

STATE FOOTNOTES

NASMHPD Research Institute

State Mental Health Agency Revenues and Expenditures: FY 2004

Alabama: Facility Medicaid far exceeds their Disproportionate Share Medicaid. Large 1-year change for Children's MH Services Expenditure is because of including the cost of adolescents' services paid by Medicaid expenditures. Large 1-year change for MH Block Grant Revenues is caused by large carryover from '04 to '05. Large 1-year change for Other Revenues is caused by 3 MI facilities being closed. Large 1-year change for Forensic Patients: Patient days, Forensics: Cost per pt Day, and Civil Patients: Patient Days is due to an acute care crisis in state hospitals.

Alaska: Nearly every item on the edit report shows a large change over what was reported in FY03. The FY03 report pulled data from a period that pre-dated State of Alaska's departmental reorganization that resulted in mental health activities being administered under one Division. The following excerpt from the FY04 CMHS Grant Implementation Report explains the root cause of the changes:

*Excerpts from the FY04 CMHS Implementation Report
Summary of Significant Events that Impacted State Mental Health System in FY04*

Effective July 1, 2003, the Department of Health & Social Services enacted a major reorganization that restructured several divisions and functions. The Division of Behavioral Health (DBH) was created by bringing together programs and services previously delivered through the mental health portion of the former Division of Mental Health & Developmental Disabilities, the former Division of Alcoholism & Drug Abuse, the former Division of Medical Assistance, and the Office of Fetal Alcohol Syndrome. The creation of DBH heralds Alaska's emerging integrated system and recognition that, across all age groups, a significant number of individuals with substance use disorders also have serious mental illness. DBH worked throughout FY04 toward blending mental health and substance use functions and to redesign grant structures and service systems. This work will continue through FY05 and beyond. During FY04, DBH applied for and was awarded a five-year Co-occurring Disorder State Initiative Grant (COSIG) from the Substance Abuse and Mental Health Services Administration (SAMHSA).

DBH continued to work with Medicaid staff to ensure the most effective use of Medicaid dollars. Increases in Medicaid billings have clearly resulted in an expansion of service delivery but have not been proportional to the growth of expenditures. Emphasis continues to be placed on integrating and reorganizing the services supported by DBH to ensure that the most therapeutic and cost effective program designs are being implemented.

Source: MHBG 2004 Implementation Report

Arizona: State Mental Health Agency Controlled Mental Health Expenditure – Inpatient includes Level 1 RTC for children, and Other 24 Hour (Residential) includes Level 2 & 3 Residential

Large 1-year change in Children’s Mental Health Services Expenditures is due to increase in Medicaid eligibility and changes in rates.

Large 1-year change in Total Medicaid Revenues (State plus Federal), State Medicaid Revenues, and Federal Medicaid Revenues is due to increase in Medicaid eligibility, change in rates, and Disproportionate Share is now reported in Tables 1 and 2.

Large 1-year change in MH Block Grant Revenue, Federal Revenues and Total Revenues is because revenue and expenditures do not always occur within the same state fiscal year. In addition, there was a CMHS grant increase during this timeframe.

Large 1-year change in Total Revenues: Community MH is caused by increase in Medicaid eligibility and changes in rates.

Large 1-year change in Sexually Violent Predators: Patient Days is due to a US Supreme Court Case and the AZ Supreme Court ruling in the Leon G. case (final ruling handed down December 16,2002 – citation 204Ariz15 59P.3d779), presented by Attorney General Janet Napolitano.

Revenues and Expenditures do not always occur in the same fiscal year.

Arkansas: None

California: For total Medicaid (State Hospitals – state + fed) percentage change reflects additional funds that became available during the year. MH portion was larger than last year. Other revenues – a notable increase in reporting by counties of Other Revenues. Also, an increase in county fund contributions over the percentage amounts prescribed by law (County((over)match)

Colorado: None

Connecticut: FY’03 State Hospital Expenditures by Priority Group Patient Days – Forensic, Voluntary and Total (Table 3) have been corrected. Figures submitted before were incorrect.

