

STATE FOOTNOTES

NASMHPD Research Institute, Inc. State Mental Health Agency Revenues and Expenditures: FY 2006

Alabama:

- Table 4: *FY 2006 Mental Health Agency State Hospital Expenditures by Priority Groups* expenditures data is not available for Sexually violent predators, and civil (voluntary and involuntary) adults and children because no specific cost center is available that captures expenditures associated with these categories.
- The total revenues of the state mental health authority exceed total expenditures by \$1,800,000 allowing for funds to be carried forward to fiscal year 2007.
- The total revenues for community programs exceed total expenditures by \$1,800,000 allowing for funds to be carried forward to fiscal year 2007.
- The large decrease in mental health block grant revenues from FY05 to FY06 is due to the block grant being carried forward to FY2007.

Alaska:

FY 2006 Medicaid revenue and expenditure data is for the following service areas: Community Mental Health Clinic, Physician Mental Health Clinic, Child Welfare, State Inpatient Psychiatric, Other Inpatient Psychiatric, and Residential Psychiatric Treatment Centers.

Arizona:

- Total revenues of the state mental health authority exceed the expenditures of the state mental health authority by \$14,600,000 because revenues and expenditures do not always occur in the same fiscal year. Prior year revenue is not included in this report if previously reported to NRI.
- Total revenues for state hospitals exceeds total expenditures for state hospitals by \$1,300,000. This revenue was received and sent to the General Fund.
- Total revenues for community programs exceed the expenditures for community programs by \$6,800,000 because revenues and expenditures do not always occur in the same fiscal year.
- The 18.8% increase in Total Administration expenditures reflects the capitation rate increase in T XIX for FY 2006.
- The 18.3% increase in total Medicaid revenues (state and Federal) reflects the capitation rate increase in T XIX for FY 2006.
- The 43.3% increase in State Medicaid Revenues reflects the capitation rate increase in T XIX for FY 2006.
- The 26.4% increase in Total State Revenues reflects the capitation rate increase in T XIX for FY 2006.
- The 15.6% increase in total revenues for Community Mental Health reflects the capitation rate increase in T XIX for FY 2006.
- The 18.8% decrease in civil patient's patient days reflects the decision that Maricopa County stay within the count cap of 55 patients to comply with the Arnold vs. Sarn lawsuit.

- The decrease in sexually violent predators' patient days reflects a revision of the 2005 data. The FY 2005 data should be 39,940. The decrease is due to the following:
 - Due to a US Supreme Court Case and the Arizona 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. The Supreme Court Decision has impacted us in several key ways:
 - Residents are screened against the Supreme Court higher standards, which has meant fewer referrals/admissions from DOC because the County Attorney/Outside evaluators cannot make the case;
 - Residents are admitted or discharged much quicker than in years past – some pretrial detainees waited up to six years previously before ever receiving a hearing about whether they met the criteria to be committed as an SVP. Now, their hearings happen within a few months. If they don't meet the criteria, they are immediately discharged.
 - Residents who are admitted to the program are moving through the program levels much faster and subsequently are being discharged much sooner than they used to be.

Arkansas:

- The large increase from FY05 to FY06 in Total State Hospital Expenditures (16.5%) occurred because the program was transferred from Admin to the hospital.
- The large decrease from FY05 to FY06 in Total Administration Expenditures (38.1%) occurred because the program was transferred from admin to the hospital.
- The large increase in Adult and Elderly Services expenditures from FY05 to FY06 (19.8%) occurred because there were increased expenditures on contract nursing.
- The large increase in total revenues for State Hospitals from FY05 to FY06 (16.5%) occurred because the hospital received additional funds from the Legislature.
- The large decrease in total Disproportionate Shared Medicaid from FY05 to FY06 (18.7%) occurred because Arkansas received the full Disproportionate Share funds.

