M00L
Mental Hygiene Administration
Department of Health and Mental Hygiene

Operating Budget Data

($ in Thousands)

	FY 11 Actual	FY 12 Working	FY 13 Allowance	FY 12-13 Change	% Change Prior Year
General Fund	$641,947	$681,365	$690,844	$9,479	1.4%
Contingent & Back of Bill Reductions	0	0	-6,247	-6,247	
Adjusted General Fund	**$641,947**	**$681,365**	**$684,596**	**$3,232**	**0.5%**
Special Fund	20,935	23,285	18,216	-5,069	-21.8%
Contingent & Back of Bill Reductions	0	0	6,247	6,247	
Adjusted Special Fund	**$20,935**	**$23,285**	**$24,463**	**$1,178**	**5.1%**
Federal Fund	334,918	358,510	353,777	-4,732	-1.3%
Adjusted Federal Fund	**$334,918**	**$358,510**	**$353,777**	**-$4,732**	**-1.3%**
Reimbursable Fund	4,880	5,734	4,464	-1,271	-22.2%
Adjusted Reimbursable Fund	**$4,880**	**$5,734**	**$4,464**	**-$1,271**	**-22.2%**
Adjusted Grand Total	**$1,002,680**	**$1,068,893**	**$1,067,301**	**-$1,593**	**-0.1%**

- Deficiency appropriations for the Mental Hygiene Administration (MHA) include $14.1 million in general funds to pay for bills rolled into fiscal 2012 from fiscal 2011. However, this funding is insufficient to meet all of MHA's needs.

- The fiscal 2013 allowance is almost $1.6 million, or 0.1%, below the fiscal 2012 working appropriation. Funding for community mental health services is down slightly, with increases for enrollment and other initiatives offset by cost containment. Funding for the State-operated psychiatric facilities is essentially flat.

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

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Personnel Data

	FY 11 Actual	FY 12 Working	FY 13 Allowance	FY 12-13 Change
Regular Positions	2,861.05	2,825.95	2,918.95	93.00
Contractual FTEs	171.46	191.66	189.02	-2.64
Total Personnel	**3,032.51**	**3,017.61**	**3,107.97**	**90.36**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	175.21	6.20%
Positions and Percentage Vacant as of 12/31/11	150.95	5.34%

- The budget includes 93 new regular positions, all at Clifton T. Perkins Hospital. These positions are a response to two patient murders at that facility during the 2011 interim.

Analysis in Brief

Major Trends

Enrollment Trends in the Fee-for-service Community Mental Health System: Enrollment growth in the fee-for-service community mental health services broadly mirrors that of Medicaid generally. While still growing, the pace appears to be slowing.

Expenditure Trends in the Fee-for-service Community Mental Health System: Expenditure growth broadly mirrors enrollment growth. There is some evidence that more individuals are being served in lower-cost settings. Certainly, utilization of Residential Treatment Centers is slowing.

Issues

Clifton T. Perkins Hospital: Two patient murders in the 2011 interim have prompted recommendations for significant changes at that facility. Significant staffing changes are already underway.

Integration of Behavioral Health Care: The current provision of behavioral health services is fragmented. A 2011 interim consultant's report commissioned by the Department of Health and Mental Hygiene recommended significant changes to the delivery of those services. Although the department demurred on any final decision at this point, it is committed to a process to propose legislative changes in the 2013 session for implementation in 2014.

Recommended Actions

		Funds	Positions
1.	Add language to restrict funding pending the receipt of a report on costs, children served, and outcomes at the public and private residential treatment centers.		
2.	Reduce funds for contractual employment.	$ 150,000	
3.	Concur with language reducing general funds contingent on the availability of funds from a nonprofit health service plan.		
4.	Add language to restrict transitional housing assistance to persons with a primary diagnosis of serious mental illness.		
5.	Delete funding for purchase of care beds.	2,100,000	
6.	Reduce funding and positions by accelerating the closure of assisted living units at Springfield and Spring Grove from September 1, 2012, to July 1, 2012.	618,075	61.0
	Total Reductions	**$ 2,868,075**	**61.0**

Updates

Capital-related Joint Chairmen's Reports: In fiscal 2012 operating budget deliberations, two different capital-related reports were requested. The status of those reports will be provided.

M00L

Mental Hygiene Administration

Department of Health and Mental Hygiene

Operating Budget Analysis

Program Description

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

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

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

- ***MHA Headquarters*** coordinates mental health services throughout the State according to the populations served, whether in an institutional or community setting.
- ***Core Service Agencies (CSA)*** work with MHA, through signed agreements, to coordinate and deliver mental health services in the counties. There are currently 19 CSAs, some organized as part of local health departments, some as nonprofit agencies, and 2 as a multi-county enterprise.
- ***State-run Psychiatric Facilities*** include five 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.

The carved-out system is overseen by MHA, although it contracts with an administrative services organization (ASO), ValueOptions, to administer the system. Services are also available to non-Medicaid clients. Prior to fiscal 2003, eligibility for non-Medicaid clients was up to 300% of the federal poverty level (FPL), with services provided on a sliding-fee scale. After fiscal 2003, eligibility for new clients was limited to 116% of FPL. With the development of the Maryland Primary Adult Care (PAC) program beginning in fiscal 2007, persons with severe mental illnesses with incomes up to 116% of FPL were transitioned to the Medicaid program for the purposes of reimbursement of mental health services.

However, a significant pool of non-Medicaid clients who do not meet the eligibility criteria for PAC continues to be served by MHA. Specifically, the safety net serves those who have received services within the public mental health system in the past two years (alleviating continuity of care issues for those who occasionally lose Medicaid coverage); the homeless; people who received Social Security Disability Insurance due to psychiatric impairment and are eligible for Medicare (excluding them from PAC) but who need services beyond those covered by Medicare; people who are on court-ordered conditional releases from a State-run psychiatric hospital; anyone discharged from a Maryland psychiatric hospital in the past three months; and anyone within three months of release from a correctional institution.

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

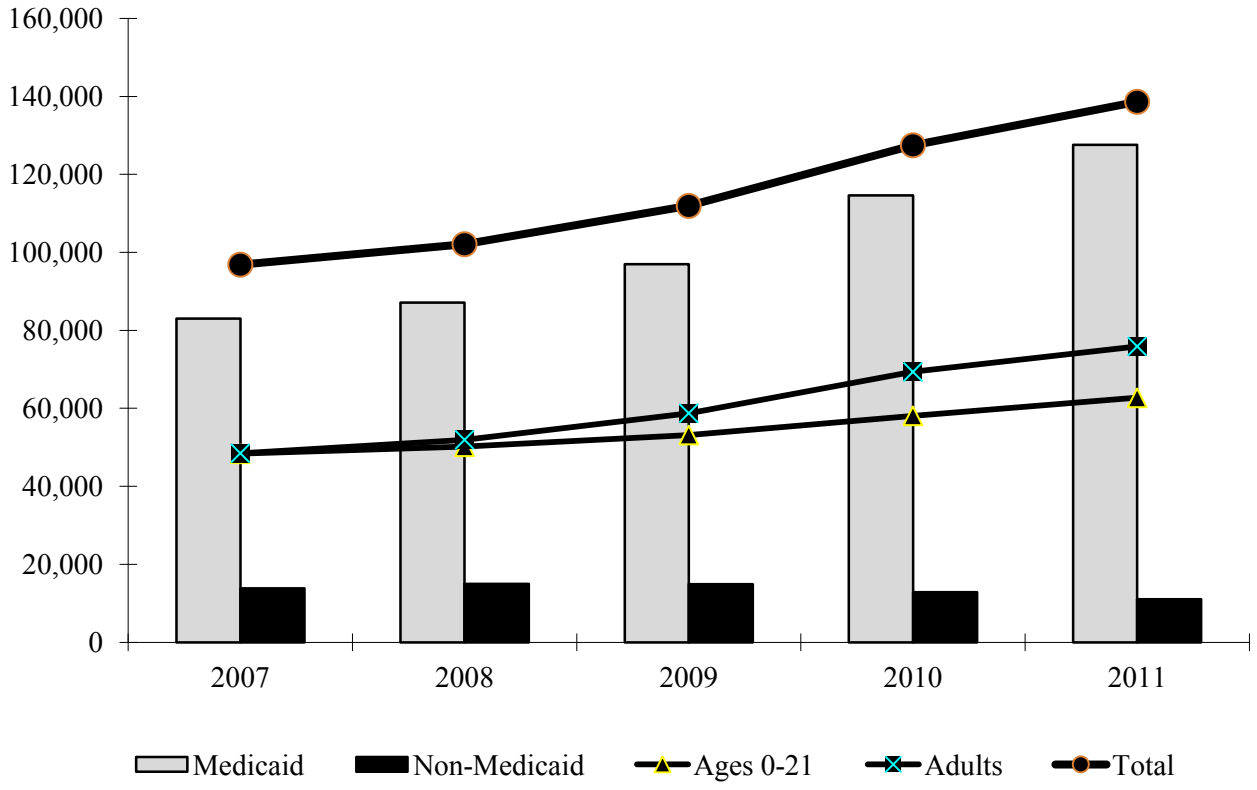
The key goals of the agency include improving the efficacy of community-based care for persons with mental illness and promoting recovery among persons with mental illness in State-run psychiatric facilities so that they may move into less restrictive settings.

Performance Analysis: Managing for Results

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

As shown in **Exhibit 1**, total enrollment in the FFS community mental health system (Medicaid and non-Medicaid) has increased at an average annual rate of 9% between fiscal 2007 and 2011. Consistent with the growth in the Medicaid program overall, the recession as well as Medicaid expansion beginning in fiscal 2009 has resulted in enrollment growth accelerating in recent years, rising by 14% between fiscal 2009 and 2010. Enrollment growth in the FFS community mental health system, as with Medicaid, is beginning to slow although growth is still anticipated at 9% between fiscal 2010 and 2011.

Exhibit 1
Community Mental Health Services Enrollment Trends
Fiscal 2007-2011



Note: Data for fiscal 2011 is incomplete. Enrollment counts may be duplicated across coverage types. Includes enrollment in the Baltimore City capitation project.