Delaware: Total revenues of state mental health authority is higher than expenditures because total Medicaid and Medicare revenues are deposited directly to the State’s general fund; funds are not used to support expenditures.

Total revenue of the state psychiatric hospitals is higher than expenditures because inpatient Medicaid and Medicare revenues are deposited to the State’s general fund; funds are not used to support expenditures.

Total revenues of community programs is higher than expenditures because Community Mental Health program Medicaid and Medicare revenue are deposited directly to the State general fund; funds are not used to support expenditures.

Total DSH reported on Table 3 is higher than State plus federal Medicaid to State hospitals because the disproportionate share of Medicaid is deposited directly to the State's general fund, therefore it is not reported as revenue and is not used to support expenditures.

District of Columbia: None

Florida: None

Georgia: None

Hawaii: The primary reason for the large 1-year increase in Total Administration Expenditures; Expenditures for Adults and Elderly Services; Total Medicaid Revenues (State plus Federal); Other Revenues; and, Total Revenues for State Hospitals, is due to compliance with various court orders.

Idaho: The negative number in the revenue for Community Programs column is due to the transfer of funds from one program to another.

Illinois: None

Indiana: Fiscal Year 2004 reporting by Indiana on revenues and expenditures has adopted a revised methodology using data from the Family and Social Services Administration (FSSA) Financial Services Division. The information contained in this revenue and expenditure report is consistent with data presented during monthly financial reviews of the Division of Mental Health and Addiction by the Secretary of FSSA. The major change from previous reporting is the inclusion of all community mental health funding through the state's Medicaid program.

As in previous years, SMHA-controlled expenditures for mental health services by type of service for community-based programs is not allocated to Inpatient, Other 24-Hour (Residential) or Less than 24-Hour. In Indiana, community-based programs receive state funding through enrollment of consumers rather than type of services provided.

Iowa: None

Kansas: None

Kentucky: We receive additional revenues from Medicaid over and above DSH funds for our psychiatric hospitals.

The 19.8% drop in children's MH services is mainly due an initiative to reduce and contain the rising costs of one of our programs fully funded by Medicaid.

The 33.8% drop in Medicaid revenue is due to the reduction of expenses of one of our children's programs.

Louisiana: None

Maine: Mental Health Block Grant Funds were awarded late and did not have time to be fully spent.

Maryland: None

Massachusetts: None

Michigan: None

Minnesota: A portion of Mental Health Block Grant funds are used for training, technical assistance to local providers, planning and evaluation and are listed as administrative expenditures.

Mississippi: The large increase in “other revenues” is due to a spend down of cash balances. DSH was cut by nearly 50% in FY 2004.

Missouri: None

Montana: Mental Health Block Grant revenues decreased from the figure reported in FY 2003 because the 2004 funding was awarded late and so Montana could only spend 1 quarter.

Nebraska: The reduction in children’s mental health expenditures from FY'03 to FY'04 was due to the completion of a three million dollar children's youth grant.

FY’2003 Revenues have been corrected to show Federal Medicaid and Medicare allocated to state hospitals in 2003 (Table 2). These funds were originally listed under Other Federal Funds.

SMHA-Controlled expenditures include funds for mental health services in jails or prisons to the extent that a MH Center sends a clinician to a jail to do an assessment, the funding for Less than 24 hr Care includes those funds. This is rare.