California:

Colorado:

Connecticut:

- The total expenditures of the State Mental Health Authority are \$30,200,000 less than the total revenues reported in Table 2 because Medicaid, Medicare, and Third Party Revenue are posted to the State of Connecticut General Fund and not DMHAS.
- The total expenditures of the State Hospitals are \$15,300,000 less than the Revenues reported in Table 2 because Medicaid, Medicare, and Third Party Revenue are posted to the State of Connecticut General Fund and not DMHAS.

- The total expenditure for Community Programs are \$14,900,000 less than the revenues reported in Table 2 because Medicaid, Medicare, and Third Party Revenue are posted to the State of Connecticut General Fund and not DMHAS.
- The 19.9% increase in Total Administration Expenditures from FY05 to FY06 is due to the consolidation of Safety Services and Human Resources
- The 21.4% decrease in Total Medicaid Revenues from FY05 to FY06 is due to one time retroactive claims processed in State Fiscal Year 05.
- The 28.1% decrease in Total Medicaid Revenues for Community Services from FY05 to FY06 is due to one time retroactive claims processed in State Fiscal Year 05.
- The 21.4% decrease in State Medicaid Revenues from FY05 to FY06 is due to one time retroactive claims processed in State Fiscal Year 05.
- The 51.6% increase in Other Revenues from FY05 to FY06 is due to increased funding and reimbursement.

Delaware:

District of Columbia:

Florida:

The large increase (17.4%) from FY05 to FY06 in state Medicaid Revenues is likely because the FY05 amount was likely underreported.

Georgia:

Hawaii:

Idaho:

Illinois:

Indiana:

Iowa:

Kansas:

Kentucky: Most of the Medicaid revenue that the community programs receive is received by them directly from Medicaid.

Some of the SMHA-Controlled expenditures include funds for Mental Health services in Jails and Prisons.

Difference between Total DSH reported on Table 3 and State plus Federal Medicaid to state hospitals reported on Table 2 is not equal to 0. According to them this is Medicaid revenue received for the 65 and over population that were served in state psychiatric hospitals.

Total Medicaid Revenues (State plus Federal) show a large one year change which is due to the fact that they received a 4,400,000 one-time only prior year DSH supplemental in 2006.

Large one year change in Federal Medicaid Revenues is because they received a 4,400,000 one-time only prior year DSH supplemental in 2006, of which 3,100,000 was Federal.

There is a large one year change in Other Revenues because there was an increase in private insurance receipts and an increase in collections for clients.

Large one year change in Total DSH is because they received a 4,400,000 one-time only prior year DSH supplemental in 2006.

Louisiana: There is \$8,880,000 UCC in the revenues to community administered programs which were funds used from the Katrina UCC pool. This explains difference of &s between the Total DSH reported on Table 3 and State plus federal Medicaid to state hospitals on table 2.

This was the State Fiscal Year of Hurricane Katrina and the agencies' budget was cut by 5%. However, the primary difference between this year and last year's Total community mental health expenditures is due to the transfer of Orleans and Florida Parishes clinic to local governing authorities.

Increase in Total administration Expenditures is primarily from federal funds received as a result of Hurricanes Katrina and Rita for crisis counseling services.

Decrease in MH block grant Revenues and Total Community MH revenues is because there were problems with private providers operating at the full capacity due to the distinct nature of the hurricanes.

Maine:

Total MH expenditures increased dramatically this year due to a significant change in the methodology used to compile this expenditure data. Major changes to the data involve the inclusion of Federal Medicaid expenditures for all community mental health programs which have not previously been reported. It also includes a more comprehensive picture of child and adult mental health expenditures, including all children with primary MH diagnoses who receive residential (PNMI) services, and inpatient psychiatric services as well as the inclusion of acute psychiatric inpatient service use for adults in community hospital psychiatric units. This refined methodology reflects a more complete and accurate picture of mental health expenditures in Maine and will be used to generate subsequent annual revenue and expenditure reports. Given the change in methodology this year, comparisons with previous years is not appropriate.

