

M00L
Mental Hygiene Administration
Department of Health and Mental Hygiene

Operating Budget Data

	(\$ in Thousands)				
	FY 08	FY 09	FY 10	FY 09-10	% Change
	<u>Actual</u>	<u>Working</u>	<u>Allowance</u>	<u>Change</u>	<u>Prior Year</u>
General Fund	\$626,342	\$629,921	\$664,786	\$34,865	5.5%
Contingent & Back of Bill Reductions	0	0	-2,110	-2,110	
Adjusted General Fund	\$626,342	\$629,921	\$662,675	\$32,755	5.2%
Special Fund	5,081	8,595	8,639	44	0.5%
Contingent & Back of Bill Reductions	0	0	-4	-4	
Adjusted Special Fund	\$5,081	\$8,595	\$8,636	\$40	0.5%
Federal Fund	261,531	275,034	286,300	11,266	4.1%
Contingent & Back of Bill Reductions	0	0	-1,015	-1,015	
Adjusted Federal Fund	\$261,531	\$275,034	\$285,285	\$10,251	3.7%
Reimbursable Fund	5,953	9,129	8,299	-829	-9.1%
Contingent & Back of Bill Reductions	0	0	-5	-5	
Adjusted Reimbursable Fund	\$5,953	\$9,129	\$8,295	-\$834	-9.1%
Adjusted Grand Total	\$898,906	\$922,679	\$964,891	\$42,211	4.6%

- The Mental Hygiene Administration (MHA) has \$2,122,217 in fiscal 2009 deficiency appropriations, principally in unforeseen federal grant funding and Medicaid recoveries for the Administrative Services Organization contract and the Baltimore City capitation project.
- To date, cost containment actions have reduced MHA's fiscal 2009 budget by just under \$19.5 million. These reductions reflect a mix of personnel savings and programmatic changes.
- MHA's fiscal 2010 budget increases by \$42.211 million (4.6%). Most of this increase (\$23.8 million) is for fee-for-service community mental health services representing growth in enrollment and utilization as well as provider rate adjustments (0.9%, except for 3.0% for inpatient and 0.0% for residential treatment centers). Despite this increase, the fiscal 2009 and 2010 budgets for fee-for-service community mental health services appear inadequate.

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

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Personnel Data

	<u>FY 08 Actual</u>	<u>FY 09 Working</u>	<u>FY 10 Allowance</u>	<u>FY 09-10 Change</u>
Regular Positions	3,345.70	3,181.20	3,146.20	-35.00
Contractual FTEs	<u>218.53</u>	<u>237.69</u>	<u>230.96</u>	<u>-6.73</u>
Total Personnel	3,564.23	3,418.89	3,377.16	-41.73

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	212.05	6.74%
Positions and Percentage Vacant as of 12/31/08	193.35	6.08%

- MHA’s fiscal 2010 budget reduces the overall personnel complement by 41.73 full-time equivalents (FTEs). Of these, 35.00 FTEs are regular positions. The bulk of these position abolitions, 28.00 FTEs, are at Springfield Hospital.
- The position reductions at Springfield are part of a budget proposal that provides for the movement of individuals diagnosed as mentally ill and developmentally disabled out of State psychiatric facilities into community placements and other institutional placements. This excess of psychiatric bed capacity results in ward closures at Springfield and the closure of State-operated psychiatric capacity at the Carter Center (Carter) effective October 1, 2009.
- Another part of the budget proposal sees most of the positions currently at Carter transferred to Perkins Hospital in order to open the new wing at that hospital.

Analysis in Brief

Major Trends

Enrollment and Expenditure Trends: Enrollment and expenditure trends show a sharp increase between fiscal 2007 and 2008. This increase, combined with anticipated enrollment pressures given the national economic situation, will likely strain the fiscal 2009 and 2010 budgets for community mental health services.

State-run Psychiatric Facility Staffing Levels Are Still Inadequate: The ongoing cuts in positions at the State-run psychiatric facilities have resulted in ward closures and programming changes. Vacancy levels and turnover rates have ameliorated in calendar 2008, but remain high. While MHA contends that hiring trends and actions taken to reduce capacity mean that staffing levels at the facilities have not worsened since a 2007 staffing study, that is little consolation given that that study noted the State-run psychiatric facilities were 400 regular positions below that needed to meet MHA's standards.

State-run Psychiatric Hospital Readmission Rates Rise: Overall, readmission rates within 30 days rise for all State-run psychiatric hospitals except for the Eastern Shore.

Issues

Changes at the State-run Psychiatric Facilities: The fiscal 2010 budget makes significant changes to the operating capacity of the State-run psychiatric facilities, changes that come hard on the heels of bed reduction driven by cost containment actions. Even after the changes proposed in the fiscal 2010 budget, significant challenges lie ahead for the facilities.

Recommended Actions

- | | <u>Funds</u> |
|---|---------------------|
| 1. Adopt narrative requesting the Mental Hygiene Administration update its 2007 Staffing Study to reflect the various changes in State-run Psychiatric Facility operating capacity and personnel allocations in recent and proposed budget actions. | |
| 2. Reduce fiscal 2010 grant funding because of the availability of fiscal 2009 funding for Veterans Behavioral Health Services. | \$ 1,200,000 |
| 3. Reduce fiscal 2010 funding for Veterans Behavioral Health Services based on estimated demand. | 1,800,000 |

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- | | |
|--|-----------|
| 4. Reduce general fund support for Targeted Case Management in anticipation of the resumption of claiming federal matching funds for these services. | 3,500,000 |
|--|-----------|

Total Reductions	\$ 6,500,000
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Updates

Implementation of the Program to Provide Behavioral Health Services for Maryland Veterans of the Afghanistan and Iraq Conflicts: Chapters 555 and 556 of 2008 established a new program for behavioral health services for Maryland veterans of the Afghanistan and Iraq conflicts. The fiscal 2009 budget bill withheld funds for that program pending the receipt of certain information regarding the establishment of that program. A brief review of program implementation is provided.

Pilot Integrated Case Management System: In other states, high-cost users of mental and physical health services have been identified and provided with intensive case management services in order to improve health outcomes. In the 2008 session, the Department of Health and Mental Hygiene was asked to look at this kind of pilot integrated case management program with a view to implementation in Maryland. While the department is supportive of efforts to improve outcomes for persons with severe mental illness through improved integration of care, lack of funding is currently limiting its efforts to low- or no-cost approaches.

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Department of Health and Mental Hygiene

Operating Budget Analysis

Program Description

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

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

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

- ***MHA Headquarters*** coordinates mental health services throughout the State according to the populations served, whether in an institutional or community setting.
- ***Core Service Agencies (CSA)*** work with MHA, through signed agreements, to coordinate and deliver mental health services in the counties. There are currently 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 two residential treatment centers – Regional Institutions for Children and Adolescents (RICA) – for the mentally ill.

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

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The carved-out system is overseen by MHA, although it contracts with an Administrative Services Organization (ASO), 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. Specifically, the safety-net serves those who have received services within the public mental health system in the past two years (alleviating continuity of care issues for those who occasionally lose Medicaid coverage); the homeless; people who received Social Security Disability Insurance due to psychiatric impairment and are eligible for Medicare (excluding them from PAC) but who need services beyond those covered by Medicare; people who are on court-ordered conditional releases from a State-run psychiatric hospital; anybody discharged from a Maryland psychiatric hospital in the past three months; and anybody within three months of release from a correctional institution.

In addition to those services administered by 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.

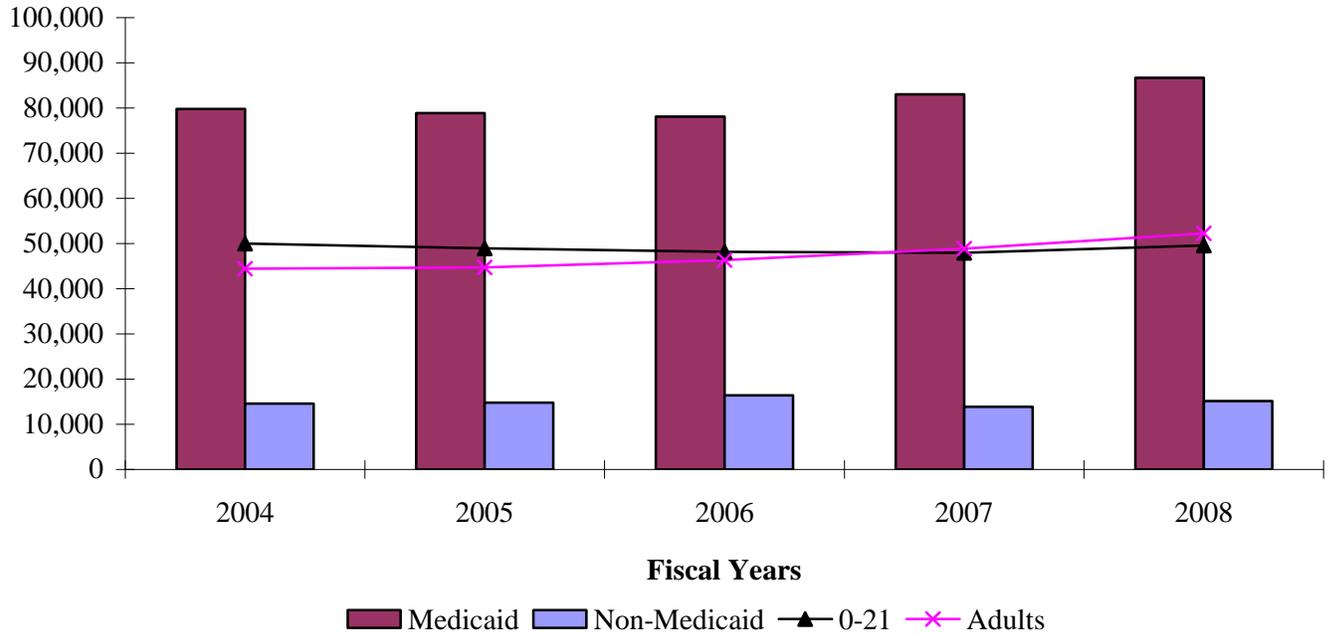
The key goals of the agency include improving the efficacy of community-based care for persons with mental illness and promoting recovery among persons with mental illness in State-run psychiatric facilities so that they may move into less restrictive settings.

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 2% between fiscal 2004 and 2008. More importantly, enrollment growth was level between fiscal 2004 and 2006, before growing in fiscal 2007 and rising even more sharply between fiscal 2007 and 2008 (5%).

Exhibit 1
Community Mental Health Services Enrollment Trends
Fiscal 2004-2008



Note: Data for fiscal 2008 is incomplete. Enrollment counts may be duplicated across coverage types. Includes enrollment in the Baltimore City capitation project which serves approximately 341 individuals.

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

Looking at the total population served:

- Enrollment growth among children (aged 0-21), which through fiscal 2004 had been driving enrollment trends, has been declining from fiscal 2004 through 2007. However, that trend reversed itself in fiscal 2008, with a 3.00% increase in children enrolled in the system. The penetration rate (the proportion of Medicaid enrollees that are served in the public mental health system) into the public mental health system by children which had declined each year between fiscal 2003 and 2007, increased slightly to 8.81% in fiscal 2008 from 8.67% in fiscal 2007.
- The growth in adult enrollment that has been evident since fiscal 2005 continues in fiscal 2008. Enrollment among adults grew by 7.00% between fiscal 2007 and 2008.