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

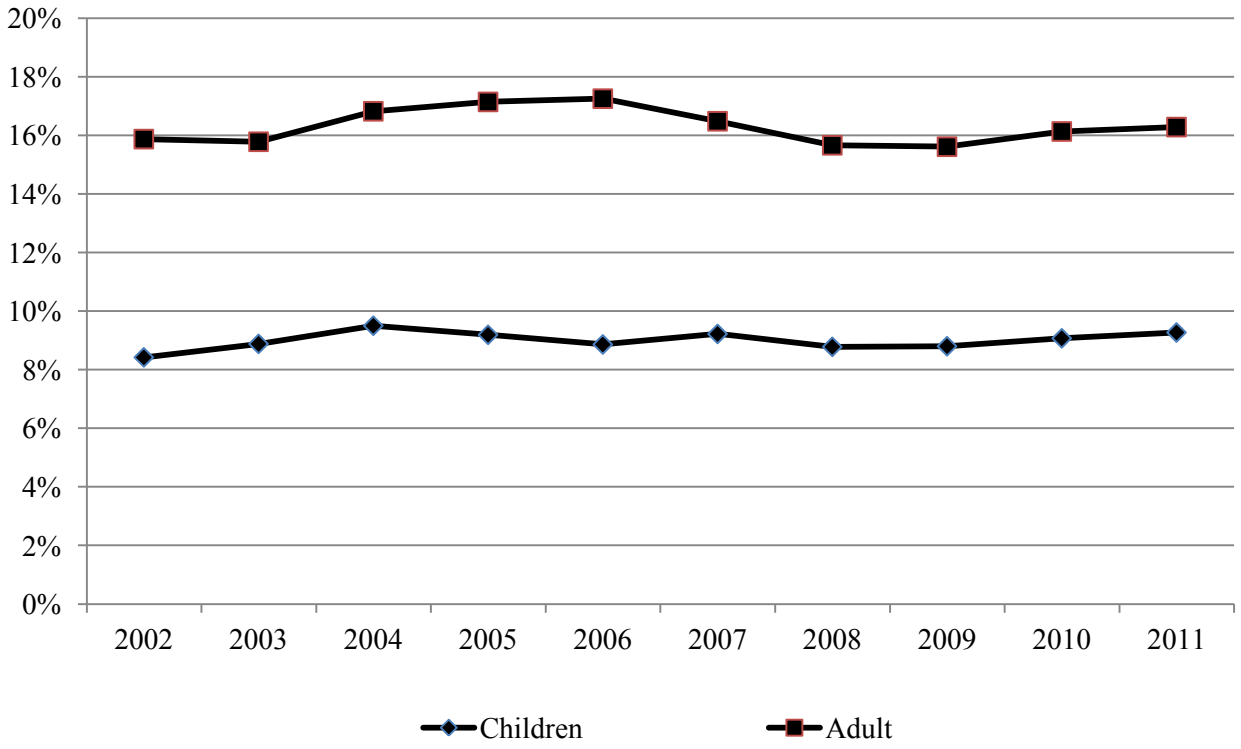
The exhibit also shows:

- Enrollment growth over the period has been driven by adults (12.0% between fiscal 2007 and 2011) reflecting the Medicaid expansion to parents and also to some extent the recent strong growth in the PAC program. Adults make up 55.0% of total enrollment in fiscal 2011. However, between fiscal 2010 and 2011, the growth between the adult and 0-21 group was similar (9.0% versus 8.0%).

- Another piece of the enrollment picture is not simply the overall increase in Medicaid enrollment but also a relative increase, albeit small, in the percentage of Medicaid enrollees utilizing FFS community mental health services. Known as the penetration rate, between

fiscal 2010 and 2011, the rate grew from 9.07 to 9.27% among children enrolled in Medicaid/Maryland Children's Health Program and from 16.13 to 16.28% among adults. While the rates are not as high as they have been in the past (see **Exhibit 2**), they have grown steadily in recent years. As noted last year, the administration believes that on the adult side, this increase is due to a larger number of dual-eligible individuals (with substance abuse and mental health issues) becoming eligible for Medicaid or PAC, and this will continue with Medicaid expansion under the federal Patient Protection and Affordable Care Act.

Exhibit 2
Community Mental Health Services Penetration Rate
Fiscal 2002-2011



Note: Data for fiscal 2011 is incomplete.

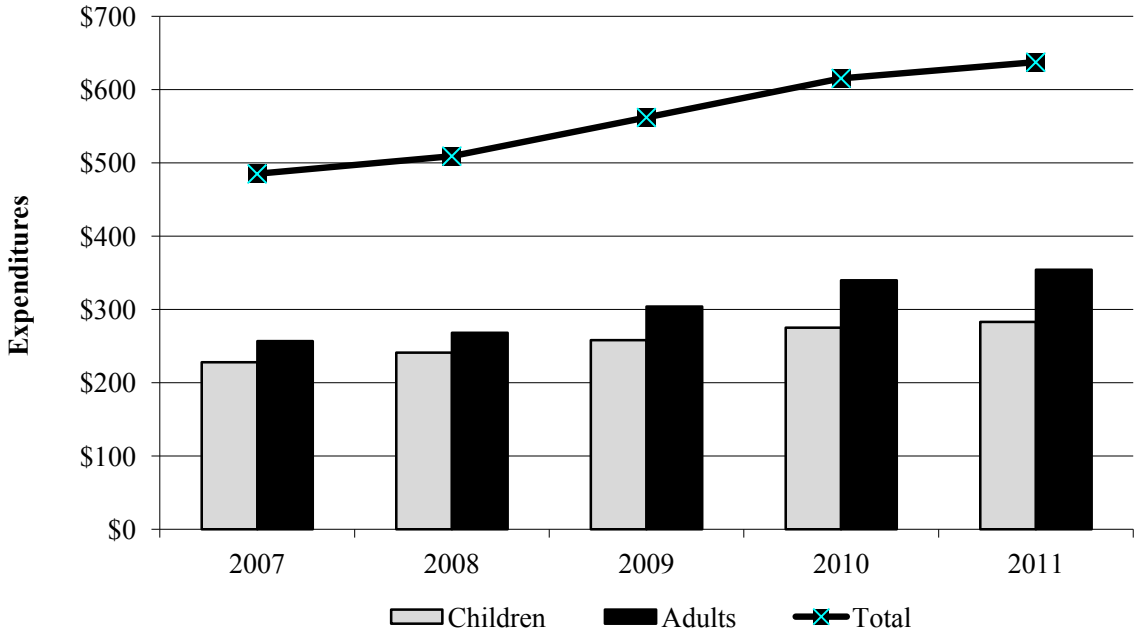
Source: Department of Legislative Services; Department of Health and Mental Hygiene

- Within the two claims categories of clients served (Medicaid and non-Medicaid/uninsured), while historical trends are a little distorted by category definition changes that have influenced enrollment data, recent growth is almost exclusively in the Medicaid-eligible category (11.0% between fiscal 2010 and 2011) with the non-Medicaid population falling for the second year in a row, down 14.0% between fiscal 2010 and 2011.

This drop in the non-Medicaid population served reflects a series of efforts to drive down non-Medicaid service spending, which is entirely State funded. These efforts were, in part, a decision of the Administration to take this path for cost containment rather than other cost containment measures to Medicaid-eligible programs, thereby limiting the total impact of any cost containment measure only to the State funding rather than also losing any federal match.

Expenditure patterns broadly mirror enrollment growth (**Exhibit 3**). Expenditure growth over the period fiscal 2007 to 2011 is 7.1%, although more recent growth is slightly higher (9.5% between fiscal 2009 and 2010). As shown in Exhibit 3, there is some moderation of spending between fiscal 2010 and 2011 (3.6%), although fiscal 2011 data is incomplete. The Department of Legislative Services' (DLS) projected spending for fiscal 2011 over 2010 does call for a higher expenditure growth rate (5.0%). Factors that may suppress expenditure growth in fiscal 2011 include the lack of a provider rate increase in fiscal 2011 (as in fiscal 2010) and lower relative spending on more expensive inpatient and Residential Treatment Center (RTC) settings, as shown in **Exhibit 4**.

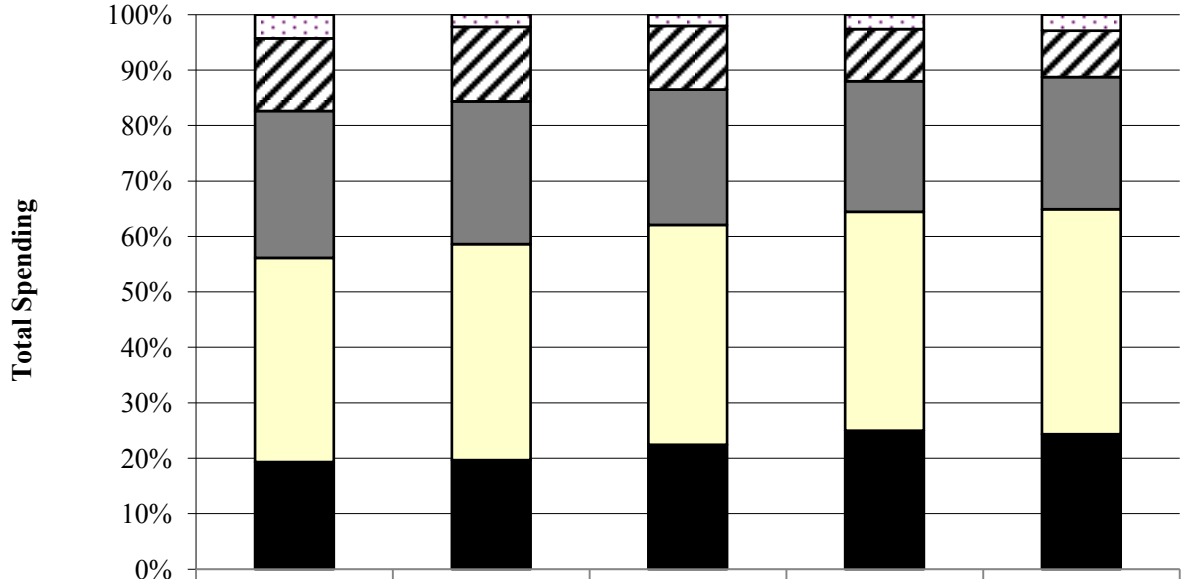
Exhibit 3
Community Mental Health
Fee-for-service Expenditures
Fiscal 2007-2011
($ in Millions)



Note: Data for fiscal 2011 is incomplete. Total expenditures exclude funding for the Baltimore City capitation project.

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

Exhibit 4
Community Mental Health Service Expenditures by Service Type
Fiscal 2007-2011



	2007	2008	2009	2010	2011
Other	$20,873,121	$11,122,399	$11,532,624	$16,193,059	$18,272,137
RTC	$63,369,535	$68,559,249	$64,336,357	$57,740,714	$53,347,388
PRP and RRP	$128,525,670	$131,096,389	$137,360,840	$144,943,636	$151,919,676
Outpatient	$178,514,568	$198,318,560	$222,659,482	$242,648,281	$258,536,562
Inpatient	$93,692,663	$100,014,714	$126,052,831	$153,745,083	$155,200,809

PRP: Psychiatric Rehabilitation Programs
RRP: Resident Rehabilitation Programs
RTC: Residential Treatment Centers

Note: Data for fiscal 2011 is incomplete.

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

Spending on RTC level care in particular continues to decline significantly in both absolute dollars and relative to other mental health services. RTC spending, which accounted for 13% of total spending in fiscal 2007, represented only 8% in 2011, with expenditures down from $63.4 million to $53.3 million over the same period. This decline reflects consistently declining utilization, with RTC beds increasingly used for short-term diagnostic and evaluation rather than longer treatment stays plus the impact of the roll-out of community slots under the RTC Alternatives Demonstration waiver. Spending on RTC placements is expected to continue to decline in fiscal 2013.

Outcomes for Community Mental Health Services

Outcome data from MHA's Outcomes Measurement System continues to be limited to outpatient clinics. The data presented in **Exhibit 5** is restricted to clients with at least two data points (generally six months but up to four years apart) and with the same questionnaire type (*i.e.,* the same age group) for those responses. The data presented in Exhibit 5 compares data from the fiscal 2008, 2009, 2010, and 2011 cohorts. While this is not an unduplicated sample, there are gains in improved functioning for adults and children. What is perhaps not surprising but is still jarring is the level of employment among adults. Three out of every four respondents were unemployed in both observations.

Exhibit 5
Community Mental Health Services
Outpatient Fee-for-service Selected Outcomes
Fiscal 2008-2011

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

Source: Department of Legislative Services; Mental Hygiene Administration

ASO Performance

In 2009, MHA rebid its ASO contract. The existing vendor, APS, was replaced by ValueOptions. In the initial months under ValueOptions, several problems were reported, and at one point the ASO performance was of sufficient concern that MHA was withholding payment. Data presented in the 2010 session indicated both the challenges that ValueOptions had as well as some indication of improvement. Monthly data available to DLS since that time indicates that ValueOptions is meeting all of its administrative performance targets.

Facility Performance Measures

Data presented in **Exhibits 6**, **7**, and **8** examines trends in three outcomes at the State-run psychiatric hospitals. For the purposes of this discussion, Clifton T. Perkins Hospital (Perkins) is excluded given the nature of programming at that facility.