Expenditures for forensic patients is significantly lower this year because of an apparent error in dollar calculations last year which will be fixed and updated.

Data for FY2006 includes: Federal & State Medicaid Expenditures for the following service areas:

Section 13: Children's Targeted Case Management - 13.12

Section 17 - Community Support Services: Community Integration Services, Intensive Community integration, Intensive Case Management, Assertive Community Tx, Skills Development, Day Support, Specialized outpatient services

Section 65 - Mental Health Services: Emergency/Crisis, Outpatient, Medication Management, Family Psychoeducation

Section 97 - PNMI - Residential/Group Services: (Children's & Adults)

Psych. Inpatient Units in Community Hospitals: St Mary's Hospital, Northern ME Medical Center, Pen-Bay Hospital, ME General Hospital, Mid-Coast Hospital, and Southern ME Medical Center (Children & Adults) Private Psych. Inpatient Facilities: Spring Harbor Hospital, Acadia Hospital, State Psychiatric Institutes: Riverview Psychiatric Institute; Dortha Dix Psychiatric Institute.

Data Sources:

MaineCare Paid Claims System: Paid Claims Cube Refreshed September 30, 2008 - Expenditures based on date of service

State Grant Funds: Obtained from Mental Health Block Grant Report (September, 2006) and Office of Adult Mental Health Services Data. State Psychiatric Facility Data

Federal Match Rate (Blended): State: 36.40; Federal: 63.40

Total community MH expenditures are higher this year because this year it includes all Children with Primary MH Dx. in Residential care, General Psych. Inpatient & Federal Medicaid for community programs.

SMHA controlled expenditures are also higher because of the fact that this year it includes all Children with Primary MH Dx, in Residential, Psych. Inpatient Units in Community Hospitals & Federal Medicaid for community programs. This is the same reason that all the revenues are higher this year as well.

Expenditure of forensic patients is significantly lower this year, this comes out because of a potential error in dollar calculations last year which might be fixed and updated soon.

Maryland:

Budget in Md does include a very small amount of payment for services in jails but very small amount. Almost all mental health services in jails and prisons are under other administrations.

Massachusetts: Where applicable 27.38% fringe benefit rate has been added to personnel expenses. Regarding the differences in revenues and expenditures: these differences are partly a function of your tables and Massachusetts' system. Funding MH services in Mass. is not based on retained revenue and revenues are not a one to one offset of expenditures. Massachusetts general fund revenues represent the amount DMH is appropriated each year to run its programs. Generally any revenues brought in through the year go back to the general fund. Total revenues for State Psychiatric Hospitals do not equal total expenditures because the revenues represent the inpatient expenditures at the State Psychiatric Hospitals while in the expenditures table inpatient

expenditures at SMHA-controlled community based programs are included. DMH did not collect any DSH in FY 2006.

Michigan:

Minnesota:

For Federal Revenues from MH Block Grant, the Support activities include planning and evaluation as well as other administration.

Part of the large one year change in Local Revenues is due to increase in county costs for state hospital, forensic and sex offender stays.

Large one year change is shown in Sexually Violent Predators: Expenditures and Sexually Violent Predators: Patient Days, this change is due to the fact that additional beds have been added to Sex Offender Unit.

Large one year decrease in Civil Patients: Patient Days from last year is because Minnesota has been closing several state hospitals.

Mississippi:

SMHA-Controlled Expenditures of Community-Based Programs on Table 1 include both Residential and non-residential expenditures. But these are mostly Non-residential and Medicaid.