Within the two claims categories of clients served (Medicaid and non-Medicaid), historical trends are distorted by a number of factors that have influenced enrollment data, including definitional changes as to who is counted as Medicaid-eligible as well as programmatic changes such

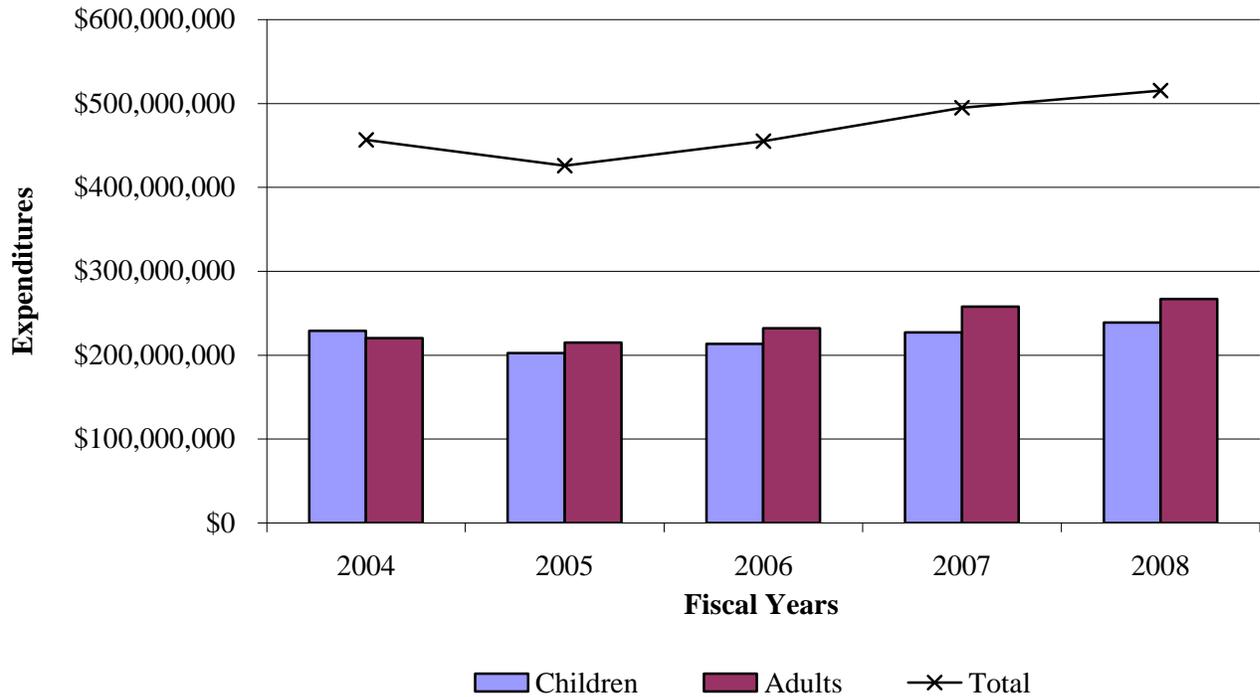
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as the start of the PAC program. The rate of growth in the non-Medicaid program (9%) between fiscal 2007 and 2008 is greater than the growth in the Medicaid program (4%) or total enrollment (5%). In absolute terms, however, the Medicaid enrollment growth is much higher.

Spending patterns broadly mirror enrollment growth (**Exhibit 2**), although cost containment actions taken in late fiscal 2004 are easy to identify. The impact of that cost containment slows the overall rate of growth during the period to 3% (driven by spending on adults, increasing 5% in contrast to 1% for children). However, again, the pace of spending has increased markedly beginning in fiscal 2006. This growth appears to ameliorate slightly between fiscal 2007 and 2008 but still shows a 4% increase. This growth reflects

- increased enrollment;
- 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); and
- a higher number of services utilized based on increased enrollment rather than a significant change in average service utilization (See **Exhibit 3**).

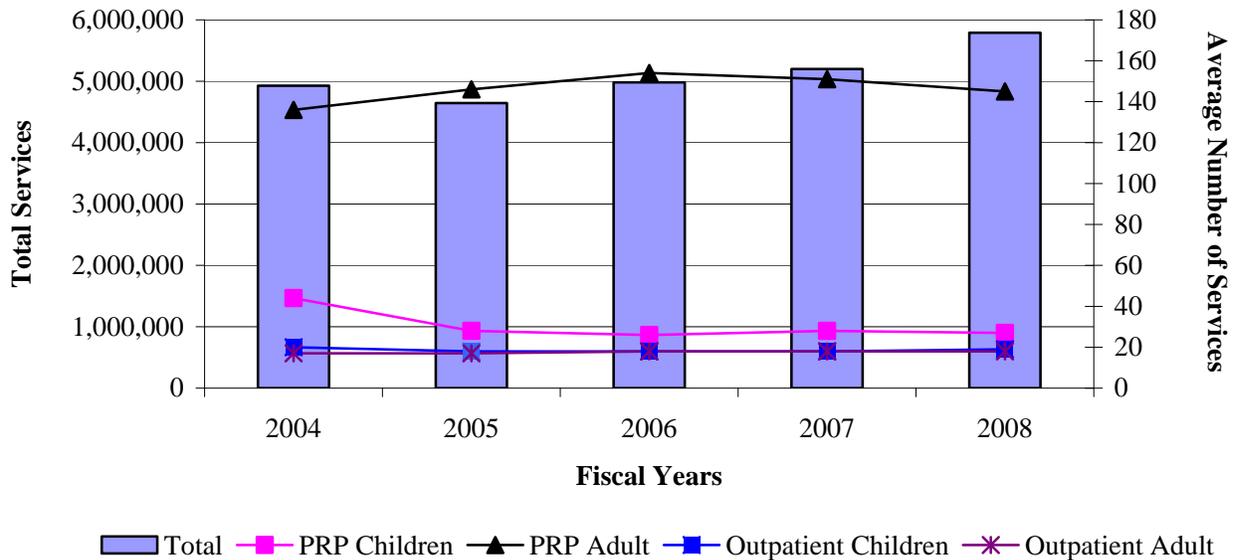
Exhibit 2
Community Mental Hygiene
Fee-for-service Expenditures
Fiscal 2004-2008



Note: Data for fiscal 2008 is incomplete. Total expenditures include funding for the Baltimore City Capitation project at approximately \$10 million per year. Funding by children and adults does not reflect that project.

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

**Exhibit 3
Various Service Utilization Measures
Fiscal 2004-2008**



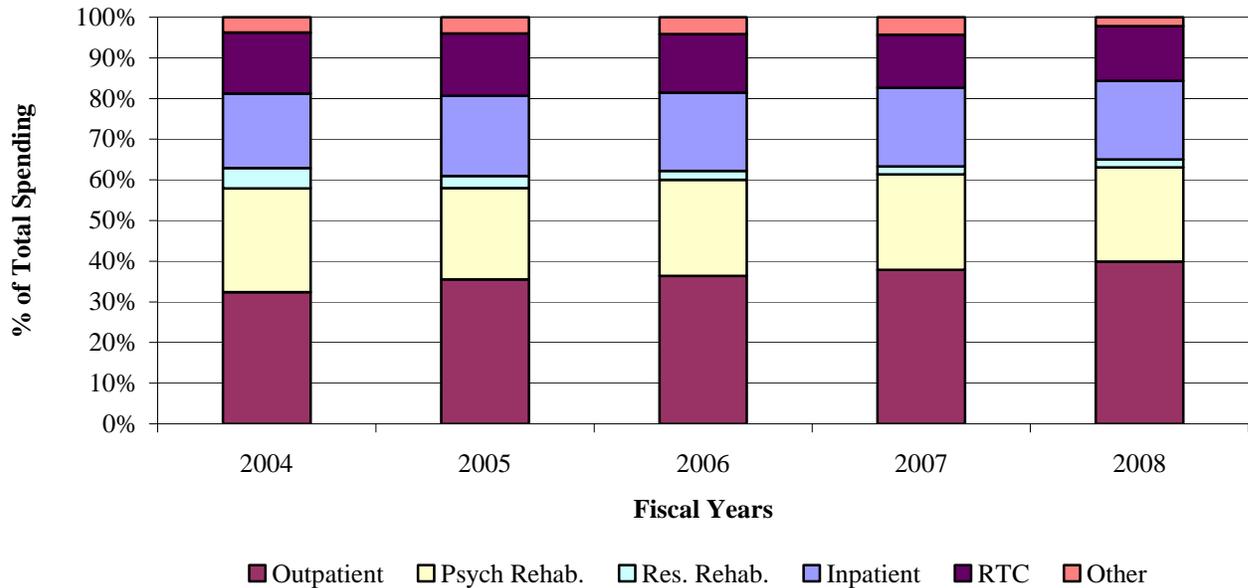
PRP: Psychiatric Rehabilitation Programs

Note: Data for fiscal 2008 is incomplete.

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

Which mental health services are experiencing the most rapid growth? As shown in **Exhibit 4**, the most recent trend between fiscal 2007 and 2008 underscores that of earlier years: namely a shift away from psychiatric rehabilitation services to outpatient services. This trend results from the imposition of case rates in February 2004 as well as stronger enforcement of medical necessity criteria. Outpatient services now consume 40% of fee-for-service spending. The only major change in service change shown in Exhibit 4 is in the “other” category. This category is made up of spending on case management, crisis services, respite care, and supported employment. Beginning in fiscal 2008, case management expenditures are no longer included in the data shown in the chart because these services were no longer eligible for federal fund reimbursement and are now delivered via contracts rather than on a fee-for-service basis.

Exhibit 4
Community Mental Health Service Expenditures by Service Type
Fiscal 2004-2008



RTC: Residential Treatment Centers

Note: Data for fiscal 2008 is incomplete.

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

Outcomes for Community Mental Health Services

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

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

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Data is drawn from questionnaires from 18,371 adults and 20,042 children. The data presented in **Exhibit 5** underlines observations from the prior year, and it is encouraging that overall clients report gains in various ways during treatment (for example, improved functioning). However, the data also provides some sense of the significant and multiple issues facing this population in terms of homelessness and unemployment.

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

Adult Outcomes

Net improvement in functioning (% of total observations)	8.0%
Increase in employment between observations (%)	3.0%
Persons unemployed in both observations (%)	69.0%
Homelessness in both observations (%)	18.0%

Children and Adolescents Outcomes

Net improvement in functioning (% of total observations)	8.0%
School suspensions in both observations (%)	12.0%

Source: Department of Legislative Services; Mental Hygiene Administration

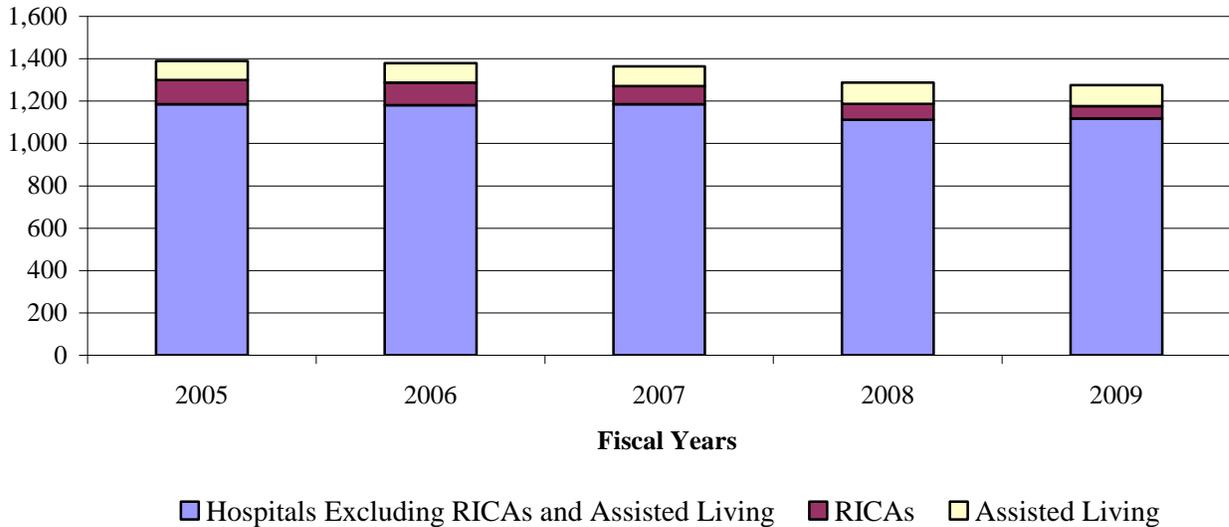
State-run Psychiatric Facilities: Population and Outcome Trends

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. In recent years:
 - a unit at the Carter Center (Carter) has closed because the State has been unable to procure sufficient contract psychiatrists from the University of Maryland, Baltimore to keep all of the units open;
 - wards at Springfield and Spring Grove were cut to respond to a 2007 staffing study that indicated serious shortfalls in staffing;
 - beds at all three RICAs were closed in fiscal 2008 due to budget cuts; and
 - RICA Southern Maryland was closed based on legislative actions in the 2008 session.

