STATE FOOTNOTES

NASMHPD Research Institute, Inc.
State Mental Health Agency Revenues and Expenditures: FY 2007

Alabama:

All Alabama state agencies were required by the Alabama Examiners of Public Accounts to change the accounting method for recording the state match expenditures in FY2007. This created a large change between FY2006 and FY2007. Prior to FY2007, the state match payment to the Alabama Medicaid Agency was coded as a reduction in Medicaid revenue. The expenditure was recorded as the payment to the providers. In FY2007 and later, the state match to the Alabama Medicaid Agency was also recorded as expenditure. This appears to increase both revenues and expenditures for our Mental Illness Division by $31 million; however, it is only the result of a change in our accounting procedure.

- Total Revenues exceed Total Expenditures due to carryover funds into FY2008.
- Total expenditures for state hospitals are less than Total Revenues for state hospitals due to carryover funds into FY2008.
- Total expenditures for community programs are less than Total Revenues for community programs due to carryover funds into FY2008.
- State and federal Medicaid revenues to state hospitals exceed total DSH, because the state hospitals get other Medicaid for clients under the age of 21 and over the age of 65.
- Multi-year changes:
    - Total Community Mental Health Expenditures increased 19.3% from 2006 to 2007. $26.6 million is due to an accounting change in recording the state match as expenditure rather than a reduction in revenues.
    - Total Administration Expenditures increased 29.9% from 2006 to 2007. This is due to a 6% COLA and the accounting change in recording state match for administrative costs billed to Medicaid.
    - The grand total for SMHA-controlled expenditures increased 15.6% from 2006 to 2007. $26.6 million is due to an accounting change in recording the state match as expenditure rather than a reduction in revenues.
    - Total Medicaid Revenues (State plus Federal) increased 32.4% from FY2006 to FY2007. $31.3 million is due to an accounting change in recording the state match as expenditure rather than a reduction in revenues.
    - Total Medicaid Revenues for State Hospitals (State plus Federal) increased 37.8% from FY2006 to FY2007. $4.7 million is due to an accounting change in recording the state match as expenditure rather than a reduction in revenues.
    - Total Medicaid revenues for community programs (state plus federal) increased 31.5% from FY2006 to FY2007. $26.6 million is due to an accounting change in recording the state match as expenditure rather than a reduction in revenues.
    - State Medicaid revenues increased 33.2% from FY2006 to FY2007. $7.3 million is due to an accounting change in recording the state match as expenditure rather than a reduction in revenues.

- Federal Medicaid revenues increased 32.2% from FY2006 to FY2007. $16.2 million is due to an accounting change in recording the state match as expenditure rather than a reduction in revenues.
- Mental Health Block Grant revenues increased 67.6% from FY2006 to FY2007 due to unspent carry forward from the FY06 Block Grant.
- Total federal revenues increased 29.8% from FY2006 to FY2007 due to the accounting change for Medicaid and CMHS Block Grant carry forward.
- Other revenues increased 60.8% from FY2006 to FY2007 due to a $3 million carry forward from the prior year.
- Total revenues increased 16.5% from FY2006 to FY2007. $31.3 million is due to an accounting change in recording the state match as expenditure rather than a reduction in revenues.
- Total revenues for state hospitals increased 12.9% from FY2006 to FY2007. $4.7 million is due to an accounting change in recording the state match as expenditure rather than a reduction in revenues.
- Total revenues for community mental health programs increased 19% from FY2006 to FY2007. $26.6 million is due to an accounting change in recording the state match as expenditure rather than a reduction in revenues.

Alaska:

- Total state hospital expenditures increased from 2006 to 2007. Alaska has only one state-owned psychiatric hospital. The increase is related to the hospital moving to a newly constructed facility.
- In FY03, Alaska was ranked 23 in per capita funding of SMHA-controlled expenditures among states. Starting in FY04, Alaska rose to the top or near the top in per capita funding. This climb has been without any significant change to our funding. What clearly changed was our methodology for the calculation of Alaska funds due to the full reporting of Medicaid. The Alaska Division of Behavioral Health awards community programs with state and federal funding. Each community program is also authorized to bill Medicaid-covered mental health services. While the DBH administers the Medicaid program, the DBH does not have control of provider participation and overall Medicaid reimbursement. In FY07, the reimbursement of Medicaid-covered services is no longer recognized as state-controlled revenues and expenditures. This has resulted in a large decrease in the following areas:
    - The grand total for SMHA-controlled expenditures
    - Total community mental health expenditures
    - Children's mental health services
    - Adult and elderly services
    - Total Medicaid revenues (State plus Federal)
    - State Medicaid revenues
    - Federal Medicaid revenues
    - State revenues total
    - Federal revenues total
    - Total revenues
    - Total revenues: community mental health
- The decrease in Total Administration Expenditures is largely attributable to the transition of the federally funded Alaska Comprehensive Systems Development Grant from full

operations to the lower-funded evaluation year. In prior years, the majority of those expenditures were reported under Administration Research and Training.

