Funding Sources and Expenditures Of State Mental Health Agencies: Fiscal Year 2002

Theodore Lutterman
Director of Research Analysis
NASMHPD Research Institute, Inc.

Vera Hollen, M.A.
Research Analyst

Robert Shaw, M.A.
Systems Analyst

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National Association of State Mental Health Program Directors Research Institute, Inc.
66 Canal Center Plaza, Suite 302, Alexandria, Virginia 22314 ■ 703-739-9333 ■ FAX 703-548-9517 ■ www.nri-inc.org

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The authors are particularly grateful to Triumph Technologies, Inc., and the Division of State and Community Systems Development, at the Center for Mental Health Services for its significant financial support of compilation of the data necessary for this report under a CMHS contract. This final report was prepared by the NRI without financial reimbursement from the Federal Government.

We are confident that working with the Center for Mental Health Services, these data will be useful to local, state, and national policy makers and lead to a better understanding of the financing of our nation's public mental health systems.

Theodore Lutterman, Director of Research Analysis, directed this study as he has the previous SMHA Funding Sources reports. Data entry, edits, and analyses were provided by NRI staff members Vera Hollen, Robert Shaw, Marie Huddle, and Kathleen Monihan.

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Preface

State Mental Health Commissioners have identified quality and accountability as one of their highest priorities for future programmatic and policy decisions. Embedded in that determination is recognition of the powerful and essential role that data play in achieving the goal of a recovery-based system that improves service delivery and mental health outcomes.

In the past, data collection often has been seen as an obligation rather than a necessity. This is no longer the case. Last year, at a full NASMHPD meeting, the commissioners unanimously voted to view data as a key deliverable – a product that would be available to all, transparent and more user friendly, to help inform efforts regarding system change.

This comprehensive review of revenue and expenditure trends among state mental health agencies sheds much-needed light on the current mental health system. As we strive to transform our mental health system, it is essential that we all analyze these trends and begin to proactively forecast how best to deal with the changing environment of human services delivery.

While acknowledging the value of these data, we must be cognizant of their limitations. Mental health services often are not delivered under the auspices of the state mental health authority. Consequently, data on services in the criminal justice system, schools, child welfare system, and, at times, the Medicaid system are not captured. These missing data reflect our fragmented system and can distort planning efforts. To its credit, NRI is committed to examining how to obtain data on expenditures by these other state agencies for mental health services and with work with SAMSHA and CMHS to develop better protocols and estimates.

Despite these limitations, the data presented in this report provide a critical starting point for examining the efficiency and effectiveness with which state mental health agencies expend their resources. We hope you find the information useful in your ongoing efforts to enhance the quality of community-based mental health services.

Stephen W. Mayberg, Ph.D., Director
California Department of Mental Health

State Mental Health Agency Contact Persons and Commissioners

State	Contact Person	Commissioners
Alabama	Jodie Dunlap	Kathy E. Sawyer
Alaska	Leslie Houston/Bill Hogan	William H. Hogan
Arizona	Glenn Russell	Leslie Schwalbe
Arkansas	Rose Jones	Pat Dahlgren
California	Stan Johnson	Stephen W. Mayberg, Ph.D.
Colorado	Michael Crane	Debra Kupfer
Connecticut	Cheryl Arora	Thomas A. Kirk, Ph.D.
Delaware	Steven Dettwyler	Renata J. Henry
D.C.	Joy Sandler	Martha B. Knisley
Florida	Jodi Riley	Celeste Putnam
Georgia	Lenore Staples	Gwendolyn B. Skinner
Hawaii	Amy Yamaguchi	Michelle R. Hill
Idaho	Ray Millar	Raymond M. Millar, C.P.M., L.M.S.W.
Illinois	Fred Nirde	Christopher Fichtner, M.D.
Indiana	Ramano Pross	Suzanne Clifford
Iowa	Jim Overland	Kevin Concannon
Kansas	Toni Albright	Laura Howard
Kentucky	Rachel Cox	Pat Wear, II
Louisiana	Jean B. Mulmore	Cheryll Bowers-Stephen, M.D., M.B.A.
Maine	Elaine Babb/Greg Couture	Brenda M. Harvey
Maryland	Randy Price	Brian Hepburn, M.D.
Massachusetts	Gary Pastva	Elizabeth Childs, M.D.
Michigan	Larry Sklapsky	Patrick Barrie
Minnesota	Jerry Storck	Sharon Autio
Mississippi	Glynn Kegley	Albert Hendrix, Ph.D.
Missouri	Gary Kunsteing	Dorn Schuffman
Montana	Bob Mullen	Lou Thompson
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Nevada	Priscilla Colegrove	Carlos Brandenburg, Ph.D.
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New Mexico	Susahn March/Rich Tavares	Pamela Martin, Ph.D.
New York	Paul Moore	Sharon E. Carpinello, Ph.D., R.N.
North Carolina	Phillip Hoffman/Wanda Mitchell	Mike Moseley
North Dakota	Lauren Sauer	JoAnne D. Hoesel
Ohio	Amy Luba	Michael F. Hogan, Ph.D.
Oklahoma	Melissa Lange	Terry Cline, Ph.D.
Oregon	Carolina Marquette	Robert E. Nikkel, M.S.W.
Pennsylvania	Susan Ferrario	Joan L. Erney
Puerto Rico	Edwin Perez	Johnny Rullan, M.D., FACPM
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Virginia	Ken Gunn	James S. Reinhard, M.D.
Washington	Christina Winans	Karl Brimner
West Virginia	Jim Elzey	Eugenie P. Taylor
Wisconsin	Tim Conner	John T. Easterday
Wyoming	Marilyn Patton	Phyllis Sherard, Ph.D.

Introduction

"States continue to grapple with short term cyclical and long-term structural problems. Plagued by budget shortfalls for the past three years, states still face uncertainty in the current fiscal year and difficult budgetary choices in the years ahead..."
National Governors' Association, December 2003[1]

This report is the ninth in a series focusing on the mental health expenditures and revenues directly controlled by all state mental health agencies (SMHAs) dating back more than 20 years to FY 1981. Not all expenditures for mental health by state governments are reported herein; instead the focus is on the expenditures and funding sources of the designated mental health authority in each state. The focus of this report is primarily on the funds for mental health services over which SMHAs have direct managerial control or responsibility. The SMHA has been designated by the State Governor as the state's central authority for public mental health services. As such, the SMHA is the entity that administers the Federal Community Mental Health Services Block Grant (MHBG) and is responsible for planning, organizing, and financing community mental health systems.

When comparing this new FY 2002 data with the prior report (FY 2001) the impact of the slowing state economy and resulting budget pressures on state government begins to show up in many states. However, we want to caution readers, that the FY 2002 was just the start of what the National Governor's Association has described as the worst fiscal situations for states in the last 50 years. Between 2001 and 2004, almost every state has received major budget reductions in their overall state government budgets, and often mental health services have had to bear a portion of the burden of these budget reductions.

Most states have just completed their Fiscal Year 2004, and according to the National Governor's Association: "States pared back spending significantly in Fiscal 2003 and Fiscal 2004." This report on Fiscal Year 2002 State Mental Health Expenditures, must therefore be read, with an understanding that the Fiscal Year 2003 and Fiscal Year 2004 budget environments in many states grew much worse than the Fiscal Year 2002 data reported here.

In 2003, the President's New Freedom Commission on Mental Health issued its landmark report ""Achieving the Promise: Transforming Mental Health Care in America." This report found that recovery from mental illness is possible, that mental health treatments work, but:

> "...*for too many Americans with mental illnesses, the mental health services and supports they need remain fragmented, disconnected and often inadequate, frustrating the opportunity for recovery. Today's mental health system is a patchwork relic—the result of disjointed reforms and policies.*"[2]

SMHAs increasingly rely on a complicated and fragmented set of state; federal, local, and private funding sources to underwrite their mental health services. This report illustrates some of the variety and changing nature of the funding sources on which SMHAs rely to provide services and demonstrates a major shift in the types of services that SMHAs are providing to persons with mental illnesses.

The reader should not assume that the expenditures and revenues reported in this document include all expenditures for mental health services within a state government. The responsibilities and organization of state mental health agencies vary significantly from state to state. Some SMHAs operate only inpatient services through their state and contract-out all other ser-

vices (either directly or through city and county governments), while other states directly operate some or all community mental health services. Still other states have merged Medicaid funds with SMHA funds to contract for managed mental health care. These types of organizational and policy variations account for major differences among states in mental health spending controlled by the SMHA.

The funding sources that SMHAs directly control usually include: State General Funds, State special appropriations, Federal Mental Health Block Grant Funds, Medicaid and Medicare revenues to SMHA-operated programs, other Federal Funds (such as research and demonstration grants), State-required local government Match funds, and various first and third party funds. Excluded from the definition of SMHA-control are significant funds from non-SMHA sources received by programs the SMHA may fund but not directly operate. These types of funds include: first and third party funds received by many community programs, including Medicaid funds in some states.

By focusing on SMHA-controlled expenditures, the authors recognize that this report does not depict all mental health spending in a state. State governments expend considerable resources to provide mental health services through other state governments and those funds are not included in this report. For example, in many states the Corrections Agency provides mental health services in prisons and jails, the Education Department funds mental health services to children in schools, the Child Welfare Agency often provides mental health services to children in their charge, and the Vocational Rehabilitation Agency underwrites the cost of employment services to persons with mental illnesses.

The major state government expenditure that is not fully depicted in this report is Medicaid. Medicaid has been one of the fastest growing expenditures of state governments in the last 20 years and mental health services constitute a significant part of this Medicaid growth. Unfortunately, Medicaid usually pays for mental health services through an insurance model where the state Medicaid agency directly reimburses private practitioners and health organizations for services provided. Medicaid pays for mental health services by specialty mental health providers and general medical providers who serve persons with mental illnesses.