Additionally, not reflected in the fiscal 2009 data shown in Exhibit 6, are changes at the Finan Center (Finan) to convert one ward to a lower intensity assisted living unit as well as any further capacity reductions required in fiscal 2009 due to cost containment actions. The fiscal 2010 budget also proposes capacity changes which are discussed further below.

Exhibit 6
State-run Psychiatric Facilities: Average Daily Population Trends
Fiscal 2005-2009



RICA: Regional Institutions for Children and Adolescents

Note: Fiscal 2009 data is through October 2008.

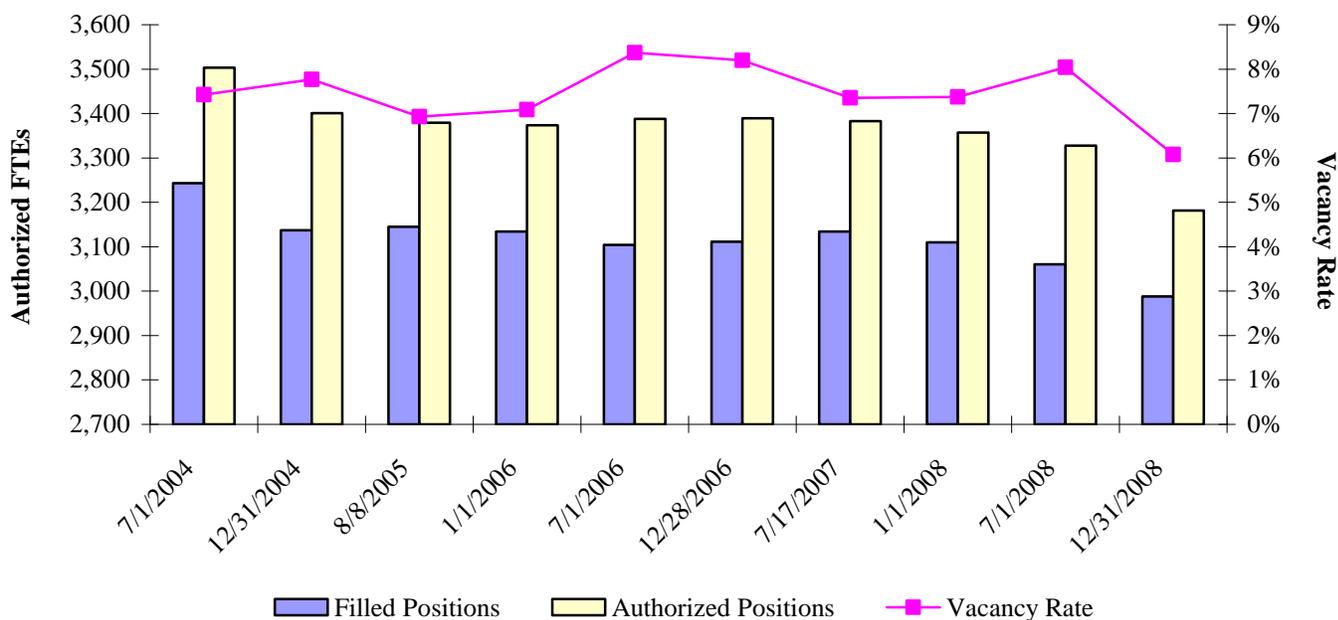
Source: Department of Legislative Services; Department of Health and Mental Hygiene

Staffing

As noted in the 2008 analysis, staffing levels at MHA’s facilities have been a problem for some time. A 2007 staffing study revealed that the facilities were staffed at almost 400 full-time equivalent positions (FTEs) below that required to meet MHA’s own standards. Further, as the report notes, lack of information about current vacancy levels understated the staffing shortfall. MHA responded to the staffing study by closing down a number of wards.

As shown in **Exhibit 7**, vacancy levels across MHA have actually fallen in the past six months, down to 6.1% at the end of calendar 2008, although this relates as much to reductions in the number of authorized positions as any up tick in hiring. Indeed, the number of filled positions continues to decline. According to MHA data presented in **Exhibit 8**, facility direct care vacancy levels are a little higher than across the workforce as a whole, 7.0%, although there is some considerable variance from facility to facility. **Exhibit 9** notes that vacancy rates among nurses at the psychiatric facilities are higher still, 10.0% at the end of calendar 2008, although that is also lower than in prior years. Again, while part of the explanation is the drop in the overall number of authorized nursing positions at the facilities (down 77 FTEs from calendar 2006 to 2008), turnover among nurses (the number of separations during the calendar year compared to authorized positions) fell sharply in calendar 2008, and the number of hires in the calendar year exceeded the number of separations for the first time in some years.

Exhibit 7
Mental Hygiene Administration Vacancy Rate
Fiscal 2004-2008



FTEs: full-time equivalent positions

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

Exhibit 8
State-run Psychiatric Facilities
Direct Care Positions – Vacancy Rates
December 2008

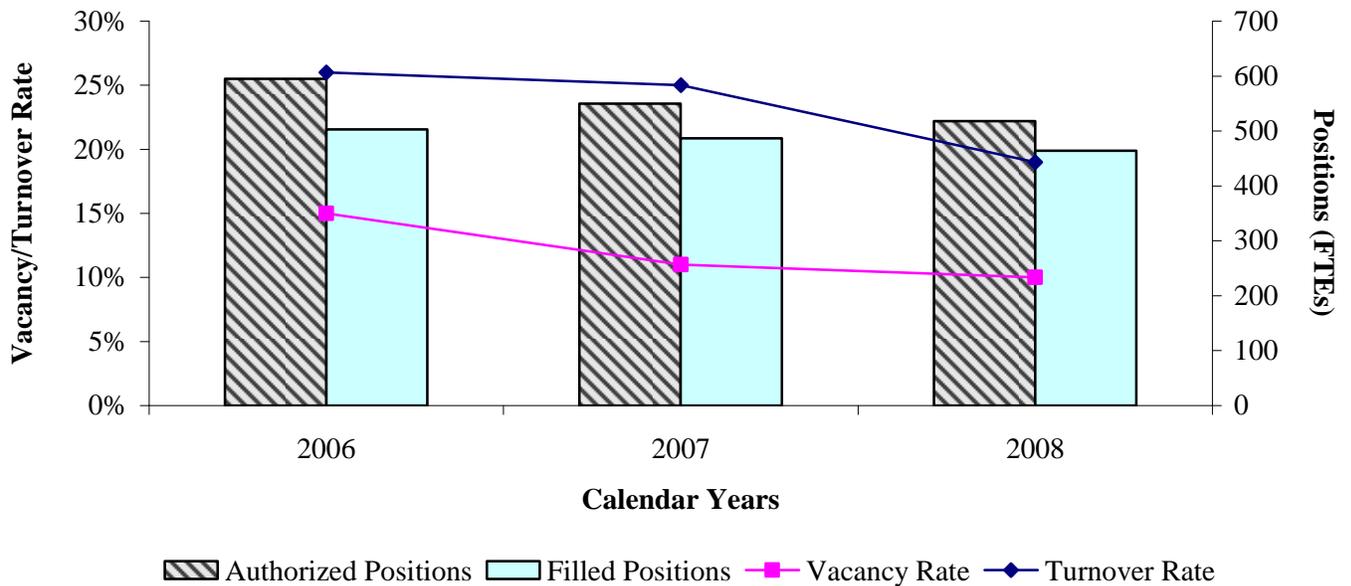
	<u>Dec-08 Positions</u>	<u>Direct Care Vacancies</u>	<u>Direct Care Vacancy Rate</u>
RICA Gildner	117.6	8.0	6.8%
RICA Baltimore	100.0	6.0	6.0%
Perkins	301.0	21.0	7.0%
Finan	122.0	1.0	0.8%
Carter	96.1	10.0	10.4%
Eastern Shore	127.2	12.5	9.8%
Upper Shore	68.0	6.5	9.6%
Spring Grove	585.5	53.5	9.1%
Springfield	685.5	36.5	5.3%
Total	2,202.9	155	7.0%

FTEs: full-time equivalent positions

RICA: Regional Institutions for Children and Adolscents

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

**Exhibit 9
MHA Nurse Vacancy and Turnover Rates
Calendar 2006-2008**



FTEs: full-time equivalent positions
MHA: Mental Hygiene Administration

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

When considered together, MHA contends that the bed and staffing levels at the State-run psychiatric facilities are currently at the same point as that noted in the 2007 staffing study, *i.e.*, staffing levels are still inadequate but have not worsened. This, of course, is before any additional actions in fiscal 2009 and 2010.

Facility Outcomes

While it is difficult to infer just from data whether quality of care has been compromised as a result of staffing shortages, data presented in **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 2004-2008

	<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	Trend 2004-2008	Trend 2007-2008
Carter	2.3%	1.7%	4.0%	5.1%	8.5%	X	X
Eastern Shore	5.8%	2.0%	5.9%	7.5%	5.8%	No change	√
Finan	1.5%	2.3%	2.2%	0.0%	5.3%	X	X
Spring Grove	3.6%	3.5%	3.6%	3.6%	3.8%	X	X
Springfield	4.4%	4.6%	4.2%	6.0%	8.8%	X	X
Upper Shore	4.0%	1.3%	2.6%	5.7%	7.6%	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 2004-2008

	<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	Trend 2004-2008	Trend 2007-2008
Carter	1.16	0.62	0.25	0.40	0.83	√	X
Eastern Shore	1.58	2.77	0.55	0.32	0.28	√	√
Finan	0.17	0.15	0.08	0.03	0.25	X	X
Spring Grove	0.42	0.29	0.10	0.05	0.02	√	√
Springfield	0.38	0.29	0.29	0.19	0.18	√	√
Upper Shore	0.97	0.79	1.45	0.02	0.15	√	X

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 2004-2008

	<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	Trend 2004-2008	Trend 2007-2008
Carter	0.50	0.05	0.28	0.46	0.29	√	√
Eastern Shore	0.36	0.21	0.11	0.04	0.14	√	X
Finan	0.25	0.18	0.15	0.23	0.38	X	X
Spring Grove	0.30	0.35	0.32	0.20	0.26	√	X
Springfield	0.64	0.63	0.51	0.32	0.27	√	√
Upper Shore	0.85	0.41	0.92	0.50	0.65	√	X

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

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 trend in readmissions within 30 days, both long- and short-term trends, are almost universally worsening, although all facilities still remain below the latest available national benchmark for readmission rates (9.1%). MHA has expressed concerns about this 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. Nonetheless, in virtually all cases, readmission rates are up.
- Trends in the use of seclusion and elopements, which had generally been favorable in the five years through fiscal 2007, remain broadly positive over the five-year period fiscal 2004 to 2008 but are certainly less favorable from fiscal 2007 to 2008. However, in terms of seclusion, all facilities aside from Carter fall below the national benchmark of 0.6 per 1,000 patient hours.