- The decrease in MH Block Grant revenue is due to the overlap of two-year grants. Revenue and expenditures do not always occur within the same fiscal year.
- Total revenues of State Hospitals: Hospital rates have increased each year since moving to the new facility. Private insurance collections have increased.
- The decrease in total DSH was due to an uncommon Institutional Community Health Care payment and an uncommon payment for low-income patients.
- The cost per day for forensics rose because hospital rates have increased each year since moving to the new facility.

Arizona:

- Tribal fee for service was paid from administration funds during FY2007 ($2.4 million) and overall there was a 36.1% increase in expenditures for administration during FY2007.
- The 19.8% decrease in patient days for sexually violent predators is 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 the state in several key ways:
    - Residents are screened against the Supreme Court higher standards, which have meant fewer referrals/admissions from Department of Corrections 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 every 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 do not 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.
- In FY2007, the hospital had a Corrective Action Plan to make direct care services salaries competitive with the market in order to reduce turnover. All direct care positions had pay increases, which greatly increased annual expenditures for civil (non-forensic) patients by 16.7% from the previous year.
- Total revenues exceed total expenditures by $11,760,000 because revenues and expenditures do not always occur in the same fiscal year.
- Total revenues for state hospitals exceed total expenditures for state hospitals by $760,000 because revenue was received, but sent to the General Fund.
- Total revenues for community programs exceed total expenditures for community programs because revenues and expenditures do not always occur in the same fiscal year.

Arkansas:

Disproportionate share Medicaid is less than the total Federal and State Medicaid revenue reportedly given to state hospitals. This data has been verified, but an explanation for the difference is unavailable at this time.

California:

- Metropolitan State Hospital closed the children's program in FY2007/2008. The children's program continued to decline in the preceding years. The program shrank from 125 patients to 25 patients in FY07. It was determined to place the remaining 25 children in local settings and to close the program. This segment of the population generated the largest revenue due to their eligibility for Medi-Cal.

Colorado:

- Some children's mental health expenditures are included in SMHA-Controlled expenditures. Expenditures at the County Child Welfare and the Division of Youth Corrections are included.
- The percentage of the Mental Health Block Grant allocated to support activities exceeds 5% because the funds include monitoring and University of Colorado expenses that are in excess of the 5% administrative costs.
- State plus Federal Medicaid to state hospitals exceeds total Disproportionate Share Medicaid (DSH) by $10,217,216 because Colorado does not participate in DSH.

Connecticut:

- Total revenues exceed total expenditures because Medicaid, Medicare, and Third Party Revenue are posted to the State of Connecticut General fund and not DMHAS.
- Total revenues for state psychiatric hospitals exceed total expenditures for the same because Medicaid, Medicare, and Third Party Revenue are posted to the State of Connecticut General fund and not DMHAS.
- Total revenues for community programs exceed total revenue for the same because Medicaid, Medicare, and Third Party Revenue are posted to the State of Connecticut General fund and not DMHAS.
- Total administration expenses decreased from FY06 to FY07 because starting in FY07, the state modified the methodology to allocate a portion of administrative expenditures to MH that allocated Safety Services based on the payroll database.
- Total Medicaid revenues to community services decreased because FY06 contained retroactive claims.
- Mental Health Block Grant Revenues decreased due to a $700,000 intra-agency transfer.
- Other revenues decreased from 2006 to 2007 due to correcting methodology moving grant transfers between state agencies to CAP other state.
- Total DSH exceeds State plus Federal Medicaid to state hospitals because Medicaid, Medicare, and Third Party Revenue are posted to the State of CT General Funds and not DMHAS; and DSH funds for DMHAS are included under State Revenues General – this is because in Connecticut 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:

- Medicaid revenues are only reported for a limited number of community programs that are operated by the SMHA directly, or under SMHA contractual arrangements with community providers.