State hospital expenditures include nursing homes operated by East Mississippi State Hospital and Miss. State Hospital. These nursing homes mainly house patients with a history of mental illness and/or other dementia that the private for profit nursing homes don't want to house

Details about costs and patient days for the nursing homes are:

Cost: \$39,800,000
Patient days: 223,716
Cost per day: \$178

Revenue source:

Federal Medicaid: \$26,500,000
State Medicaid: \$8,400,000
State other: \$4,900,000
Total: \$39,800,000

Table 3: Did not provide numbers for Federal Share and State Match, since they normally do receive DSH funds at Mississippi State Hospital, 2006 was a year that receipt was delayed. They got two year's worth in 2007, in other words. That is the reason it was stated that these DSH funds were reported on Table 1 and 2. Since they always include those in tables, even though they did not receive any numbers this year.

Difference between Total DSH reported on Table 3 and State plus Federal Medicaid to state hospitals reported on table 2, came up to be -38,400,000. According to them, they receive more

than just DSH from Medicaid; they also receive nursing home, acute care hospital, physician and pharmacy.

Missouri:

Table 1. FY 2006 State Mental Health Agency Controlled Mental Health Expenditures

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 \$1,688,434 of estimated 2006 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 Table 1.

Table 2. FY 2006 State Mental Health Agency Controlled Mental Health Revenues

SMHA revenues do not equal SMHA expenditures due to revenues that are collected by the SMHA but transferred back to the State of Missouri General fund. A total of \$160,967,787 is collected by the SMHA and transferred to the General Revue fund: \$152,258,680 is attributed to state psychiatric hospitals; \$8,709,107 is attributed to community programs.

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

Table 3. FY 2006 Disproportionate Share Medicaid

The Disproportionate Share State Match represents the certified state match of in-kind expenditures. This certified State Match in Table 3 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 \$133,474,093 is collected by the SMHA and transferred to the Missouri General Revenue Fund.

Montana:

Nebraska: In 2004, the Nebraska Unicameral enacted legislation (LB1083) which reformed Behavioral Health Services in the state. The legislation prioritized community based services for consumers to better meet their needs. During state FY 2006 (July 1, 2005 – June 30, 2006), the impact from the initial phases of this reform were reported in the data, resulting in decreased number of patient days and a decrease in Medicaid revenues for Regional Centers (State Psychiatric Hospitals). Correspondingly, there was an increase in revenues and expenditures for Community Administered Programs.

Source: Nebraska Department of Health and Human Services (DHHS) DHHS Operations - Financial Services prepared the State Mental Health Agency Controlled Expenditures and Revenues reported. DHHS Division of Behavioral Health - Lincoln Regional Center reported the Patient Days.

New Hampshire: Total Medicaid revenues are 39.9% higher than FY05. According to them, for the first time, DSH Revenue source built into the budget of the state psychiatric hospital. Previously DSH revenue went into the state's general fund and was not counted as Medicaid Revenue in Table 2.

Total Administration expenditures are 22% higher than FY05, this increase due to increases in personnel costs, research/training, costs, and inclusion of some costs not counted in previous years.

Total Medicaid Revenues are 39.9% higher than FY05, for 1st time, DSH revenue was a revenue source built into the budget of the state psychiatric hospital. Previously DSH revenue went into the state's general fund and was not counted as Medicaid revenue in Table 2.

Nevada:

New Jersey:

The Arthur Brisbane Children's Treatment Center closed on December 31, 2005. As a result, the revenues and expenditures for this State Psychiatric Hospital reflect the period July 1, 2005 through December 31, 2005 in this study. Future studies will therefore not include costs for this facility. This also explains the Large 1 year change for Children's Mental Health Services.

Disproportionate share revenues for 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. This also explains the Internal Consistency Edits for DSH.

MH Block Grant Revenues: Large 1-Year Change is due to fact that the MH Block Grant funds can be obligated and expended over a two-year time period and therefore, on occasion, there will be differences in expenditures from year to year.

Total DSH: Large 1-Year Change is due to reporting methodology. In past years, we reported the total Disproportionate Share state claim amount. This year we reported the amount based on the FFP cap, which is considerably less.