Fiscal 2009 Actions

Proposed Deficiency

The deficiency appropriations for MHA in the fiscal 2010 budget are as follows:

- \$1,795,775 in federal funds to cover costs associated with the development of a statewide framework for early childhood mental health, the Baltimore City capitation project, and the ASO contract.
- \$326,442 in special funds from increased tenant collections at Carter and collections from shared services at Finan.

Impact of Cost Containment

To date, cost containment actions taken by the Board of Public Works (BPW) in June and October 2008 have reduced MHA's fiscal 2009 budget by just under \$19.5 million. Much of this cost containment related to reductions in personnel expenditures from abolishing vacant positions, deleting funding for Other Post Employment Benefits as well as reducing budgeted funding for health insurance costs based on the use of statewide health insurance balances.

However, MHA has also experienced specific reductions to programs, including:

- A reduction in the proposed fiscal 2009 provider rate adjustment from 2.7 to 2.0%. This 2.0% increase still represented a 0.5% increase over that originally provided in the fiscal 2009 budget. This additional increase was supported by overattained fiscal 2008 lottery revenues.
- A 1.0% reduction in fee-for-service community mental health general fund support (\$2,970,000 in general funds, \$2,542,000 in federal funds). In order to generate these savings, the MHA ASO has tightened up on inpatient and residential treatment center (RTC) admissions and length of stay while leaving medical necessity criteria unchanged.
- A 1.0% across-the-board reduction in general fund support for CSA grant awards (\$630,000). These reductions were adopted across all categories of spending: administrative and service reductions.
- \$552,000 in savings from the fiscal 2009 Veterans Behavioral Health initiative based on start-up and implementation delays.
- \$470,000 by lowering reimbursements to RTCs. RTCs are cost settled, so although these savings are realized in fiscal 2009, the actual costs of these services will ultimately be paid for or recovered.

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- \$422,000 in savings at the Springfield Hospital Center based on a lower than budgeted census.
- \$393,000 in savings at Finan by changing the bed mix of one ward from intermediate/long-term care to assisted living. This lower level intensity of care requires lower levels of staffing.
- \$304,000 in savings at the Spring Grove Hospital from increased utilization review of off-grounds hospitalization, although as noted below, these expenditures are anticipated to rise sharply in fiscal 2010 questioning how real these savings actually are.
- \$175,000 in savings at the Eastern Shore Hospital achieved by replacing the existing in-house food service with an outside contractor. This action resulted in the lay-off of eight employees.

A general fund reduction was also taken at Springfield related to the repayment of an energy loan contract. Those funds will be back-filled by special funds from the Strategic Energy Investment fund. The Strategic Energy Investment fund was created to decrease energy demand and increase energy supply to promote affordable, reliable, and clean energy. The main source of revenue for the fund is the auction proceeds from the sale of carbon dioxide allowances under the Regional Greenhouse Gas Initiative (the 10-state regional climate change and energy efficiency cooperative).

Furlough savings are also not yet reflected in the fiscal 2009 working appropriation.

Proposed Budget

As shown in **Exhibit 13**, after adjusting for contingent reductions, MHA's fiscal 2010 budget is just over \$42.2 million (4.6%), above the fiscal 2009 working appropriation. The two contingent reductions are:

- elimination of the deferred compensation match (just over \$1.1 million); and
- savings that are generated through False Claims Act legislation (\$2 million). Under the federal Deficit Reduction Act of 2005, incentives were offered to states that enacted anti-fraud legislation modeled after the federal False Claims Act. The federal False Claims Act provides for penalties and triple damages for anyone who knowingly submits or causes the submission of false or fraudulent claims to the United States for government funds or property. Given Medicaid's size, growth, diversity, and financial management weaknesses, the General Accountability Office estimates the nationwide improper payment rate at 3%. Any state with a law relating to false or fraudulent claims that meets federal standards receives an enhanced federal medical assistance percentage for claims settlements reached through their state False Claims Act. According to the National Conference of State Legislatures, 19 states and the District of Columbia all have False Claims Act laws that meet federal standards. It should be noted that this legislation has not been successful in the past.

Exhibit 13
Proposed Budget
DHMH Mental Hygiene Administration
(\$ in Thousands)

How Much It Grows:	<u>General</u> <u>Fund</u>	<u>Special</u> <u>Fund</u>	<u>Federal</u> <u>Fund</u>	<u>Reimb.</u> <u>Fund</u>	<u>Total</u>
2009 Working Appropriation	\$629,921	\$8,595	\$275,034	\$9,129	\$922,679
2010 Allowance	<u>664,786</u>	<u>8,639</u>	<u>286,300</u>	<u>8,299</u>	<u>968,025</u>
Amount Change	\$34,865	\$44	\$11,266	-\$829	\$45,345
Percent Change	5.5%	0.5%	4.1%	-9.1%	4.9%
 Contingent Reduction	 -\$2,110	 -\$4	 -\$1,015	 -\$5	 -\$3,134
Adjusted Change	\$32,755	\$40	\$10,251	-\$834	\$42,211
Adjusted Percent Change	5.2%	0.5%	3.7%	-9.1%	4.6%
 Where It Goes:					
Personnel Expenses				\$8,431	
Employee and retiree health insurance					\$7,284
Additional assistance (primarily associated with the opening of the new Perkins wing).....					6,271
Retirement contribution					1,718
Miscellaneous adjustments					653
Other fringe benefit adjustments					25
Workers' compensation premium adjustment					-531
Deferred compensation (contingent on legislation).....					-1,124
Regular salaries.....					-1,129
Deletion of funds for Other Post Employment Benefits' unfunded liability					-1,143
Turnover adjustments and cost containment					-1,482
Abolished positions (35 FTEs: 28 FTEs Springfield; 7 FTEs Finan).....					-2,111
Community Mental Health Services					
Fee-for-service Expenditures				\$23,836	
Enrollment/utilization					18,825
Provider rate adjustment (0.9% except 3.0% inpatient, 0.0% RTC)					7,011
Savings as a result of the False Claims Act (contingent on legislation).....					-2,000

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Where It Goes:

Grants and Contracts	\$4,534	
Administrative Services Organization Contract		2,204
Early Childhood Mental Health Grant (federal funds)		1,456
Veteran’s Behavioral Health (services only)		573
Provider rate adjustment (0.9%)		489
Transformation grant contracts (federal funds)		292
Prior year grant activity (special funds).....		127
Community Mental Health Block Grant (federal funds)		-287
Unspecified cost containment.....		-320
Facilities	\$5,195	
Energy loan payments and contract for energy services contract at Spring Grove and Springfield		2,186
Fuel and utility costs except for Spring Grove		1,487
Eastern shore dietary contract costs.....		698
Off-grounds outpatient and inpatient medical care.....		582
On-grounds somatic care contract at Spring Grove.....		533
Other medical care contracts across the facilities		450
Environment of Care standard improvements		419
Carter Center dietary costs (special funds collected from tenants).....		362
Finan Center dietary costs (mix of general, special, and reimbursable funds based on costs and recoveries).....		241
Medicine and drug expenses.....		-523
Fuel and utility costs at Spring Grove		-1,241
Other		215
Total		\$42,211

FTEs: full-time equivalents

RTC: residential treatment center

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

Personnel Reductions

Overall, personnel expenses increase by just over \$8.4 million. Aside from fringe benefit costs, the changes of note in the personnel area relate to structural changes in the operations at the State-run psychiatric facilities. Specifically:

- bed closures at Springfield and Carter that relate to the movement of patients with mental illness and developmental disabilities out of the State-run psychiatric hospitals;
- the opening of the new 48-bed wing at Perkins (a move that involves the transfer of 89 FTE positions from Carter to staff the wing); and
- staff changes at Finan to reflect the change in program intensity in one ward from intermediate/long-term care to assisted living.

These changes are discussed at greater length further in Issue 1.

Two additional notes about the fiscal 2010 personnel budget assumed for MHA:

- The budgeted turnover level, 6.74%, is above the current vacancy rate. However, this turnover rate is artificially high because savings from the closure of State operations at Carter are budgeted as turnover. The actual turnover rate is closer to 4.5%.
- The budget already assumes the abolition of 35 positions, and additional fiscal 2009 and 2010 potential BPW and across-the-board personnel reductions will almost inevitably include positions at the State-run psychiatric facilities which collectively are the largest employer within the Department of Health and Mental Hygiene (DHMH).

Community Mental Health Services: Fee-for-service Expenditures

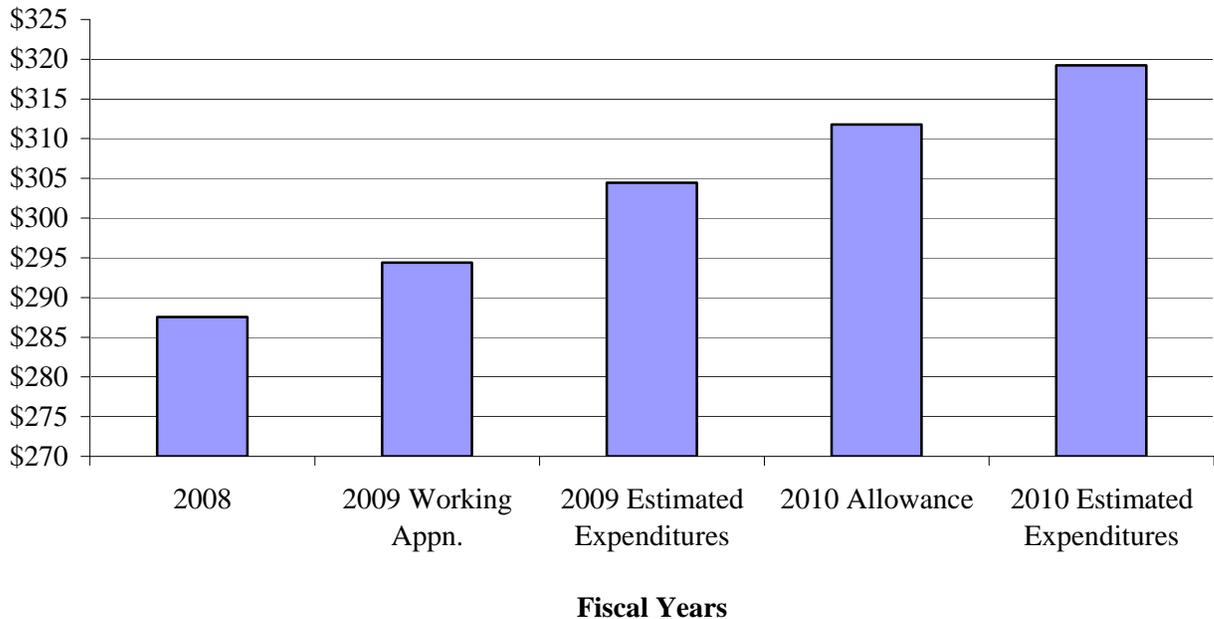
The funding available for the fee-for-service component of the public mental health system increases by just over \$23.8 million (this represents funding for both Medicaid-eligible and Medicaid-ineligible clients). Of this amount, MHA estimates that just over \$7.0 million (\$4.2 million general funds, \$2.8 million federal funds) is to provide rate increases of 3.0% for rate-regulated services as well as a 0.9% rate adjustment for all other services. RTCs, which are cost-settled services, receive no rate increase. This leaves just over \$16.8 million remaining for increased enrollment and utilization after taking into account savings generated from more accurate claims contingent on the enactment of the False Claims Act.