Unfortunately, Medicaid's billing and reporting systems do not differentiate mental health from any other physical health services reimbursed by Medicaid. SMHAs are unable to report fully on the total Medicaid-funded mental health expenditures unless either the SMHA or the state Medicaid Agency has conducted an expensive and thorough analysis of Medicaid paid claims files. Increasingly, SMHAs are conducting these analyses and we hope that future versions of this report will include the results. Due to the lack of paid claims analyses in all states, we are limited to reporting those Medicaid revenues that SMHAs can count.

Most SMHAs (47 states) were able to report on how much Medicaid revenues were received by the community mental health programs that they directly operate and/or fund. As described below, these Medicaid funds to the community mental health programs the SMHAs control were the fastest growing source of revenues to SMHA systems over the last decade.

In Fiscal Year 2002, SMHAs directly controlled the expenditures of $25.2 billion for mental health services to individuals with mental illnesses.

Though this report does not provide a comprehensive view of all state government expenditures for mental health services, we believe it does provide a very useful func-

tion in describing the roles and expenditures of the SMHAs. The $25 billion dollars of FY 2002 expenditures for mental health services that SMHAs control, form an essential part of the safety net for providing services to individuals with mental illnesses. This report does provide a valid comparison of the resources directly available to the SMHAs in each state.

This series documents a dramatic shift in the financing of public mental health services from a reliance on state general fund sources to Medicaid-reimbursed services. Over the last 12 years, constant "inflation adjusted dollar" State General Funds for mental health have decreased 24%, while Medicaid funds grew 188%, revenue from all Federal Government sources grew 133%, and revenue from other sources grew 66%.

From FY'90 to FY'02, over 62% of all new SMHA-controlled revenues for mental health were derived from Medicaid. This shift in the funding sources of state mental health agency programs has major implications for future mental health services as states now struggle to contain Medicaid expenses.

A second historic shift is the move away from reliance on state psychiatric hospitals to comprehensive community-based systems of care as demonstrated by system financing. This report documents the accomplishments of states in expanding community-based mental health services and reflects significantly more SMHA-controlled spending on community services than ever before. This report depicts the national trends in SMHA spending for mental health services and discusses important interstate and regional differences in spending.

Tables 1 to 24 focus on SMHA-controlled expenditures for mental health services in FY'02. Tables 25 to 31 document SMHA-controlled revenue in FY'02. Tables 32 to 45 show changes from FY'90 to FY'02 in SMHA-controlled revenues and expenditures.

We hope that this report will be a useful resource to state mental health agency officials, mental health advocates, and the public as each strives to improve the availability and quality of mental health services.

Study Results

Trends in State Mental Health Agency-Controlled Expenditures for Mental Health Services: FY'1990 to FY'2002: From Fiscal Year 2001 (FY 2001) to FY 2002, SMHA-controlled expenditures for mental health services increased from $23 billion to $25.2 billion, an increase of 9.5%. This increase in SMHA controlled expenditures came about despite many states experiencing major revenue shortfalls that required reductions in services across state government. According to the National Governor's Association:

> *"Beginning in fiscal 2001, states were confronted with a fiscal situation more severe than any they had dealt with during the past 60 years. State revenues----particularly the personal income tax----collapsed, declining in inflation-adjusted terms for eight straight quarters. States were forced to make stark budget cuts, increase taxes, and drain their reserve funds."*

This observation is confirmed by this report that shows not all SMHAs increased their expenditures during this time period. While 43 SMHAs reported increased budgets, eight SMHAs reported reductions in their total SMHA expenditures for mental health services. Seventeen SMHAs reported reductions in their state psychiatric hospital budgets, and eleven states reported reductions in their community mental health budgets. This FY 2002 study demonstrates that despite the tight fiscal environment, states continued to invest in mental health services in FY 2002.

> *From FY'01 to FY'02, 43 SMHAs reported increased budgets, eight SMHAs reported reductions in their total SMHA expenditures for mental health services. Seventeen SMHAs reported reductions in their state psychiatric hospital budgets, and eleven states reported reductions in their community mental health budgets.*

An analysis of SMHA-controlled expenditures for mental health over the last twelve years (from FY 1990 to FY 2002) shows state expenditures more than doubled, from $12 billion in FY'90 to over $25 billion in FY 2002. This was an average annual increase

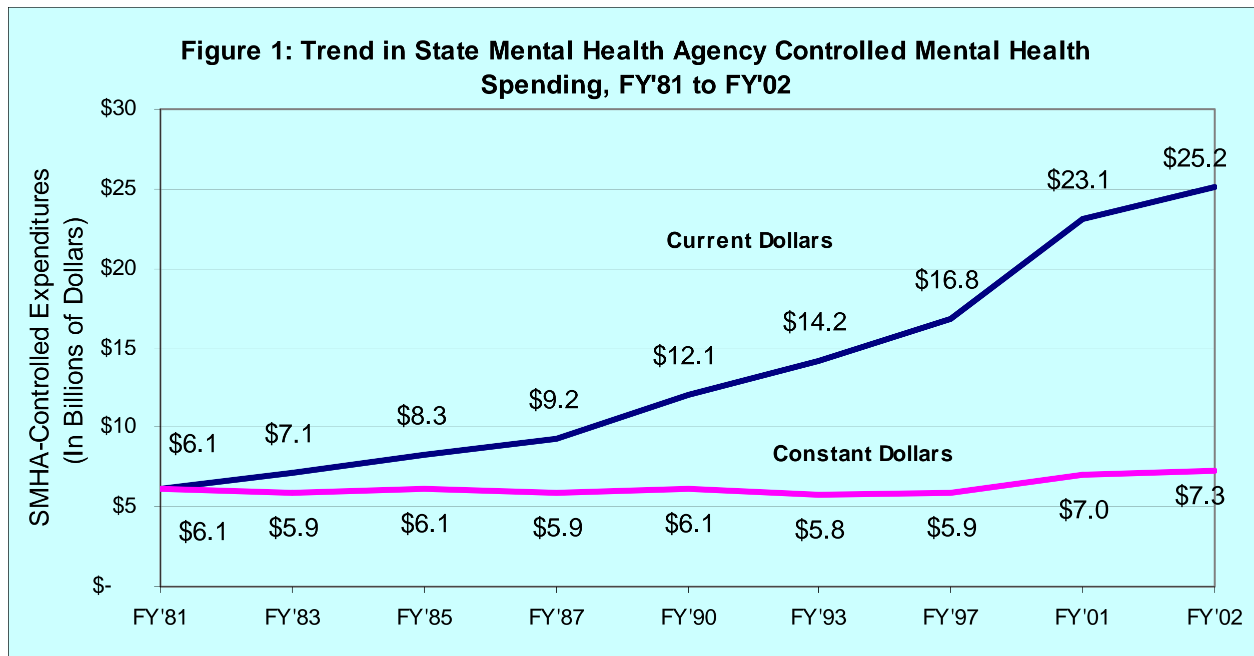


Figure 1: Trend in State Mental Health Agency Controlled Mental Health Spending, FY'81 to FY'02

of 6.3% per year. When these expenditures are adjusted for inflation , SMHA expenditures increased to $14.3 billion, an increase of only 18.6% over twelve years. This is an average annual increase of only 1.6% per year.

When expenditures are examined on a population adjusted basis, per capita expenditures for mental health averaged $48.55 in FY 1990 and increased to $87.65 in FY 2002 (an annual average increase of 5.8%). From FY 2001 to FY 2002, per capita expenditures increased from $81.02 to $87.65, an increase of 8.2%.

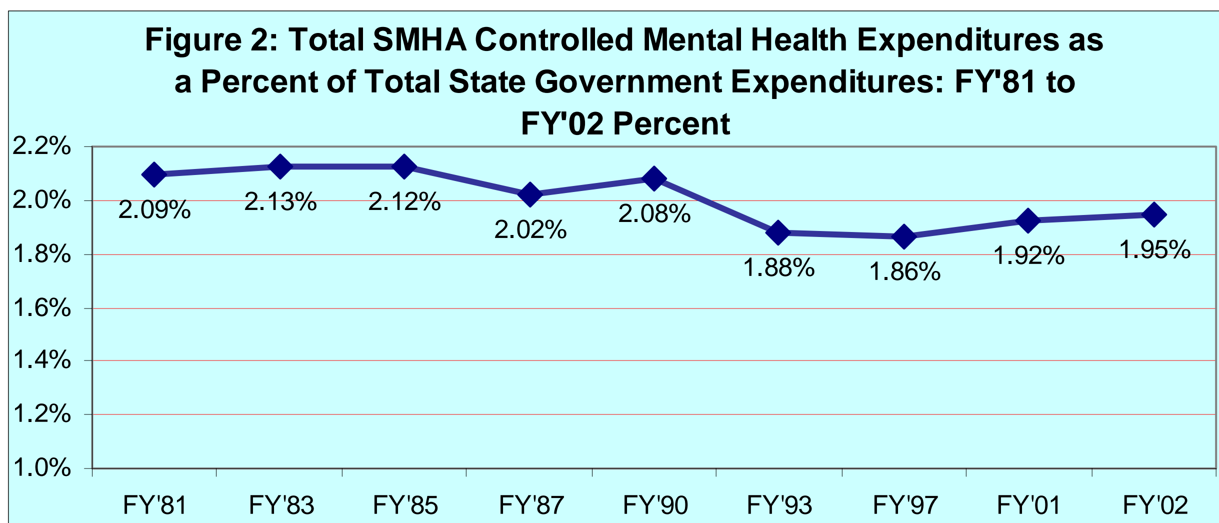
When total SMHA-controlled mental health per capita expenditures are adjusted for inflation, there is a increase from FY 1990 to FY 2002 of 2.8% (0.3% per year) with adjusted FY 2002 expenditures of $49.89. However, over the one-year period, from FY 2001 to FY 2002, SMHA per capita and inflation adjusted expenditures increased faster than inflation, up 3.5%.