- Revenues listed under Federal Revenues for the State Mental Hospital Program are deposited to the State General Fund.
- Most of the DSH funds are not reported under revenues and expenditures. DSH funds are deposited to the General Fund, the Division of Medicaid and Medical Assistance, and the SMHA. Only the SMHA portion is included in the tables. These funds are reflected under revenues of the State Mental Hospital, Other State Revenue.
- The total expenditures of the SMHA are less than the total revenues reported. The difference is because State Mental Hospital Program revenue from Medicare, Medicaid, 1st Party, and 3rd Party is deposited to the State General Fund. As mentioned above, "Revenues listed under Federal Revenues for the State Mental Hospital Program are deposited to the State General Fund."
- Total DSH exceeds State plus Federal Medicaid to State hospitals. For the most part, DSH funds are *not* reported under revenues or expenditures. DSH funds are deposited to the General Fund, the Division of Medicaid and Medical Assistance, and the SMHA. Only the SMHA portion is reflected in this report. The DSH funds are included in revenues under State Mental Hospital, Other State Revenue.

District of Columbia: None

Florida:

- Expenditures by priority group: There was a large increase in expenditures for forensic patients from 2006 to 2007. The reason for this increase is that adult mental health treatment facilities received additional state funding in 2007.
- The decrease in civil days is due to the conversion of civil beds to forensic step-down beds.

Georgia: None

Hawaii: FY2007 data not reported

Idaho:

- Federal Revenues: SHS realized an increase in revenues due to an increase in census/patient days as compared to FY06. This increase coupled with eligibility of the patients being admitted resulted in the increase in Medicaid Revenue.

- Other Revenues: SHN revenue for patient services will fluctuate, depending on patients' ability to pay room and board (patient personal resources such as monthly benefits and third party payors). FY06 to 07 SHN individuals and third party payments increased.

- Federal and State Medicaid Revenues (state hospital): SHS realized an increase in revenues due to an increase in census/patient days as compared to FY06. The increase coupled with eligibility of the patients being admitted resulted in the increase in Medicaid Revenue.

- Federal Medicaid Revenues (all): SHS realized an increase in revenues due to an increase in census/patient days as compared to FY06. This increase coupled with eligibility of the patients being admitted resulted in the increase in Medicaid Revenue.

- Forensic Expenditures – State Hospital Inpatient: SHN increased bed capacity by 10% from 50 to 55 beds effective October 1, 2006 (beginning second quarter FY2007). FY06 to FY07 average census increased from 43 to 48 (12%) and FY06 to FY07 patient days increased from 15,677 to 17,513 (+1,836 patient days or 12%).

- Forensic Patient Days – State Hospital – In FY2006 SHN admitted two patients 18-212 criminal code unfit to proceed/reported as forensic (201 patient days). In FY2007, all admissions were civil commitments (non-criminal/forensic).

- Sexually Violent Predator Expenditures – State Hospital: The increase in Forensic patient days at SHS has resulted in an increase in the expenses because these patients do not qualify for Medicare or Medicaid funding.

- Sexually Violent Predator Days – State Hospital: SHS saw a much higher volume in the number of Forensic patient days at the hospital. This is due to a few admits early in the year and the higher than average length of stay in these individuals.

- Civil Subtotal Days – State Hospital Inpatient: In FY07 SHS reduced the average length of stay from 126.1 to 95.4 along with developing more efficiency between admissions and discharges. This resulted in fewer days of vacant beds and in turn, increased the total patient days for the facility.

Illinois: None

Indiana: None

Iowa: None

Kansas:

- Federal and State Medicaid Revenue: State Hospital Programs: Large one year decrease in Federal and Medicaid Revenue for State Hospital Programs (from FY06 to FY07) is due to the conversion of the Rainbow Mental Health Facility (RMHF) from providing a majority of services to children and adults to an adult only facility.

- Forensic Patients Expenditures and Patient Days – State Hospital Inpatient: Large one-year increase in forensic patients' expenditures and Patient Days (from FY06 to FY07) is due to the combination of Transition House budget with Larned State Hospital (LSH) budget.

- Forensic Cost per Patient Day: State Hospital Inpatient: The large one-year decrease in forensic cost per patient day (from FY06 to FY07) is a result of an increase in the average daily census.