Administrative Auspices (Table 1)

State Psychiatric Hospitals

- *Inpatient (licensed hospital beds)* Under Age 18 (Children)
 - LRC Psy Inpatient/Residential, not include HRC Adolescent Drug Res (1.5 M)
 - Age 18 and over (Adults)
 - LRC, NRC, HRC including Forensics excluding MH Center Outreach from the Budget Status Report as of 30 June 2004
- *Less than 24 Hour Care (Residential)* Age 18 and over (Adults)
 - HRC/LRC - MH Center Outreach provided as of 30 June 2004 indicated on Budget Status Report

SMHA Controlled Expenditures of Community-Based Programs

- *Inpatient (licensed hospital beds)* Age 18 and over (Adults)

Treatment, EPC Services, Post Commitment Day Treatment - Mental Health Regional Services Reported 26 FEB 04

- *Other 24 Hour (Residential)* Age 18 and over (Adults)
Psych Residential Rehab & Dual Residential (SPMI/CD) - Mental Health Services Regional Report 26 FEB 04
- *Less than 24 Hour Care* Under Age 18 (Children)
Children's Services reported on Mental Health Services Report 26 FEB 04 (excluding Crisis Inpatient) Includes 3 Grant - (1,500,000) under allocation worksheet.

Age 18 and over (Adults)

Emergency Services, Treatment Services, and Rehab & Support Services via Mental Health Services Regional Report 26 FEB 04 excluding inpatient & residential services reported.

- *Other/Unknown* Age 18 and over (Adults)
Local Expense of Tax Match from Regions (1.2M) for Non-Res/ER/Other (Source Document - Actuals from Regions), and Indigent Drugs (1.5M) (Source Document Allocation Worksheet as of 26 FEB 2004)

Administration

- *Central/Regional Office Support* Any Age Unknown
Budget Status Report as of 6/30/04 under 50% of Services Agency/Mental Health/Substance Abuse Division includes \$300,000 region admin from Regional Summaries Report as of 26 Feb 04
- *Research/Training*
ASO Utilization and IMS and Consumer & Family reported from 026 (F&S) Agency, Subprograms under 840 (Community Based Mental Health) reported 30 June 2004

Revenue Source (Table 2 & 3)

State Revenues

- *General*
 - State Mental Health Hospital Programs
 - LRC, HRC, NRC Reported Allocation
 - Revenues to Community Administered Programs
 - Reported 26 FEB 04 via Program 38 - Behavioral Health Aid Subprogram Allocation
 - SMHA Support Activities
 - Budget Status Report as of 06/30/04 - Dept Central Office 1.5 M (50% MH 50% SA) + 750000 (State and Other Federal....i.e. SA Block Grant) - 250,000
- *Other State*
 - State Mental Health Hospital Programs
 - LRC, HRC, NRC Reported Data as of 6/30/04 - Budget Status Report (CASH Funds Reported).
 - Revenues to Community Administered Programs
 - Reported 26 FEB 04 via Program 38 - Behavioral Health Aid Subprogram Allocation (200,000 - Tribe Generated + CASH 9,700,000-1.5M for SA Services)

Nebraska (Continued)

Federal Revenues

- Medicaid

State Mental Health Hospital Programs

HRC, LRC, NRC - Medicaid Dispro. Share under Budget Status Report 30 June 04

Revenues to Community Administered Programs

Reported 26 FEB 04 via Program 38 - Behavioral Health Aid Subprogram Allocation -Sheet 2

- Medicare

State Mental Health Hospital Programs

HRC, NRC, LRC Medicare revenues reported under Budget Status Report as of 30 June 04

- Mental Health Block Grant Revenues to Community Administered Programs

Reported 26 FEB 04 via Program 38 - Behavioral Health Aid Subprogram Allocation

SMHA Support Activities

Reported 26 FEB 04 via Program 38 - Behavioral Health Aid Subprogram Allocation

- Other SMHA

Revenues to Community Administered Programs

Reported 26 FEB 04 via Program 38 - Behavioral Health Aid Subprogram Allocation - MH Homeless PATH Grant & Lancaster CO MH Youth Grant

- Other Federal

State Mental Health Hospital Programs

Non-Gove Sources, Investment Incomes, Health Care MTNCE on Budget Status Report as of 30 June 04

SMHA Support Activities

Budget Status Report as of 06/30/04 - Dept Central Office 1.5 M (50% MH 50% SA) + 750000 (State and Other Federal...i.e. SA Block Grant) - 400,000

Local Revenues

Revenues to Community Administered Programs

Coordination Accounts pulled from FY04 Actuals (excluding other revenues) as of Sept 05

SMHA Support Activities

Reg 1-6 Network Mgmt/Reg Admin pulled from FY04 Actuals (excluding other revenues) as of Sept 05

State Hospital Inpatient (Table 4)

- Forensic

Expenditures

LRC Subprogram- Budget Status Report as of 30 JUN 04 to include overhead cost determined 08 Aug 06.