SMHA-controlled Mental Health Spending Related to Other State Government Expenditures: Despite the substantial growth in SMHA-controlled expenditures for mental health discussed above, total State Government expenditures for all purposes has grown at a faster rate than State mental health agency-controlled expenditures for mental health over the last 22 years. According to the U.S. Census Bureau, in FY 1981, State Governments expended over $291.5 billion and SMHA-controlled mental health expenditures ($6.1 billion) represented 2.09% of total state expenditures (Figure 2). Twenty-one years later, State Government. Expenditures had increased by over 343%, to just over $1,016 billion dollars.

Total State Government expenditures for all purposes has grown at a faster rate than State mental health agency-controlled expenditures for mental health over the last 22 years.

In FY 2002, SMHA-controlled expenditures for mental health dropped to 1.95% of total State Government expenditures. If SMHAs had received in FY 2002, the same percentage of total state government expenditures they received in FY 1981, total SMHA expenditures would have been $1.6 billion higher than SMHAs actually received in FY 2002.

However, the data also shows that during the time period from FY 2001 to FY 2002, as many states were experiencing overall budget reductions, that SMHA expenditures for mental health faired better than overall state spending. From FY'01 to FY 2002, SMHA expenditures as a share of total state government actually increased slightly, from 1.92% of spending to 1.95%.



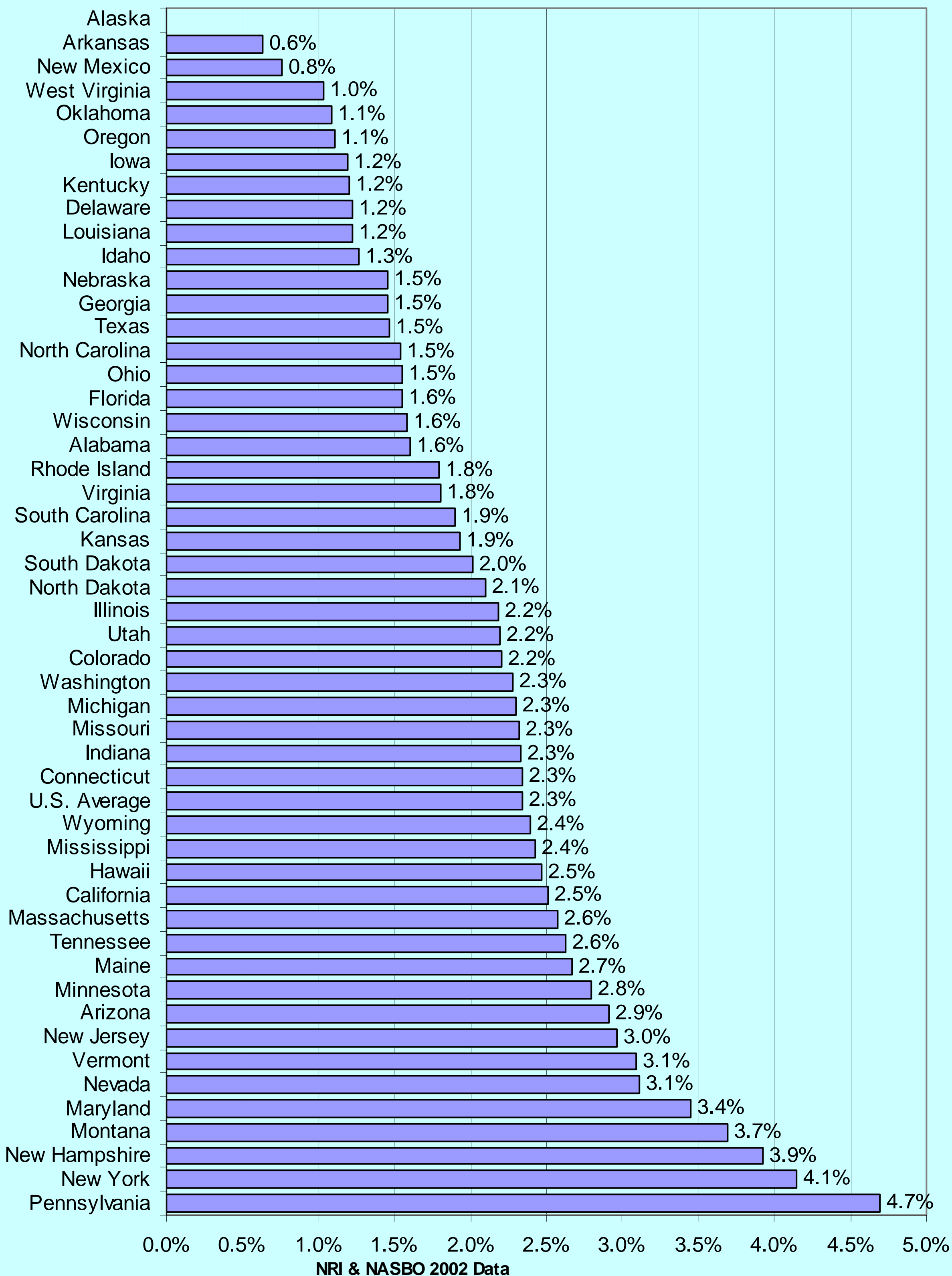


Figure 3: FY'02 SMHA-Controlled Expenditures as a Percent of Total State Government Expenditures
Alaska
Arkansas 0.6%
New Mexico 0.8%
West Virginia 1.0%
Oklahoma 1.1%
Oregon 1.1%
Iowa 1.2%
Kentucky 1.2%
Delaware 1.2%
Louisiana 1.2%
Idaho 1.3%
Nebraska 1.5%
Georgia 1.5%
Texas 1.5%
North Carolina 1.5%
Ohio 1.5%
Florida 1.6%
Wisconsin 1.6%
Alabama 1.6%
Rhode Island 1.8%
Virginia 1.8%
South Carolina 1.9%
Kansas 1.9%
South Dakota 2.0%
North Dakota 2.1%
Illinois 2.2%
Utah 2.2%
Colorado 2.2%
Washington 2.3%
Michigan 2.3%
Missouri 2.3%
Indiana 2.3%
Connecticut 2.3%
U.S. Average 2.3%
Wyoming 2.4%
Mississippi 2.4%
Hawaii 2.5%
California 2.5%
Massachusetts 2.6%
Tennessee 2.6%
Maine 2.7%
Minnesota 2.8%
Arizona 2.9%
New Jersey 3.0%
Vermont 3.1%
Nevada 3.1%
Maryland 3.4%
Montana 3.7%
New Hampshire 3.9%
New York 4.1%
Pennsylvania 4.7%
0.0% 0.5% 1.0% 1.5% 2.0% 2.5% 3.0% 3.5% 4.0% 4.5% 5.0%
NRI & NASBO 2002 Data

Individual States vary substantially in how much of their state budgets are devoted to mental health services. Figure 3 (prior page) shows that SMHA expenditures, as a share of state government expenditures, vary from almost 5% to under 1%.

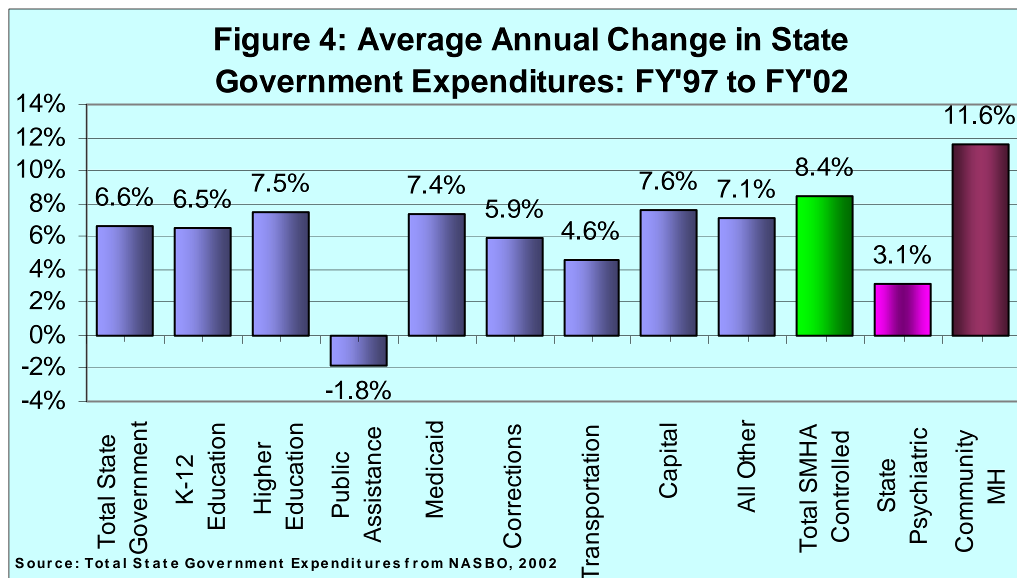


Figure 4: Average Annual Change in State Government Expenditures: FY'97 to FY'02

Source: Total State Government Expenditures from NASBO, 2002

Using data from both the NRI study and the National Association of State Budget Officers, it is possible to see that SMHAs have done better than most other major state government agencies during the last five years (from FY 1997 to FY 2002). During this time period, SMHAs have averaged an increase of 8.4% per year in expenditures, while overall state expenditures increased by 6.6%. Over this 5-year period, SMHAs actually received a larger increase in expenditures than state Capital projects (up 7.6%), Higher Education (up 7.5%) and Medicaid (7.4%), the state agencies that grew the fastest. (See figure 4).

From FY 1997 to FY 2002, SMHAs actually received a larger increase in expenditures (up 8.4%) than state Capital projects (up 7.6%), Higher Education (up 7.5%) and Medicaid (7.4%), the state agencies that grew the fastest.