- Sexually Violent Predators Expenditures: State Hospital Inpatient: The large one-year increase in sexually violent predators' expenditures (from FY06 to FY07) is due to combined expenditures of Transitional House Services (THS) and Sexual Predator Treatment Program (SPTP).

Kentucky:

- Children's Mental Health Services: (Large one-year change in data reported between SFY2006 & SFY2007): There was $1.5 million appropriated in SFY07 for Children's Crisis Stabilization Units. In addition, we received $700,000 in new federal awards. The SMHA also spent nearly $3 million more in SFY07 in the Impact Plus program.
- State Revenues: (Large one-year change in data reported between SFY2006 & SFY2007): There was an additional $10 million appropriated in SFY07 for inpatient care. On the community side, the Community Mental Health Centers (CMHCs) can choose where (MH, SA< ID/DD) to put a portion of their flexible funds so in addition to the terms listed above for children's mental health services, the CMHCs could have put more of their flexible funds into mental health during SFY07.
- Other Revenues: The large one-year change in 'Other Revenue' data reported between SDY2006 & SFY2007 is caused by the fact that third party revenues increased due to increased insurance collections.

Louisiana:

- Federal Mental Health Block Grant Revenues: Though Block Grant revenues are reported in State Hospitals and SMHA Support Activities, most of these revenues relate to community services; less than 5% of these revenues support administrative expenses.

- Administration Expenditures (22% increase in expenditures from FY06 to FY07):
- State fiscal year 2007 includes expenditures for the crisis counseling grant dedicated for Hurricanes Katrina and Rita, both the Immediate Services Program and the Regular services Program, whereas state fiscal year 2006 only included expenditures for the immediate services Program/Crisis Counseling Grant.

- Federal Revenues (22% increase in revenues from FY06 to FY07): State fiscal year 2007 includes federal funding for SSBG ($18,557,603). This fund was allotted to OMH to help meet the health care and mental health needs of people affected by the hurricanes in the Gulf of Mexico in calendar year 2008 and lacking health insurance or other adequate access to care. OMH was also to help health care "safety net" providers restore and resume their operations. State fiscal year 2006 only included $532,000 in SSBG funds.

- In addition, state fiscal year 2007 includes federal funding for the Regular Services Program/Crisis Counseling Services, which were not in state fiscal year 2006.

- Other Revenues (20% decrease in other revenues from FY06 to FY07: State fiscal year 2006 included revenues from the Acute Unit in New Orleans which closed after Hurricane Katrina in SFY2006 (state fiscal year 2007 does not include revenues for this acute unit).

- Civil (Voluntary and Involuntary) Expenditures (18% increase from FY06 to FY07): State fiscal year 2007 State Hospital Inpatient Expenditures include SSBG expenditures whereas state fiscal year 2006 did not. In addition, there was a significant reduction in salaries and related expenses in SFY2006 after hurricane Katrina due to many displaced individuals employed in the hospitals that were in the affected areas.

<u>Maine</u>:

- Data for FY2007 includes Federal & State Medicaid Expenditures for the following service areas:
  - Section 13: Children's Targeted Case Management – 13.2
  - Section 17: Community Support Services: Community Integration Services, Intensive Community Integration, Intensive Case Management, Assertive Community Treatment, 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): Proc. Adult MI: RMI, Hospital, ME General Hospital, Mid-Coast Hospital and Southern ME Medical Center (Children & Adults with Psych. ICD-9 diagnosis)
  - Private Psychiatric Inpatient Facilities: Spring Harbor Hospital, Acadia Hospital (Children & Adults) - Psychiatric Inpatient Expenditures are based on estimated payments. Identification of mental health service users in Residential Facilities and Inpatient Psychiatric Facilities required the use of ICD-9 Diagnoses codes (291 through 314.99)
  - State Psychiatric Institutes: Riverview Psychiatric Institute; Dorthea Dix Psychiatric Institute – Data obtained from Psychiatric Institute Financial Data.
  - Mental Health Block Grant Expenditures and SAMHSA Child System of Care Grant Expenditures included in Less than 24 Hour Care data.
  - Mental Health Administration: Expenditures include – State General Funds for all Central/Regional Office support activities including personnel costs.
- Data Sources:
  - MaineCare Paid Claims System: Paid Claims data refreshed March 15, 2009 – expenditures based on date of service
  - Claim Status: 71 paid – No claim adjustments made
  - State Grant Funds: Obtained from ME-DHSS Administrative Data Systems (AdvantageME System)
  - State Psychiatric Facility Data
  - Federal Match Rate 2007 (Blended): State – 36.82; Federal – 63.18

- <u>Total Administration Expenditures</u>: Significantly large one-year change between FY06 data and FY07 data is due to the exclusion of Central Office/Regional Personnel expenditures in prior years reporting.