New York: The total expenditures of the state mental health authority are greater than revenues because we have outpatient providers reporting more expenditures than revenues. The total expenditures for state hospitals is higher than revenues is fully accounted for by community providers-general hospital based outpatient providers. This is not unusual since hospitals often draw upon revenue sources not reported to us, i.e. fund raising and/or desire to document unfunded expenditures.

New Mexico:

Medicaid Revenue increased by \$200,000. Medicaid rate increased plus census went up in the Medicaid program. Downside - Medicare Part D. Did not implement on-line adjunction (electronic billing) and revenues from the pharmacy were lost.

CMHS Block Grant was under reported in FY 2005. It should have been stated as \$1,900,000 as it is FY 2006. Therefore there is zero change.

Correcting for the block grant revenue of \$1,000,000 the real change is an increase of \$200,000

Forensic expenditures for FY 2005 were not reported. They are reported in FY 2006. While they could provide patient days, but not the exact cost.

North Carolina:

Table 1:

Medicaid revenues for community programs are included in SMHA-Controlled expenditures. 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.

Children's mental health expenditures are included in SMHA-Controlled expenditures. Expenditures for Community-Based Programs excludes \$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 funds for mental health services in jails or prisons. Only a very minor amount is included but cannot be determined. Amounts reported above 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.

Table 2&3:

N.C. NOTE: 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 noted in Table 2 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.

Table 4:

Unable to break out cost for Sexually Violent Predators separately.

Civil Commitments: Information not broken out by age, however, the following commitment information is provided:

- ◇ 1.93%: % of total days of service provided in Forensic Treatment Unit (would be considered Involuntary)
- ◇ 5.41% : % of total days of service provided for voluntary admissions.
- ◇ 92.66%: % of total days of service provided for involuntary admissions (does not duplicate Forensic)
- ◇ 100.00%: Total Percent

North Dakota:

The patient population increased in the sex offender program and thus the expenditures increased. The cost per day actually decreased from \$158 to \$106 per day – so these numbers are flip flopped. Increase in population allowed for economies of scale and a decrease.

Civil expenditures and cost per day declined because of reduction in patient population.

More clients were seen at the regional human service centers that were Title XIX eligible, resulting in an increase in Federal Medicaid revenues

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 and 2006, revenue appears to exceed expenditures.

Total Revenues for State Hospitals exceeded Total Expenditures for State Hospitals. 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 06.

There were decreased expenditures among all categories of community inpatient and residential services from FY 2005 to FY 2006.

Other revenues depend on first and third party billings/eligibility; 2006 Revenue similar to 2004.

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

Oklahoma: For Medicaid revenues for community programs included in SMHA-controlled expenditures: Oklahoma some revenues included: 1) adults - only state portion reported for private nonprofit CMHCs, state and federal reported for state Operated CMHCs. 2) children not reported for outpatient services at private nonprofit CMHCs, state & federal reported for state operated CMHCs. Total Administration increase from last year is Oklahoma have had program expansion. Children's MH Service increased is due to pay raise and increase in Retirement Rate. Federal Medicaid Revenues increased is Medicaid collected at Oklahoma Youth Center & Carl Albert CMHC. MH Block Grant Revenues increased is due to Federal vs State Fiscal Year Time Issue. Other revenues increase is due to interagency revenue.

Oregon: The large decrease on Children's MH Services and large increase on Adult and elderly service is the 2005 community amounts for Adults were missing applied to Children. (120 Million In Other and 30 Million in other 24 hour). The other revenues increase is due to late revenue in 2005 charged to 2006. It also increases at the State Hospital. Total DSH increase is due to timing of Revenue received in the State Hospital.

Pennsylvania: The large increase in Forensic Patients and Forensics: cost per pt. day is due to interim rate used for '05 calculations; '06 is based on actual per diem rates. The total expenditures and revenues are correct. The discrepancy is a result of the community program's expenditures exceeding the revenues. OMHSAS is unable to reconcile the difference in the statewide accounting systems.

