readjustment counseling and outreach services (Aberdeen, Baltimore, Cambridge, Elkton, and Silver Spring).

In addition, there are other geographically proximate facilities in neighboring states and the District of Columbia.

- While there is data concerning prevalence of PTSD and mental disorders among combat veterans and MHA estimates 10,000 Marylanders have served in Iraq and Afghanistan with 5,000 more expected to return from those theaters by the end of 2008, it is unclear how the gap funding estimate has been derived. Even assuming that 25% of this population would need treatment for PTSD or other mental disorders and that half of this population was not able to initially access care through the VA, based on current average service expenditure rates for crisis and outpatient therapy and providing gap services for three months, expenditures of \$1.2 million appear more reasonable than the \$2.6 million proposed.

Thus, even though this is a federal responsibility, if the State is going to provide gap services DLS recommends:

- **deleting five FTE regional coordinators and utilizing the existing statewide infrastructure to provide access to gap services; and**
- **reducing funding for gap services based on an estimate of take-up and current service cost.**

Further, the State should seek reimbursement from the federal government and any other insurer for all costs incurred in providing services to veterans. **DLS recommends committee narrative requesting MHA to report back to the committees on program expenditures and specific efforts to seek reimbursement for these expenditures.**

Community Mental Health Services Block Grant Funding for the Emergency Department Diversion

During budget deliberations in the 2007 session, one area of concern for the committees was emergency department (ED) overcrowding. This was not a new issue, and the committees ultimately asked MHCC to convene a task force of interested parties to develop a plan for the appropriate

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continuum of mental health services in Maryland. This request was based on an MHCC report on the pressures faced by EDs that recommended that MHA develop a plan to guide the future role and capacity of State-run psychiatric hospitals. In order to do this, MHA essentially has to plan for the entire continuum of mental health services (public and private). The MHCC-convened task force was expected to report back to the legislature by November 1, 2007, but an extension of that deadline was requested and granted. The report is now expected by December 1, 2008.

MHA had, in any event, already begun several initiatives to divert patients from EDs. The fiscal 2008 budget analysis reported on initial efforts in Montgomery County (using recycled State grant funds), and MHA continued this initiative in Anne Arundel County and Baltimore City using \$1.5 million in previously unsubscribed Community Mental Health Services Block Grant Funding.

However, as noted in Exhibit 12, the fiscal 2009 budget contains just over \$1.9 million less in Block Grant funding than in fiscal 2008. This represents the \$1.5 million ED diversion initiative funding noted above plus an additional \$400,000 reduction based on a recalculation of the federal funding formula. The fiscal 2009 budget does not explicitly fund the initiative. Rather, MHA intends to continue the initiative through hoped-for savings in inpatient costs.

Facilities Funding

Other than personnel costs, there is little change in funding for the State-run psychiatric facilities. Inflationary increases in medical and food costs are to be expected. The housekeeping contract at Carter increases as a result of the Living Wage legislation enacted in 2007. Hourly wages under this contract will rise from \$6.65 per hour to \$11.30 per hour. Outsourcing of laboratory testing at Spring Grove shows an increase of \$242,000 in expenditures only because the savings are in the personnel line. Proposed expenditures for office supplies are up after one-time budget savings in fiscal 2008, but still remain significantly below the most recent actual.

Budget Summary

The MHA fiscal 2009 budget is a mixed bag:

- the provider COLA, while welcome, is unlikely to be seen as sufficient and is too small to allow MHA to further implement EBPs as it should be doing;
- fee-for-service community mental health funding is at best tight and most likely too small to meet current demand;
- staffing at State-run psychiatric facilities is inadequate;
- ED diversion initiatives begun in fiscal 2008 are not explicitly funded in fiscal 2009, although MHA indicates it will continue them by generating savings in inpatient costs;

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- the deleterious impact of CMS rules governing case management are avoided, but overall funding for case management falls below actual 2007 levels;
- effective January 1, 2009, the State is ending cost containment imposed on hospitals through day limits; and
- mental health services to veterans are expanded.

Issues

1. Utilization of Perkins Hospital in the Rosewood Closure Plan

In January 2008, the Governor announced the closure of the State Residential Center at Rosewood (see the analysis of the Developmental Disabilities Administration (DDA) budget for more details). As part of the closure plan, DHMH has indicated that it intends to use a vacant medium-security ward at Perkins for evaluation of forensic (court-involved) developmentally disabled individuals.