Exhibit 6
State-run Psychiatric Hospitals: Readmissions within 30 Days of Discharge
(Percent of Total Admissions)
Fiscal 2007-2011

	2007	2008	2009	2010	2011	Trend 2007-2011	Trend 2010-2011
Eastern Shore	7.5%	5.8%	10.5%	4.0%	3.0%	√	√
Finan	0.0%	5.3%	2.7%	1.8%	4.4%	X	X
Spring Grove	3.6%	5.0%	4.0%	4.0%	2.0%	√	√
Springfield	6.0%	8.8%	4.6%	3.4%	4.7%	√	X

X: worsened
√: improved

Note: Data excludes assisted living patients
Source: Department of Legislative Services; Department of Health and Mental Hygiene

Exhibit 7
State-run Psychiatric Hospitals: Use of Seclusion
(Rate Per 1,000 Patient Hours)
Fiscal 2007-2011

	2007	2008	2009	2010	2011	Trend 2007-2011	Trend 2010-2011
Eastern Shore	0.32	0.28	0.26	0.86	0.49	X	√
Finan	0.03	0.25	0.03	0.05	0.08	X	X
Spring Grove	0.05	0.02	0.02	0.05	0.02	√	√
Springfield	0.19	0.18	0.10	0.07	0.08	√	X

X: worsened
√: improved

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

Exhibit 8
State-run Psychiatric Hospitals: Elopements
(Number Per 1,000 Patient Days)
Fiscal 2007-2011

	2007	2008	2009	2010	2011	Trend 2007-2011	Trend 2010-2011
Eastern Shore	0.04	0.14	0.15	0.09	0.09	X	Same
Finan	0.23	0.38	0.27	0.17	0.27	X	X
Spring Grove	0.20	0.26	0.29	0.24	0.18	√	√
Springfield	0.32	0.27	0.09	0.08	0.12	√	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, the following observations can be made from these exhibits.

- Short-term trends in readmission rates within 30 days are mixed, but all facilities remain below the latest available national benchmark for readmission rates (9.2%).

- Short-term trends in the use of seclusion are also mixed, although seclusion is a relatively seldom used practice generally at the State-run facilities.

- Short-term elopement trends are generally unfavorable.

In the 2010 and 2011 interim, murders of patients by fellow patients at Perkins once again put a spotlight on outcomes at the State-run psychiatric facilities. However, the Managing for Results data really does not provide any indication of systemic issues, even at Perkins.

As has been pointed out in prior analyses, MHA does not meet its desired staffing ratios at the facilities. Reductions to staff based on unit closures and deleting vacant positions has left the administration with patient-staff ratios that are above desired levels, but because of a lower patient census, were at least no worse than in prior years. Although the MHA vacancy rate of 5.3% at the end of calendar 2011 was much lower than the 7.0% at the end of calendar 2010, MHA actually has slightly fewer filled positions available to it.

Fiscal 2012 Actions

Proposed Deficiency

The following are two fiscal 2012 deficiencies for MHA:

- Just under $3.2 million in federal funds for Maryland Mental Health Transformation activities and community alternatives to institutionalization for children and youth with mental illness; and

- $14.1 million in general funds to cover deficits in the community mental health FFS system.

However, as shown in **Exhibit 9**, the $14.1 million general fund deficiency is insufficient to meet the significant deficiencies faced by MHA, not only in the FFS system, but in other parts of its budget.

Exhibit 9
Mental Hygiene Administration
Fiscal 2012 Deficiency Analysis
(General Funds)

Item	Dollars
Medicaid-eligible Fee-for-service Deficiency (Latest Estimate)	$33,200,000
Uninsured Fee-for-service/Grants and Contracts Deficiency (Latest Estimate)	3,115,000
Grants and Contracts Deficiency (Baltimore County Core Service Agency)	1,119,989
Facilities: Laboratory and pharmacy services	217,710
Clifton T. Perkins (latest estimate of the cost of 65 additional positions either regular/contractual plus overtime)	4,000,000*
Subtotal	***$41,652,699***
Deficiency Appropriation	$14,100,000
Outstanding Deficits	**$27,552,699**

* The Department of Health and Mental Hygiene indicates that it intends to use a projected surplus in the Maryland Children's Health Program to cover this deficit.

Source: Department of Legislative Services; Mental Hygiene Administration

Specifically, at fiscal 2011 closeout, MHA recorded a variety of general fund payables, *i.e.,* amounts equal to bills received in fiscal 2011 for which there were no available funds in fiscal 2011. The largest were in the community mental health FFS system: $37.0 million for Medicaid-eligible recipients and just over $3.2 million in uninsured and other payments (*e.g.,* purchase of care (POC) beds and the Baltimore City capitation project). As shown in the exhibit, that estimated deficit has fallen slightly over the past seven months but still amounts to $36.3 million. Other deficits recorded at closeout included a payment to the Baltimore County CSA as well as various expenses at the facilities.

Added to these deficiencies is a new expense related to Perkins. The death of two inpatients at that facility has prompted the addition of staff. The hospital has already hired 47 new staff and expects to hire 65 staff in total prior to the end of fiscal 2012. Currently, no new positions or additional funding has been provided for this expansion (although 93 new positions and funding are added in fiscal 2013). MHA estimated that expenditures relating to these additional positions plus the cost of additional overtime will reach $4 million in fiscal 2012.

At this point, the $14.1 million deficiency appropriation only partially offsets MHA's deficiency needs.

Section 47 of Chapter 395 of 2011

Section 47 of the fiscal 2012 budget bill required the abolition of 450.0 regular positions in addition to a general fund reduction. For MHA, that resulted in the abolition of 35.1 full-time equivalent regular positions.

Proposed Budget

As shown in **Exhibit 10**, the Governor's fiscal 2013 allowance for MHA falls by just under $1.3 million (0.1%) from the fiscal 2012 working appropriation. However, that apparent level funding masks a significant amount of change in the budget both in community mental health services as well as at the facilities.

Exhibit 10
Proposed Budget
DHMH – Mental Hygiene Administration
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
2012 Working Appropriation	$681,365	$23,285	$358,510	$5,734	$1,068,893
2013 Allowance	690,844	18,216	353,777	4,464	1,067,301
Amount Change	$9,479	-$5,069	-$4,732	-$1,271	-$1,593
Percent Change	1.4%	-21.8%	-1.3%	-22.2%	-0.1%
Contingent Reduction	-$6,247	$6,247	$0	$0	$0
Adjusted Change	$3,232	$1,178	-$4,732	-$1,271	-$1,593
Adjusted Percent Change	0.5%	5.1%	-1.3%	-22.2%	-0.1%

Where It Goes:		
Personnel Expenses	**$2,662**	
New positions (93 at Clifton T. Perkins Hospital)		$4,280
Retirement contributions		2,760
Employee and retiree health insurance		2,206
Miscellaneous adjustments		308
Other fringe benefit adjustments		-19
Social Security contributions		-99
Workers' compensation premium assessment		-436
Regular salaries		-1,325
Removal of fiscal 2012 one-time $750 bonus		-2,156
Turnover adjustments (including closure of assisted living beds at Springfield and Spring Grove hospitals)		-2,857
Community Mental Health Services	**-$2,400**	
Fee-for-service Expenditures	***-$1,161***	
Enrollment and utilization (including savings from lower RTC utilization)		25,999
Statutory rate adjustment for non-rate regulated providers (0.88%)		5,050
Expansion of community psychiatric rehabilitation services for individuals moving from assisted living beds at Springfield and Spring Grove		1,900
Elimination of psychiatric rehabilitation benefit for most uninsured		-1,500
Eliminate psychiatric rehabilitation services in HSCRC-regulated space (Bayview)		-3,000
Reduce by two-thirds funding for Purchase of Care beds		-4,250
Fraud, waste, and abuse savings		-5,360

Where It Goes:		
Inpatient utilization review		-20,000
Grants and Contracts	***-$1,239***	
Housing assistance initiative		1,000
Identification assistance		500
Administrative Services Organization contractual fee		252
Various federal grants		-448
Community alternatives to RTC placements (reimbursable funds)		-1,105
Grants and contracts to CSAs (after adjustments for ID assistance, ASO fee, and rate adjustment)		-1,438
Facilities (Nonpersonnel)	**-$2,339**	
Various health care services (across all facilities)		193
Utilities		-266
Food costs (includes savings from assisted living unit closures)		-266
Contractual employment		-471
Food services at Upper Shore Community Mental Health Center (food service contract transferred to building tenants)		-541
Drug costs (includes savings from assisted living unit closures, recent changes that have seen several brand-name drugs go generic, and efforts to reduce medication costs)		-988
Executive Direction	**$497**	
Increased oversight of community forensic compliance		497
Other		-13
Total		**-$1,593**

ASO: Administrative Services Organization
CSA: Core Service Agency
FTE: full-time equivalent
HSCRC: Health Services Cost Review Commission
RTC: Residential treatment Center

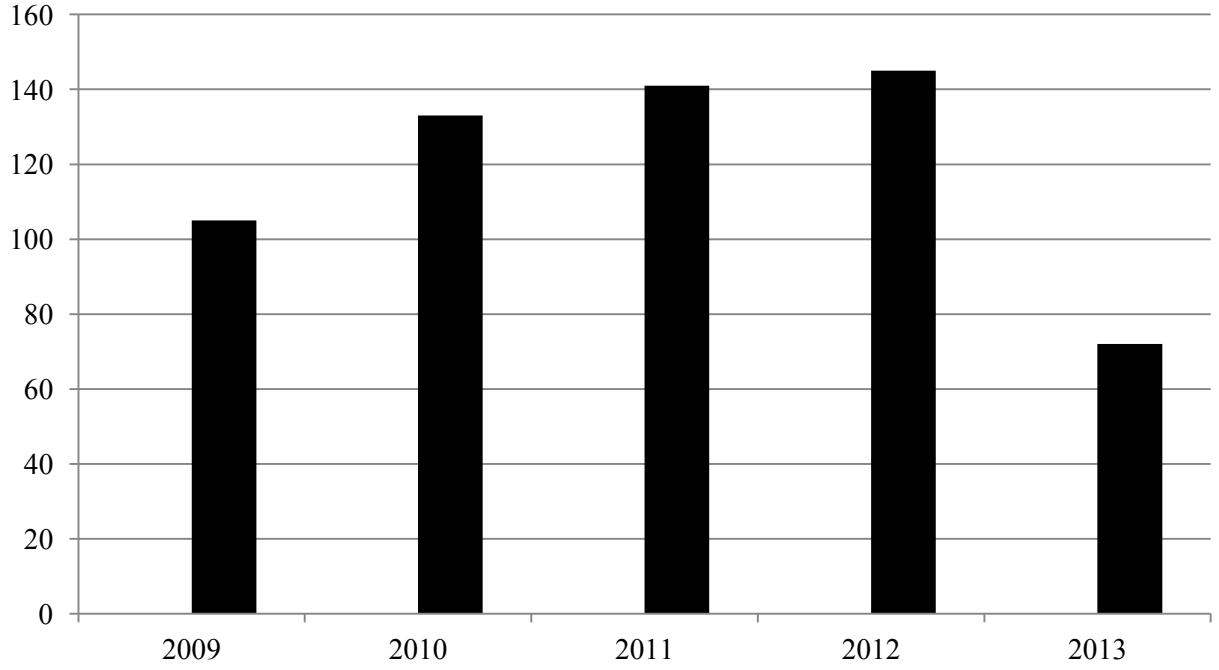
Note: Numbers may not sum to total due to rounding.

Personnel and Facilities Spending

The budget includes 93 new regular positions at Perkins at a cost of almost $4.3 million. As noted above, MHA is already adding new staff and plans to have 65 of these positions filled in fiscal 2012. The proposed changes at this hospital are discussed in greater detail in Issue 1. There are additional significant increases in retirement (almost $2.8 million) and health insurance (just over $2.2 million) costs. These increases are somewhat offset by several large reductions including just over $2.2 million from the removal of the one-time fiscal 2012 $750 bonus and almost $2.9 million in increased turnover adjustment.