However, the allowance for enrollment and utilization may appear somewhat healthier than it actually is. Although providing for an increase of 3% over the fiscal 2009 working appropriation, after taking into account the proposed rate adjustments, the adequacy of the fiscal 2009 appropriation itself was questioned in the 2008 analysis, and current data continues to suggest that the working

appropriation may be insufficient. **Exhibit 14** provides an analysis of State fund adequacy in the fee-for-service system (recognizing that in fiscal 2009, a small amount of special funds is included in the fee-for-service budget in order to eliminate fiscal 2009 Medicaid day limit cost containment). In the exhibit, fiscal 2009 expenditures are estimated based on the most recent estimates of expenditures for fiscal 2008 adjusted for rate increases and enrollment/utilization increases of 2% (which may be considered low) in the Medicaid-eligible and Medicaid-ineligible populations. As shown in the exhibit, under these assumptions, the fiscal 2009 appropriation still appears to be inadequate by \$10 million in general funds

Looking specifically at the fiscal 2010 budget, again building off estimated fiscal 2009 expenditures and assuming budgeted rate increases and enrollment/utilization increases of 3.0% in both the Medicaid-eligible and Medicaid-ineligible population, the general fund appropriation appears slightly below (\$7.5 million), what appears to be required for fiscal 2010.

Exhibit 14
Community Mental Health Services Fee-for-service Funding
State Funds Adequacy
Fiscal 2008-2010
(\$ in Millions)



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

Community Mental Health Services: Grant and Contract Expenditures

The fiscal 2010 budget for mental health services delivered through grants and contracts increases by just over \$4.5 million from the fiscal 2009 working appropriation. Significant increases include:

- Additional funding for the ASO contract (\$2.2 million) reflecting an enhanced scope of work incorporated into the contract in fiscal 2009. It should be noted that the ASO contract is currently being re-bid.
- Maryland was recently awarded a system of care federal grant from the Substance Abuse and Mental Health Services Administration as part of a collaborative effort to divert and return foster care children from group home care using a care management entity model with wraparound service delivery and child and family teams. Services will initially be focused in west Baltimore. The fiscal 2010 budget includes just under \$1.5 million for this effort; this is also one piece of the MHA deficiency appropriations.
- Funding available for behavioral health services for veterans of the Afghanistan and Iraq wars increases by \$573,000. As noted above, this program was reduced as part of October BPW cost containment actions based on start-up delays (additional detail on program implementation is provided in Update 1.) As of December 31, 2008, MHA had spent \$413,000 of the remaining \$2,273,029 approved budget, including \$51,000 on services. MHA projects it will only spend \$256,000 on services in fiscal 2009 out of an available budget of \$1,452,281. **Thus, the Department of Legislative Services (DLS) recommends reducing fiscal 2010 grant funding for MHA by \$1.2 million, allowing MHA to encumber these projected surplus funds to offset fiscal 2010 expenses.**

The fiscal 2010 budget for Veterans Behavioral Health Services (excluding administrative costs) is just under \$2.3 million. Even allowing for a doubling in the amount of service expenditures, the fiscal 2010 appears generous. **DLS recommends reducing fiscal 2010 service funding by \$1.8 million.**

- The grants and contracts budget also contains funding for a 0.9% increase to contracts. However, it should also be noted that after accounting for all of the various increases, the grants and contract budget also contains \$320,000 in unspecified reductions. This would be in addition to the 1.0% across-the-board reduction already taken for fiscal 2009.

Facilities

Aside from personnel expenses, there are a number of significant increases at the State-run psychiatric facilities:

- The largest increase, almost \$2.2 million, relates to energy efficiency performance contracts (loan payments and associated services contracts). Fiscal 2010 represents the fifth year of the

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performance contract at Springfield. The contract at Spring Grove is more recent. That contract was entered into with NORESCO at the end of 2007. Specifically, the project aims to reduce energy consumption, utility costs, and greenhouse gas emissions at the Spring Grove Hospital. Under the contract, savings realized from reduced energy consumption pays for equipment investment, installation, and related financing. The work at Spring Grove involves such things as lighting upgrades; occupancy sensors; water conservation; and heating, ventilation, and air conditioning renovation. The fiscal 2010 budget for Spring Grove includes additional funding for the loan payments associated with the energy contract (which, for the first time, includes a principal payment) as well as service contract costs. Savings in utility costs at Spring Grove offset much of the fiscal 2010 cost associated with contract.

The apparent increase in the contract at Springfield in fiscal 2010 is artificial in that special funds from the Strategic Energy Investment Fund to back-fill an October 2008 BPW cost containment action that have yet to be transferred into the MHA budget. In both cases, most of the fiscal 2010 funding associated with these contracts is special funds from the Strategic Energy Investment Fund.

- Off-grounds outpatient and inpatient somatic medical costs rise significantly across the facilities (\$582,000), as do costs for other medical services. While rising medical costs are not unexpected, it should be noted that at least anecdotally, there are occasions when the State-run psychiatric facilities end up paying for significant medical care for patients transferred from local correctional facilities, often just at the point where medical intervention is required. **DLS recommends that some cost-sharing for somatic medical costs be considered for forensic patients transferred from local correctional facilities to the State-run psychiatric facilities. Specifically, that the county of origin should reimburse the State for medical expenses that exceed \$25,000 for any transferred individual forensic patient.** This would be an item for consideration as an addition to the Budget Reconciliation and Financing Act of 2009. MHA should experience some cost savings as a result, but the extent of those savings is difficult to quantify.
- Dietary costs increase at various facilities. However, the dietary contract increase at the Eastern Shore Hospital is somewhat artificial in that it obscures the savings made in personnel, foodstuffs, and equipment replacement by contracting out for dietary services. That the contract for fiscal 2010 is so much higher than the fiscal 2009 savings identified through cost containment actions, reflects the fact that the savings in fiscal 2009 were for only part of the year.
- \$419,000 in funding is included in the operating budget for improvements required to meet new standards established by the Joint Commission on the Accreditation of Healthcare Organizations. Specifically, \$5.4 million in funding is estimated to meet new patient safety goals for psychiatric hospitals (with a specific emphasis on suicide prevention) otherwise known as Environment of Care patient safety standards. The fiscal 2010 capital budget provides \$2.5 million (with \$2.5 million planned for fiscal 2011). The \$419,000 in the operating budget is for noncapital items such as closed circuit television cameras, replacement light fixtures, replacement ventilation grills, replacement furniture, and replacement doors.

Issues

1. Changes at the State-run Psychiatric Facilities

As referenced above, cost containment actions, legislative actions, and other influences have resulted in substantial changes to the State-run psychiatric facilities in recent years. Additional change is proposed in the fiscal 2010 budget, including:

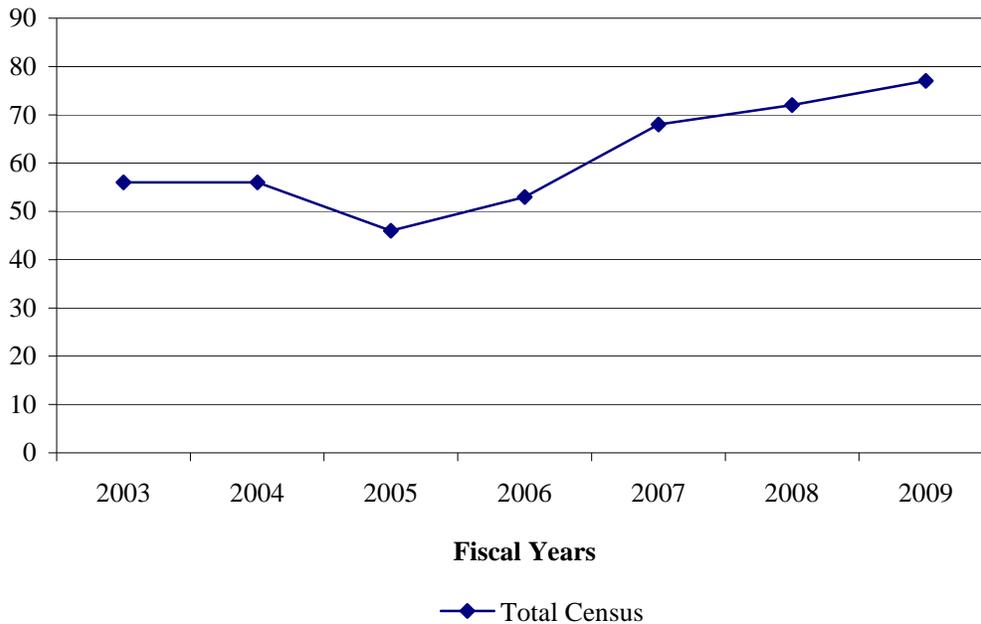
- altering capacity as a result of changing the treatment of individuals with mental illness and development disabilities; and
- opening a new 48-bed wing at Perkins.

Transition Plan for Developmentally Disabled Eligible and Pending Eligibility Individuals in State-run Psychiatric Facilities

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 15**, as of November 2008, 77 developmentally disabled individuals, eligible or pending eligibility for either the full range of Developmental Disabilities Administration (DDA) services or individual support services, were housed in State-run psychiatric hospitals. Additionally, 7 patients with Traumatic Brain Injury are also eligible for the full range of DDA services or individual support services. Forty-three of these individuals are forensic patients. Further, as noted in prior analyses, 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.

Exhibit 15
Developmentally Disabled Eligible/Pending Eligibility Individuals in
State-run Psychiatric Facilities
Fiscal 2003-2009



Source: Mental Hygiene Administration

In the 2008 session, the budget committees asked the department to develop a transition plan with the goal of moving developmentally disabled eligible individuals at State-run psychiatric facilities to an appropriate placement. The department submitted that report in December 2008. The report noted three parts to a transition plan:

- Discharging those individuals who are ready for discharge into a community placement. Two key obstacles to this part of the plan were identified:
 - funding availability; and
 - opposition to placement from the family, individuals, or community providers (depending on the history of the individual client).
- Establishing a specialized residential setting for those individuals who need continued inpatient treatment to be staffed by DDA staff in a milieu based on the habilitation model used in State residential centers. Psychiatric care would be a complementary service provided in the facility. The report notes both a long-term approach for the residential facility, as well as a short-term approach. The short-term solution would be to site such a facility at an existing facility.

- Developing community teams to address crisis situations. These teams would function both to limit the need for inpatient care as well as assist in the transition from inpatient care.

While the department stressed its concern about how best to serve this population, the report itself lacked specific details about how a plan could be implemented as well as cost details. However, the fiscal 2010 budget significantly alters inpatient psychiatric capacity at the State-run psychiatric hospitals and accommodates the movement of the developmentally disabled and pending-eligible population from State-run psychiatric facilities as envisaged in the plan (see **Exhibit 16**).

Exhibit 16
Budget Plan to Move Developmentally Disabled Eligible/Pending Eligibility
Individuals from State-run Psychiatric Facilities

	<u>Position Count (FTE)</u>	<u>Service Capacity (Beds/Institutional Slots)</u>	<u>General Fund Expenditures</u>	<u>General Fund Revenues</u>	<u>Total General Fund Benefit/Cost</u>
Springfield	-28.0	-25	-\$2,400,000	-\$244,056	\$2,155,944
Carter	-23.3	-33	-5,100,000	-254,759	4,845,241
DDA Community Placements		64	2,600,000		-2,600,000
Brandenburg	61.0	20	3,900,000	2,824,603	-1,075,397
Total	9.7	26	-\$1,000,000	\$2,325,788	\$3,325,788

DDA: Developmental Disabilities Administration
 FTE: full-time equivalent

Note: Brandenburg positions are transferred from Rosewood; 11 Carter positions remain at the facility; and 89 are transferred to Perkins. Funding for the Developmental Disabilities Administration Community Placements will also draw down \$2.4 million in federal Medicaid funds.