The ward at Perkins has been vacant for a considerable time. A number of years ago it was re-designed specifically to treat persons with developmental disabilities with the intent of transferring forensic patients from Rosewood to Perkins. However, such transfers ran into legal challenges, and the movement of patients did not occur. With the proposed closure of Rosewood, many of the previously-encountered legal obstacles are no longer pertinent, and DHMH indicates that it intends to operate 15 beds at Perkins for evaluation purposes. Funding for the positions associated with the operation of the ward is in the DDA budget.

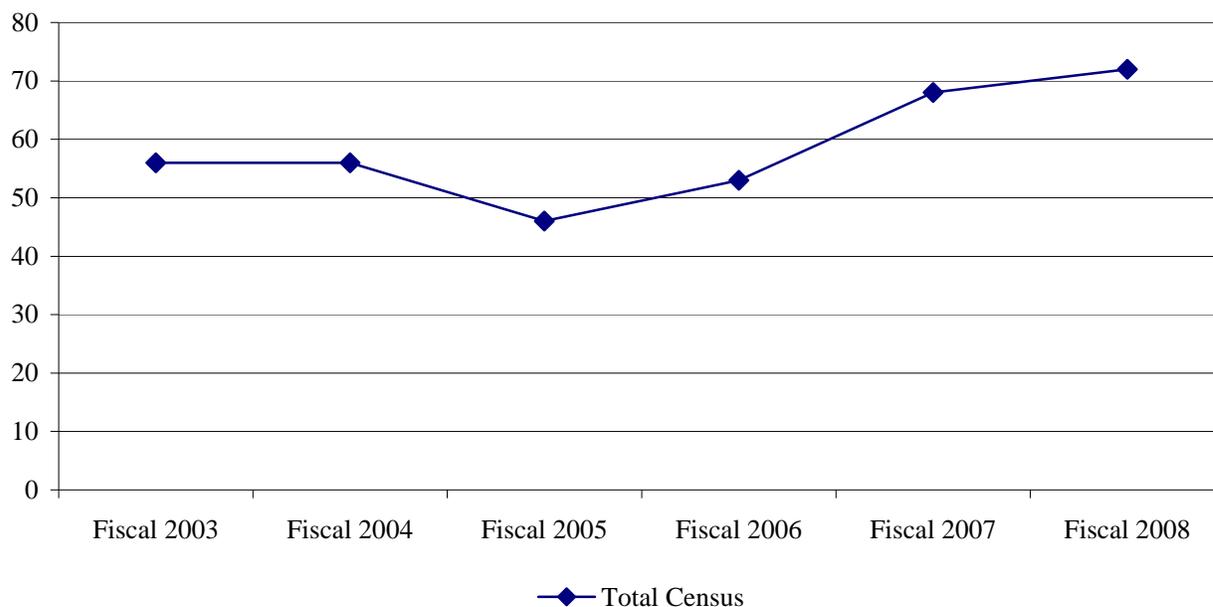
One concern about housing any persons with developmental disabilities at Perkins is how the ward will actually be used. While DLS' understanding is that the intent is to simply evaluate individuals and then transfer them to an appropriate placement, DDA does not have a good track record of prioritizing the movement of developmentally disabled eligible individuals out of State-run psychiatric facilities, especially those with forensic involvement.

Maryland has a longstanding practice of treating individuals with co-occurring mental illness and developmental disabilities at State-run psychiatric hospitals. However, when these individuals are considered to be treated for their mental illness and ready to move into a more appropriate placement, such placements are often difficult to make.

As shown in **Exhibit 16**, as of January 2008, 72 developmentally disabled individuals, eligible or pending eligibility, for either the full range of DDA services or individual support services were housed in State-run psychiatric hospitals. Additionally, 11 patients with Traumatic Brain Injury are also eligible for the full range of DDA services or individual support services. Over half of these individuals are forensic patients. Further, the average length of stay for these patients is considerable (6.6 years for those patients remaining in State-run psychiatric hospitals as of January 31, 2007 – the most recent date that analysis was done), and many wait long periods to be appropriately placed.