If SMHAs received in FY 2002 the same percentage of total state government expenditures they received in FY 1981, total SMHA expenditures would have been $1.6 billion higher.

Although the data show that SMHA expenditures grew faster than the expenditures of other state agencies, the data also documents a substantial shift in the funding sources of SMHAs over time. SMHAs are increasingly being funded by Medicaid and have experienced a slower growth in State government dollars than most other state agencies over this time period.

Figure 5: Change in State Government Expenditures: FY'97 to FY'02

	Average Annual Change FY'97 to FY'01			FY'01 to FY'02 Change		
	State Funds	Federal Funds	Total	State Funds	Federal Funds	Total
Total State Government	7%	7%	7%	3%	9%	5%
K-12 Education	7%	8%	8%	2%	11%	2%
Higher Education	7%	25%	9%	4%	-2%	3%
Public Assistance	-3%	0%	-2%	-4%	2%	-1%
Medicaid	6%	7%	7%	16%	8%	11%
Corrections	8%	1%	7%	1%	12%	1%
Transportation	5%	10%	7%	-8%	0%	-4%
Capital	11%	7%	9%	-16%	-3%	1%
All Other	8%	5%	7%	3%	18%	6%
SMHA	6%	11%	9%	4%	15%	10%

From FY 2001 to FY 2002, most of the new funds that SMHAs received were derived from federal sources (primarily Medi-

caid), which increased 17%, while funding from state general fund and special fund sources decreased by -0.3%. During this same time period, most other major state agencies also relied on federal funds for growth, as state revenues remained scarce.

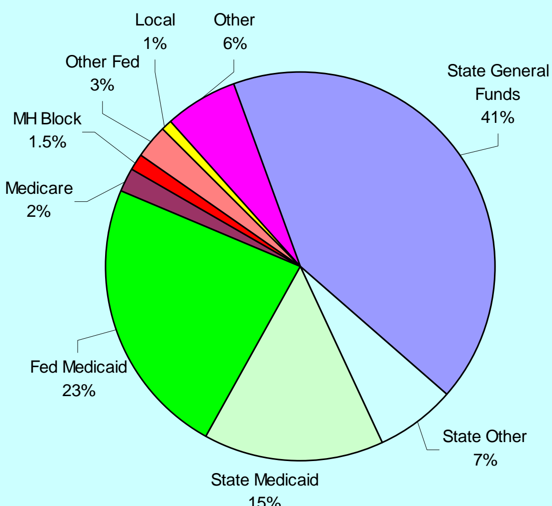
From FY 1997 to FY 2001, SMHAs received less funds from state sources, averaging 6% per year, than overall state government, which averaged up 7%. SMHAs have relied more on federal funding sources for new resources from FY 1997 through FY 2002 than other major state agencies.

SMHAs continue to receive most (64%) of their funding from state government sources.

State Mental Health Agency Funding Sources: SMHAs continue to receive most (64%) of their funding from state government sources. This is, however, a decline from state sources representing 67% of mental health funding in FY 2001. In FY 2002, state tax dollars accounted for $16 billion of the funding for SMHA's mental health services. These funding sources included State General and Special Funds of over $12.2 billion, and State Medicaid Match funds of over $3.75 billion.

The Federal Government was the second largest funder of SMHA services, with FY 2002 dollars totaling $7.4 billion of Federal Funds (30% of SMHA total funding). The bulk of the Federal Revenues came from the Medicaid program ($5.85 billion), followed by Other Federal Funds ($705 million), Medicare ($478 million), and the Community Mental Health Block Grant ($378 billion). Local and other funds contributed the remaining $1.6 billion of funds expended by SMHAs.

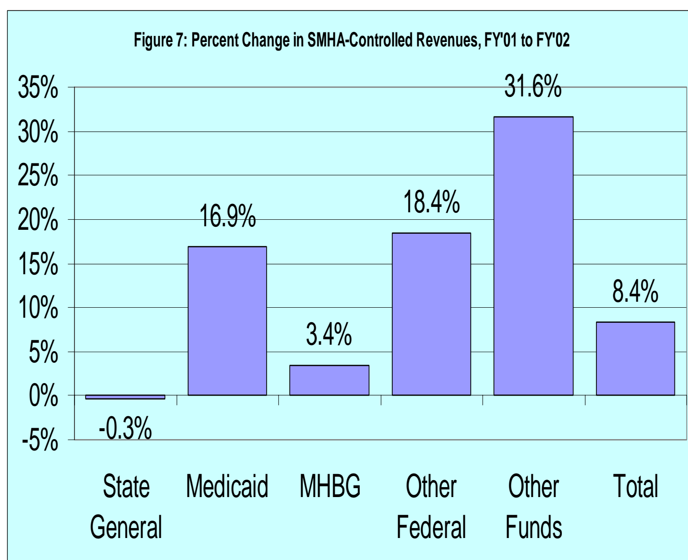
SMHA Revenue Trends: FY 1990 to FY 2002: From FY 1990 to FY 2002, revenues from state government sources increased from $9.8 billion to almost $16 billion, an increase of 62% over the dozen years. However, controlled for inflation, state funds actually declined by 6.7% over this time period. Most of the increase in state funds was from state Medicaid Match funds, over this time period, state general and special funds for mental health increased by only 33% and in inflation-adjusted dollars decreased by 24%.



The Federal Government was the second largest funder of SMHA services, with FY 2002 dollars totaling $7.4 billion (30% of SMHA total funding).

From FY 2001 to FY 2002, state government funds expended for mental health increased from $15.4 billion to $16 billion, an increase of 3.9%. Adjusted for inflation, this was an decrease of -0.6%. State general and special funds actually decreased slightly (down 0.3%) from FY 2001 to FY 2002, and in inflation-adjusted dollars declined 4.5% over the prior year.

Federal government funding sources increased much more over this time period. From FY'90 to FY 2002, federal funds increased from $1.8 billion to over $7.4 billion (an increase of 298%). Even after adjusting

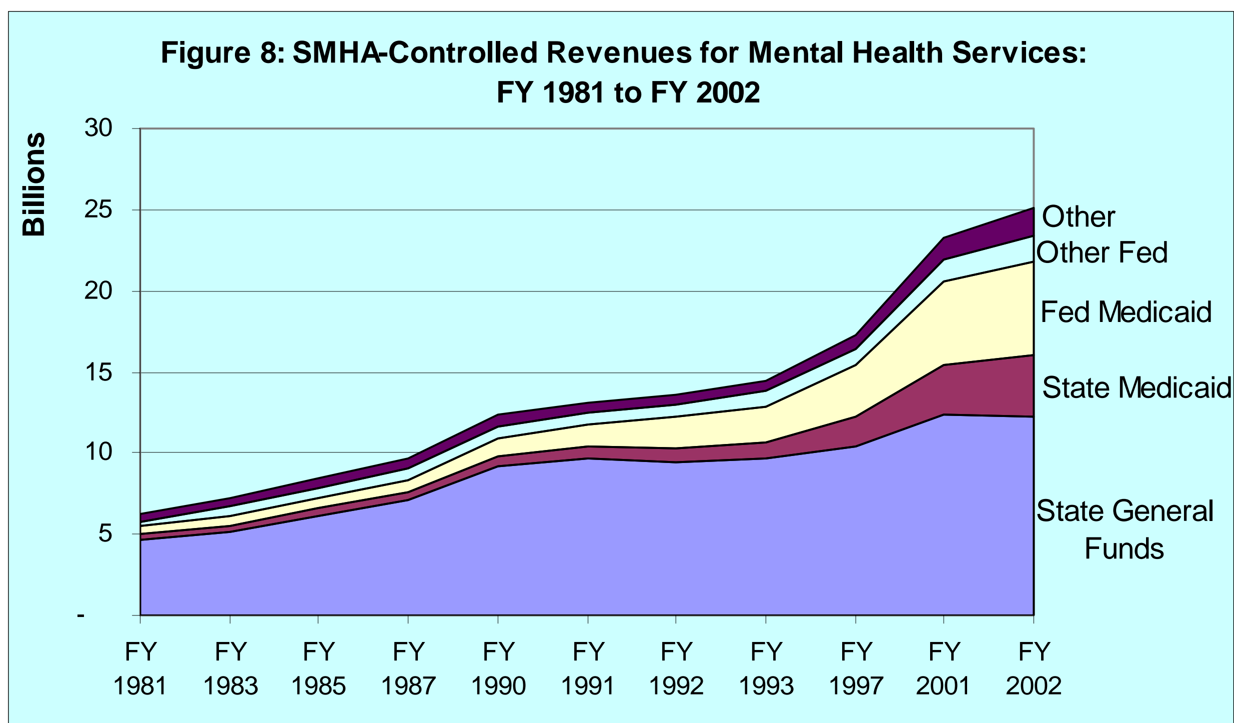


for inflation, federal funds increased to $4.2 billion, an increase of 133% over the 12 years. From FY 2001 to FY 2002, federal funds increased by 14.7% in current dollars, and in inflation adjusted dollars still increased by 9.8%.

Medicaid dollars (both state and federal) used by SMHA-controlled programs grew from $1.7 billion in FY 1990 to over $9.6 billion in FY 2002 (an increase of 389%). Even in inflation adjusted dollars, Medicaid increased by over 188% from FY 1997 to FY 2002.

Medicaid revenues for mental health grew much faster during the 1990s (FY 1990 to FY 2002) when they increased by 15.8% per year, than they did in the 1980s (7.9% per year), when they increased slightly slower than State General Revenues. The increase in Medicaid is mostly related to the Medicaid's increasing use to pay for community-based mental health services, through Medicaid options such as the Rehabilitation Option, Clinic Option, and the COBRA Case Management Option, as well as the increased use of Medicaid managed care waivers.