Patient Days

Reported by F/S as of 08 Aug 06

- *Sexually Violent Predators*

Expenditures

Reported by F&S documented as transitional services to include overhead cost reported 08 Aug 06.

Patient Days

Reported by F/S as of 08 Aug 06.

- *Civil (Voluntary and Involuntary)*

Children – Expenditures

LRC Psy Inpatient/Residential not including HRC Adolescent Drug Res (1.5 M).

Children are considered 18 years and younger. Only reflect direct cost. General

Overhead Cost reflected in grand total.

Adults – Expenditures

LRC, NRC, HRC excluding Forensics and Sexually Violent Predators

Nevada: The majority of the reduction in the children's information is due to a transfer of Title XIX Medical from the Division of Child and Family Services to the Division of Health Care Financing and Policy (\$9,176,401). There was also a \$3.2 million reduction in Child Welfare expenses from FY03 to FY04 and an additional \$2 million reduction in 2 other budgets. Mental Health expenditures for adults were increased from FY 03 to FY04.

New Jersey: Total Medicaid revenue for state hospitals (State and Federal) increased by 29.2% because of an increase in FY'04 revenue (State and Federal) due to an increase in rate adjustments and prior years settlements.

Total Federal revenue increased by 15.9% because of an increase in rate adjustments, prior years settlements and increased eligible service in the communities.

Expenditures for Sexually Violent Predators increased 25.6% and patient days increased 21.5%. The Northern Regional Unit (NRU) – the Department of Corrections facility where inmates receive psychiatric treatment services administered by the Division. From FY'03 to FY'04, the operation continued to expand. The average daily population during FY'03 was 246 and increased to 299 for FY'04. State appropriations increased as more staff were hired during FY'04 for the additional psychiatric treatment.

Expenditures for Forensic patients increased 21.1% and Forensic costs per patient day increased 21.2%. The increase in Forensic costs in FY'04 was primarily due to a significant number of additional Medical Security Officers that were hired to address security/coverage concerns at the Ann Klein Forensic Center. At the same time, the average daily population at the facility was basically unchanged between the two years – thus resulting in the higher cost per patient day.

New York:

Not able to accurately partition expenditures by age for community-based programs.

Administration category contains nearly \$61 million in research expenditures.

State hospital inpatient contains \$133 million for distinct forensic hospitals. Additional forensic services are provided in "civil" facilities, but we are not able to assign an expenditure to such services.

NYS SMHA funds services for adults and children, forensic (distinct hospitals and services in state prisons and local jails), and administers a large research budget. Any state-to-state comparisons should involve states with similar responsibilities, i.e., not all state SMHA control funds for children, forensic, housing, or research.

Reported expenditures for SMHA owned and operated services include staff fringe benefits and administrative services which are not in the SMHA budget.

New Mexico: Amounts do not include children's M/H Dollars. Amounts are estimated.

North Carolina: None

North Dakota: None

Ohio: The DSH amounts are not the actual amount of revenue received by ODMH, but the total amounts received by the state. ODMH received approx. \$2.9 million of this in FY 04.

Ohio does not currently have a "Sexual Offender" or "Sexually Violent Predators" law that allows for the direct commitment into a State Psychiatric Inpatient Facility.

Ohio does not capture expenditures by forensic category, thus in order to estimate forensic expenditures, forensic res days were used to prorate hospital system costs with a 4% adjustment for increased costs of forensic (due to increased security and staff time).