- <u>Forensic Expenditures and Forensic Patient Days (State Hospital Inpatient</u>): The large one-year change between FY06 and FY07 data is due to data being underreported in the FY06 reporting. Adjustments were made for the FY07 reporting.

- <u>Civil Patients Patient Days and Civil Patients Cost Per Patient Day:</u> The large one year change between FY06 and FY07 data is due to data being over reported in the FY06 reporting. Adjustments were made for the FY07 reporting.

Maryland:

- Federal Revenues (all programs total) and Federal Medicaid Revenues (all Programs): The large one-year increase (between FY2006 & FY2007) in Federal Revenues (all programs total) and Federal Medicaid Revenues (all programs) are due to retro eligibility changes.

Massachusetts:

- Differences in Revenues and Expenditures: Funding mental health services in Massachusetts is not based on retained revenues and revenues are not a one to one offset of expenditures. Our general fund revenues represent the amount DMH is appropriated each year to run its programs. Generally, any revenues we bring in through the year go back to the general fund.
- State Psychiatric Hospital Expenditures: Total SMHA controlled Mental Health Expenditures for State Psychiatric Hospitals ($127,400,000) does not match the grand total of State Hospital expenditures by priority groups ($216,000,000) because the later includes the inpatient expenditures for State Psychiatric Hospitals and the inpatient expenditures of Community Based Programs.

- Disproportionate Share Medicaid (DSH): The Department of Mental Health did not collect any DSH in FY2007.

Michigan: None

Minnesota:

- Federal Mental Health Block Grant Revenue: Reported SMHA support activities revenue includes planning and evaluation as well as other administration.

- Disproportionate Share Medicaid (DSH): Minnesota is a low DSH State – for further information see Federal Register, Vol. 73, No. 245 (12/19/08), page 77713.

- Local Revenues (all programs): The decrease in local revenues reported for FY07 (from FY06) is due to cuts in block grants to counties as well as budget issues.

- Forensic Expenditures & Forensic Cost (State Hospital Inpatient): The increase in forensic expenditures & cost for state hospital inpatient between FY06 & FY07 is due to the conversion of an MI State Hospital Unit to a forensic unit.

- Sexually Violent Predators Expenditures (State Hospital Inpatient): The increase in state hospital inpatient expenditures for sexually violent predators between FY06 & FY07 is due to the addition of beds for treatment of sexual offenders.

- Civil (Voluntary and Involuntary) Expenditures & Patient Days: The decrease in civil expenditures and civil patient days in State Hospital Inpatient settings between FY06 & FY07 is a result of a reduction in state hospital days due to closure of state hospital units.

- Civil (Voluntary and Involuntary) Cost per Patient Day: The increase in civil cost per patient day between FY06 & FY07 may be attributed to the reduction in patients due to transition in closing State Hospital units while units were still open with fixed costs.

Mississippi:

- Forensic Patients Expenditures (State Hospital Inpatient): The almost 16% increase in forensic expenditures between FY2006 and FY2007 is due to increased funding for what we were already doing along with new funding for expansion of our crisis centers (a total of seven crisis centers which were all fully funded for the first time in FY2007) and expanding operations at our adolescent treatment facility on the Gulf Coast. We also did a better job of drawing down Medicaid at our State Hospital operated nursing homes.

Missouri:

- FY2007 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 $2,371,084 of estimated 2007 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.
- FY2007 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 Revenue fund: $147,632,994 is attributed to state psychiatric hospitals; $12,503,987 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.
- Disproportionate Share Medicaid (DSH): The DSH state match represents the certified state match of in-kind expenditures. The reported 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 DSH received by the State of Missouri is not controlled by the SMHA. The $134,748,452 is collected by the SMHA and transferred to the Missouri General Revenue Fund.
- Sexually Violent Predators: The State of Missouri only admits sexually violent predators (they are never discharged).