The increase in turnover adjustment relates to the proposal in the budget to close 88 assisted living or domiciliary care beds: 48 at Spring Grove Hospital Center (leaving 24 beds for court-involved patients) and 40 beds at Springfield Hospital. Assisted living beds are considered step-down placements for patients in the State-run psychiatric facilities who no longer need hospital-level care but either are not considered fully ready for community placements or are difficult to place. Ironically, as shown in **Exhibit 11**, this comes after several years when MHA has increased the number of assisted living beds during various cost containment actions *i.e.,* closing hospital-level of care beds in favor of assisted living beds which are cheaper to operate. MHA proposes to close this capacity effective September 1, 2012, effectively eliminating 61 regular positions, although MHA has indicated that it will place all affected staff in vacant positions at the same facility where they are currently employed. Community FFS funding for psychiatric rehabilitation services goes up by $1.9 million for additional community services to serve this population. Additionally, a portion of the funding for housing assistance will also benefit the population transitioning from the assisted living units (ALU).

Exhibit 11
State-operated Psychiatric Facilities
Assisted Living Beds
Fiscal 2009-2013



Source: Department of Legislative Services; Mental Hygiene Administration

Two additional points should be noted about MHA's ALU proposal:

- In the past, there has been some talk of simply privatizing ALUs, allowing a private vendor to operate the same programming at the same location and also claiming Medicaid funds for services provided. However, according to MHA, CMS has become increasingly intolerant about private facilities operating on State hospital grounds and at the same time claiming Medicaid funding and this is not an option.

- To the extent that many of the individuals in the ALUs (like the State-run psychiatric hospitals in general) are court-involved, MHA will need to work closely with the Judiciary to ensure that patients in the ALUs can move into community-based settings (although it should be noted that these patients already have more latitude than patients in other wards to go on- and off-campus).

Finally, in addition to personnel savings, the closure of the ALUs also generates savings in such things as food and drugs. These savings contribute to a significant drop in nonpersonnel operating expenditures at the State-run Psychiatric Facilities.

Community Mental Health Services: Fee-for-service Expenditures

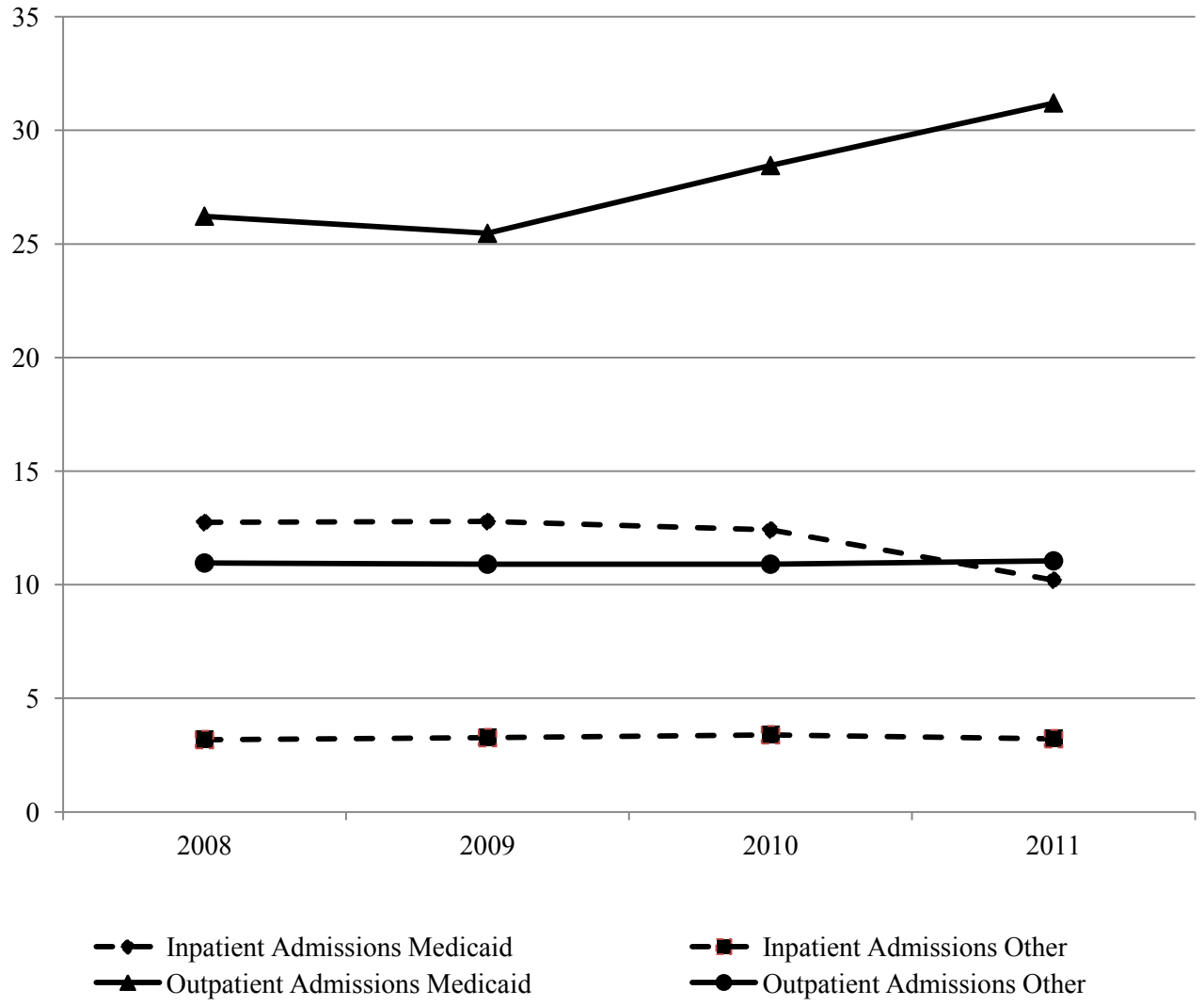
As shown in Exhibit 10, total expenditures in the FFS community mental health system are budgeted to fall between fiscal 2012 and 2013. However, that small decline reflects a combination of increases and offsets through cost containment.

Funding for enrollment growth and utilization is budgeted to increase $26 million, most of which is in the Medicaid-eligible program. In that program, the underlying rate of budget growth over fiscal 2012 (before adjusting for cost containment, psychiatric rehabilitation services for individuals transitioning for State-operated assisted living beds, and the 0.88% provider rate adjustment) is 3.7%. This assumes a continued decline in the use of RTC capacity in favor of community alternatives. The increases in the Medicaid-eligible program are largely offset by significant cost containment actions:

- $20.0 million in savings from diverting patients from expensive inpatient care. The intent is to better coordinate care between CSAs, ASO, and community providers to place people in crisis beds and otherwise serve them in less expensive settings. There is little doubt that it appears more could be done to reduce the utilization of inpatient care. **Exhibit 12**, for example, shows that the rate of Medicaid individuals presenting at emergency rooms with psychiatric symptoms and the rate of Medicaid individuals who are subsequently admitted for inpatient care with psychiatric symptoms is significantly higher than the comparable rates for other payers.

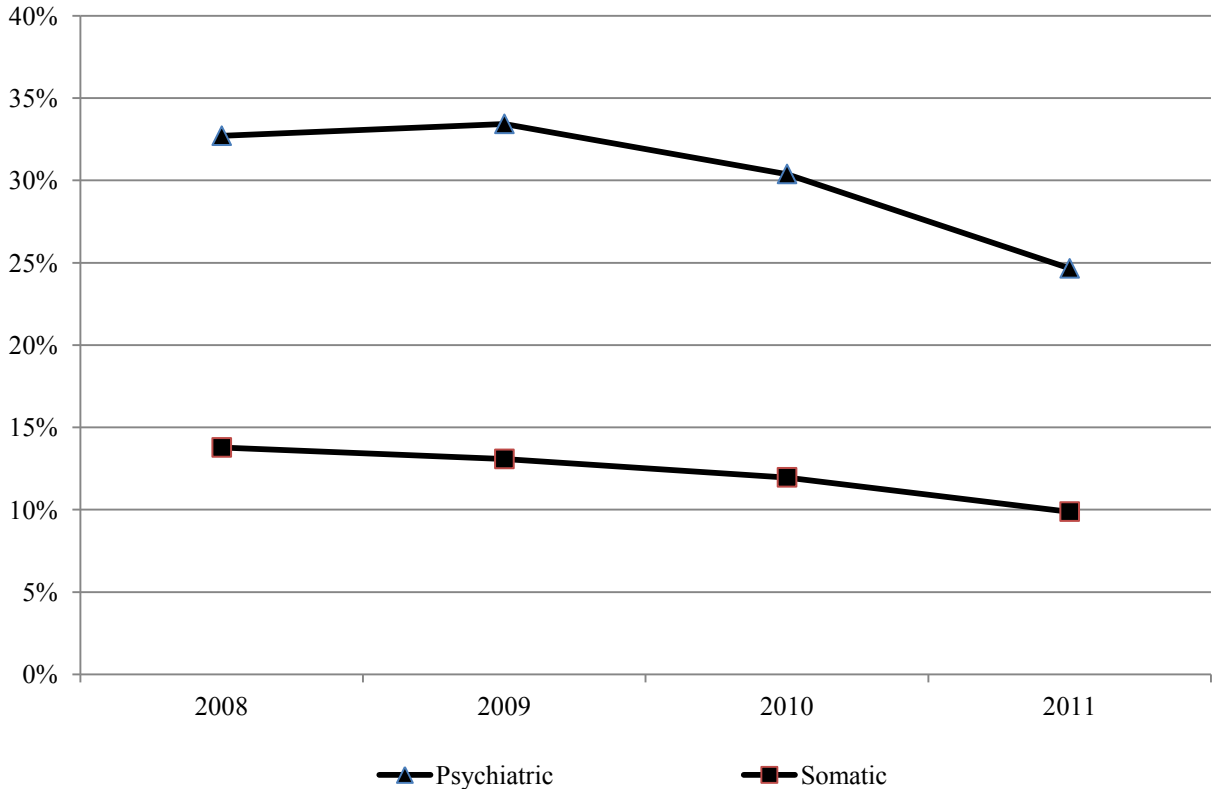
  Similarly, **Exhibit 13** shows that, among Medicaid recipients, the percentage of emergency room visits that result in an inpatient admission is significantly higher for individuals presenting with psychiatric symptoms than for somatic care.

Exhibit 12
Emergency Room Outpatient and Inpatient Admissions
Individuals with Psychiatric Symptoms
Various Payers
Fiscal 2008-2011
(Rate Per 1000 Population)



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

Exhibit 13
Inpatient Admission via the Emergency Room
Medicaid Recipients Presenting with Psychiatric and Non-psychiatric Symptoms
Fiscal 2008-2011
(Percent of Emergency Room Admissions)



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

In recent years, DLS has reported that CSAs have had some success diverting patients from emergency rooms. However, the concern about this current proposal is that MHA's budget does not contain additional funding for some of the alternative services, such as crisis beds. Indeed, as noted in Exhibit 10, traditional grant funding for CSAs is significantly lower in fiscal 2013 than in fiscal 2012.