Clearly, it is the hope that the opening of the ward at Perkins for developmentally disabled forensic client evaluation will not exacerbate what is already a longstanding problem. **Further, DLS recommends DHMH develop a transition plan with the goal of moving developmentally disabled eligible individuals at State-run psychiatric facilities to an appropriate placement.**

Exhibit 16
Developmentally Disabled Eligible/Pending Eligibility Individuals in
State-run Psychiatric Facilities
Fiscal 2003-2008



Source: Mental Hygiene Administration

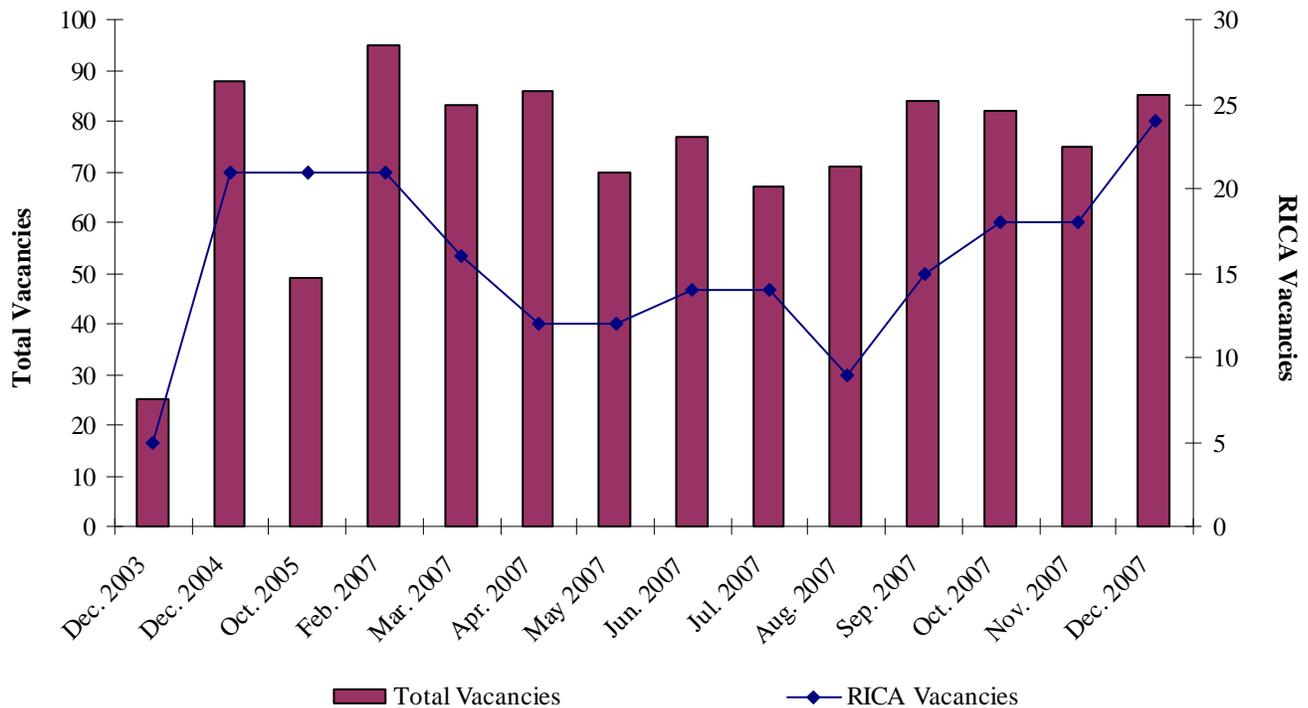
2. RTC Capacity

As noted in earlier discussions concerning staffing at State-run psychiatric facilities, budget reductions have forced the closure of beds at both State psychiatric hospitals and the three RICAs (or RTCs). Interestingly, MHA chose to reduce capacity at all three facilities rather than simply consolidating services at two locations. The impact of this is to drive up average costs at the facilities.

While facility closure can be both programmatically and politically difficult, at some point it has to be questioned whether facilities should remain open. In the case of the State RICAs, this question is especially pertinent because these facilities exist in parallel to a broader network of privately operated RTCs (nine facilities). **Exhibit 17** presents vacancy data for public and private RTCs. The data shows several things:

- Vacancy levels in the past 12 months are at or around the highest level they have been in several years.
- In recent months, vacancies at State RICAs have risen sharply.

**Exhibit 17
Public and Private Residential Treatment Center Vacancy Levels
Various Times**



RICA: Regional Institutions for Children and Adolescents

Note: Vacancies are as reported on the fifth of each month.

Source: Mental Hygiene Administration

- Vacancies at private RTCs are spread across facilities, although approximately half of the private RTC vacancies are at one facility: Potomac Ridge Eastern Shore.

Looking specifically at the State facilities, the number of youth served at RICA-Southern Maryland has fallen significantly in recent months to anywhere between 14 and 17. **Given the capacity that exists at other State facilities as well as private RTCs and also given the ongoing emphasis on RTC diversion both through Local Management Board funding and the new RTC Demonstration Waiver program, DLS recommends that the State close RICA-Southern Maryland.** Other programming in the buildings attached to RICA-Southern Maryland (special education programming operated by Prince George’s County public schools) can be continued if the county wishes to continue to utilize the facility at the county’s expense.