Montana: None

Nebraska:

Differences in reporting from FY2006 to FY2007 are due to the following:

- As a result of some staffing changes within the Division of Behavioral Health, there is now improved capacity to prepare these reports. Most of the changes are due to that improved reporting capacity.
- FY2007 includes the implementation of Nebraska's Behavioral Health Reform efforts. This reform was created by LB 1083, passed in 2004. The LB1083 Behavioral Health Reform focused on increasing access to community-based care, moving people from Regional Centers to local care, and preventing people from being institutionalized whenever appropriate. Under LB 1083 Behavioral Health Reform, there was a promise to transfer $25.8 million from Regional Centers to Community Services. In the end, $30.1 million was transferred.
- As part of the Reform effort, a significant number of consumers were moved from the State Hospitals to Community Based Services. As such, the funds related to service provision for these persons was also transferred. This has resulted in the subsequent drop in DSH payments and increase in Medicaid services.
- Significant staffing changes within the SMHA resulted in a drop in expenditures.
- Previous years Medicaid Revenues did not include all dollars accordingly. In addition, a portion of the increase is due to person moved from State Hospitals to Community Based Services.
- There were various increases and decreases in Federal Grant amounts.
- The Hastings Regional Center, one of the State Hospitals, transitioned to a Youth Substance Abuse facility. As a result, it was not included in the FY07 Revenues and Expenditures Study.
- Some change is reported due to the transfer of state funds from Regional Centers to community funds.
- Local Revenues is recorded as not available in FY 2007. The six Regional Behavioral Health Authorities do certify local match against specified state funds. However, those local dollars are not given to the State Mental Health Authority. They are retained and used based on local choice. Thus, the local revenues are not reported here since the SMHA does not direct the use of those funds.
- For the patient days, the inpatient psychiatric units only were counted. It does not include any units designated as "residential".

New Hampshire: None

Nevada:

- State Mental Health Agency Controlled Mental Health Expenditures:
  - Southern Nevada Adult Mental Health Services (SNAMHS) increased capacity from 103 beds to 190 beds in FY 2007.
  - SMHA-Controlled expenditures include funds for mental health services in jails and prisons for forensic facility.
  - Children's mental health expenditures for Rural Op are included in SMHA-Controlled expenditures.
- Disproportionate Share Medicaid: MHDS did not receive DSH payments in FY 2007.

- Multi-year changes:
    - Lake's Crossing Center (forensic facility) increased inpatient bed capacity by 20 beds, or 35% in FY 2007 which has caused the reported state hospital expenditures increase by 73.1% from FY 2006 to 2007.
    - Total community mental health expenditures have increased 17.4% from FY 2006 to 2007 due to increased outpatient services.
    - Administrative Expenditures show an increase of 17.7% form FY 2006 to 2007 due to the creation of a Billing Unit in the MHDS Central Office.
    - More aggressive billing practices have resulted in increased revenues in FY07 (when compared to FY06
    - The 23% decrease in the Mental Health Block Grant revenues between FY2006 & FY2007 is a result of the reduction in the Block Grant for FY2007.
    - Expenditures for forensic patients show a significant decrease of 76.4% from FY 2006 to 2007, which is due to the change in how revenues are placed in the budget.
    - Forensic patient days and cost per patient day show a significant decrease from last fiscal year due to the change in how costs are reported.

New Jersey:

- Disproportionate Share revenues for State Hospitals are included, but since 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 and Federal Medicaid amounts.
- Data from the Division of Child Behavioral Health Services (DCBHS) of the Department of Children and Families (DCF) was included this year, which has contributed to large one-year changes in Revenues and expenditures from FY 2006 to 2007.

New York: None

New Mexico:

- Prior to FY07-Department of Health/Behavioral Health Services Division (BHSD) completed the Revenue and Expenditures reports, which was part of the Department of Health prior to FY07. BHSD interpreted that DOH was the State Mental Health Agency and BHSD personnel only included in the NRI reports funds for mental health services controlled by DOH. This limited inclusion of data to state hospital funding and adult services funded through BHSD controlled state general funds.
- For the FY07 NRI Report it was decided to designate the New Mexico Behavioral Health Collaborative as the SMHA. The Behavioral Health Collaborative (Collaborative) was created by Governor Bill Richardson and the New Mexico State Legislature during the 2004 Legislative Session. The Legislation allows several state agencies and resources involved in behavioral health prevention, treatment, and recovery to work as one in an effort to improve mental health and substance abuse services in New Mexico. The Collaborative is charged with a with creating a single behavioral health care and services delivery system that promotes mental health, emphasizes prevention, early intervention, resiliency, recovery and rehabilitation and funds are managed efficiently, and ensures availability of services throughout the State. Funding for public mental health services

for adults and children is primarily accomplished through contracting with a single, statewide entity (SE) managed care organization.