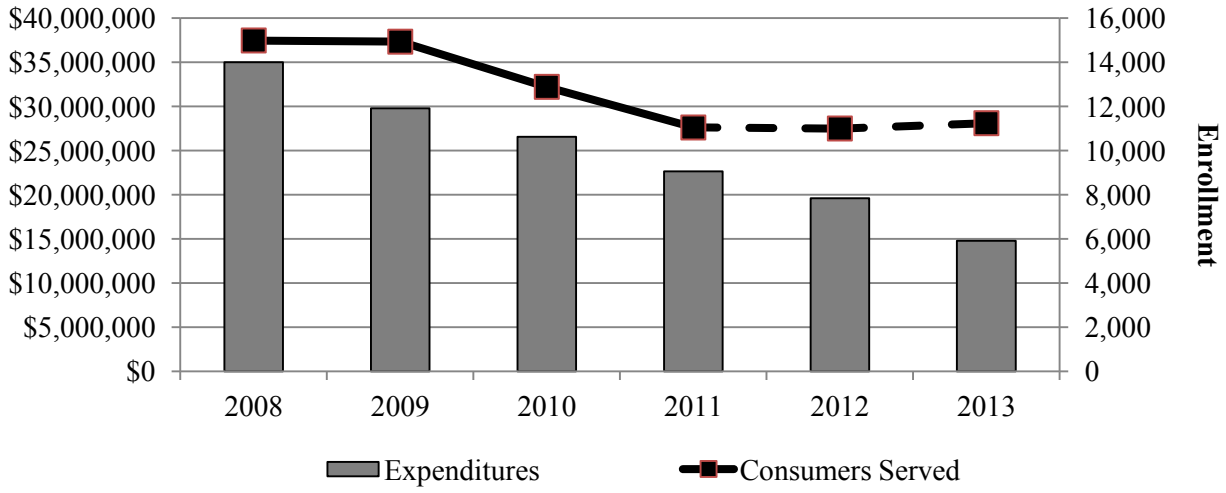
- The budget proposes to generate almost $5.4 million in savings by reducing fraud, waste, and abuse. The Office of the Inspector General's budget includes 6 new positions to facilitate this effort. The concern with this proposal is again not the intent, but rather whether the amount of savings will actually be realized, especially in the first year.

- Finally, in the Medicaid-eligible budget, $3.0 million in savings are proposed by eliminating psychiatric rehabilitation services in the Health Services Cost Review Commission (HSCRC)-regulated space. This proposal impacts one program, at Hopkins Bayview. While MHA acknowledges the quality of the program at that facility, the cost of the program is relatively high because it is in HSCRC-regulated space. While MHA would like to keep the program open, this can only happen if Bayview can develop some alternative to the current cost structure so that the requisite cost savings are generated.

As noted earlier, in recent years, cost containment efforts in the Medicaid-ineligible FFS area have been quite dramatic. In addition to limiting eligibility to lower income individuals (below 200% of FPL), MHA has also tightened eligibility by requiring applications for Medicaid, eliminating coverage for partial hospitalization and intensive outpatient services, and increasing utilization review by ASO. While this is reducing expenditures, it is also reducing the number of consumers served. Traditionally, MHA has argued that spending on this population ultimately reduces State spending in other areas, for example, State hospitals and prisons, as well as reducing overcrowding in emergency rooms and jails.

As shown in **Exhibit 14**, the tightening of spending for the uninsured continues in fiscal 2013.

Exhibit 14
Community Mental Health
Medicaid-ineligible Enrollment and Fee-for-service Expenditures
Fiscal 2008-2013



Note: Data for fiscal 2011 is incomplete.

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

The underlying change in uninsured spending is down 27% from fiscal 2012. The two major cost containment actions in the uninsured program are:

- The elimination of the psychiatric rehabilitation benefit for the uninsured with exceptions made on a case-by-case basis, for a savings of $1.5 million. MHA indicates that it will still pay for psychiatric rehabilitation services for current recipients and beyond that in certain circumstances (for example, for individuals being released from prison or discharged from State-run psychiatric facilities). For others, individuals who would have been served in those settings will be moved into lower-cost outpatient treatment.

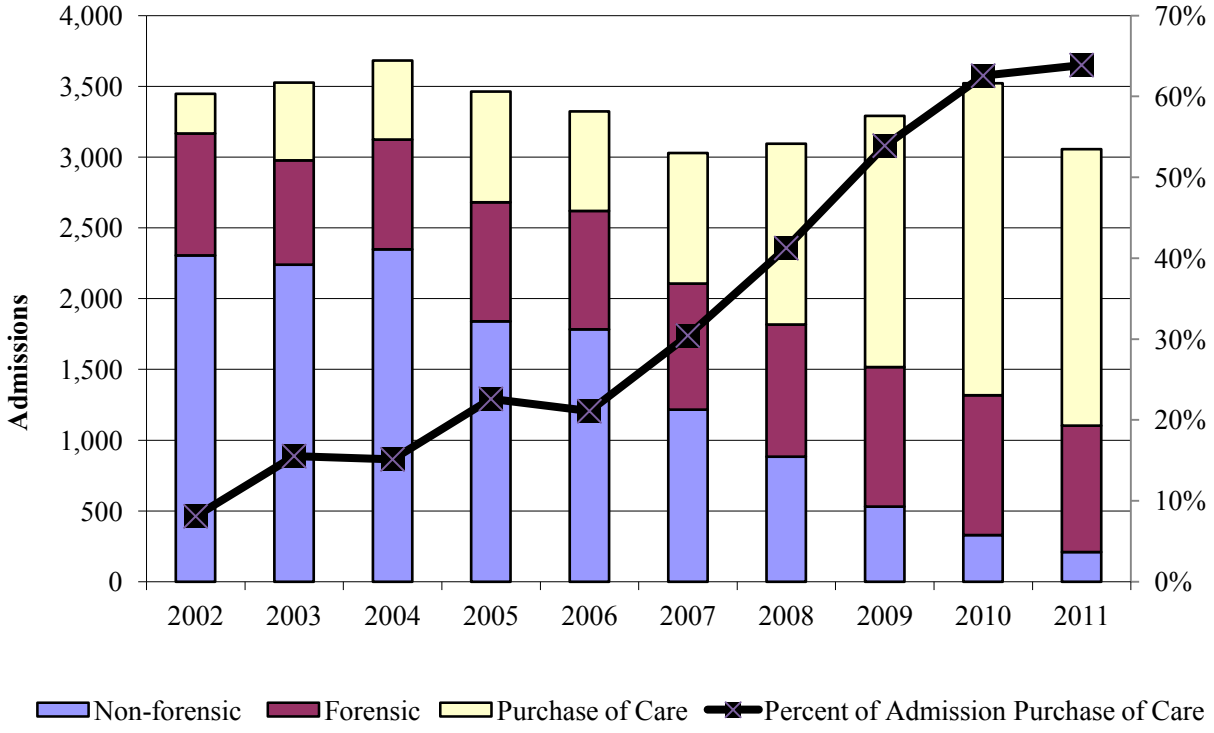
- Reducing funding for purchase of care beds at private psychiatric hospitals (Shepherd Pratt, Brook Lane Health Services, and Adventist Hospital) by two-thirds, a savings of $4.25 million. For some years MHA has been utilizing POC beds at private hospitals *i.e.*, paying for hospital admissions in the private sector, rather than admitting patients to State-run psychiatric hospitals. As shown in **Exhibit 15,** which details all admissions to the State-run psychiatric hospitals as well as the POC admissions between fiscal 2002 and 2010, MHA's policy has significantly reduced the number of what otherwise would have been civil admissions to the State-run psychiatric hospitals. MHA notes that under the federal Emergency Medical Treatment and Active Labor Act (EMTALA) these hospitals will not be able to reject patients, refuse to treat them, or transfer them to public hospitals because they are unable to pay.

  Under the EMTALA, if a hospital has no inpatient psychiatric capability, they are responsible for transferring the patient that needs to be admitted for inpatient treatment to a facility with an inpatient bed and that facility must accept the transfer. If a facility has inpatient capability but no empty bed, again they must transfer the patient to a facility with inpatient capacity. For uninsured patients, care will be provided as uncompensated care and ultimately reflected in facility rates.

  The EMTALA has been in existence since 1986; in recent years, the Centers for Medicare and Medicaid Services has been more rigorous in enforcing all aspects of the law. MHA initially responded by capping POC expenditures and is now proposing to reduce funding by two-thirds. If the logic behind the reduction is that services will still be provided because of the federal law, it would seem logical to simply end the payments. Certainly, MHA did not indicate why a certain pool of funding was retained except to say that it preferred to transition away from these payments over a longer period. **Nonetheless, DLS recommends a reduction of $2.1 million, eliminating the POC funding.**

It should also be noted that in the fiscal 2012 budget, language was added restricting $3 million that would otherwise have gone to fund RTC placements be diverted to community placements. MHA has worked to develop projects to increase diversion including enhanced case review to support timely discharge from RTCs; an expedited RTC discharge pilot project at Villa Marie; a Baltimore City Emergency Department Diversion project; the development of statewide capacity for pediatricians to consult with child psychiatrists including a specific rural model on the

Exhibit 15
State-run Psychiatric Hospital Admission Data
Fiscal 2002-2011



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

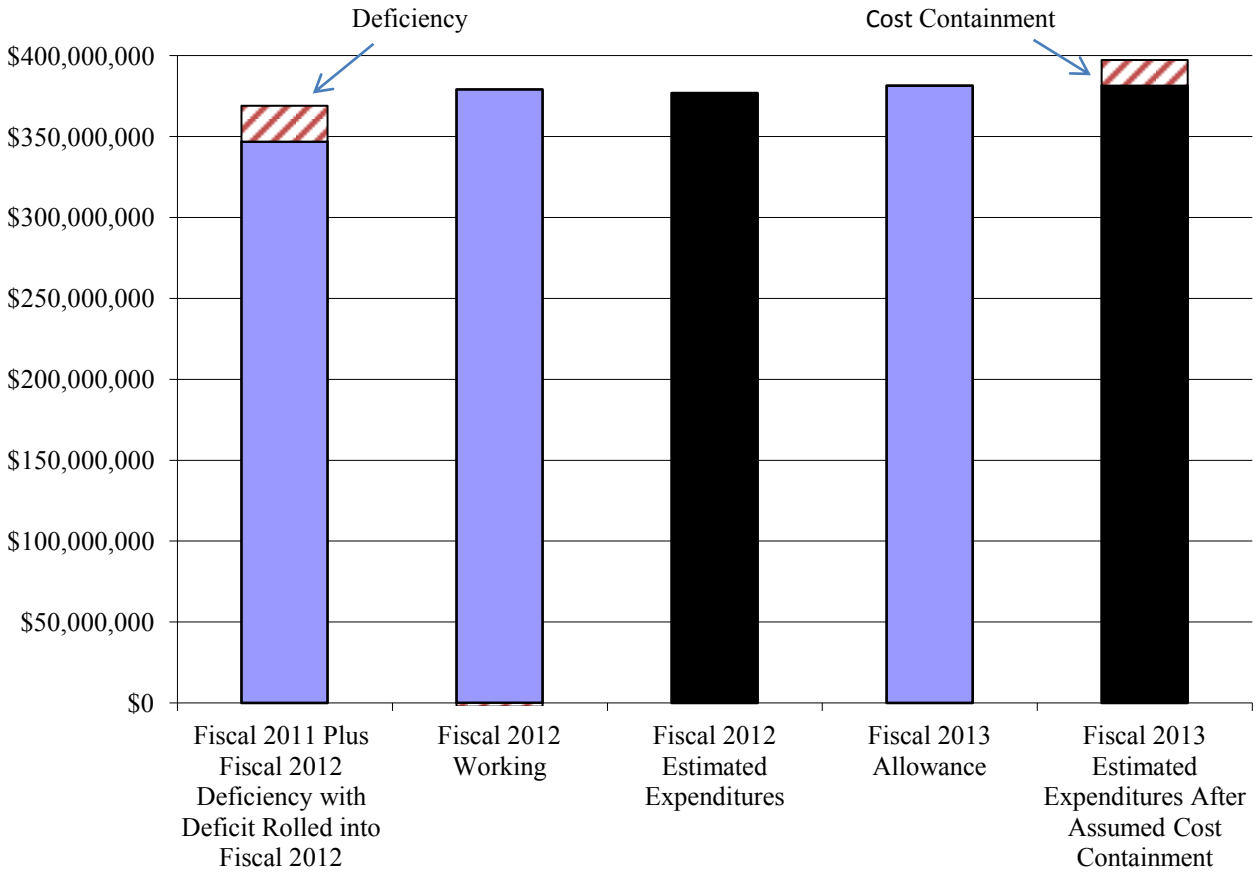
Source: Department of Health and Mental Hygiene; Department of Legislative Services

Eastern Shore; practice improvements through the University of Maryland School of Medicine; and funding for peer support services. In fiscal 2013, no additional funding is provided for these initiatives. Rather, the $3 million earmarked in fiscal 2012 will cover projects for both fiscal 2012 and 2013. Funding beyond that time is not guaranteed.