3. Integration of Care

One of the stark realities for people living with serious mental illness is their life expectancy is 25 years less than others in their age cohorts (even after adjusting for higher suicide rates and medication issues). Further, despite all the advances in care for the mentally ill, this difference is getting worse not better. Research indicates that persons with serious mental illness have high rates of diabetes, hypertension, cardiac disease, obesity, cancers, HIV infection, and Hepatitis. These health problems often go undiagnosed or untreated.

A growing number of states and the federal government have initiatives to integrate all aspects of care, including mental health care, for targeted groups. In some instances, these initiatives target specific populations that include persons with severe mental illness, for example, the federal Integrated Care Program grants that target dual eligibles (individuals covered by both Medicare and Medicaid). In other cases the focus is specifically on persons with serious mental illness who also have other multiple chronic conditions.

Examples of the latter types of programs include different types of integrated models:

- somatic care is embedded within a mental health program, or conversely mental health specialists are within a somatic care facility;
- single organizations that provide both types of care; and
- administrative collaborations between separate entities.

Integrated care programs can exist within behavioral carve-in or carve-out models and can operate through managed care or fee-for-service systems.

The Robert Wood Johnson Foundation in a 2007 research brief on the integration of publicly funded physical and behavioral health services, noted some commonalities across the different program approaches. For example, programs:

- used communication tools to effectively promote collaboration among individuals;
- relied heavily on evidence-based practices in clinical approaches to treatment; and
- utilized extensive case management services.

The Massachusetts Essential Care Medical Management Model

One example of a state that is using an integrated care model for individuals with multiple chronic conditions is Massachusetts. This program is targeted at Medicaid-eligible adults with chronic medical conditions, a high prevalence of mental health and substance abuse issues, and who

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have a history of frequent service utilization, high levels of treatment and medication non-compliance, and are likely to incur health care costs of more than \$20,000 in the next 12 months. Participation in the program is voluntary. Participants receive extensive case management services tailored to an individual's needs including appointment scheduling, accompanying participants to medical appointments, liaising between clinical staff and the individual, providing education on disease and lifestyle choices, and connecting the person with social service agencies.

Outcomes from the program are illuminating:

- program participants showed much lower use of all types of medical services (inpatient, outpatient, and ED) post-enrollment in the program compared to pre-enrollment;
- medication compliance improved;
- mental and physical functioning as measured on internationally recognized quality of life assessments improved; and
- per-month costs for program participants were 19% lower post-enrollment in the program compared to pre-enrollment.

Integrated Care in Maryland

There has been activity in terms of integrating mental health and somatic care in Maryland. For example:

- The Community Behavioral Health (CBH) Association has its own task force on integrated care that has been meeting for almost a year. Most of the individuals that CBH has been focused on appear to be the dually eligible Medicare and Medicaid population, identifying needed services that are not provided by the public mental health system or Medicare.
- In 2007, the Community Health Resource Commission made a three-year grant award to The Johns Hopkins Bayview Medical Center's outpatient mental health center to provide three new services for patients served in the program: health risk screening, primary care and preventive health services, and case management.

However, at this point it does not appear that the State is close to replicating some of the more intensive case management models found elsewhere that target persons with serious mental illness and multiple chronic physical health conditions. **Given the programs already implemented in other states, and the outcomes achieved by those programs, DLS recommends that the State consider identifying a small group of high-cost, chronically ill Medicaid-eligible recipients with both serious mental illness and multiple chronic physical health issues and develop a pilot intensive integrated care management program for implementation beginning in fiscal 2010.**

Recommended Actions

1. Add the following language:

It is the intent of the General Assembly that funding for Community Services (M00L01.02) and Community Services for Medicaid Recipients (M00L01.03) be expended in accordance with 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 budget committees of the change and the committees shall have 30 days to review and consider it before it becomes effective. In reporting any change, the department shall also include an assessment of the impact on clients and providers.

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 funding for community mental health services by more than \$500,000. The report should include the potential impact on clients and providers.