The community boards have the ability to roll funds into the subsequent fiscal year. Often times, services performed during the last quarter of a FY are paid in the subsequent FY. Therefore, a specific fiscal year may appear to have expenditures that exceed revenues.

This reflects approximately a 4% cash flow. Revenues other than GRF can be carried over from one year to the next, this reflects the carryover.

The 2003 report used a statistic based on prospective Medicaid state dollars and planned match resources from Medicaid contracts from the boards. The 2004 report calculates a statistic based on total match resources in the system assuming the proration to be the same as the total matchable resources (state and local).

Oklahoma: None

Oregon: None

Pennsylvania: Pennsylvania don't block grants to hospitals, block grants go only to Community.

Rhode Island: None

South Carolina: None

South Dakota: Timing of Expense & Posting of Revenue

Tennessee: Tennessee was under a waiver and did not get DSH payments.

\$63 million of community inpatient services were shown as age unknown in FY2003 report.

Tennessee has updated FY01 data. The changes in the report reconcile differences between the way the department chose to show its expenditures and revenue in FY2001 and in the years after FY2001.

Texas: DSH reported - per note on Table 3 these funds were not included in totals.

Approximately \$12 million dollars was reduced in the 04/05 LAR. This reduction was for research and training in an attempt to prevent the reduction of client services over the next biennium.

Increase revenues for NorthSTAR IAC with HHSC for Medicaid match, hospitals appropriated receipts, and Administration IACs.

Utah: Large 1-year change in Children's MH Services, Local Revenues and Total DSH is because the prior year did not include a check for the Disproportionate Share Medicaid. Only the added portion of the DSH was included. The current year has the total Medicaid with DSH attached.

Vermont: 1.Total Administration from \$2,600,000 to \$3,200,000, increase 23.1%. This is correct. There were some new administrative costs in FY 04 that will continue into the future. 2. Federal Medicaid Revenues increase 15.2%. This is correct. 3. MH Block grant revenues decrease 20%. There wasn't a variance, actually. This is a result of rounding up one year and rounding down the next. 4. Other revenues decrease 25%. This is correct.

Virginia: Mental Health Survey Note Disclosures for the Fiscal Year Ended June 30, 2004

Note 1: The Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services

As the title of the agency denotes, the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) is the administrative authority for the provision of mental health, mental retardation and substance abuse services throughout the Commonwealth of Virginia. The Department operates ten inpatient mental health facilities, five training centers for the developmentally disabled and, beginning in fiscal year 2004, a special facility designed for the behavioral rehabilitation of those individuals deemed to be sexually violent predators. Total average inpatient census at the ten mental health facilities was 1,519 for the fiscal year ended June 30 2004.

DMHMRSAS provides both state and Federal funding to community programs across the Commonwealth. These funds are allocated predominantly to our forty community services boards where mental health, mental retardation and substance abuse services are provided in community settings. Each services board serves one or more localities across the Commonwealth and all localities are provided with services. During fiscal year 2004 182,329 citizens received community based mental health services. Of a total \$231 million in state and Federal funding passed through to community programs, \$113 million was allocated to community mental health services. Our services boards also bill the Commonwealth's Medicaid agency for covered mental health services. Finally, Virginia's local governments provided nearly \$67 million in local government funding for mental health services for the fiscal year ended June 30, 2004. Because DMHMRSAS does not control local government funding, such funding is not included in this survey.

Note 2: Adult and Children's Services

During fiscal year 2004 76% of the individuals receiving mental health services were adults while 24% were children. This ratio has increased from the previous year ratio of 88% and 12%.

Note 3: State Mental Health Authority Controlled Expenditures

As stated in Note 1, the Commonwealth provides community programs with state and Federal funding. Each community program is also authorized to bill Medicaid covered mental health services. State funding, Federal funding and the reimbursement of Medicaid covered services are recognized as both state controlled revenues and expenditures. It should be noted that Virginia's community mental health programs collected an additional \$23.7 million in non-Medicaid fees and were funded by nearly \$67 million in local government appropriations. Neither of these revenue sources is state controlled and is, accordingly, not recognized as such in this survey.

