

# STATE FOOTNOTES

## NASMHPD Research Institute, Inc. State Mental Health Agency Revenues and Expenditures: FY 2005

**Alabama:** Alabama experienced a large carry over of FY04 CMHS Block Grant funds into FY05. FY 04 included all forensic days but only one center's expenses. There was significant downsizing in the nursing home facility and in the adolescent unit at Bryce Hospital.

**Alaska:** Beginning in FY05, costs have been identified as substance abuse or mental health by budget component in order to be in alignment with the Alaska Department of Health and Social Services Public Assistance Cost Allocation Plan. As a result, some budget components previously allocated to mental health now are allocated between mental health and substance abuse according to services delivered. This change of methodology caused an apparent reduction in MH expenditures.

State Medicaid Revenues increased 20% is due to increased authority to collect revenue. The 34.8% increase in MH Block Grant Revenues is due to the overlap of the two year grants. The reported 04 DSH revenue includes a duplicate amount for the federal share. The correct FY04 DSH revenue is \$2,612,700 state match and \$3,990,700 federal share , totaling \$6,603,400. The Forensic Patients: Expenditure increased is due to there was a change in forensic patient expenditures and calculated cost per patient day due to a change in methodology used at the state psychiatric hospital. When the new methodology was applied to FY04, the forensic patient expenditures is \$2,984,414 and the calculated cost per patient day is \$787, which drops the percent change to an expected range. There was a 27.1% decrease in patient days due to fewer admissions.

**Arizona:** Arizona reported based on the state's fiscal year. Federal revenues for state hospitals are sent to the state general fund. Arizona 39.7% increase in Children's Mental Health Services Expenditures is due to Addition of CMDP (Comprehensive Medical and Dental Plan) Program in FY05. 18.3% decrease in Sexually Violent Predators: Patient Days: is due to a US Supreme Court Case & 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. 16.5% decrease in civil patient days due to fewer admissions

**Arkansas:** Total expenditures for administration went up 29% because 10 positions were transferred to administration from the Arkansas State Hospital in FY 2005. Total expenditures for children's mental health services show and increase because \$4,682,579 is included in "Under 18" in FY 2005 and was included in the "Any Age Unknown" in FY 2004.

**California:** DMH received \$7.2 million in cost settlement for FY 2005. This "one-time" settlement was based on Medicare rates and days billed to actual cost and adjusted days. These funds were subsequently allocated to the hospitals resulting in a 25% increase to state hospital Medicaid revenue.

Administrative/Support cost is above the 5% cap because block grant funds also cover the administrative cost of the California Mental Health Planning Council. This category is not part of the 5% administrative cap. For the year of this study, administrative cost for the California Mental Health Planning Council accounted for \$1,043,864 (30.7%) of total admin cost. Based on this, the admin cost is actually 4.6% of the total block grant cost and below the 5% cap. Also, in FY 2005 there was a slight reduction in the block grant award. This cut impacted the local assistance category, but not the administrative portion.

**Colorado:** The large change in expenditures for administration resulted from Medicaid moving from the State Mental Health Authority to the State Dept. of Health Care Policy and Financing. This change resulted from State legislation.

**Connecticut:** Medicaid revenues increased due to rate increases, retroactive claims processing and more effective billings. The increase in state hospital expenditures is due to SFY 05 refill attrition due to Early Retirement Program and Layoffs. There was also a fringe benefit and collective bargaining increase.

Medicaid, Medicare, Third Party revenue are posted to the State of CT General Fund and not DMHAS. This will cause revenue to be higher than expenditures.

DSH funds for DMHAS are included under State Revenues General. This is due to the fact that in CT the Department of Social Services receives the revenue. A check is then cut to DMHAS. When DMHAS receives the funds it is posted as a reimbursement of general fund expenditures.

**Delaware:** Non-DSH Medicaid funds decreased from \$1,962,000 in FY04 to \$1,359,800 in FY05 due to the movement of some ICF/IMD hospital patients to another assisted living venue. DSH funds revert to the state general treasury and are not included in the state hospital budget.

**District of Columbia:** The DSH amounts are correct for DC.

**Florida:** None

**Georgia:** None

**Hawaii:** To date, Hawaii data does not include figures for adult mental health services.

**Idaho:** Idaho increased ACT teams and Mental Health Courts in each of the 7 regions between FY 04 and FY05. Region 7 is a national training site for Mental Health courts. There has been an increased in forensic referrals and service provision.