Information Request	Author	Due Date
Notification of changes impacting the funding of community mental health services	DHMH	As needed, with 30-day review prior to implementation

	<u>Amount Reduction</u>		<u>Position Reduction</u>
2. Reduce five new positions and associated office costs for the Veterans Mental Health Initiative. Existing State and U.S. Department of Veterans Affairs agencies can provide the necessary outreach and coordination.	\$ 273,123	GF	5.0
3. Reduce funding for gap services to veterans. The reduction of \$1.4 million is based on estimates of demand for services, current service costs, and an expectation that services will be provided for three months to bridge the gap to service provision by the U.S. Department of Veterans Affairs. This reduction still provides \$1.2 million for service expenditures.	1,400,000	GF	

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4. Reduce general funds based on sharing maintenance and related costs with tenants at the Carter Center. The maintenance budget for the Carter Center (maintenance, utilities, security, housekeeping, etc.) is just over \$2.4 million. Some of the costs are fully shared with tenants (for example, the new housekeeping contract) while others are either shared only with some tenants or not at all. This reduction simply shares all maintenance costs with tenants based on the amount of leased space (19.31% of total available space). The reduction in general funds can be back-filled by special fund attainment from tenants. Tenants include the University of Maryland Medical System and Baltimore City. 330,000 GF
5. Reduce funds for Maryland Environmental Service (MES) charges. The allowance includes just under \$900,000 in MES charges for the operations of water and wastewater plants. This represents an increase of 24% over charges for Crownsville in the last year when the site operated a psychiatric hospital with over 200 beds and water flows were four times current levels. The reduction aligns charges with the most recent actual. 280,000 GF
6. Adopt the following narrative:

Veterans Mental Health Initiative: The committees request that the Mental Hygiene Administration (MHA) report back to them by December 1, 2008, on the implementation of the proposed Veterans Mental Health Initiative, as well as utilization of services to date. Further, it is the intent of the budget committees that MHA seek reimbursement from the U.S. Department of Veterans Affairs and other payers as appropriate for services provided to veterans under this initiative. In the same report, MHA shall demonstrate how it is seeking reimbursement.

Information Request	Author	Due Date
Veterans Mental Health Initiative	MHA	December 1, 2008

7. Adopt the following narrative:

Transition Plan for Developmentally Disabled-eligible and Pending Eligibility Individuals in State-run Psychiatric Facilities: The committees are concerned about the number of developmentally disabled-eligible or pending eligibility individuals in State-run psychiatric facilities and the long delays often facing these individuals before they can be appropriately placed. Such individuals enter State-run psychiatric facilities dually diagnosed with mental illness and developmental disability and, after treatment, are developmentally disabled-eligible or pending eligibility. The Department of Health and Mental Hygiene (DHMH) is requested to develop a transition plan to facilitate the movement of these individuals into appropriate placements.

Information Request	Author	Due Date
Transition Plan for Developmentally Disabled-eligible and Pending Eligibility Individuals in State-run Psychiatric Facilities	DHMH	December 1, 2008

8. Adopt the following narrative:

Pilot Integrated Care Management Program: The committees are interested in examples from other states where groups of Medicaid-eligible high-cost users of mental health and physical health services enter intensive care management programs aimed at improving health outcomes as well as reducing overall health costs. The committees request the Department of Health and Mental Hygiene (DHMH) develop a pilot integrated care management program for persons with serious mental illness and chronic physical health issues for implementation in fiscal 2010. DHMH should update the committees on the status of plans to develop such a program by January 1, 2009.

Information Request	Author	Due Date
Pilot Integrated Care Management Program	DHMH	January 1, 2009

9. Add the following section:

SECTION X. AND BE IT FURTHER ENACTED, That 72.5 full-time equivalent regular positions, \$5,500,000 in general funds, \$2,500 in special funds, and \$41,208 in federal funds shall be reduced from the budget for the Regional Institute for Children and Adolescents (RICA)-Southern Maryland (M00L14.01). Remaining funds may only be used to serve children and adolescents at other residential treatment centers or community-based services.

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Explanation: The language deletes all of the positions and reduces most of the funding provided in the fiscal 2009 allowance to operate RICA-Southern Maryland. Some funding is provided to serve children and adolescents that might otherwise have been placed at RICA-Southern Maryland in alternative residential or community-based settings. General fund savings will be slightly offset by loss of hospital patient recoveries (just over \$1.3 million in fiscal 2007).

Total General Fund Reductions	\$ 2,283,123	5.0
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Updates

1. Mental Health Transformation Grant

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

Recent activities funded through the transformation grant include:

- the MHCC-directed study to determine what the State’s mental health continuum should look like;
- an examination of children on welfare with mental health issues;
- examining examples of recovery and learning how planning can be guided by those examples;
- examinations of health care disparities in the mental health area and the issue of culturally competent treatment;
- improving web-based resources through the development of Networks of Care web sites (one-stop shops for information about mental health services); and
- Mental Health First Aid.