Although the increased use of Medicaid by SMHAs has allowed them to expand their public mental health systems during a time of limited new state general fund resources, the reliance on Medicaid has several major limitations for SMHAs. Medicaid is only available to those individuals who qualify for Medicaid, either through Temporary Services for Needy Families (TANF) and those enrolled in Supplemental Security Income (SSI) due to a disability. Thus, Medicaid is not available to all individuals in a state who



have a mental illness. Second, not all necessary mental health services are reimbursed by Medicaid. The Medicaid program generally follows a medical model and often will not pay for housing, vocational, education, and various peer support services that mental health consumers often need to live in the community. Medicaid is a program that reimburses providers for services and which is generally outside the direct control of SMHAs. Thus, SMHAs have limited ability to shift the use of specific services or programs under Medicaid.

Several researchers have attributed the increased reliance on Medicaid to fund SMHA systems as having reduced the state's flexibility to maintain a safety net of mental health services. An article by Frank, Goldman, and Hogan found, "As states devote a higher portion of their mental health funds to meeting Medicaid match requirements, states' ability to maintain or expand MH/SA programs for a growing population of low-income uninsured people is becoming increasingly constrained.[6]"

Most of the Growth in SMHA Spending Derives from Medicaid: As a result of the different rates of growth in revenues, from FY 1990 to FY 2002 62% of the growth in SMHA-spending came from Medicaid funds controlled by SMHAs. This is a substantial increase from the 1980s, when Medicaid accounted for only 13% of the growth in SMHA spending. State General Revenues accounted for 24% of the growth in SMHA spending for mental health from 1990 to 2002. This is a substantial decline from the 1980s, when state General Fund sources accounted for 75% of the growth in SMHA mental health spending (see Figure 9).

62% of all new mental health funds for SMHA programs since FY 1990 were from Medicaid

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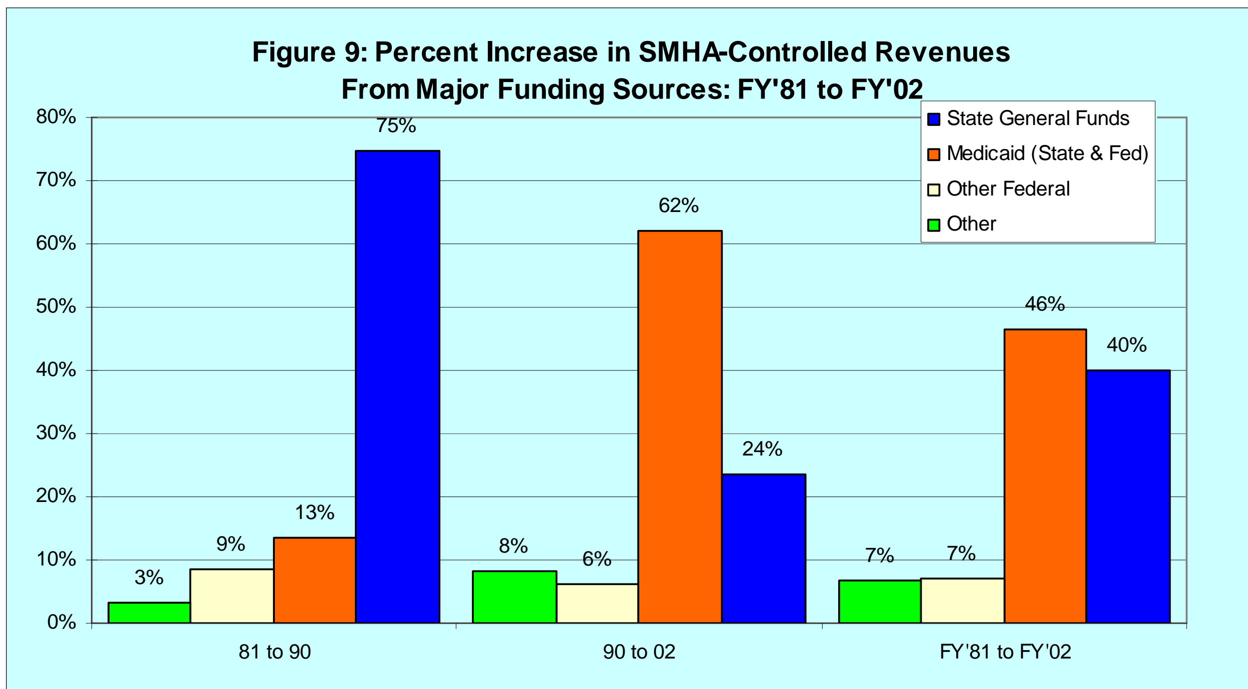
This study focuses only on Medicaid revenues that are controlled by SMHA programs. In FY 2002, forty-seven (47) states reported on Medicaid revenues for community mental health programs. In the other states, Medicaid is paying for community mental health services, but the amount of Medicaid spent is not depicted by this report. Medicaid payments for mental health services to the many providers who are not funded by SMHAs, such as private psychiatric hospitals, most general hospitals, and private mental health professionals such as psychiatrists,



psychologists, social workers, and other providers are also excluded from this study.

State Mental Health Agency-Controlled Revenues from Other Sources, FY 1990 to FY 2002: In Fiscal Year 2002, SMHAs had revenues of over $1.7 billion from other sources, including local and first/third party sources. This was an inflation controlled 32% increase over FY 2001. From FY'90 to FY 2002, SMHA revenue from other sources increased 66%, when controlled for inflation. In FY 2002 Other sources of revenues were 6.8% of all SMHA revenues, up from 5.4% in FY 1990.

State Mental Health Expenditures: Between FY 2001 and FY 2002, most of the new funds expended by SMHAs went to community-based services instead of state hospitals. From FY 2001 to FY 2002, Community expenditures increased by 11.6%, while state hospital inpatient expenditures increased by 5.2%.

The net result of the budget changes was a further shift from state psychiatric hospitals-based expenditures to community-based mental health expenditures in the states. SMHAs have experienced a major shift in the types of mental health services they provide over the last 20 plus years. In FY 2002, over 67% of SMHA-controlled expenditures were devoted to community mental health expenditures and only 30% were state psychiatric hospital inpatient expenditures.

This is a huge shift from FY 1981 when 63% of expenditures were state psychiatric hospital related and only 33% were community related and a slight 1% shift from last year (FY 2001) when community expenditures were 66% of total and hospitals were 31%.

SMHAs have experienced a major shift in the types of mental health services they provide over the last 20 plus years. In FY 2002, over 67% of SMHA-controlled expenditures were devoted to community mental health expenditures and only 30% were state psychiatric hospital inpatient expenditures.

State Mental Health Agency-Controlled Expenditures for Mental Health Services Grew Faster than Inflation, FY 1990 to FY 2002: In Fiscal Year 2002, SMHAs directly controlled the expenditures of $25.2 billion for mental health services to individuals with mental illnesses. This was an increase

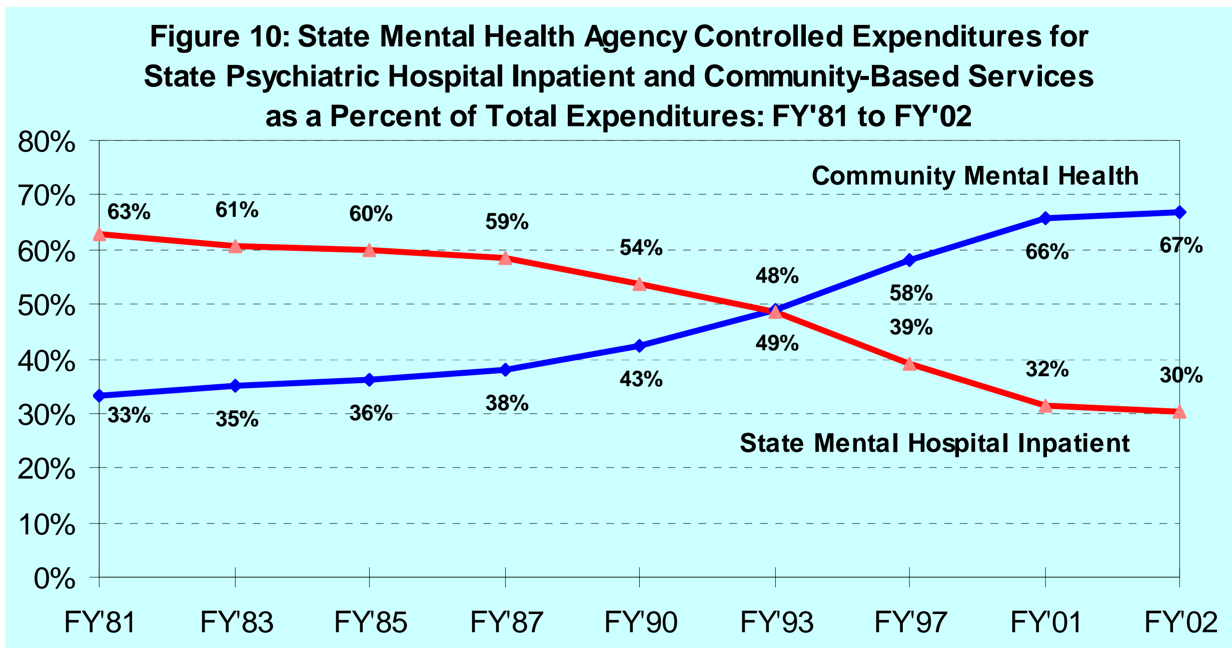


Figure 10: State Mental Health Agency Controlled Expenditures for State Psychiatric Hospital Inpatient and Community-Based Services as a Percent of Total Expenditures: FY'81 to FY'02

Figure 11: Fiscal Year 2002 SMHA-Controlled Per Capita Expenditures for Mental Health Services