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

As shown in the exhibit:

- One ward closes at Springfield for a net savings of just under \$2.2 million (after subtracting reductions in hospital patient revenues from lower operating expenditures); 28.0 FTE positions are also abolished in this action.
- State-operated beds at Carter will close for a net savings of just over \$4.8 million, although nonprofit activities at the center will continue. Closure will occur October 1, 2009, and will result in the abolition of 23.3 FTE positions. 89.0 FTE positions will be transferred to Perkins (discussed further below), and 11.0 FTE positions will remain at Carter to keep the building in operation. The State will continue to have general fund expenses related to insurance, security, utilities, and maintenance, although some of these costs would continue to be shared with existing tenants who include the University of Maryland Medical System (offering a variety of drug treatment, mental health and pediatric programs), Baltimore City (offering an alternative school), and Baltimore Crisis Response Inc. (offering community mental health and crisis intervention services).

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- An additional 64 community placements will be created in the Developmental Disabilities Administration at a cost of \$5.0 million (\$2.6 million general funds, \$2.4 million federal funds).
- For individuals unable to immediately transition to the community, the current plan is to add 20 beds at the Brandenburg Center although other sites are also under consideration, at a net cost of just under \$1.1 million. This opening will also involve the transfer of 61.0 FTE position identification numbers from Rosewood that would otherwise have been abolished as part of the closure of that facility.
- Net general fund savings from the proposal is just over \$3.3 million, with a total of 9.7 FTE positions added.
- Under this proposal, although the plan is to move 84 patients out of the State-run psychiatric hospitals, only 58 beds are reduced. The additional 26 beds, together with purchase of care beds, will be used to accommodate the admissions that had previously been made to Carter and, through bed consolidation across the facilities, will likely result in the development of an additional ward at Spring Grove. While this is fewer beds than had been operated at Carter, these beds had been filled with long-term residents as compared to the residents of Carter Center who tend to be short-stay patients.

Opening of the New Perkins Wing

The budget also includes provisions to open the new 48-bed wing at Perkins hospitals. Perkins was established in 1960 and serves as the State's sole maximum security psychiatric hospital. Defendants charged with murder, rape, arson, armed robbery, car jacking, kidnapping, or assault with intent to murder ordinarily receive evaluations at Perkins. The hospital will also handle patients with less serious charges in instances where elopement is a concern or other factors indicate the need for maximum security.

Maryland's system for the handling of the more serious forensic patients is bifurcated:

- confining and treating those patients at Perkins which is a maximum security facility; and
- treating a significant number of patients with "Perkins level" charges (an estimated 85) at other State-run psychiatric facilities. In allowing those patients to be served outside of Perkins, a determination is obviously made that those patients may be treated in a less-secure setting.

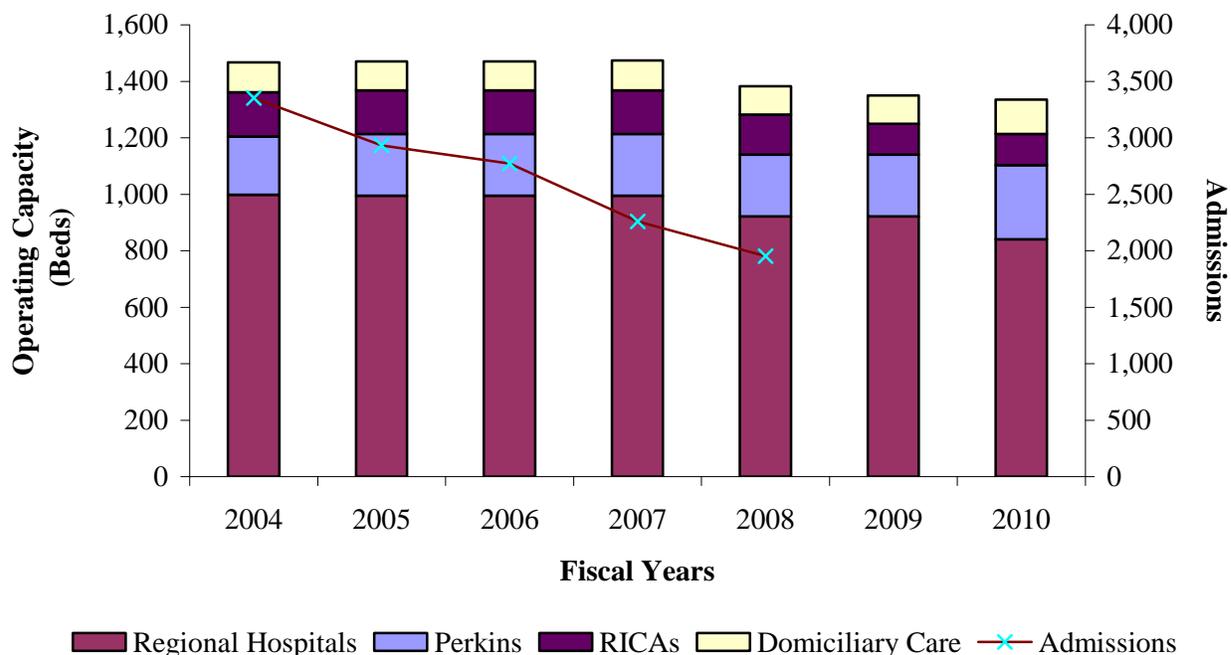
The opening of the new wing will ultimately increase operating capacity by 44 beds (because of operating requirements, 4 of the beds are not included in the capacity numbers) and will ease the ability of MHA to manage the risks associated with patients that have serious criminal charges, as well as severe mental illness. As noted above, MHA intends to move 89 FTE positions from Carter to Perkins after the closure of Carter effective October 1, 2009. The fiscal 2010 budget is built on that assumption that for fiscal 2010 the ADP for the year at Perkins will be 15.

Future Operational Capacity

As shown in **Exhibits 17** and **18**, based on the full implementation of the fiscal 2010 budget plans for the State-run psychiatric facilities:

- Overall bed capacity falls by 15 from fiscal 2009 to 2010. However, if the 26 beds that are freed from long-term occupancy by moving the developmentally disabled and pending eligibility population from the State-run psychiatric facilities are properly considered as new capacity, then overall capacity actually effectively increases by 11 beds.
- In numeric terms, this overall reduction in bed capacity is the continuation of a long-term trend. Since fiscal 2004, the average annual drop in bed capacity has been 2%.
- However, this overall decline masks other trends such as an increase in maximum security beds (at Perkins) and domiciliary care beds (primarily from the new arrangement at Finan), a 6% decline in beds at the RICAs (primarily through the closure of RICA Southern Maryland), and a 3% decline in beds at the regional hospitals.
- Admissions to the facilities have fallen on average by 13% annually between fiscal 2004 and 2008.
- MHA has also worked to manage the population at its State-run psychiatric facilities through diversion projects (while primarily aimed at alleviating over-crowding in the emergency departments, they have a secondary benefit in diverting potential clients from State-run psychiatric beds) as well as significantly increasing the purchase of psychiatric beds in private psychiatric hospitals and acute general hospitals (see **Exhibit 19**).

Exhibit 17
State-run Psychiatric Facilities: Operating Capacity and Admissions
Fiscal 2004-2010



Note: Based on full implementation of fiscal 2010 proposals.

RICAs: Regional Institutions for Children and Adolescents

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

Exhibit 18
State-run Psychiatric Facilities: Facility Operating Capacity
Fiscal 2004-2010

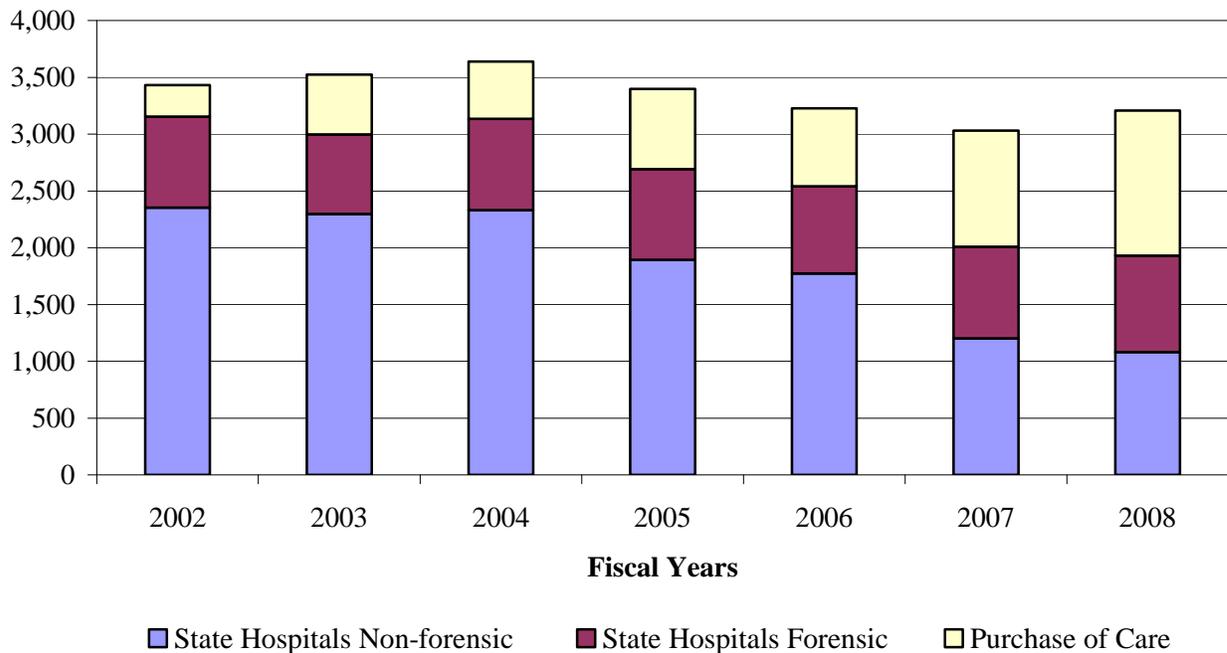
	<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>2010</u>
Crownsville	202	0	0	0	0	0	0
Eastern Shore	78	80	80	80	80	80	80
Upper Shore	37	40	40	40	40	40	40
Springfield	328	405	405	405	355	355	330
Spring Grove	330	441	441	445	425	425	425
Perkins	206	218	218	218	218	218	262
Finan	80	80	80	80	88	88	88
Carter	49	51	51	51	34	34	0
RICA – Baltimore	45	43	43	43	38	38	38
RICA – Gildner	80	80	80	80	72	72	72
RICA – Southern	32	32	32	32	32	0	0
Total	1,467	1,470	1,470	1,474	1,382	1,350	1,335

Note: Based on full implementation of fiscal 2010 proposals.

RICAs: Regional Institutions for Children and Adolescents

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

**Exhibit 19
Admission Data
Fiscal 2002-2008**



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

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

Ongoing Challenges

Moving forward, there are a number of challenges facing the State-operated psychiatric facilities:

- Continuing to adapt to serving a population that is increasingly forensic. This is reflected in the admissions data presented in Exhibit 19. Only 25% of the admissions to State hospital facilities in fiscal 2002 were forensic compared to 44% in fiscal 2008. This despite the number of forensic admissions to State hospitals being relatively flat over the period. The reason for this apparent increase is the increasing use of purchase of care beds. To date, MHA has used purchase of care beds only for civil admissions, leaving State hospital beds for forensic and civil admissions.