Of these activities, the Mental Health First Aid initiative has perhaps received the most attention because it comes as a response to the 2007 Virginia Tech shooting. Mental Health First Aid (MHFA) is the help provided to a person developing a mental health problem or in a mental health crisis and is given until appropriate professional treatment is received. While individuals are often knowledgeable of common physical health problems, there is widespread ignorance of mental health problems. In an effort to assist individuals in providing initial support for someone with a mental health problem, a MHFA training course has been developed and implemented in every state and territory in Australia. Participants in the course include teachers, nurses, government employees, and members of the general public.

Through the State’s federal Transformation Grant, DHMH has developed a Memorandum of Understanding between DHMH and the MHFA program in Australia. DHMH has pursued this effort to make the public more aware of mental illness and the resources available to individuals and their families. Representatives from DHMH attended a meeting along with 12 other states at which individuals from Australia presented information on the MHFA. In collaboration with the University of Maryland, Baltimore’s Department of Psychiatry, DHMH will evaluate and support a MHFA program that is designed to meet Maryland’s needs.

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 2007					
Legislative Appropriation	\$598,274	\$3,408	\$249,780	\$3,996	\$855,458
Deficiency Appropriation	0	373	1,164	0	1,536
Budget Amendments	-3,489	1,339	5,767	1,600	5,217
Reversions and Cancellations	-2	-358	-3,390	-124	-3,874
Actual Expenditures	\$594,784	\$4,761	\$253,320	\$5,472	\$858,338
Fiscal 2008					
Legislative Appropriation	\$623,164	\$4,995	\$260,948	\$5,242	\$894,349
Cost Containment	-4,497	0	-3,000	0	-7,497
Budget Amendments	4,595	5	1,511	675	6,786
Working Appropriation	\$623,262	\$5,000	\$259,459	\$5,917	\$893,638

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

Fiscal 2007

The fiscal 2007 legislative appropriation for MHA was increased by just under \$2.9 million. This increase was derived as follows:

- Deficiency appropriations added just over \$1.5 million. Of this amount, just under \$1.2 million were federal funds derived from a variety of grants for such things as wraparound services as an alternative to placement in a residential treatment center, respite care, counseling for families relocated to Maryland as a result of Hurricane Katrina, support for patients with traumatic brain injuries, and other administrative services. The special fund deficiencies related to various expenses throughout the State-run psychiatric facilities.
- An increase of just over \$5.2 million through budget amendments. Specifically:
 - General fund budget amendments reduced the legislative appropriation by almost \$3.5 million. This increase is almost entirely explained by several large amendments. Four increased the appropriation. First, almost \$3.0 million represents MHA's share of the fiscal 2007 COLA originally budgeted in the Department of Budget and Management (DBM). Second, \$2.3 million in surplus general funds was transferred from the AIDS Administration to support higher than budgeted utility costs throughout the facilities. Third, just over \$1.2 million represents MHA's share of fiscal 2007 ASRs and other salary adjustments. Finally, an additional \$619,000 was transferred into MHA from other parts of DHMH to fully meet the agencies fiscal 2007 COLA requirements.

More than offsetting this increase were actions in five other amendments. In three instances, DHMH switched general funds out of MHA to support other programs: a grant to Prince George's Hospital Center (\$3.0 million); to provide DDA with additional funding in order to pay the State portion of a 6% fee that is imposed on all intermediate care facilities for the mentally retarded in order to generate additional revenues into the State General Fund (\$1.5 million); and to support the Maryland Children's Health Program (\$1.4 million). In each case, the general funds were backfilled by available federal funds based on higher than anticipated prior year federal fund attainment.

In two other amendments, additional reductions were taken without a corresponding offset of federal funds: almost \$4 million as part of fiscal 2007 close-out (primarily from lower than anticipated expenditures on contractual services); and \$686,000 in cost containment reductions taken by BPW in February 2007.

- Special fund budget amendments increased the legislative appropriation by just over \$1.3 million. The major change was the increase of just under \$1.3 million derived from local education agencies (primarily Baltimore County) to cover the cost of educational services provided at RICA-Baltimore. In 2005 Budget Reconciliation and

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Financing legislation, DHMH was prohibited from billing local education agencies for services at the three State-operated RICAs. However, local education agencies retained the discretion to fund services at those facilities that would otherwise not be provided without local support. DHMH did not anticipate that these funds would be received in fiscal 2007. However, at RICA-Baltimore, locally funded services have continued to be provided.