**Illinois:** The increase in revenue is a result of increased Medicaid claiming and moving toward FFS payment.

**Indiana:** Large one year increase in Children's MH Service is due to Medicaid revenues for youth. Large one year increase in expenditures for forensic patients is due to Indiana opening

additional state hospital beds for Forensic admissions. Large one year increase in forensic patient days is due to the cost and bed day increases from FY04-FY05.

**Iowa:** Increase in Forensic Patients: Expenditures is due to SA arrests and sex offender arrests. Increase in Forensic Patients: Patient Days is due to new grants having been received from IA to assist with sexual offender arrests.

**Kansas:** Increased utilization and rate changes resulted in an increase of approximately 17% in Revenues for FY2005. The Total Disproportionate Share Medicaid (DSH) was affected for FY2005 by a change in the formula for this measurement from the previous year. Expenditures for Forensic patients saw an increase in the indirect costs associated with this Priority Group, while Patient Days for Sexually Violent Predators increased in FY2005 due to an increase of approximately 24 patients in the average daily census.

**Kentucky:** Nursing Facility Medicaid revenues were previously reported in the State Hospital section. They have been moved to the Community section.

**Louisiana:** Increase in Total Administration is due to Included in FY 2005 are additional federally funded MH programs (e.g. TANF funded Early Childhood Supports and Services. Program, a federally funded comprehensive and coordinated system of care for children with serious emotional and behavioral disorders. Increase in MH Block Grant Revenues is due to in FY 2005, included are the block grant expenditures for the local human service authority. Increase in Forensic Patients: Expenditures and Forensic Patients: Patient Days are due to Total average census of adults declined from FY 2004, partly due to some bed closures; thus the proportion of adults with forensic status increased.

**Maine:** None

**Maryland:** The 27% decrease in federal Medicaid revenues from FY 2004 to FY 2005 resulted from a one-time FFP adjustment.

**Massachusetts:** The DSH is collected in pass-through or sweep accounts for DMH; DMH does not see the monies. The 41.4% increase in Other Revenues is related to interest earned and an increase in other misc. revenues.

**Michigan:** None

**Minnesota:** Large one year increase in State Medicaid Revenues is due to the new Medicaid coverage started in FY 05. Large one year increases in *Expenditures* and declined in *Total DSH* are because FY04 totals did not include some Administrative overhead included in FY05.

**Mississippi:** Other/Unknown expenditures include costs of all SMHA funded community based programs PLUS Medicaid receipts of the 15 regional community mental health centers. The vast majority is for less than 24 hour care, and is also Medicaid. Medicaid does not pay for any 24

hour care items, and the majority of the non-Medicaid is less than 24 hour care. Medicaid (state and federal share) alone accounts for \$112,060,923 of the total community programs costs of \$127,612,586.

Many of the increases are due to community Medicaid receipts.

**Missouri:** SMHA controlled mental health expenditures include fringe benefit costs associated with the SMHA. These are included in expenditures even though fringe benefits are appropriated to and paid for by another state agency.

SMHA has excluded \$1,898,350 of estimated 2005 costs for psychiatric services provided to the inmates of the Department of Corrections from the SMHA owned and operated adult psychiatric inpatient facilities. These individuals have not been committed to the SMHA for care. Instead this is a program where the SMHA has entered into an agreement with the Department of Corrections to assist with inmates exhibiting behavioral problems while they are in the custody of the Department of Corrections.

SMHA Administration includes administrative expenditures of the Division of Comprehensive Psychiatric Services and the apportioned costs of the Office of Director that support the division. Office of Director costs that support the Division of Alcohol and Drug Abuse and the Division of Mental Retardation and Developmental Disabilities are excluded from administration expenditures.

SMHA revenues do not equal SMHA expenditures because revenues collected by the SMHA are transferred back to the State of Missouri General fund. A total of \$168,631,120 is collected by the SMHA and transferred to the General Revue fund: \$159,589,120 is attributed to state psychiatric hospitals; \$9,042,000 is attributed to community programs.

The Disproportionate Share State Match represents the certified state match of in-kind expenditures. This certified State Match is appropriated by the State of Missouri as General Revenue to the SMHA to operate state inpatient facilities.