State Fund Adequacy

Exhibit 16 provides an analysis of State fund adequacy in the FFS system (recognizing the availability of special funds). The assumptions underpinning the DLS estimates are based on the most recent available data on fiscal 2011 expenditures, enrollment, and service cost growth of 7% in fiscal 2012 and 5% in fiscal 2013 in Medicaid-funded services with the exception of RTCs where negative growth is assumed, zero enrollment and service cost growth in State-fund

Exhibit 16
Community Mental Health Services
Fee-for-service Funding
State Funds Adequacy
Fiscal 2011-2013



Note: See text for assumptions.

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

only programs, and provider rate adjustments. Based on this analysis, DLS estimates that, ignoring the carryover deficit rolled into fiscal 2012, the community mental health FFS budget appears adequately funded in fiscal 2012 and may even be able to slightly offset the fiscal 2011 deficit rolled into fiscal 2012. Fiscal 2013 also appears to be reasonably funded provided that the level of cost containment envisioned in the budget is realized.

Community Mental Health Services: Grants and Contracts

Funding for community health services not delivered through the FFS system also falls from fiscal 2012 to 2013. However, the following are two small initiatives in the budget:

- $1,000,000 in transitional housing assistance targeted at individuals with very low incomes to help provide housing support in the community. The funding will also help in the placement of individuals from the State-operated ALUs into the community. As noted in Exhibit 5, homelessness is consistently a problem for a small segment of the seriously mentally ill. Further, the rate of homelessness among the mentally ill is much greater than the population at large (an estimated 0.2%). According to MHA, this funding is to be split between individuals with mental illness and individuals with developmental disabilities.

- $500,000 that will be used to help individuals with serious mental illness obtain the identification information needed to access needed services, potentially including Medicaid. CSAs have long noted that many individuals that are served as uninsured remain in that status because they lack proper documentation.

More than offsetting the new spending associated with these initiatives and other contact expenses are reductions in federal grants ($448,000), spending on community alternatives to RTC placements (just over $1.1 million), and funding otherwise available to the CSAs (just over $1.4 million). The reduction in funding available to community alternatives to RTC placements is due to a loss of reimbursable funds from the Children's Cabinet Interagency Fund. This reduction might appear to potentially limit MHA's ability to expand community placements and reduce RTC utilization. In fact, MHA has traditionally not spent the reimbursable funds, and they have been cancelled (with the general funds being reverted in the Interagency Fund). This year the funding was simply not provided. It should also be noted that the RTC diversion program, which currently operates under a 1915(c) demonstration waiver, expires September 30, 2012. MHA is currently applying to continue the program as a 1915(i) waiver program.

Executive Direction

There is one other initiative in the main administrative office of MHA, almost $500,000 to boost the Community Forensic Aftercare Program. This program is responsible for monitoring compliance with conditional release from State-run psychiatric facilities. The program staff has higher caseloads than in prior years (800 compared to 500 in 2002) and also has to appear in courts more than in the past. The funding adds contractual staff as well as funding to upgrade information technology capacity in the Office of Forensic Services to better track cases.

Budget Reconciliation and Financing Act of 2012

There are two provisions in the Budget Reconciliation and Financing Act (BRFA) of 2012 that relate to MHA:

- There is a $6,247,276 general fund reduction in the community mental health FFS budget for the uninsured contingent on language in the BRFA authorizing the use of revenue from CareFirst to backfill for that reduction. This is revenue that otherwise would have been available to the Maryland Community Health Resources Commission. This action is similar to actions taken in recent budget proposals although the funding has hitherto not supported community mental health services. The BRFA makes those services an eligible use of the revenue on a permanent basis.

- Language in the BRFA also authorizes the use of funds in the Maryland Health Insurance Plan (MHIP) fund to be spent on community mental health FFS budget for the uninsured. However, at this time, there is no specific funding attached to this provision. Any funding transferred from MHIP to MHA would require the approval of the Centers for Medicare and Medicaid Services.

Issues

1. Clifton T. Perkins Hospital

In the 2011 interim, two patients were murdered by other patients at Perkins, the State's sole maximum security psychiatric hospital. These incidents followed another patient-on-patient murder that occurred in the 2010 interim. Despite the extremely difficult patients treated at Perkins, these were in fact the first incidents of this nature in the facility's history. That fact notwithstanding, DHMH contracted with two outside consultants to conduct a broad review of conditions and practices at Perkins in order to maximize quality of care and ensure the safety of all patients and workers.

The consultants submitted their review in January 2012. Although the report contained 73 recommendations, it noted that the intent was to make a good hospital better. The report noted the expertise across all levels of staff; the high level of clinical care; and, notwithstanding low utilization of seclusion and restraint, the limited staff and patient injury levels. Nevertheless, the report concluded improvements could be made. Some recommendations could be implemented quickly and at no cost, while others would take time and additional resources.

The report did not contain recommendations concerning physical plant security. That review was due to be concluded in mid-January but at this point is still not available. However, it was noted that there is often too much attention paid to plant security while greater benefits can accrue from other changes.

The report's recommendations were grouped into ten areas and are briefly summarized in **Exhibit 17**.

As noted in the report, some of these recommendations were already being implemented at Perkins even as the consultants were conducting their review. From a budgetary perspective, the most visible response has been the proposed addition of staff – up to 65 positions in fiscal 2012, through double-pinning and contractual employment with positions and funding formally added in fiscal 2013; and an additional 28 positions in fiscal 2013, for a total of 93 positions. According to MHA, the rationale for the additional positions was as follows:

- The addition of 65 positions was to get the facility to a new staffing standard established at Perkins in the late-fall. The staffing is intended to increase monitoring both on- and off-ward without a reliance on mandatory overtime.

- The addition of 28 positions to reduce nonmandated levels of overtime.

Exhibit 17

Summary of Consultant's Report Recommendations on Perkins Hospital

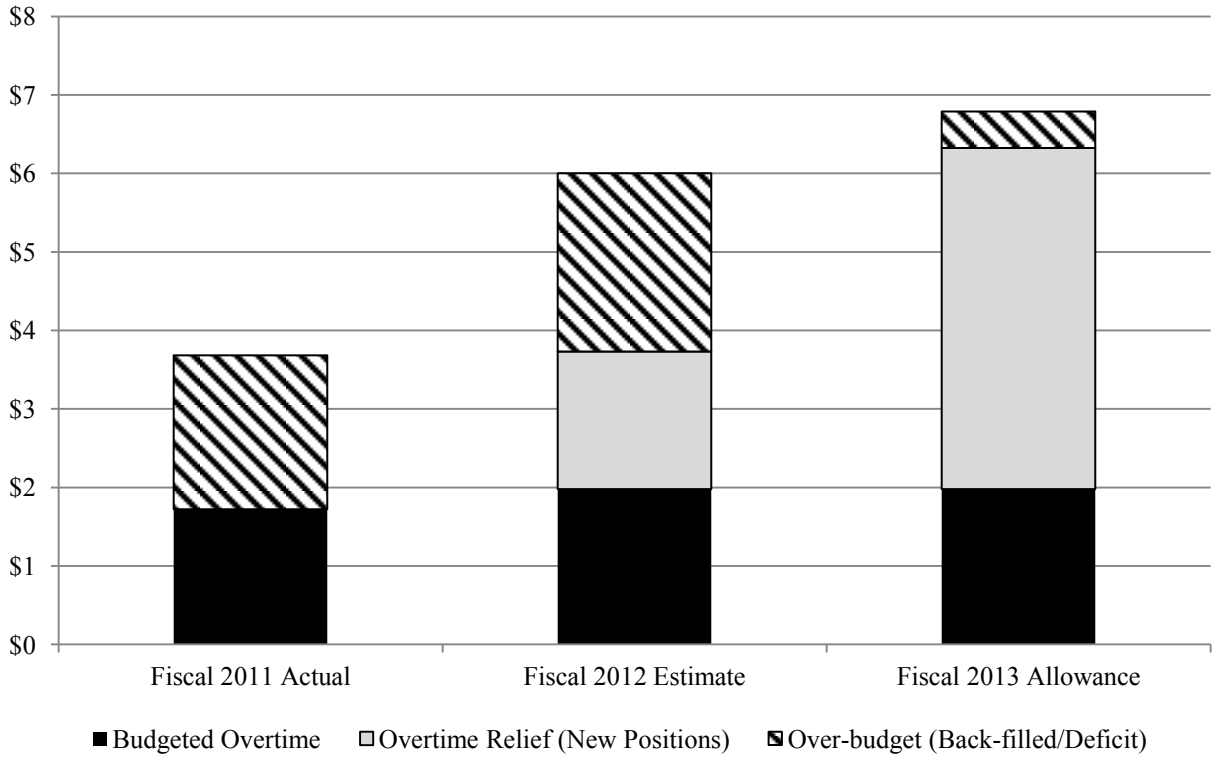
Recommendation Area	Number of Recs.	Recommendation
Leadership	9	The report identified numerous structural deficiencies in leadership at every level. The recommendations were intended to address those deficiencies and establish greater accountability at all staffing levels.
Communication and Coordination of Care and Services	12	Adequate communication and coordination is a prerequisite for effective care. The report noted improvements that could be made. For example, at the ward level, communication among all team members could be improved, and treatment team meetings needed to occur regularly and involve all appropriate staff.
Training	11	The current training provided is inadequate in terms of content, intensity, and opportunity to implement in a training environment.
Staffing	11	Current staffing patterns do not sufficiently account for coverage needs and necessitate "ordered" or mandatory overtime and sudden changing of assignments.
Access to Care	9	While most patients were positive in terms of access to care, there was a desire for additional hours of programming and a concern about the wait times for some services.
Risk Management	6	In a facility like Perkins, given the histories of aggressive behavior exhibited by most patients, good risk assessments are critical. While the risk assessments reviewed were diligently undertaken, improvement was possible.
Changing Nature of Patients Served	5	It was argued that many more patients at Perkins often have a history of imprisonment than was previously the case. This can make integration into a different, treatment-oriented setting difficult. This changing population requires different approaches be incorporated into treatment.
Environmental Safety	2	A comprehensive review of the physical plant and security issues was not undertaken as part of this review although two suggestions around security were made.
Quality Improvement	2	Recommendations made in the report should be evaluated through a formal team-based quality improvement process.
Patient and Staff Rights	6	The utilization of a Recovery Model of Care should be improved to ensure that rights to safety apply equally to staff and patients.

Source: Consultation Report on the Clifton T. Perkins Hospital Center, January 2012

As shown in **Exhibit 18**, the additional positions should reduce the level of overtime. As shown in the exhibit:

- Actual overtime levels have historically been significantly above budgeted levels. As has been noted in prior analyses, for some number of years the State-run psychiatric facilities have not met staffing standards because of a combination of a lack of positions plus high vacancy levels, and Perkins was usually the farthest from meeting those standards. One of the principal tools available to back-fill staffing needs was overtime. In fiscal 2011, for example, Perkins' actual overtime was more than twice budgeted overtime. Perkins managed that increased need for overtime funding from internal savings (through higher than budgeted turnover for example) as well as transfers from other facilities with surpluses, typically in personnel costs.