Rhode Island: None.

South Carolina: The total expenditures of the state mental health authority is not equal to the total revenues are due to in FY 06, both Medicaid Revenue and Other Revenue decreased; The total expenditures of the state psychiatric hospitals is not equal to the total revenues for hospitals is due to expenditures for Inpatient (Adults), Other 24 Hour residential Care (children), & Less than 24 Hour Care Residential (Children) slightly decreased with Other State and Medicaid Revenues decreased; The total expenditures for community programs is not equal the total revenues for community programs is due to expenditures for Inpatient (Adults), & Less than 24 Hour Care Residential (Adults) slightly decreased while Other State, Medicaid, and SAMHSA generated revenue significantly decreased.

South Dakota:

Tennessee: State Medicaid Revenues increased due to the loss of 50% of the State's exemption to the federal Medicaid IMD exclusion. Other revenues increased primarily due to increased collections from County juvenile courts for forensic evaluations related to misdemeanors.

Texas: Total Medicaid: State Hospitals (State + Fed.) decreased from last year is due to last year Medicaid was overstated due to timing of settlement payments. Other revenues decrease from last year is due to revenue from other state agency declassified in FY06.

Utah: The increased in Other Revenues is a result of increased dedicated credit collections at the State Hospital. The increased in forensic cost is due to an increase in forensic patients. We hired staff in 06 but didn't fill the beds until 07. The increase in Total DSH is due to UT's Medicaid increased significantly which increase their DSH payment.

Vermont: The large decrease on Forensic Patients: Patient Days and large increased on Forensics: Cost per pt. day is due to broken out differently in fy06. It is also the same reason for the increase on Civil (non-Forensic) Patients: Expenditures.

Virginia: 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 mental retardation training centers and a facility dedicated to the treatment of sexually violent predators. Total average inpatient census for the inpatient mental health facilities (including our sexually violent predator facility) amounted to 1,581.

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 2006 nearly 200,000 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 2006, local governments appropriated \$79,890,638 to community based mental health services.

Note 2: Adult and Children's Services

During fiscal year 2006 77% of the individuals receiving mental health services were adults while 23% were children under the age of eighteen. For fiscal year 2005 this ratio was 74% adult and 26% children.

Note 3: Central Office Support

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%.

Note 4: The total expenditures of the state mental health authority is not equal to the total revenues; and the increased in revenues:

Although DMHMRSAS balances its budget annually; inpatient mental health expenditures exceed their true sources of revenue each year. In order to balance this portion of the budget, resources from our DMHMRSAS Special Revenue Fund are transferred to our inpatient facilities throughout the fiscal year. To report these transfers would be to distort the true revenue generation capacity of the inpatient mental health portion of our system, hence, these transfers are not reported as part of this survey. The \$606.7 million in revenues reported is a true picture of revenues generated and appropriations granted to our mental health system. The \$613.4 million is a true depiction of our total expenditures for the fiscal year.

The majority of the variance between revenues and expenditures is created by inpatient operations in our state hospitals.

Note 5: Revenues Exceed Expenditures in Community Programs by \$1.8 Million

This is due to a small surplus in our Community Resource Pharmacy operated at Hiram Davis Medical Center. Although the pharmacy is operated by an inpatient facility, its purpose is to serve the pharmaceutical needs of our community programs. It is included as part of community operations for the first time in this survey. At the close of FY 2006, a surplus of \$1.8 million in appropriation existed in this operation.

Note 6. Disproportionate Share of Medicaid Program

DMHMRSAS does not participate in a Medicaid DSH program. As a result of this, our Medicaid reimbursement includes no DSH payments.