The Federal share of the Disproportionate Share Medicaid received by the State of Missouri is not controlled by the SMHA. The \$145,524,837 is collected by the SMHA and transferred to the Missouri General Revenue Fund.

**Montana:** State Medicaid Revenues increase is due to special circumstances in FFY 2003 and FFY 2004. The President and Congress approved an increased federal share of Medicaid for a 15 month period between April 2003 and June 2004. The result was a decreased state share of Medicaid costs. The large increase in MH Block Grant Revenues is because Montana did not receive the FFY2004 grant during SFY2004 in time to spend the grant.

**Nebraska:** Large 1-year increase in administration expenditures is due to behavioral health reform requirement. The large one year decrease in Children's MH service due to end of Fed

Children's Grant. The large one year increase in Total Medicaid Revenues and Federal Medicaid Revenues is due to expanded children Services at regional Centers.

Medicaid revenues for community programs are included in SMHA-Controlled expenditures: Medicaid Rehab Option services funding is included in Other Residential and Less than 24 hr care. 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.

**New Hampshire:** None

**Nevada:** General increase in both inpatient and outpatient adult services is due to tis increase represents significant new funding from the state to support both inpatient and outpatient mental health services.

**New Jersey:** Disproportionate share revenues for the State Hospitals are included but since the hospitals are "gross" budgeted with all patient revenues reverting to the state general fund, these revenues are included in general, and "other state" revenues rather than in the state & federal Medicaid amounts.

**New York:** New York was not able to accurately partition expenditures by age for community-based programs. The "Administration" expenditures category contains nearly \$66 million in research expenditures. State hospital inpatient expenditures contain \$141 million for distinct forensic hospitals. Additional forensic services are provided in "civil" facilities, but New York was not able to assign 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:** The change in Community MH Expenditures is due to reorganization with in Department. State Hospital became a part of the facilities division. Funding streams changed. The change in MH Block Grant Revenues is due to a reporting error in 2004. FY 2005 we are on a cash base reporting system.

**North Carolina:** Under State Psychiatric Hospitals, Other 24 Hour (Residential), the amounts listed for under 18 are Wright and Whitaker Schools. These are non-inpatient facilities operated directly by the SMHA and serve children with emotional problems. The amount listed for ages 18+ is for the N.C. Special Care Center which is a skilled/intermediate care facility operated directly by the SMHA and serves adults with mental health problems which require this level of nursing care.

Expenditures for Community-Based Programs exclude \$153.4m in funding for Local Management Entities [LME] (also referred to as area programs or mental health centers) for systems management services. Systems management funds are non-direct service functions which LMEs perform such as governance, claims processing, care management, identification and development of service providers, quality management and improvement, customer service, etc. The referenced \$153.4m in excluded funding includes management functions related to mental health, developmental disabilities and substance abuse services. Funding is supported by approximately \$62.8m (41%) via Medicaid administrative funding and \$90.6m (59%) in State appropriation.

SMHA-Controlled expenditures include only a very minor amount of funds for mental health services in jails or prisons. These amounts do NOT include any MH expenditures made by local law enforcement staff or N.C. Department of Corrections staff which provide MH services in jails or prisons.

In N.C., the non-Federal match for Medicaid is paid from a combination of State appropriation and required county match. Required local match for Medicaid is 15% of the non-Federal share. Amounts reported for Local Revenues reflect the required county (local) match for Medicaid.

Medicaid revenue for SMHA Support Activities is administrative funding rather than Medicaid service dollars. These are essentially earned at a 50%-50% FFP and the non-Federal share of the Medicaid administrative funds is paid totally from State appropriation (no local match required). The State matching funds for the Medicaid administrative dollars are reflected in the State Medicaid line.

North Carolina was unable break out cost for Sexually Violent Predators separately. Civil Commitments information is not broken out by age, however, the following commitment information is provided:

1.88 % of total days of service provided in Forensic Treatment Unit (Involuntary)  
7.08 % of total days of service provided for voluntary admissions  
91.04 % of total days of service provided for involuntary admissions (does not duplicate Forensic)  
100% Total Percent

DSH funds are not included as SMHA revenues.

**North Dakota:** Civil Patient: Client Days increased substantially due to civil commitment program for sex offenders. The number of sex offenders entering the program increased substantially during that time period.