Exhibit 18
Clifton T. Perkins
Overtime Analysis
Fiscal 2011-2013
($ in Millions)



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

- In fiscal 2012, based on the new staffing standards implemented after the two patient-on-patient murders, it is estimated that absent any additional staff, overtime would reach just over $6 million. For example, in the first two pay periods after enhanced staffing standards were being implementing, overtime levels were almost twice the level averaged in fiscal 2011. The staff currently being hired will limit the demand on overtime, although of course still needs to be paid for, although a significant overtime deficiency is still projected (both costs were reflected earlier in Exhibit 9).

- For fiscal 2013, the 65 new staff to be hired in fiscal 2012 will be complemented by 28 new staff to be hired in fiscal 2013 (although those positions have a 25% budgeted turnover rate). Those staff will largely reduce the demand for overtime back to budgeted levels (the relative small projected deficit appears manageable).

However, it should be noted that while the report included recommendations on the need for improvements in staffing coverage it refrained from making more detailed recommendations, especially for a specific staffing plan, because it was beyond the scope of what was possible in the time period available. In that regard, this additional staffing was not evaluated as part of the report. Thus, while the proposed staff do address some of the issues raised in the report, it is difficult to evaluate whether they are the most appropriate response to those issues.

2. Integration of Behavioral Health Care

It has long been understood that there is a high prevalence of co-occurring substance abuse and mental health conditions. Lifetime prevalence of co-occurring disorders among individuals seeking substance abuse treatment has been estimated from 25.0 to over 50.0%. National surveys reveal 51.4% of those surveyed with a lifetime substance abuse disorder also reported a lifetime mental health disorder, and 50.9% of those with a mental health disorder reported having a substance abuse disorder. However, all too often, not only are behavioral health services delivered in separate systems, so too are those systems poorly integrated with other medical care. For public health programs, such as Medicaid, this lack of integration is particularly disconcerting given that a small number of individuals in this program disproportionately consume a large percentage of overall spending. Many of these individuals have multiple chronic conditions, frequently including behavioral health problems.

2011 Interim Study

During the 2011 interim, a consultant working for the department released a report detailing options for the integration of behavioral health care. The report noted issues with the current delivery system that have also been noted in the past.

- Poor alignment of benefit design and management was considered the most glaring limitation of the current system, specifically the fragmentation of the behavioral health service system between mental health and substance abuse disorders and the lack of connection (and coordination of benefits) with general medical services.

- Fragmentation of purchasing and financing with multiple, disparate public funding sources, purchasers, and payers was evident.

- Uncoordinated care management including multiple service authorization entities and no meaningful coordinated care determination systems was also present.

- There was a lack of performance risk. With the exception of the modest value-based purchasing program for managed care organizations (MCO), no element of the system currently has any financial incentive around performance. Payment is for volume not outcomes.

- Integrated care management across the systems is lacking.

The study reviewed a variety of models and systems operating in other states but ultimately made two recommendations:

- Provide a Medicaid behavioral health benefit managed by health plans through a ―protected carve-in" selected with an emphasis on performance. Under this proposal, a health plan would receive a separate, dedicated behavioral health capitated rate that can only be spent on behavioral health treatment and recovery support. Contractual requirements would specify certain levels of behavioral health staffing in clinical leadership. Contracts would also have performance risk and require the provision of data elements including penetration rates, expenditure levels, and authorization denials.

  The report argued that this option had the advantage of accelerating integration while at the same time protecting the behavioral health benefit and allowing the testing of the notion that health plans can manage behavioral health as effectively as medical care. It places risk for general health and behavioral health outcomes in one management system and would have one integrated network. The same health plans could also manage services for the uninsured (even after Medicaid expansion and the availability of subsidies through the Exchange) as they currently do for the PAC populations.

- The second option would be the development of a Behavioral Health Plan, a risk-based contract for the management of the existing Medicaid behavioral health benefit and the State/block grant-funded benefit. This option retains the current ―carve-out" approach for mental health services and would extend it to all behavioral health services. Again, such a plan would bear both insurance and performance risk. The report did note some disadvantages with this approach: it is an approach from the 1990s when states first began the use of risk arrangements for behavioral health; it does not combine accountability for medical and behavioral health benefits in the same management system; it will require workarounds to build incentives for integration and, as such, will require alignment of two separate contracts and contracting processes; and it can only be considered an interim step to full financial and benefits integration. The consultant's report clearly did not favor this option.

It should be emphasized that both solutions are not mutually exclusive of other efforts to improve service delivery, for example, through patient-centered medical homes and chronic care medical homes. Indeed, Maryland is already moving forward with the patient-centered medical home model and includes homes within the MCO system (the development of Chronic Care medical homes is proposed in the fiscal 2013 Medicaid budget).

The report's conclusions were that the State should opt for a new system to coincide with the expansion of Medicaid on January 1, 2014. In the interim, it proposed adding performance risk to the ASO contract with the September 2012 renewal and increasing risk in MCO contracts and adding performance standards to be shared by both; conducting more data analysis including but not limited to Medicaid data on utilization of behavioral health in primary settings, expenditure patterns for primary and specialty behavioral health services, and expenditure data generally; adding the development of health homes as a contractual obligation for MCOs and ASO and attaching risk to this requirement; and aligning contracting and certification requirements. To this list might usefully be added how to measure performance in any system that emerges.

Next Steps

While the department acknowledged the flaws of the current delivery system, it concluded that it was not prepared at the current time to choose one option over another. Rather, the Secretary of the Department of Health and Mental Hygiene (DHMH) indicated that the department would develop a detailed integration plan to define:

- the potential mechanisms to align incentives across medical, mental health, and substance abuse treatment;
- what models of care in Maryland need supports;
- incentives required to deploy those models of care;
- how to measure the health care and financial outcomes of a new system; and
- the capacity of various entities to play the roles required in a new system.

The department envisages one agency to oversee the financing of medical, substance abuse and mental health services, namely the Medicaid program. Thus, the Deputy Secretary for Health Care Financing will lead the planning team to review financing and integration options. A draft proposal to integrate care based on the consultant's report will be developed by September 30, 2012, with a view to legislation in the 2013 session ahead of implementation in calendar 2014.

Recommended Actions

1. Add the following language to the general fund appropriation:

   Provided that $100,000 of this appropriation made for the purpose of executive direction may not be expended until the Mental Hygiene Administration submits a report to the budget committees that details vacancy trends, program capacity, relative costs, patient acuity, and outcomes at the State's public and private residential treatment centers. The report should include an analysis of how well the current residential treatment center system meets the needs of Maryland's children (including those in the juvenile justice system) and any barriers that exist to meet any identified unmet needs. The report shall be submitted by November 1, 2012, and the budget committees shall have 45 days to review and comment. Funds restricted pending the receipt of a report may not be transferred by budget amendment or otherwise to any other purpose and shall revert to the General Fund if the report is not submitted to the budget committees.

   Explanation: Spending on private residential treatment beds has fallen sharply in recent years and is projected to continue in fiscal 2013. Consequently, there is a surplus of private sector capacity. Public sector capacity has also shrunk because of various cost containment actions. While it appears that public sector beds are actually more costly than private beds, advocates of the public sector beds argue that quality of care is better. However, 85% of the children in residential treatment are served in private beds. At the same time, there are children in the State, especially in the juvenile justice system, who continue to need residential treatment but are unable to find it in-state. The language withholds funds pending a report that will provide the committees with better information about the care currently being provided in the residential treatment center system and what, if any, unmet needs exist.

Information Request	**Author**	**Due Date**
Various data on Residential Treatment Centers	Mental Hygiene Administration	November 1, 2012

	Amount Reduction	**Position Reduction**
2. Reduce funds for contractual employment. The fiscal 2013 budget includes funding for 4 contractual employees to enhance the community forensic aftercare program. The Mental Hygiene Administration's program direction has three long-term vacancies that should be reclassified as necessary and used for 3 of the 4 positions. The reduction still leaves over $60,000 in funding for the remaining contractual position.	$ 150,000 GF	

3. Concur with the following language to the general fund appropriation:

   , provided that $6,247,276 of this appropriation shall be reduced contingent upon the enactment of legislation authorizing the use of revenue from a nonprofit health service plan for this purpose

   Explanation: The language cuts general fund support for community mental health services contingent on the Budget Reconciliation and Financing Act of 2012 which authorizes the use of funds from CareFirst to backfill for this reduction.

4. Add the following language to the general fund appropriation:

   Further provided that $1,000,000 in funding in this budget for the purpose of providing transitional housing assistance may only be expended to support individuals with a primary diagnosis of serious mental illness.

   Explanation: The fiscal 2013 budget includes $1 million in transitional housing assistance targeted at individuals with very low incomes to help provide housing support. While the funding is in the Mental Hygiene Administration (MHA), the funding is to be split between MHA and the Developmental Disabilities Administration. Given the high level of homelessness among the seriously mental ill compared to the population at large, and also MHA's efforts to transition individuals out of assisted living beds at Springfield and Spring Grove hospitals, the language restricts the funding just to individuals with a primary diagnosis of serious mental illness.

	Amount Reduction		Position Reduction
5. Delete funding for purchase of care beds. Purchase of care beds are beds at private psychiatric hospitals used to treat uninsured individuals in need of inpatient care. These beds are an alternative to treatment in State-run psychiatric facilities. As introduced, the fiscal 2013 budget reduced funding for purchase of care beds by two-thirds based on federal law that requires hospitals to treat or appropriately transfer patients that require inpatient care. Uninsured patients will still receive appropriate inpatient care, and the administration assumes the hospitals will be reimbursed for the higher level of uncompensated care through their rates. The administration anticipated reducing the full amount over a longer period. The reduction eliminates the funding in fiscal 2013.	2,100,000	GF	

6.	Reduce funding and positions by accelerating the closure of Assisted Living Units at Springfield and Spring Grove from September 1, 2012, to July 1, 2012. The reduction also allows $196,000 in savings to be transferred to community mental health services to serve the individuals in those units for an additional two months. Positions that would have been eliminated effective September 1, 2012, are eliminated. However, all workers currently employed on those units will be placed in vacant positions at the same facility. The Mental Hygiene Administration has a long and successful history of being able to close units and whole facilities and can do this by July 1, 2012.	618,075	GF	61.0
	Total General Fund Reductions	**$ 2,868,075**		**61.0**

Updates

1. Capital-related *Joint Chairmen's Reports*

Chapter 395 of 2011 (the fiscal 2012 budget bill) included language directing funds be spent on two different reports with implications for the long-term capital needs of the public mental health system, and specifically the State-operated psychiatric capacity:

- First, language restricted a total of $200,000 in the budgets of the State-run psychiatric hospitals for the purpose of conducting an independent analysis of population and placement trends at those hospitals. This report is intended to be a starting point in the assembling of data necessary to properly plan future capacity at the State-run hospitals. The report was due to the legislature by December 1, 2011.

  In a letter dated December 16, 2011, the Secretary of DHMH requested that the report deadline be extended to September 1, 2012. The reason provided for the delay was the time taken to procure the appropriate vendor. To date a solicitation has been made, oral presentations from vendors completed, and best and final offers from qualified vendors requested. The department anticipates making an award to allow for the work to be completed by summer 2012.

  In January 2012, the budget committees approved the request for an extension.

- Second, language restricted $50,000 to be used as a contract with the Maryland Economic Development Corporation to develop a redevelopment plan for Spring Grove Hospital Center. At the time of writing, that plan has not been received.