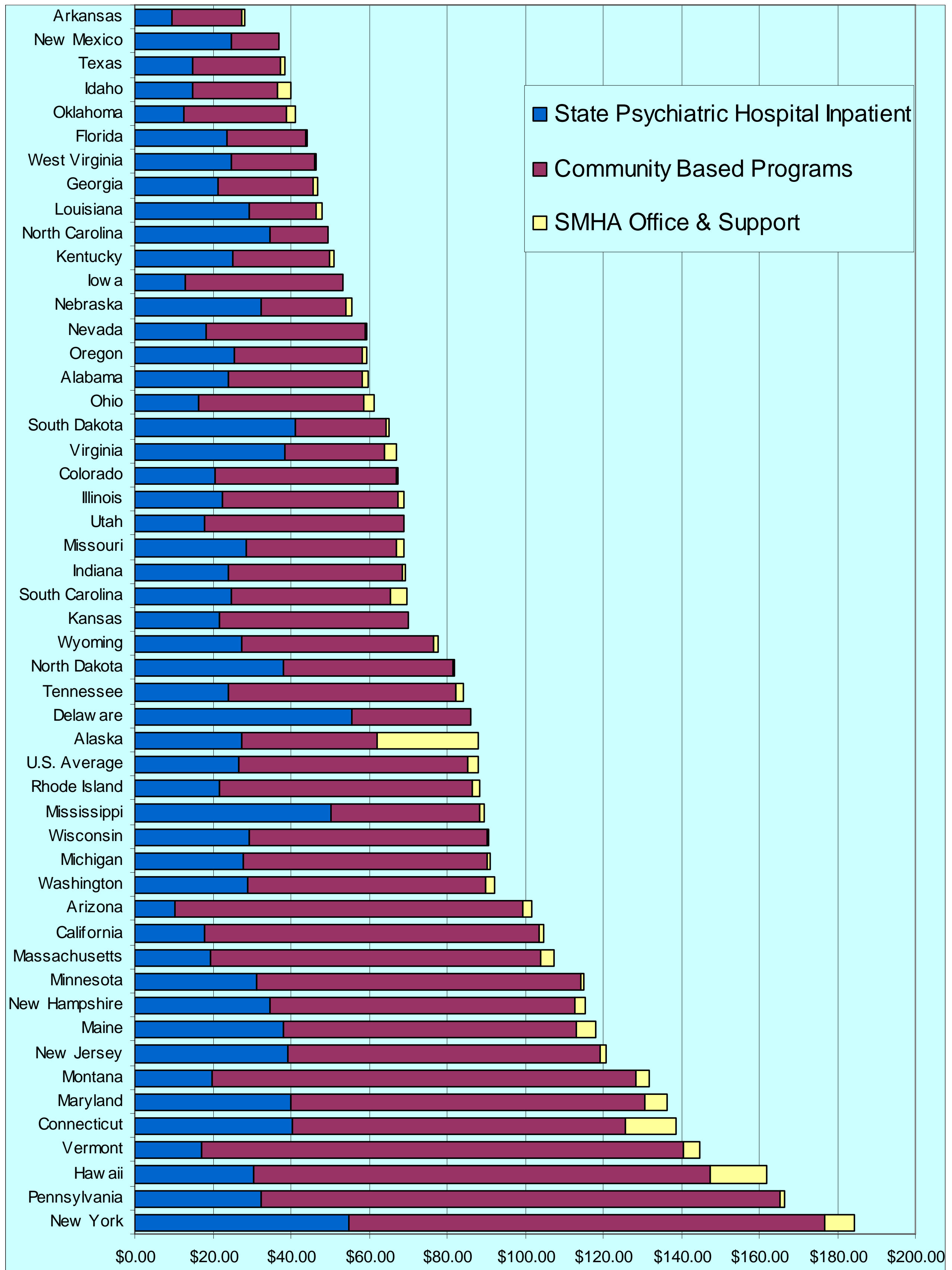
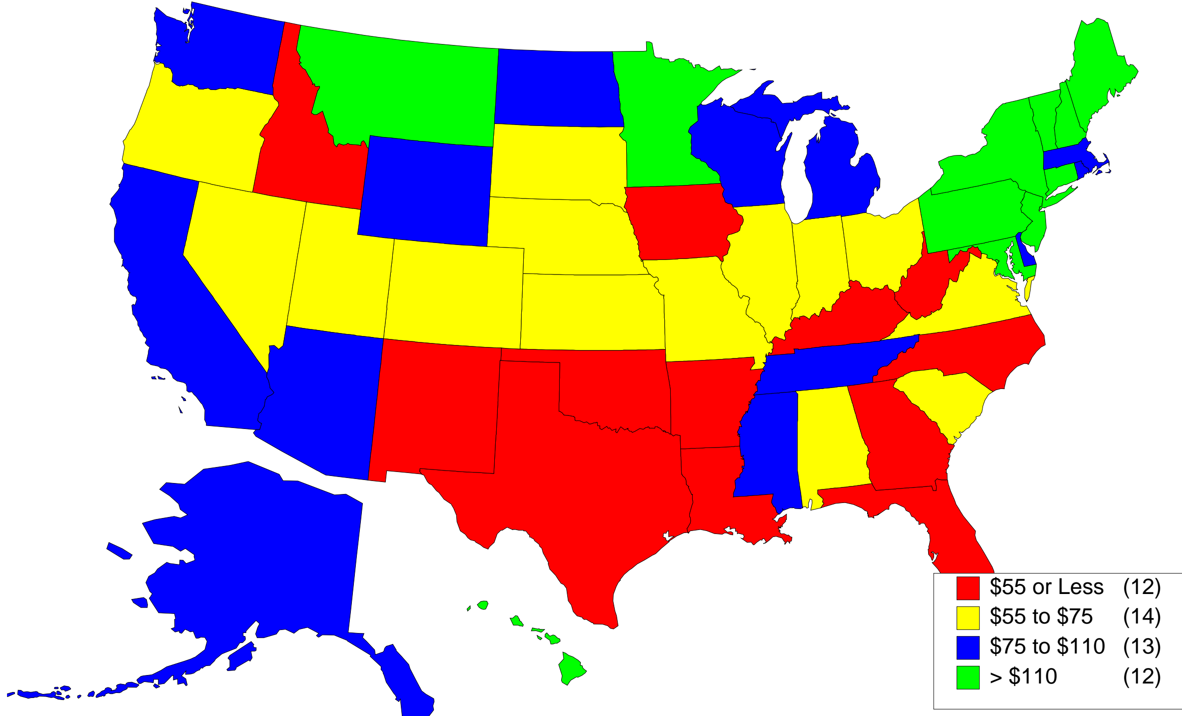


Figure 12: Total FY2002 SMHA-Controlled Per Capita Mental Health Expenditures



of $2.2 billion (9.5%) over FY 2001. When controlled for inflation, it was a 4.8% increase.

When expenditures are adjusted for population growth, SMHA-controlled expenditures grew 8.2% from FY 2001 to FY 2002, The average, inflation controlled, per capita increase was 3.5%, though the median was actually a virtually no change at 0.2%.

Controlling for inflation, in 19 SMHAs mental health expenditures failed to keep pace with inflation since FY 2001, and 15 states since FY 1990.

From FY 1990 to FY 2002, SMHA capita expenditures increased 106.5% in current dollars, or 18.6% when controlled for inflation. When adjusted for inflation and population growth, SMHA expenditures increased by only 2.7% from FY 1990 to FY 2002. From FY 2001 to FY 2002 there were inflation controlled increases in 36 states and decreases in 15 states.

Variations in SMHA Expenditures: Controlling for inflation, in 19 states total SMHA-controlled mental health expenditures failed to keep pace with inflation since FY 2001, and 15 states since FY 1990. The $25.2 billion SMHA-controlled expenditures in FY 2002 amount to over $87.65 for every civilian resident in the United States. The median state — the point where 25 states were above and 25 States were below - was Kansas, with per capita expenditures of $70.02. As Figure 11 demonstrates, there was a wide variation among states in their SMHA-controlled spending. In FY 2002, per capita SMHA-controlled expenditures varied from $184 in New York to $28 in Arkansas.

Figure 12 shows that the states with the highest expenditures are concentrated in the Northeast and MidAtlantic regions, all of which have greater than average expenditures. States in the Southeast and South Central regions tend to spend the least, with 10 states with below average expenditures, four with average expenditures, and none with above average expenditures.

Figure 13 displays regional averages for mental health spending. SMHAs in the MidAtlantic ($163.45), New England ($116.89) and West ($98.99) had the highest per capita expenditures for mental health while states in the South Atlantic ($51.56) and South Central ($50.20) have the lowest per capita expenditures.

States in the West (78%) and Mountain (76%) region spent the highest proportion of their budgets on community-based services, followed by New England and MidAtlantic states. Only states in the South Atlantic expended more on hospital services than community services.

Shifting Funds from State Psychiatric Hospital Inpatient Services to Community-Based Mental Health Programs: During more than two decades of relatively flat level of inflation adjusted SMHA expenditures for mental health services, a major shift in the types of services funded by SMHAs has occurred. The building of comprehensive community mental health systems and the reduction of the role of state psychiatric hospitals have resulted in state mental health systems that spend substantially more on community services than institutional services. In FY 2002 states are spending significantly more on community mental health services (67%) than on inpatient care in state psychiatric hospitals (30%). As Figure 10 showed, this is a major change in the allocation of resources from earlier years. In FY 1981, community mental health programs received only 33% of SMHA controlled expenditures, while state psychiatric hospital inpatient services received 63%. In 1993, expenditures for community programs matched or slightly exceeded state psychiatric hospital inpatient spending for the first time. This trend accelerated over from FY 1997 to FY 2002, as SMHAs substantially increased spending on community mental health services by $7.2 billion or 73%. SMHAs spent $16.9 billion to provide community-based mental health services in FY 2002. Controlled for inflation, expenditures for community programs increased 87.1% from FY 1990 and 6.8% from FY 2001.