- The change in interpretation of SMHA resulted in a significant increase in funds being used in the calculation for the NRI report. Funding included within the FY07 NRI Report that was not included in prior reports is:
  - Children-Residential Treatment funded through Medicaid.
  - Children-Less than 24 hour mental health services funded through Medicaid and State General Funds.
  - Adult- Less than 24 hour mental health services funded through Medicaid.
  - Adult-Inpatient and residential funded through Medicaid and state revenues.

- The change in data inclusion has resulted in a $141,291,833 (286%) increase in reported mental health funding between FY06 and FY07. this is an artifact of data collection and not any significant increase in funding.

North Carolina:

- State Mental Health Agency Controlled Mental Health Expenditures:
  - Under State Psychiatric Hospitals, Other 24 Hour (Residential), the amounts listed for under 18 are for Wright School. 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 that require this level of nursing care.
  - Expenditures for Community-Based Programs exclude $128m 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 of service providers, quality management and improvement, customer service, etc. The referenced $128m in excluded funding includes management functions related to mental health, developmental disabilities, and substance abuse services. Funding is supported by approximately $55.7m (43%) via Medicaid administrative funding and $72.3m (57%) in State appropriation.
  - Only a very small amount for mental health services in jails and prisons is included in SMHA-Controlled expenditures 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.
- Disproportionate Share Medicaid:
  - 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 provided for state mental health agency controlled mental health revenues 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.

- State Mental Health Agency State Hospital Expenditures by Priority Groups:
  - Unable break out cost for Sexually Violent Predators separately.
  - Civil Commitments: Information not broken out by age, however, the following commitment information is provided:
  - 1.4% of total days of service provided in Forensic Treatment Unit (Would be considered Involuntary)
  - 5.5% of total days of service provided for voluntary admissions.
  - 93.1% of total days of service provided for involuntary admissions (Does not duplicate Forensic)
  - Medicaid community support services are added beginning SFY 07. This contributed to the large changes form last fiscal year in Total Community mental health expenditures, children as well as adult services expenditures, federal Medicaid revenues and total federal revenues.
  - There was an increase in the state match for added Medicaid community support services that contributed to the large one-year change from last fiscal year in revenue dollars.
  - 27.3% decrease in the forensic patient days from FY2006 to 2007 can be attributed to the decrease in Outpatient program of Forensic patients in Psychiatric Hospitals.
  - 54.8% Increase in Forensics cost per patient from FY2006 to 2007 can be attributed to the development of new programs for criminal offenders.

North Dakota: None

Ohio:

- State mental health agency controlled mental health expenditures reported are less than the state mental health agency controlled revenues. The community boards have the ability to roll funds into the subsequent fiscal year. Often times, services performed during the last quarter of a fiscal year are paid in the subsequent FY. In such a case, a specific FY may appear to have expenditures that exceed revenues. FY 08 may see higher expenditures than revenue. Additionally, both the Department and the boards have been relying more heavily on cash reserves for the last two fiscal years that appears as an increase in revenue.
- The Department began utilizing cash reserves in FY07 to offset the no-growth GRF budget that shows higher state mental health agency controlled mental health revenues as compared to expenditures for state psychiatric hospitals.
- FY 08 may see higher expenditures than revenue. Additionally, both the Dept and the boards have been relying more heavily on cash reserves for the last two fiscal years, which appears as an increase in revenue.
- 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.
- Ohio does not distinguish 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 increased costs of forensic care (increased security and staff time)

- FY 2006 experienced a decrease on Children's MH Services. FY 2007 is closer to the FY 2005 amount. This showed a 41.0% increase from FY 2006 to 2007.

Oklahoma:

- State Mental Health Agency Controlled Mental Health Expenditures:
    - Some of the Medicaid revenues for community programs in SMHA-Controlled expenditures are
        - Adults- Only state portion reported for private nonprofit CMHCs, state and federal reported state operated CMHCs.
        - Children- not reported for outpatient services at private nonprofit CMHCs, state and federal reported for state operates CMHCs.
    - SMHA-Controlled expenditures only include minimal funds for mental health services in jails or prisons.
- State Mental Health Agency Controlled Mental Health Revenues:
    - Other revenues reported are interagency revenues.
- Multi-year Changes:
    - Expenditures for child MH services show an increase of 18.7% from FY 06 to 07 due to the program extensions, pay increase ad increase in retirement rate.
    - Federal Medicaid Revenues show a 54% increase from FY 06 to 07 due to major differences in Medicaid collected at OYC and CA.
    - MH Block grant revenues show a 35% increase from FY 06 to 07 due to Federal vs. State Fiscal year time issues.