- Federal fund budget amendments added just under \$5.8 million to the legislative appropriation. This was almost entirely derived from the back-filling of general fund reductions noted above as well as a slight offset (\$110,000) based on lower than anticipated Mental Health Transformation Grant expenditures.
- Reimbursable budget amendments added just over \$1.6 million to the legislative appropriation. The largest amendments added almost \$1.1 million for the provision of mental health services at the Hickey School, \$280,000 for emergency preparedness training, and \$100,000 related to a study of supported employment services. The remaining funds were derived from a variety of sources to support such things as higher fuel and utility expenses.
- The increase to the legislative appropriation derived from deficiencies and budget amendments was partially offset by almost \$3.9 million in reversions and cancellations. Virtually all of this, almost \$3.4 million, relates to overestimation of budgeted federal fund attainment in the fee-for-service community mental health services program.

Fiscal 2008

To date, the fiscal 2008 legislative appropriation has been reduced by \$711,000. This change reflects:

- Cost containment taken by BPW in July 2007 totaling almost \$7.5 million.
- Cost containment reductions have been partially offset by just under \$6.8 million in budget amendments. Specifically:
 - General fund budget amendments have increased the appropriation by just under \$4.6 million. Of this amount, the major amendments are just over \$3.3 million representing MHA's share of the fiscal 2008 COLA originally budgeted in DBM; and a little under \$1.3 million due to the reallocation of utility costs from DHMH Operations to the various State-operated Psychiatric Facilities.
 - A federal fund budget amendment of just over \$1.5 million from available Community Mental Health Block Grant funds added to expand Emergency Department diversion programs.

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- \$675,000 in reimbursable funds from the Department of Public Safety and Correctional Services added to operate the Chrysalis House. Chrysalis House provides mental health, substance abuse, parenting, child care, and educational services to pregnant and post-partum women and their children.

Audit Findings

Unit	Spring Grove Hospital Center
Audit Period for Last Audit:	April 18, 2003 – June 15, 2006
Issue Date:	April 2007
Number of Findings:	10
Number of Repeat Findings:	2
% of Repeat Findings:	20%
Rating: (if applicable)	n/a

- Finding 1:** Pharmaceutical invoices were paid without verifying that the costs charged were proper. The center agreed with the finding and the recommendation for remediation.
- Finding 2:** Invoices paid for certain laboratory testing services lacked adequate verifications. The center agreed with the finding and recommendations for remediation.
- Finding 3:** The center did not obtain specific budgetary authorization to use general funds totaling an estimated \$196,000 to subsidize certain costs incurred related to the operation of its employee and visitor cafeteria. The center agreed with the finding and the recommendation for remediation.
- Finding 4:** The center circumvented State procurement regulations and did not obtain required approvals from BPW and the Department of General Services for certain procurement transactions. The center did not fully agree with this finding, arguing that it did not divide contracts in order to avoid required approvals and it did not avoid the competitive bidding process. However, other aspects of the finding and concomitant recommendations the center did agree with.
- Finding 5:** **The center did not adequately monitor and take effective corrective actions to ensure that overtime costs did not exceed budgetary estimates. This item relates to hospital support positions (e.g., maintenance and housekeeping) rather than clinical positions. The center agreed with the finding and the recommendation for remediation.**
- Finding 6:** The center lacked adequate internal controls over its regular employee payroll. The center agreed with the finding and the recommendation for remediation.
- Finding 7:** **The center did not properly control and account for equipment items totaling \$1.1 million received from Crownsville Hospital Center. In addition, the center did not conduct physical inventories of equipment and maintain certain records**

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as required. The center agreed with the finding and the recommendation for remediation.

Finding 8: Materials and supplies inventories were not adequately controlled. The center agreed with the finding and the recommendation for remediation.

Finding 9: The center's motor vehicle fleet was significantly underutilized. The center did not agree with the finding.

Finding 10: The center lacked adequate controls over certain cash receipts. The center agreed with the finding and the recommendation for remediation.