From FY 1997 to FY 2002, SMHAs substantially increased spending on community mental health services by $7.2 billion .

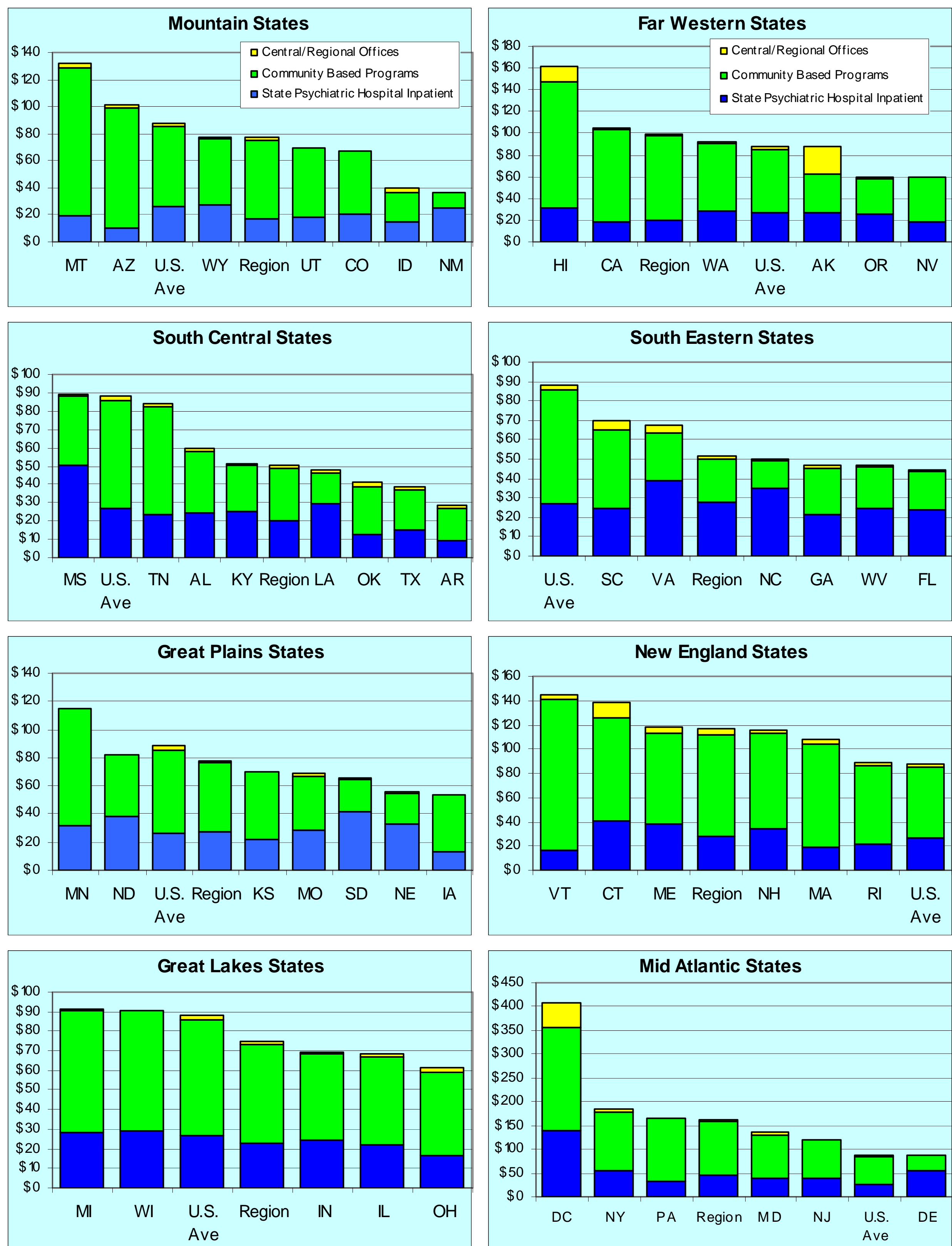
In FY 2002, SMHAs spent $7.6 billion on inpatient services in state psychiatric hospitals, an increase of $378 million (5.2%) from FY 2001. Controlled for inflation, expenditures for state psychiatric hospitals declined 33.1% from FY'90 and increased only 0.7% from FY 2001.

The decrease in state expenditures for state psychiatric hospital inpatient services is consistent with the findings of the NRI's State Mental Health Agency Profiles System that has documented the closing or merger of 46 state psychiatric hospitals during the from 1990 to 2002. From 1981 to 2000, the Federal Government has documented a 57% decline in state and county psychiatric hospital patients.[2] Several states use their state

Figure 13: FY 2002 SMHA-Controlled Per Capita Mental Health Expenditures by Region

REGIONS (Average)	State Psychiatric Hospital- Inpatient	Community-Based Programs	Central/ Regional Offices	Total	% Hospital
MidAtlantic	$45.47	$112.93	$5.05	$163.45	28%
New England	$27.81	$83.45	$5.62	$116.89	24%
West	$20.26	$76.97	$1.76	$98.99	20%
U.S. Average	$26.63	$58.80	$2.66	$87.65	30%
Great Plains	$27.12	$49.69	$0.95	$77.76	35%
Great Lakes	$23.19	$49.97	$1.33	$74.49	31%
Mountain	$15.59	$59.16	$1.30	$76.06	21%
South Atlantic	$27.54	$22.60	$1.42	$51.56	53%
South Central	$20.55	$28.23	$1.42	$50.20	41%

Figure 14: Fiscal Year 2002 SMHA-Controlled Per Capita Mental Health Expenditures for State Psychiatric Hospital Inpatient and Community Services, By Region

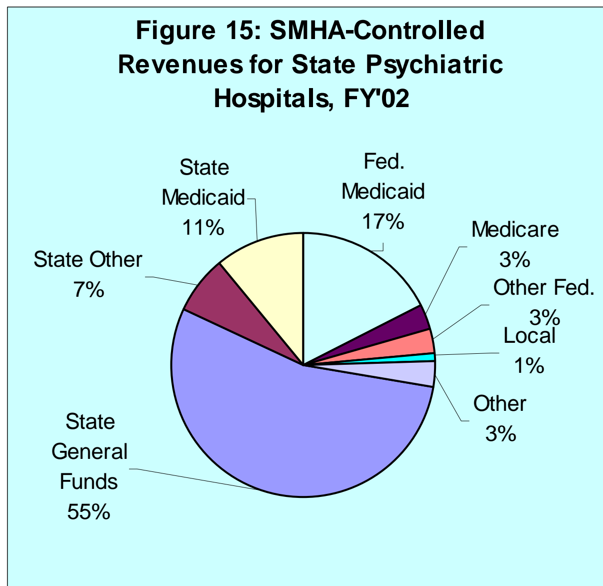


psychiatric hospitals to serve involuntarily committed Forensic patients, who are an increasing portion of the hospital population in these states. When state-to-state comparisons are made, readers should take into account the forensic responsibilities of states as described later in this report.

Funding State Psychiatric Hospitals: State general and other funds were the major funding source for state psychiatric hospitals in FY 2002 and were 61% ($5.1 billion) of total funding. State Medicaid matches were 11% ($.95 billion). Federal sources were 24% ($2 billion), most of which ($1.5 billion) was from Medicaid. Local government ($75 million), first and third party payments ($130 million), and other revenue ($140 million) were 4% of the funding. Expenditures for state psychiatric hospitals as a percent of total state mental health expenditures ranged from 70% (North Carolina) to 10% (Arizona) and a mean of 30% of total SMHA expenditures.

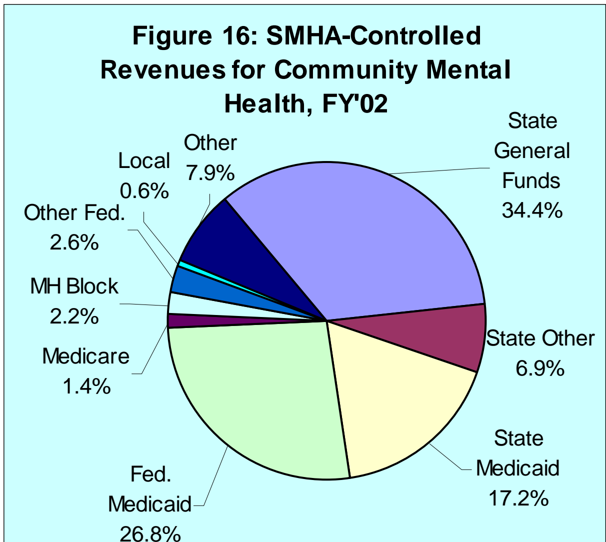
State general and other funds were the major funding source for state psychiatric hospitals in FY 2002 (61% or $5.1 billion of total funding).

Figure 15: SMHA-Controlled Revenues for State Psychiatric Hospitals, FY'02



Funding Community Mental Health Programs: State general funds were the major funding source for community mental health programs in FY 2002 and were 41% ($6.7 billion) of total funding. State Medicaid matches were 17.2% ($2.8 billion). Federal sources were 33% ($5.4 billion), most of which ($4.4 billion) was from Medicaid. The Community Mental Health Block Grant contributed $363 million (2.2%), Local government $90 million(0.6%), first and third party payments $297 million (1.8%), and other revenue $979 million (6%).