**Ohio:** 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. When this happens, a specific fiscal year may appear to have expenditures that exceed revenues. This was the case in FY 2004; therefore, in FY 2005 revenue appears to exceed expenditures. This reflects approximately less than 3% cash flow. Revenues other than GRF can be carried over from one year to the next, this reflects the carryover.

The DSH amounts are not the actual amount of revenue received by ODMH, but the total amounts received by the state. ODMH received approx. \$3 million of this in FY 05. The 23% increase in other revenue is due to increase in third party eligibility.

**Oklahoma:** Some Medicaid revenues for community programs included in:

1. Adults-only state portion reported for private nonprofit CMHCs, state and federal reported for state operated CMHCs.
2. Children- not reported for outpatient service at private nonprofit CMHCs, state and federal reported for state operated CMHCs.

The large increase in Total Community MH Expenditures is due to program expansion. The large increase in Children's MH Services is due to a large expansion, primarily system of care service.

**Oregon:** None

**Pennsylvania:** None

**Rhode Island:** Rhode Island operates a State run Long term care hospital which has a psychiatric unit. The expenditures reflect the costs for that unit and its patients. The State does not receive DSH for this unit.

**South Carolina:** None

**South Dakota:** None

**Tennessee:** Tennessee's waiver in FY 2005 did not allow for DSH payments to the State Psychiatric Facilities. Tennessee's waiver included an exception to the IMD exclusion which allowed the State to receive Medicaid reimbursement for inpatient services provided to Medicaid patients in these facilities. Large one year decline in State Medicaid Revenues is because the Medicaid program reform has decreased covered population & State Medicaid expenditures. The large one year increase in Other Revenues is due to more private insurance payments. The large one year change in Forensic Patients of Expenditure and Forensics of Cost per pt. day is because the rightsizing of children's programs has increased cost per day.

**Utah:** Utah did not expend the full amount of the Mental Health Block Grant in FY 2005, so when calculating this requirement against expenditures, the numbers will be different.

**Vermont:** None

**Virginia:** 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 mental retardation training centers and a facility dedicated to the treatment of sexually violent predators. Total average inpatient census for the ten mental health facilities amounted to 1,487 in fiscal year 2005.

DMHMRSAS provides both state and Federal funding to community programs across the Commonwealth. These funds are allocated predominantly to the forty community services boards where mental health, mental retardation and substance abuse services are provided in a community setting. Each services board serves one or more localities. During fiscal year 2005 nearly 189,000 citizens received community based treatment.

DMHMRSAS does not control local government funding appropriated to our community services boards. These funds are not included in this survey but are a substantial part of the funding of our community services system. For the fiscal year 2005, local governments appropriated \$73,556,577 to community based mental health services.

During fiscal year 2005 74% of the individuals receiving mental health services were adults while 26% were children under the age of eighteen. For fiscal year 2004 this ratio was 76% adult and 24% children.

Because DMHMRSAS administers mental health, mental retardation and substance abuse programs, a proportionate amount of the Central Office cost was allocated to mental health services based upon total mental health costs in comparison to total program costs. This percentage was computed to be 55%.

**Washington:** None

**West Virginia:** The increase in Total Community MH Expenditures is due to an increase in Medicaid payments to community providers and increased legislative appropriations. The decline in Children's MH service is because FY 04 was the final year of the System of Care Grant which had significant carryover funds. The increase in State and Federal Medicaid Revenues is due to an increase in Medicaid payments to community providers. The increase in MH Block Grant Revenues is because providers underspent block grant funds; unspent funds carried over into FY06. The increase in Total Community MH Revenues is due to increase in Medicaid payments to community providers and increased legislative appropriations. The increase in Forensic Patient's Expenditures/ Forensic Patients Patient Days is due to an increasing forensic population.

**Wisconsin:** There are five Medicaid fee-for-service benefits (i.e., targeted case management, crisis intervention services, comprehensive community services, community support programs, and outpatient mental health services for adults that are provided in-home) that the county provides the match to FFP. These expenditures were not included in the FY04 report. FY04 Medicaid expenditures were underreported for Wisconsin.

Wisconsin pays Medicaid claims to its two State psychiatric hospitals in excess of what is received through the Disproportionate Share process.

**Wyoming:** None