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- The same data also demonstrates that while the State-run psychiatric hospitals remain a major player in inpatient psychiatric care, they are increasingly part of a system that also includes private psychiatric and acute general hospitals (including emergency departments). Perhaps the most striking change is that non-forensic admissions to State hospitals have fallen from 69% of total admissions in fiscal 2002 to 34% in fiscal 2008. Conversely, purchase of care admissions comprise 40% of total admissions in fiscal 2008 compared to 8% in fiscal 2002. This change is driven by a drop in the number of non-forensic admissions from the emergency departments to the State hospitals. Thus, one of the challenges facing MHA is to ensure that this mix of public and private psychiatric beds remains available.
- The specific issue of emergency department use by individuals with serious mental illness remains unresolved. The Maryland Health Care Commission was asked to study this issue in the 2007 session but has not produced a report. Certainly MHA has been working to reduce emergency department use through its expanded diversion programs. Other more general efforts have been made to increase through-put at emergency departments. However, concerns remain.
- Another challenge for the State-run psychiatric hospitals is the age of those facilities. Spring Grove and Springfield in particular are vestiges of a long-gone era of institutional care when thousands of patients filled those campuses. After the closure of Crownsville, a replacement facility for Spring Grove was proposed in the out-years of the *Capital Improvement Program* but never received funding in a capital bill. Numerous proposals have been considered for the redevelopment of the Spring Grove campus that would include a new hospital, the latest being an ambitious multi-billion dollar commercial/residential development. But as of yet, nothing has come to fruition.
- Staffing issues, noted above, will continue to be an area of concern. Indeed, the proposed capacity plan for State-run psychiatric facilities noted in Exhibits 17 and 18 will certainly change again should MHA have to further reduce positions as would be expected given the additional position cuts required by Section 18 and cuts in contractual assistance in Section 23 of the fiscal 2010 budget bill. **DLS recommends that committee narrative is adopted requesting MHA to update its 2007 staffing study to reflect the changes proposed in the fiscal 2010 budget bill.**

Recommended Actions

1. Adopt the following narrative:

Staffing Study Update: In 2007, the Mental Hygiene Administration (MHA) completed a staffing study that pointed to serious staffing shortages throughout the State-run psychiatric facilities. That study prompted a reduction of operating bed capacity. Since that time, cost containment actions have further impacted capacity and personnel allocations, and the fiscal 2010 budget proposes yet more changes. The committees request MHA to update its staffing study following the implementation of these latest changes.

Information Request	Author	Due Date
Staffing Study Update	MHA	November 1, 2009

	<u>Amount Reduction</u>	
2. Reduce fiscal 2010 grant funding because of the availability of fiscal 2009 funding for Veterans Behavioral Health Services. Based on current projections, only \$256,000 of \$1,452,281 available for services will be utilized in fiscal 2009. The Mental Hygiene Administration may encumber these funds to back-fill for the proposed fiscal 2010 reduction.	\$ 1,200,000	GF
3. Reduce fiscal 2010 funding for Veterans Behavioral Health Services based on estimated demand. The allowance contains just under \$2.3 million for services. The reduction still allows for a doubling of expenditures anticipated in fiscal 2009.	1,800,000	GF
4. Reduce general fund support for Targeted Case Management in anticipation of the resumption of claiming federal matching funds for these services. Beginning in fiscal 2008 and fully implemented in fiscal 2009, the Mental Hygiene Administration (MHA) 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	3,500,000	GF

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for Medicare and Medicaid Services to change the reimbursement for case management from a monthly rate to a rate based on 15-minute service times. Case management services continued via contract through State funds only. MHA is currently seeking to restore federal fund participation for case management services.

Total General Fund Reductions **\$ 6,500,000**

Updates

1. Implementation of the Program to Provide Behavioral Health Services for Maryland Veterans of the Afghanistan and Iraq Conflicts

Chapters 555 and 556 of 2008 established a new program for behavioral health services for Maryland veterans of the Afghanistan and Iraq conflicts. The fiscal 2009 budget bill withheld funds for that program pending the receipt of certain information regarding the establishment of that program.

Specifically, the legislature wished to know how service coordination for veterans would be handled and what program eligibility and medical necessity criteria would be utilized for participation in the program.

Service Coordination

Service coordination for eligible veterans is handled by regional resource coordinators in four regions of the State. The coordinators are responsible for linking a veteran eligible for services to those services in the appropriate geographic region. The coordinators are currently being trained in the various crisis services available in the State as well as how to handle referrals to the U.S. Veterans Administration (USVA).

Eligibility and Medical Necessity Criteria

The population targeted under this program must meet three criteria:

- Individuals must be veterans of the Afghanistan or Iraqi conflicts.
- Individuals must meet the medical necessity criteria that are currently applicable under the public mental health system for the types of services being offered under the program (*i.e.*, outpatient services such as evaluation, medication, medication management, and group and family therapy). These criteria are:
 - a Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) diagnosis (the DSM-IV-TR is the widely used standard diagnostic classification system of mental health disorders);
 - a description of DSM-IV-TR symptoms that are consistent with the diagnosis; and
 - at least mild symptomatic distress and/or impairment in functioning due to psychiatric symptoms.

- Individuals meeting the medical necessity criteria must have been unable to access USVA services within two weeks of their contact with MHA.

Other Program Activities

In addition to the program implementation efforts noted above, other activities of note relating to this initiative include:

- planned training for providers on issues that are specific to veterans (for example, military culture and Posttraumatic Stress Disorder);
- the establishment of a separate accounting methodology to track program expenditures; and
- a plan to seek reimbursement from the federal government for the costs incurred by the State.

2. Pilot Integrated Case Management System

In other states, high-cost users of mental and physical health services have been identified and provided with intensive case management services in order to improve health outcomes. In addition to improved health outcomes, other states have also seen lower costs associated with these intensive case management efforts.

In the 2008 session, DHMH was asked to look at this kind of pilot integrated case management program with a view to implementation in Maryland. The department has submitted the report. The report focuses on three different approaches to this issue:

- The report acknowledges what was stated in the 2008 session, namely that individuals with mental illness die 25 years earlier than those without mental illness. The key drivers behind this are smoking (it is estimated that 75% of people with mental illness are tobacco dependent) and obesity (many psychotropic medications cause weight gain). The department is specifically addressing these two risk factors by:
 - collaborating on several pilot projects to encourage individuals with mental illness to quit smoking within peer-support programs, outpatient mental health centers, and psychiatric rehabilitation programs;
 - incorporating non-smoking with Wellness Recovery Action Plan training;
 - collaborating with the National Alliance on Mental Illness (NAMI) to implement NAMI's Six Weeks to Wellness Program; and
 - making all State psychiatric hospitals smoke-free effective September 2008.

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- The department chairs a Medicaid Managed Care Organization Integration of Care Committee that has looked into various ways to improve care including providing Medicaid physicians' access to pharmacy information for individuals receiving mental health services as well as improving care for individuals with frequent emergency room visits and multiple inpatient admissions.

The report also notes efforts at Hopkins BayView and the University of Maryland to improve somatic care for persons with mental illness. The Hopkins program specifically targets risk factors (smoking, nutrition, lifestyle, diabetes, and hypertension) with the development of individual wellness plans. The University of Maryland program is geared toward getting access to needed preventive and medical services.

- Another approach that the department believes holds significant promise is the creation of medical homes and integrated care. The Department of Psychiatry in the University of Maryland School of Medicine is exploring efforts in this area and believes the model holds promise and is actively seeking additional funding for research. The Mental Health Transformation Grant could be a funding source, although it is unclear if there is available funding through that grant.

In summary, while the department is supportive of efforts to improve outcomes for persons with severe mental illness through improved integration of care, lack of funding is currently limiting its efforts to low- or no-cost approaches.

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 2008					
Legislative Appropriation	\$623,164	\$4,995	\$260,948	\$5,242	\$894,349
Deficiency Appropriation	0	151	2,282	0	2,433
Budget Amendments	7,875	133	1,518	771	10,297
Cost Containment	-4,697	0	-3,000	-15	-7,713
Reversions and Cancellations	0	-198	-217	-45	-460
Actual Expenditures	\$626,342	\$5,081	\$261,531	\$5,953	\$898,906
Fiscal 2009					
Legislative Appropriation	\$641,369	\$5,272	\$271,902	\$8,773	\$927,315
Cost Containment	-17,920	-2	-1,504	0	-19,426
Budget Amendments	6,472	3,325	4,636	356	14,790
Working Appropriation	\$629,921	\$8,595	\$275,034	\$9,129	\$922,679

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

Fiscal 2008

The fiscal 2008 legislative appropriation for MHA was increased by just under \$4.6 million. This increase was derived as follows:

- Deficiency appropriations added just over \$2.45 million. Most of this amount, nearly \$2.3 million, was federal funds derived from a variety of grants including the implementation of evidence-based practices, seclusion and restraint training, administering the Mental Health First Aid Training Project, improving cultural and linguistic competency, as well as other administrative expenses. The special fund deficiencies related to various operating expenses throughout the State-run psychiatric facilities.
- An increase of almost \$10.3 million through budget amendments. Specifically:
 - General fund budget amendments increased the legislative appropriation by almost \$7.9 million. First, just over \$3.3 million represents MHA’s share of the fiscal 2008 cost-of-living adjustment (COLA) originally budgeted in the Department of Budget and Management (DBM). Second, almost \$1.3 million represents the transfer of funds into MHA to support higher than budgeted utility costs throughout the facilities. These funds were originally budgeted in the DHMH Administration. Finally, almost \$3.2 million was transferred into MHA from other parts of DHMH as part of the close-out process. These funds were primarily directed at the State-run psychiatric facilities to offset budget shortfalls at those facilities.
 - Special fund budget amendments increased the legislative appropriation by \$133,000.
 - Federal fund budget amendments added just over \$1.5 million to the legislative appropriation. The bulk of this was additional drawing down on Community Mental Health Services Block Grant funding in order to support inpatient diversion activities in various jurisdictions.
 - Reimbursable budget amendments added \$771,000 to the legislative appropriation. The largest amendment was \$675,000 from the Department of Public Safety and Correctional Services for the operation of Chrysalis House which provides mental health, substance abuse, parenting, child care, and educational services to pregnant and post-partum women and their children. The remaining funds were derived from a variety of sources and primarily supported higher fuel and utility and other operating expenses at various State-run psychiatric facilities.
- The increase to the legislative appropriation derived from deficiencies and budget amendments was partially offset by just over \$7.7 million in fiscal 2008 cost containment actions taken by BPW. The bulk of this reduction, \$6.0 million, represented the imposition of hospital day limits for the whole of the fiscal year (this cost containment measure had been scheduled to be lifted in the second half of fiscal 2008). Other cost containment actions saw the abolition of positions as well as a variety of operating reductions (travel, turnover, fleet vehicles, and so forth) across the State-run psychiatric facilities.

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- The legislative appropriation was further reduced by \$460,000 in cancellations spread across special, federal, and reimbursable funds.

Fiscal 2009

To date, the fiscal 2008 legislative appropriation has been reduced by just over \$4.6 million. This change reflects:

- Cost containment taken by BPW in June and October 2008, totaling over \$19.4 million. Additional detail on these actions is provided above.
- Cost containment reductions have been offset by almost \$14.8 million in budget amendments. Specifically:
 - General fund budget amendments have increased the appropriation by almost \$6.5 million. Of this amount, just over \$3.3 million represents MHA's share of the fiscal 2009 COLA originally budgeted in DBM. Another \$2.9 million is for an additional 1.2% provider rate increase for MHA grantees and most fee-for-service rates over and above the 1.5% increase originally provided in the fiscal 2009 appropriation. These funds were available as a result of overattainment in fiscal 2008 lottery revenues and legislation (Chapters 335 and 589 of 2008) directing those overattained funds to such an increase. However, it should be noted that subsequent BPW cost containment action in October 2008 reduced that additional increase to 0.5%, or 2.0% in total. Other smaller increases include the transfer of the nursing retention bonus (\$264,000) from the DHMH Administration budget to the State-run psychiatric facilities and the similar transfer of annual salary review adjustments and other centrally-budgeted costs (\$114,000). One minor general fund budget amendment offset was the transfer of \$105,000 back to the DHMH Administration budgets as part of the creation of the new Deputy Secretariat for Behavioral Health.
 - Special fund budget amendments have increased the appropriation by just over \$3.3 million. The most significant transfer is \$2.7 million from the Health Care Coverage Fund to effectively eliminate Medicaid day limits in fiscal 2009. Additional special funds of \$476,000 are available from tenant collections at Carter. Of this amount, \$330,000 will be used to back-fill a legislative general fund reduction made in the 2008 session on the basis of sharing facility maintenance and utility costs with tenants at Carter. The remaining \$146,000 is due to higher than anticipated tenant collections due to Carter increasing the amount of leased space to tenants since the 2008 session. A similar increase of \$177,000 results from anticipated tenant revenues at RICA Southern Maryland. DHMH is in ongoing negotiations to lease the facility which was closed as part of fiscal 2009 budget deliberations.