Total Community MH Expenditures increased is due to In FY 2006 MH Case Management Medicaid rates were increased. This resulted in the reimbursement of an additional \$34 million for this Medicaid covered service. Also, for the first time, the expenditures of the Community Resource Pharmacy are reported as community expenditures. Previously these were included as inpatient expenditures. Grand Total SMHA Controlled Expenditures increased (\$531.5 million to \$613.4 million) is due to this variance is attributable to the MH Case Management Medicaid rate increase described above; some increase in state funding to MH community services, and the fact that the FY 2005 NASMHPD edit check does not include \$15.5 million in Administration cost as we originally reported for that fiscal year. One other variable was the processing of one additional pay period during FY 2006. During that fiscal year, our General Assembly remained in session well past the normal deadline for legislation. There was a concern that without the timely development and passage of the 2006-2008 budget, state government would be temporarily shut down. As a result of this, the payroll scheduled for July 3 of that year was moved forward to June 30. This created a 25th pay period in FY 2006 and, hence, additional expenditures in that year. The General Assembly did sign the Appropriations Act for the 2006-

2008 biennium budgets on June 30, 2006. The Other Revenues decreased is due to part of this variance is due to the increase in forensic commitments during FY 2006. These patients tend to have little to no insurance coverage or other personal financial resources. Furthermore, in FY 2005 we erroneously reported some MR first party revenue having nothing to do with reimbursement for MH service delivery. Increase in Forensic Expenditures is due to our inpatient appropriations followed our commitment patterns. Forensic patient days increased substantially in FY 2006 due to higher numbers of forensic commitments as opposed to civil commitments. Our Office of Forensic Services is working to provide more MH services in jail settings in order to reduce the volume of forensic commitments currently occurring in our system. Increase in Sexually Violent Predator Days is due to this population is growing as is our need to fund operations associated with this group. The census at our sexually violent predator facility (Virginia Center for Behavioral Rehabilitation) grew from 11 to 28 in FY 2006. We completed construction of a new 300 bed facility for this population in FY 2008. The current census stands at 67 and is projected to continue to grow over time.

Washington: State Revenues Total increased is due to State legislature invested large sum to offset loss of federal revenue. The large decrease for Forensic Patients: Patient Days and Forensics: Cost per pt. day is due to Last years bed days were inaccurate.

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.

SMHA Controlled Expenditures of Community-Base Programs/Other 24 Hour (residential) for Under Age 18 Children and Adults data are not available; these data are included in less than 24 hour care; Administration for Central/regional office support for Any Age Unknown and (all ages) total data are not available, they are unable to separate by MH, SA, DD, long term care, acute hospital. SMHA Controlled Mental Health Revenues/Federal Revenues/MH Block Grant/SMHA Support Activities data is not available; they are included in community Adm. Program.

Wisconsin: Wisconsin pays Medicaid claims to its two State psychiatric hospitals in excess of what is received through the Disproportionate Share process. Wisconsin claims less that they could for the disproportionate share for inpatient stays. A more conservative interpretation is used than that of other states.

Wisconsin's total Federal Revenues (Medicaid, not block grant) increased from 2005 to 2006. The single largest factor in the increase is that many more counties have a certified comprehensive community services program (a Medicaid psychosocial rehabilitation services benefit), so the FFP in 2005 for this benefit was \$1,158,722 and in 2006 it was \$3,456,520. Another area of significant increase was crisis intervention services; FFP in 2005 was \$13,836,111 to \$15,946,534. The total increase for FFP from 2005 to 2006 was \$93,877,299 and \$98,561,488, respectively. The decrease of total Administration was a result of a change in funding for some staff positions from Medicaid to Block Grant funding. Total DSH decrease from last year was one of the two states psychiatric hospitals were not eligible for DSH in 2006. And the numbers have been verified by the State Medicaid agency.

Wyoming: Total Community MH Expenditures decrease from last year and the Civil (non-Forensic) Patients: Expenditures increase from last year is due to a review of biennium expenditure reports indicates that the change between FY05 and FY06 could be attributed to cost reports derived at the midpoint in the biennium reporting cycle. The FY06 civil expenditure dollars have been verified and are correct.