Note 4: Central Office Support, Research and Training Expenditures

Because DMHMRSAS administers mental health, mental retardation and substance abuse services, a proportionate amount of Central Office cost was allocated to mental health services on the basis of total mental health costs in relation to total program costs. This percentage was computed at 54%.

During fiscal year 2003 DMHMRSAS reduced its Central Office staff by 30 positions. These individuals were paid a severance amount based upon years of service. All severance expenses were incurred no later than early fiscal year 2004, hence, the cost of Central Office operations decreased yet again in FY 2004.

Note 5: Budgeting for State Psychiatric Hospitals

The survey indicates that total mental health expenditures exceed revenues by \$7.5 million. State mental health facilities do not operate at a budgetary deficit because our Special Revenue Fund (comprised of fee collections for covered inpatient services from Medicaid and Medicare along with patient pay and commercial insurance fees) is centrally managed with funds being allocated to both mental health and mental retardation facilities. This survey simply recognizes what our mental health facilities actually collect in terms of fees. Any shortfalls that may occur during the year are handled by carefully managing our centrally controlled Special Revenue Fund.

Washington: None

West Virginia: Due to difficulties MOE requirements from the Mental Health Block Grant, West Virginia began to include Medicaid payments for psychotropic medications prescribed for individuals receiving services provided by Comprehensive Mental Health Providers. These additional Medicaid payments are reflected for the first time in the FY2004 report and account for the increase in state and federal Medicaid revenues.

The increase in FY2004 state general revenue funds is a result of increased funds requested by the Governor for mental health services and appropriated by the West Virginia legislature.

MH Block Grant support activities include non-administrative activities such as training, technical assistance provided by the Office of Behavioral Health Services, evaluation and planning.

Wisconsin: Due to a change in reporting by counties, the totals for "Other 24 hour" and "Less than 24 hour care" now include expenditures funded through all sources. In the past these totals were reported for expenditures that were funded with federal, state, and county match funds. The totals now include third-party payments, private pay, and other sources.

Wyoming: Overall Comments as to method: The State Auditor Report the total expenditures for each EORGN (Budget). These reports contain both expenditures and budget deviation. Verification to the actually biennial appropriation was used to verify as much as possible the budget that should have existed.

There are three problem issues for FY2004 report. The first is that Medicaid money was reported inside the Mental Health Budget, even though it was not Mental Health Money, but was Medicaid. Wyoming uses a biennium instead of a Fiscal Year. During 2004 the Wyoming State Hospital and the Mental Health Division was under a single administration.

The first problem was solved in the FY04 report by reporting the Medicaid Money in the MHD budget. It is believed that a different treatment was used in the prior year; validation cannot occur because of staffing changes. Although one-half of the biennial appropriation would be available each year, it normally does not work that way. However, FY04 reports approximately half of the appropriation as revenue for this year. Expenditures of the Wyoming State Hospital as well as the revenue were reported by the hospital and not the Mental Health Division. It is presumed the extra money shown spent by the Hospital came from the Mental Health Division. This assumption is supported by the fact that the amount budgeted in the Mental Health Division was less than had been appropriated.

Specific Notes: Children's MH Services: State Hospital did not report expenses in 2003.
State Medicaid Revenues: Medicaid Expenses were roughly one third more in 2004. Also, per the budget, the federal percent increased. The expenditure/revenue was split based on the percent shown in the budget document.

MH Block Grant: The state draws down the federal money as it is spent. This is the amount spent in 2004.

Federal Revenue totals were affected by the amount of federal grants drawn down and by the way the Medicaid money has been reported.

Of note: Medicaid will not be a part of this budget in the next reporting year, so some substantial changes will happen in 2005 regarding Federal Money.