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

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

<u>Object/Fund</u>	<u>FY07 Actual</u>	<u>FY08 Working Appropriation</u>	<u>FY09 Allowance</u>	<u>FY08-FY09 Amount Change</u>	<u>Percent Change</u>
Positions					
01 Regular	3389.05	3357.25	3333.70	-23.55	-0.7%
02 Contractual	237.96	242.77	230.75	-12.02	-5.0%
Total Positions	3627.01	3600.02	3564.45	-35.57	-1.0%
Objects					
01 Salaries and Wages	\$ 219,402,845	\$ 218,405,046	\$ 235,476,955	\$ 17,071,909	7.8%
02 Technical and Spec. Fees	10,486,005	9,920,860	9,807,411	-113,449	-1.1%
03 Communication	1,012,095	1,028,808	949,344	-79,464	-7.7%
04 Travel	211,297	217,827	182,784	-35,043	-16.1%
06 Fuel and Utilities	13,059,678	13,843,111	13,428,133	-414,978	-3.0%
07 Motor Vehicles	895,177	780,293	820,612	40,319	5.2%
08 Contractual Services	592,240,240	628,422,282	657,567,413	29,145,131	4.6%
09 Supplies and Materials	19,007,013	19,303,197	19,478,285	175,088	0.9%
10 Equipment – Replacement	796,365	626,244	656,658	30,414	4.9%
11 Equipment – Additional	266,702	81,508	122,705	41,197	50.5%
12 Grants, Subsidies, and Contributions	237,088	286,571	295,143	8,572	3.0%
13 Fixed Charges	723,211	722,351	629,104	-93,247	-12.9%
Total Objects	\$ 858,337,716	\$ 893,638,098	\$ 939,414,547	\$ 45,776,449	5.1%
Funds					
01 General Fund	\$ 594,783,845	\$ 623,261,937	\$ 653,369,273	\$ 30,107,336	4.8%
03 Special Fund	4,761,249	5,000,146	5,279,897	279,751	5.6%
05 Federal Fund	253,320,454	259,459,394	271,992,748	12,533,354	4.8%
09 Reimbursable Fund	5,472,168	5,916,621	8,772,629	2,856,008	48.3%
Total Funds	\$ 858,337,716	\$ 893,638,098	\$ 939,414,547	\$ 45,776,449	5.1%

Note: The fiscal 2008 appropriation does not include deficiencies.

Fiscal Summary
DHMH – Mental Hygiene Administration

<u>Program/Unit</u>	<u>FY07 Actual</u>	<u>FY08 Wrk Approp</u>	<u>FY09 Allowance</u>	<u>Change</u>	<u>FY08-FY09 % Change</u>
01 Mental Hygiene Administration	\$ 575,595,227	\$ 612,520,229	\$ 641,158,154	\$ 28,637,925	4.7%
03 Walter P. Carter Community Mental Health Center	13,716,397	14,016,044	13,950,932	-65,112	-0.5%
04 Thomas B. Finan Hospital Center	17,837,276	17,331,989	19,010,035	1,678,046	9.7%
05 Regional Institute for Children and Adolescents – Baltimore	13,004,565	12,785,472	13,392,506	607,034	4.7%
06 Crownsville Hospital Center	1,972,785	2,034,263	1,785,870	-248,393	-12.2%
07 Eastern Shore Hospital Center	17,562,667	17,149,687	19,080,630	1,930,943	11.3%
08 Springfield Hospital Center	72,836,409	72,912,318	77,030,490	4,118,172	5.6%
09 Spring Grove Hospital Center	77,406,780	77,489,127	81,127,468	3,638,341	4.7%
10 Clifton T. Perkins Hospital Center	41,203,201	40,614,754	43,857,642	3,242,888	8.0%
11 Regional Institute for Children and Adolescents – Montgomery	12,277,983	12,212,871	13,427,887	1,215,016	9.9%
12 Upper Shore Community Mental Health Center	8,927,164	8,529,877	9,362,167	832,290	9.8%
14 Regional Institute for Children and Adolescents – Southern MD	5,997,262	6,041,467	6,230,766	189,299	3.1%
Total Expenditures	\$ 858,337,716	\$ 893,638,098	\$ 939,414,547	\$ 45,776,449	5.1%
General Fund	\$ 594,783,845	\$ 623,261,937	\$ 653,369,273	\$ 30,107,336	4.8%
Special Fund	4,761,249	5,000,146	5,279,897	279,751	5.6%
Federal Fund	253,320,454	259,459,394	271,992,748	12,533,354	4.8%
Total Appropriations	\$ 852,865,548	\$ 887,721,477	\$ 930,641,918	\$ 42,920,441	4.8%
Reimbursable Fund	\$ 5,472,168	\$ 5,916,621	\$ 8,772,629	\$ 2,856,008	48.3%
Total Funds	\$ 858,337,716	\$ 893,638,098	\$ 939,414,547	\$ 45,776,449	5.1%

Note: The fiscal 2008 appropriation does not include deficiencies.