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- Federal funds have increase by just over \$4.6 million, representing the federal fund Medicaid match related to the termination of Medicaid day limits and rate increases.
- \$356,000 in reimbursable funds from the Developmental Disabilities Administration associated with the operation of the new forensic and forensic evaluation units at Springfield and Perkins hospitals, respectively.

Audit Findings

Agency:	Mental Hygiene Administration
Audit Period for Last Audit:	July 1, 2004 – June 30, 2007
Issue Date:	May 2008
Number of Findings:	11
Number of Repeat Findings:	3
% of Repeat Findings:	27%
Rating: (if applicable)	n/a

- Finding 1:** MHA did not ensure that federal reimbursement rates for certain services corresponded to the related rates paid to providers which, in calendar 2006, resulted in federal funds totaling \$1.15 million not being claimed. The agency concurred with the finding and recommendation.
- Finding 2:** Eligible provider claims were not always submitted for federal reimbursement within the two-year time frame required by federal regulations. The agency concurred with the finding and recommendation.
- Finding 3:** MHA did not adequately develop and document its procedures for selecting ASO authorization decisions to ensure sufficient coverage. The agency concurred with the finding and recommendation.
- Finding 4:** The ASO did not perform the required number of inpatient facility claim audits. The agency concurred with the finding and recommendation.
- Finding 5:** Interest income totaling approximately \$1.8 million earned on the bank account used by the ASO to pay provider claims had not been transferred to the State’s general fund, and review and approval of the related bank reconciliations was not documented. The agency concurred with the finding and recommendation.
- Finding 6:** Claims reviews performed by the ASO did not include certain critical attributes, including testing for federal fund eligibility and timeliness of billing submissions. The agency concurred with the finding and recommendation.
- Finding 7:** **MHA did not ensure that all significant deficiencies and discrepancies reported by the ASO were investigated and corrected. The agency concurred with the finding and recommendation.**
- Finding 8:** Documentation to support patient eligibility for services paid entirely from the State’s general fund was not always obtained and verified by MHA or the ASO. The agency concurred with the finding and recommendation.

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Finding 9: Sufficient action had not been taken to collect provider advances totaling approximately \$737,000. The agency concurred with the finding and recommendation and is actively recovering funds from the three remaining providers with outstanding advances.

Finding 10: Internal controls over cash receipts were insufficient. The agency concurred with the finding and recommendation.

Finding 11: MHA did not formally analyze and document the potential cost benefits and feasibility of expanding the capitation program, in spite of potential cost savings from the program. The agency concurs that no formal analysis was completed but notes that an analysis was made. As a result, the decision was made to expand Assertive Community Treatment but not to expand the capitation project statewide.

Agency:	RICA – Gildner
Audit Period for Last Audit:	March 28, 2005 – November 30, 2007
Issue Date:	May 2008
Number of Findings:	0
Number of Repeat Findings:	n/a
% of Repeat Findings:	n/a
Rating: (if applicable)	n/a

Agency:	RICA – Baltimore
Audit Period for Last Audit:	November 1, 2005 – June 30, 2008
Issue Date:	October 2008
Number of Findings:	0
Number of Repeat Findings:	n/a
% of Repeat Findings:	n/a
Rating: (if applicable)	n/a

Agency:	Spring Grove Hospital Center
Audit Period for Last Audit:	Special Review Based on Allegations Received via Fraud Hotline
Issue Date:	November 2008
Number of Findings:	4
Number of Repeat Findings:	0
% of Repeat Findings:	n/a
Rating: (if applicable)	n/a

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Finding 1: Numerous questionable transactions totaling \$167,106 were noted related to one contractor. For example, the Maintenance Department’s bidding process for services procured from this contractor appeared to be significantly compromised. The agency agreed with the recommendation that it should comply with State procurement regulations. Although it did offer explanations for some of the transactions within the context of a hospital environment, the agency conceded that these explanations do not fully satisfy the finding.

Finding 2: Projects totaling \$232,000 were frequently directed by the Maintenance Department to three other contractors that employed a certain individual. No competition was sought for these procurements and certain other questionable practices were identified. The agency acknowledges not strictly complying with proper procurement procedures and agrees with the recommendation to do so. However, the agency also noted that the practices, in its view, did not lead to inappropriate value in the services received or waste.

Finding 3: Projects were awarded to several contractors that had personal relationships with certain Spring Grove Hospital Center employees. At a minimum, the awarding of these projects created an appearance of conflicts of interest that may have violated State Ethics Law and a related Governor’s executive order. The agency agrees that action should be taken to ensure compliance with the State Ethics Law and the Governor’s executive order. The agency also agrees that the analysis may give the appearance of a possible conflict of interest. However, the agency also notes that it finds no evidence that prestige of office was used for private gain nor that the State Ethics Law and Governor’s executive order was, in fact, violated.

Finding 4: Spring Grove Hospital Center submitted, and was reimbursed for, a questionable insurance claim made to the State Treasurer’s Office totaling \$35,022. The agency concurs with the recommendation that it only filed claims that are appropriate, however argues that the specific claim in question was not inappropriate but rather lacked proper and timely paperwork.

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Agency:	Eastern Shore Hospital and Upper Shore Community Mental Health Center
Audit Period for Last Audit:	August 1, 2005 – March 23, 2008
Issue Date:	November 2008
Number of Findings:	2
Number of Repeat Findings:	0
% of Repeat Findings:	0%
Rating: (if applicable)	n/a

Finding 1: Efforts were not made to obtain certain medical services for the Eastern Shore Hospital Center and the Upper Shore Community Mental Health Center at the lowest possible prices. The agency took exception to the finding and specifically to the comparison of rates paid by the centers for medical services to Medicaid and State employee health plan rates. The agency analysis of rates paid by the centers compared to those of other specialists in the area found them to be comparable.

Finding 2: The Eastern Shore Hospital Center did not properly monitor contract billings for pharmacy services. The agency concurred with the finding and recommendation.

Agency:	Thomas B. Finan Hospital Center and the Joseph D. Brandenburg Center
Audit Period for Last Audit:	June 1, 2005 – June 30, 2008
Issue Date:	December 2008
Number of Findings:	1
Number of Repeat Findings:	0
% of Repeat Findings:	0%
Rating: (if applicable)	n/a

Note: The Brandenburg Center is a State Residential Center for individuals with developmental disabilities. However, the centers Finan and Brandenburg are in adjoining buildings and administrative functions are centralized.

Finding 1: The centers did not always procure goods and services in accordance with State procurement regulations. The agency concurred with the finding and recommendation.

*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>FY08 Actual</u>	<u>FY09 Working Appropriation</u>	<u>FY10 Allowance</u>	<u>FY09 - FY10 Amount Change</u>	<u>Percent Change</u>
Positions					
01 Regular	3345.70	3181.20	3146.20	-35.00	-1.1%
02 Contractual	218.53	237.69	230.96	-6.73	-2.8%
Total Positions	3564.23	3418.89	3377.16	-41.73	-1.2%
Objects					
01 Salaries and Wages	\$ 218,121,341	\$ 218,183,490	\$ 227,748,278	\$ 9,564,788	4.4%
02 Technical and Spec. Fees	10,006,512	9,821,660	10,007,893	186,233	1.9%
03 Communication	1,013,008	896,631	857,896	-38,735	-4.3%
04 Travel	185,138	176,041	196,475	20,434	11.6%
06 Fuel and Utilities	13,585,314	12,547,685	14,369,643	1,821,958	14.5%
07 Motor Vehicles	998,124	754,421	827,303	72,882	9.7%
08 Contractual Services	634,117,397	659,451,171	693,682,177	34,231,006	5.2%
09 Supplies and Materials	19,051,968	19,095,572	18,783,201	-312,371	-1.6%
10 Equipment – Replacement	642,426	656,658	527,419	-129,239	-19.7%
11 Equipment – Additional	150,186	177,715	112,444	-65,271	-36.7%
12 Grants, Subsidies, and Contributions	261,828	295,143	346,634	51,491	17.4%
13 Fixed Charges	773,021	623,033	565,177	-57,856	-9.3%
Total Objects	\$ 898,906,263	\$ 922,679,220	\$ 968,024,540	\$ 45,345,320	4.9%
Funds					
01 General Fund	\$ 626,341,600	\$ 629,920,718	\$ 664,785,502	\$ 34,864,784	5.5%
03 Special Fund	5,080,810	8,595,454	8,639,377	43,923	0.5%
05 Federal Fund	261,531,136	275,034,431	286,300,372	11,265,941	4.1%
09 Reimbursable Fund	5,952,717	9,128,617	8,299,289	-829,328	-9.1%
Total Funds	\$ 898,906,263	\$ 922,679,220	\$ 968,024,540	\$ 45,345,320	4.9%

Note: The fiscal 2009 appropriation does not include deficiencies. The fiscal 2010 allowance does not include contingent reductions.

Fiscal Summary
DHMH – Mental Hygiene Administration

<u>Program/Unit</u>	<u>FY08 Actual</u>	<u>FY09 Wrk Approp</u>	<u>FY10 Allowance</u>	<u>Change</u>	<u>FY09 - FY10 % Change</u>
01 Mental Hygiene Administration	\$ 617,542,952	\$ 642,656,304	\$ 673,951,510	\$ 31,295,206	4.9%
03 Walter P. Carter Community Mental Health Center	13,111,592	13,556,053	9,204,714	-4,351,339	-32.1%
04 Thomas B. Finan Hospital Center	17,734,291	18,060,519	18,871,110	810,591	4.5%
05 Regional Institute For Children & Adol. – Baltimore City	12,879,620	13,055,419	13,682,286	626,867	4.8%
06 Crownsville Hospital Center	2,010,463	1,505,870	1,507,091	1,221	0.1%
07 Eastern Shore Hospital Center	17,359,313	18,058,126	19,143,155	1,085,029	6.0%
08 Springfield Hospital Center	72,887,776	73,261,132	74,800,855	1,539,723	2.1%
09 Spring Grove Hospital Center	77,932,478	77,598,489	81,333,587	3,735,098	4.8%
10 Clifton T. Perkins Hospital Center	40,942,978	42,413,381	52,107,210	9,693,829	22.9%
11 John L. Gildner Reg. Institute for Children & Adol.	12,158,441	13,086,075	13,468,046	381,971	2.9%
12 Upper Shore Community Mental Health Center	8,648,556	9,077,296	9,488,984	411,688	4.5%
14 Regional Institute for Children & Adolescents – S. MD	5,697,803	350,556	465,992	115,436	32.9%
Total Expenditures	\$ 898,906,263	\$ 922,679,220	\$ 968,024,540	\$ 45,345,320	4.9%
General Fund	\$ 626,341,600	\$ 629,920,718	\$ 664,785,502	\$ 34,864,784	5.5%
Special Fund	5,080,810	8,595,454	8,639,377	43,923	0.5%
Federal Fund	261,531,136	275,034,431	286,300,372	11,265,941	4.1%
Total Appropriations	\$ 892,953,546	\$ 913,550,603	\$ 959,725,251	\$ 46,174,648	5.1%
Reimbursable Fund	\$ 5,952,717	\$ 9,128,617	\$ 8,299,289	-\$ 829,328	-9.1%
Total Funds	\$ 898,906,263	\$ 922,679,220	\$ 968,024,540	\$ 45,345,320	4.9%

Note: The fiscal 2009 appropriation does not include deficiencies. The fiscal 2010 allowance does not include contingent reductions.