Appendix 1

Current and Prior Year Budgets

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

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2011					
Legislative Appropriation	$627,277	$23,369	$321,854	$5,773	$978,272
Deficiency Appropriation	12,253	-2,253	17,382	0	27,382
Budget Amendments	2,418	367	-501	38	2,321
Reversions and Cancellations	0	-548	-3,817	-930	-5,296
Actual Expenditures	**$641,947**	**$20,935**	**$334,918**	**$4,880**	**$1,002,680**
Fiscal 2012					
Legislative Appropriation	$675,077	$23,283	$356,974	$5,734	$1,061,068
Budget Amendments	6,288	2	1,536	0	7,826
Working Appropriation	**$681,365**	**$23,285**	**$358,510**	**$5,734**	**$1,068,893**

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

Fiscal 2011

The fiscal 2011 legislative appropriation for MHA was increased by just over $24.4 million. This change is derived as follows:

- Deficiency appropriations added almost $27.4 million including:
  - $25.0 million ($10.0 million general funds and $15.0 million federal funds) to support community mental health services due to unpaid prior year bills rolled over into fiscal 2011.
  - $2,383,232 in federal funds for a three-state partnership (together with Georgia and Wyoming) to develop/expand a Care Management Entity provider model for children and youth with mental illness. The aim is to provide coordinated, individualized, culturally competent, and efficient care to improve clinical and functional outcomes while reducing inappropriate and costly inpatient, residential treatment, and therapeutic group care.
  - $2,252,516 in general funds to offset a shortfall in Strategic Energy Investment Fund revenues (a like amount of special funds being withdrawn). These funds are provided for energy performance contracts at Springfield and Spring Grove hospitals.
- Budget amendment added an additional $2.3 million. Specifically:
  - General fund amendments added just over $2.4 million, primarily the transfer of funds from other parts of DHMH to cover deficits in two areas: higher-than-budgeted overtime costs at State psychiatric facilities; and community mental health services for non-Medicaid eligible individuals.
  - Special fund amendments added $367,000, most of which ($245,000) related to funding of shared services at the Upper Shore Community Mental Health Center.
  - A drop in federal funds ($501,000) driven by lower than anticipated Community Mental Health Block Grant expenditures.
  - Reimbursable fund amendments of $38,000.
- The budget increases from deficiency appropriations and budget amendments were partially offset by cancellations of almost $5.3 million. Specifically:
  - Special fund cancellations of $548,000. The largest cancellations were related to strategic energy loan payments based on funding availability ($201,000) and lower than anticipated prior year grant activity ($159,000). The remaining cancellations

were spread across the facilities and reflected lower than anticipated employee food sales, donations, and tenant reimbursements.

- Federal fund cancellations of over $3.8 million. The bulk of this was lower than expected attainment from the Maryland Children's Health Program (just under $1.9 million) plus lower than anticipated expenditures from a number of federal grant sources including: Projects for Assistance in Transition from Homelessness ($606,000); Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances ($520,000); Substance Abuse and Mental Health Services Projects of Regional and National Significance ($510,000); and Alternatives to Psychiatric Residential Treatment Facilities for Children ($481,000). Various other federal grants saw increases in spending but only enough to marginally offset the decreases noted above.

- Reimbursable fund cancellations of $930,000, mostly from funding received from the Children's Cabinet Interagency Fund to match the federal Alternatives to Psychiatric Residential Treatment Facilities for Children grant.

Fiscal 2012

To date, MHA's fiscal 2012 appropriation has been increased by just over $7.8 million. This increase is primarily derived from three amendments:

- Just under $2.2 million (almost all general funds) to support the fiscal 2012 $750 one-time bonus for State employees, funding originally budgeted in the Department of Budget and Management (DBM).

- Almost $3.6 million (just over $2.0 million general funds and $1.5 million federal funds) to fund community mental health services, again funding originally budgeted in DBM.

- Just under $2.0 million in general funds transferred from the Medical Care Programs Administration to cover the cost of an assessment that was imposed on hospitals (including State-run Psychiatric Hospitals) by Chapter 397 of 2011 (the BRFA of 2011).

Appendix 2

Audit Findings

Agency	Mental Hygiene Administration – Headquarters
Audit Period for Last Audit:	July 1, 2007 – June 30, 2010
Issue Date:	July 2011
Number of Findings:	8
Number of Repeat Findings:	2
% of Repeat Findings:	25%
Rating: (if applicable)	n/a

Finding 1: **MHA lacked adequate procedures to ensure that required documentation to support patient eligibility for mental health services paid entirely by the State's general fund was obtained and verified. The department agreed with the finding and recommendation to establish adequate procedures.**

Finding 2: An automated match between death records maintained by the Social Security Administration and the ASO's paid claims records disclosed questionable recipient data and claims payments. The department agreed with the finding and recommendations to conduct matching to reduce the risk of invalid claims and take other appropriate actions.

Finding 3: Certain independent reviews of claims processed by ASO have not been performed since March 2009. The department agreed with the finding and recommendation and has awarded a contract to undertake the independent review.

Finding 4: MHA's contract with ASO did not contain specific provisions obligating ASO to address certain information technology security and operational risks. The department agreed with the finding and associated recommendations.

Finding 5: Access and monitoring controls over the ASO's servers hosting the portal and the web server software were not adequate. The department agreed with the finding and associated recommendations.

Finding 6: The ASO's account and password controls were not adequate. The department agreed with the finding and associated recommendations.

Finding 7: MHA did not adequately monitor contracts established by the State local CSAs. The department agreed with the finding and associated recommendations.

Finding 8: **Internal controls over cash receipts were not sufficient. The department agreed with the finding and associated recommendations.**

Agency	RICA Baltimore
Audit Period for Last Audit:	July 1, 2008 – March 21, 2011
Issue Date:	December 2011
Number of Findings:	1
Number of Repeat Findings:	0
% of Repeat Findings:	n/a
Rating: (if applicable)	n/a

Finding 1: Formal agreements had not been executed with local education agencies (LEA) that provided educational staff to RICA, and with LEAs and State entities whose students received educational services from RICA. The department agreed with the finding and recommendation to establish formal agreements defining costs of educational resources provided, related responsibilities of each party, and any contribution rate to be paid for educational services.

Agency	Eastern Shore Hospital Center Upper Shore Community Mental Health Center
Audit Period for Last Audit:	March 24, 2008 – February 23, 2011
Issue Date:	September 2011
Number of Findings:	2
Number of Repeat Findings:	0
% of Repeat Findings:	n/a
Rating: (if applicable)	n/a

Finding 1: The Eastern Shore Hospital Center awarded a service contract to a physician it employed full-time, violating DHMH policy, and continued to pay for these services after the contract period ended. The department agreed with the finding and related recommendations to follow the appropriate DHMH Compensation Policy and have appropriate approval of after-hours time records.

Finding 2: Patient fund deposit verifications were not performed by an independent employee and access to related records was not properly controlled. The department agreed with the finding and related recommendations.

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

Object/Fund Difference Report
DHMH – Mental Hygiene Administration

Object/Fund	FY 11 Actual	FY 12 Working Appropriation	FY 13 Allowance	FY 12 - FY 13 Amount Change	Percent Change
Positions					
01 Regular	2,861.05	2,825.95	2,918.95	93.00	3.3%
02 Contractual	171.46	191.66	189.02	-2.64	-1.4%
Total Positions	**3,032.51**	**3,017.61**	**3,107.97**	**90.36**	**3.0%**
Objects					
01 Salaries and Wages	$ 205,492,649	$ 210,262,824	$ 212,924,781	$ 2,661,957	1.3%
02 Technical and Spec. Fees	8,779,652	8,851,194	8,578,745	-272,449	-3.1%
03 Communication	499,830	545,223	486,072	-59,151	-10.8%
04 Travel	147,872	117,219	117,016	-203	-0.2%
06 Fuel and Utilities	10,641,523	10,706,428	10,440,743	-265,685	-2.5%
07 Motor Vehicles	741,823	622,413	649,677	27,264	4.4%
08 Contractual Services	759,747,531	821,194,352	818,888,145	-2,306,207	-0.3%
09 Supplies and Materials	14,940,112	15,470,211	14,137,066	-1,333,145	-8.6%
10 Equipment – Replacement	691,599	260,396	250,684	-9,712	-3.7%
11 Equipment – Additional	154,852	19,495	0	-19,495	-100.0%
12 Grants, Subsidies, and Contributions	281,117	335,424	336,655	1,231	0.4%
13 Fixed Charges	561,574	508,268	491,198	-17,070	-3.4%
Total Objects	**$ 1,002,680,134**	**$ 1,068,893,447**	**$ 1,067,300,782**	**-$ 1,592,665**	**-0.1%**
Funds					
01 General Fund	$ 641,947,066	$ 681,364,796	$ 690,843,704	$ 9,478,908	1.4%
03 Special Fund	20,934,846	23,284,603	18,215,636	-5,068,967	-21.8%
05 Federal Fund	334,918,052	358,509,593	353,777,494	-4,732,099	-1.3%
09 Reimbursable Fund	4,880,170	5,734,455	4,463,948	-1,270,507	-22.2%
Total Funds	**$ 1,002,680,134**	**$ 1,068,893,447**	**$ 1,067,300,782**	**-$ 1,592,665**	**-0.1%**

Note: The fiscal 2012 appropriation does not include deficiencies.

Fiscal Summary
DHMH – Mental Hygiene Administration

Program/Unit	FY 11 Actual	FY 12 Wrk Approp	FY 13 Allowance	Change	FY 12 - FY 13 % Change
01 Mental Hygiene Administration	$ 746,242,123	$ 805,612,726	$ 804,099,351	-$ 1,513,375	-0.2%
03 Walter P. Carter Community Mental Health Center	443,391	146,456	154,377	7,921	5.4%
04 Thomas B. Finan Hospital Center	17,936,378	18,198,259	18,168,609	-29,650	-0.2%
05 Regional Institute For Children and Adolescents .— Baltimore City	12,300,923	12,597,163	12,661,703	64,540	0.5%
06 Crownsville Hospital Center	1,378,686	1,315,617	954,956	-360,661	-27.4%
07 Eastern Shore Hospital Center	17,321,084	18,297,518	18,170,928	-126,590	-0.7%
08 Springfield Hospital Center	70,067,214	72,177,951	70,482,732	-1,695,219	-2.3%
09 Spring Grove Hospital Center	76,771,999	79,070,651	77,174,299	-1,896,352	-2.4%
10 Clifton T. Clifton T. Perkins Hospital Center	48,373,837	49,479,128	53,938,684	4,459,556	9.0%
11 John L. Gildner Reg. Institute for Children and Adolescents	10,517,753	10,716,990	10,741,374	24,384	0.2%
12 Upper Shore Community Mental Health Center	1,271,504	1,241,854	750,466	-491,388	-39.6%
14 Regional Institute For Children and Adolescents – Southern Maryland	55,242	39,134	3,303	-35,831	-91.6%
Total Expenditures	**$ 1,002,680,134**	**$ 1,068,893,447**	**$ 1,067,300,782**	**-$ 1,592,665**	**-0.1%**
General Fund	$ 641,947,066	$ 681,364,796	$ 690,843,704	$ 9,478,908	1.4%
Special Fund	20,934,846	23,284,603	18,215,636	-5,068,967	-21.8%
Federal Fund	334,918,052	358,509,593	353,777,494	-4,732,099	-1.3%
Total Appropriations	**$ 997,799,964**	**$ 1,063,158,992**	**$ 1,062,836,834**	**-$ 322,158**	**0%**
Reimbursable Fund	$ 4,880,170	$ 5,734,455	$ 4,463,948	-$ 1,270,507	-22.2%
Total Funds	**$ 1,002,680,134**	**$ 1,068,893,447**	**$ 1,067,300,782**	**-$ 1,592,665**	**-0.1%**

Note: The fiscal 2012 appropriation does not include deficiencies.