Oregon: None

Pennsylvania:

- We are only now seeing the impact of the last implementation of counties into the Health Choices mandatory managed care program. The last two waves of movement into capitation occurred on January 1, 2007 and July 1, 2007.
- We revised our reporting methodology for FY07, so that may account for some of the variance from last year's numbers.

Rhode Island: None.

South Carolina:

- The other revenues increase from last year is due to increase in Clinic Fees Revenue within the Community Mental Health Centers and other revenues within the Inpatient Facilities. Forensic Patients Expenditures increase from last year is due to change in payment funding mix. Sexually Violent Predators: Patient Days decrease is due to an increase in clients over FY06.

South Dakota:

- MH Block Grant Revenues increased is due to the CMHS BG is utilization and then ultimately timing of receipt of revenue that is crossing fiscal years. The Other Fund Sources and we received/generated additional revenue from these sources.

Tennessee: None.

Texas:

- Other revenue decreased from last year is due to 2006 other revenue overstated. Total DSH decreased is due to data gathered for disproportionate 2006 overstated. Forensic Patients: Expenditures increased is due to difference in patient days. Forensics: Patient Days increased is due to patient days reported by Program increased capacity in state system.

Utah:

- The large one-year data change on the expenditures and revenues data are due to Medicaid increased. The local revenues increased are due to Local Authority portion increased.

Vermont:

- The Federal revenue increase is due to VT gone to GC XIX funding.

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 1,607.
    - 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 2007, 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 2007, local governments appropriated $90,476,711 to community based mental health services. Our CSBs also collect non Medicaid fees that are not controlled by DMHMRSAS. These fees approximated $21 million in fiscal year 2007.
- Note 2: Adult and Children's Services
    - During fiscal year 2007, 76% of the individuals receiving mental health services were adults while 24% were children under the age of eighteen. For fiscal year 2006, this ratio was 77% adult and 23% 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 58%.
    - The revenues of our inpatient mental health facilities exceeded expenses in FY 2007 by $900,000. This is due to a budgetary option offered by the Governor's Office that allowed facilities to identify balances in their General Funds and carry these forward to the next fiscal year for use. Some of our mental health facilities took advantage of this and withheld expenditures in FY 2007 to create the needed balance for use in FY 2008.
    - Other revenue consists of commercial insurance, payor revenue, third party revenue (non-Medicaid and non Medicare sources) and can vary greatly between fiscal years depending upon the financial position of our patient mix at any given time. This explains the increase of $3.5 million in this source of income between fiscal years.
    - The patient days in our sexually violent predator facility have increased as our census has increased. Although not presented here as part of this study, in late FY 2008 a new facility was completed for the purposes of serving this population. As of the close of February 2009, the facility census was 121. We anticipate that this census will continue to increase in the future.

Washington:
- Large change in Table for Other Revenues is caused by an increase in 3rd party payments, specifically Western State Hospital, and Private/Local tax revenue.

West Virginia:
- The decreased in Children's MH services is due to $6,00,000 operating loss at psychiatric hospital – prior year funds used to cover operating loss. The increase in Forensic Patients: Expenditures is due to FY 06 last full year of a federal grant. Only 3 months funding in FY 07. The increase in Forensics: Cost per pt. day is due to Forensic: this population is growing with a longer length of stay they are requiring a larger portion of the budget.

Wisconsin:
- The Children's MH services increase is due to the percentage of children at the facilities to the total population increased from FY06 to FY07, so the share attributed to the children also increased. Total DSH decrease is due to one of the two state psychiatric hospitals was not eligible for DSH in 2007. The civil (non-Forensic) Patients: Expenditures increase is due to the overall costs at the facilities increased between these two years. Overtime and staffing is a large part of the costs and the increase. These cost increases would affect the question for expenditures by having a larger amount of costs to be allocated to the Children's percentage.

Wyoming:
- Large changes in data reported between FY06 and FY07 are attributed to:
    - We work with a biennium budget, and this report is for a single year, and
    - Additional funding from the legislature.