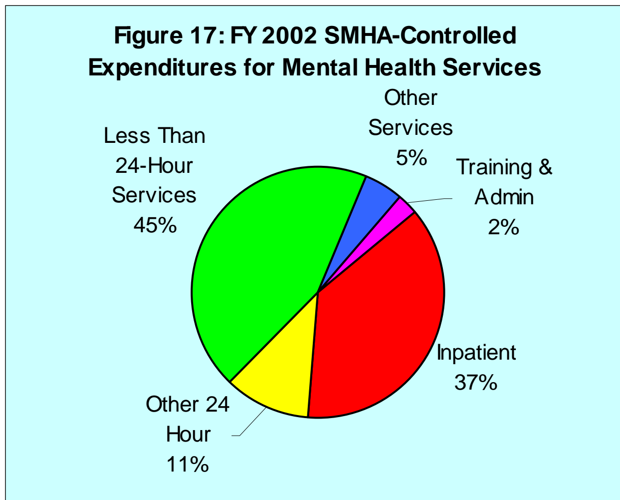
Figure 16: SMHA-Controlled Revenues for Community Mental Health, FY'02



SMHA-controlled expenditures for community programs ranged from 88% (Arizona) to 30% (North Carolina) with a national average of 67% of total SMHA expenditures. Per capita expenditures for community programs ranged from $214.40 (District of Columbia) to $4.50 (West Virginia).

Medicaid (State and Federal) Revenues for SMHA-controlled community mental health in FY 2002 (44%) exceeded state general and special funds (41%).

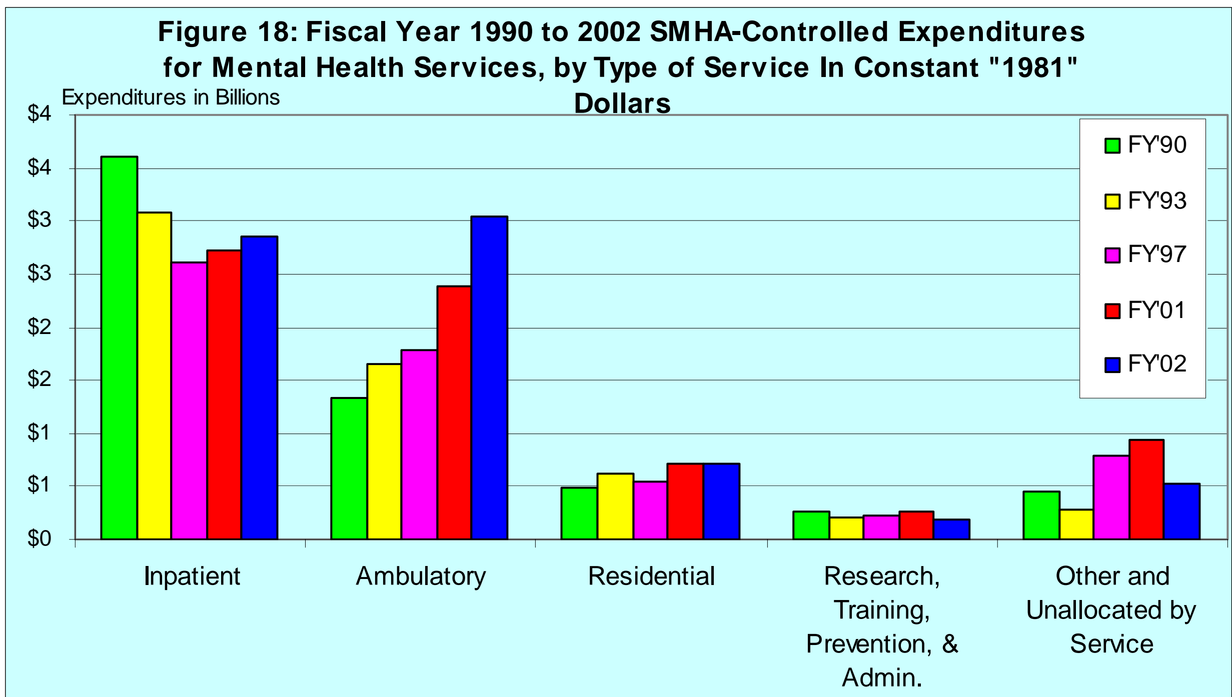
Expenditures By Type of Mental Health Services



Inpatient Mental Health Expenditures: In FY 2002, SMHA expenditures for inpatient mental health services were $9.8 billion. Controlled for inflation, this was a 10% increase over FY 2001. From FY 1990 to FY 2002, however, there has been an inflation adjusted decrease in expenditures of 21%. These inpatient expenditures are at state psychiatric hospitals (78%), and, increasingly, for general hospital inpatient psychiatric services purchased through community mental health service systems (22%). Funding for inpatient services ranged from 69.5% (North Carolina) to 14.5% (Arizona) of total SMHA expenditures with the national average of 39%. Per capita expenditures for inpatient services ranged from $140.33 (District of Columbia) to $9.53 (Arkansas) with an average of $34.18. (see Tables 2, 3, 9, and 34)

Other 24 Hour (Non-Inpatient) Mental Health Expenditures: In FY 2002, SMHA expenditures for other 24-hour (non-inpatient) mental health services were $2.5 billion. Controlled for inflation, this was a 2.6% increase from FY 2001. From FY 1990 to FY 2002, there was an inflation controlled increase in expenditures of 33.7%. Funding for other 24-hour services ranged from 37.6% (Montana) to 0.3% (Mississippi) of total SMHA expenditures and the national average was 9.8% of total SMHA spending. (See Tables 2, 3, 5, and 35)

Less than 24 Hour (Ambulatory) Mental Health Service Expenditures: In FY 2002, SMHA expenditures for ambulatory mental health services were $10.5 billion which represented the largest category of SMHA services at 42% of total. Controlled for inflation, less than 24-hour services increased 27.5% increase over FY 2001. From FY 1990



to FY 2002, there was an inflation controlled increase in expenditures of 120.8%. Ambulatory mental health services include a broad array of community-based services that are delivered in non-residential and non-inpatient settings. (See Tables 2, 3, 6, and 36) .

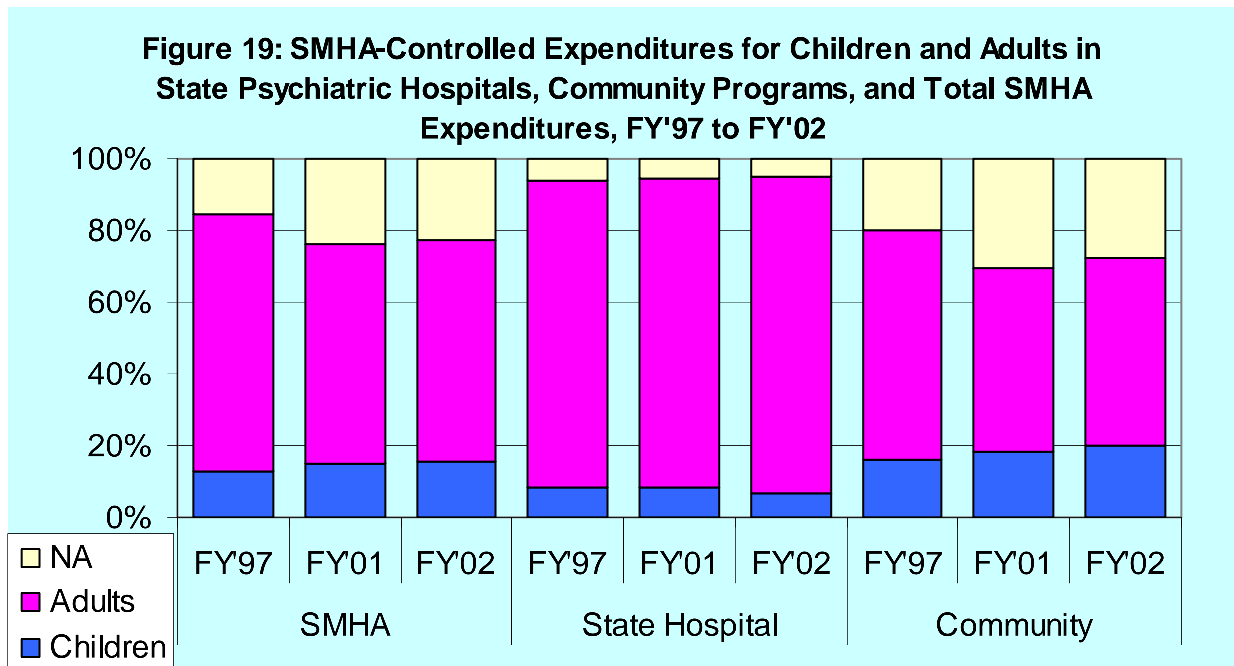
Children represented 20% of all expenditures of community mental health programs, while adults represented 51% (with 29% of community expenditures not allocated to ether adults or children).

SMHA Expenditures for Children and Adult Mental Health Services: SMHAs were asked to depict their expenditures by age groups (Children, under age 18, and Adults, aged 18 and over). Not all states fiscal systems allow them to report all expenditures by age groups, and as a result must be viewed with caution. Over $3.9 billion (16%) in expenditures were reported by 44 states for services to children/adolescents. Over $15.6 billion (62%) in expenditures were reported by 48 states for services to adults/elderly (over age 18).

Several states were not able to provide expenditures data by client age group. States reported expenditures of $5.7 billion (23%) that were not allocated to particular age groups. In several states, the SMHA focuses on providing services to adults only and a separate state agency, often a Department of Children and Families, is responsible for providing mental health services to children. Thus, several states reported zero ($0) expenditures for children since only the adult agency reported data for this report (Connecticut, Delaware, and Rhode Island).

Community mental health program expenditures by Age: Children represented 20% of all expenditures of community mental health programs ($3.3 billion), while adults represented 51% ($8.4 billion). Almost 4.7 billion (29%) of community expenditures were not allocated to ether adults or children). On a per capita basis, community-based mental health expenditures for children were higher $44.95 than for adults ($39.01).

State Psychiatric Hospital Expenditures by Age: State psychiatric hospitals are used much less by children than adults. Expenditures for children in state psychiatric hospitals averaged 8% of SMHA expenditures ($630

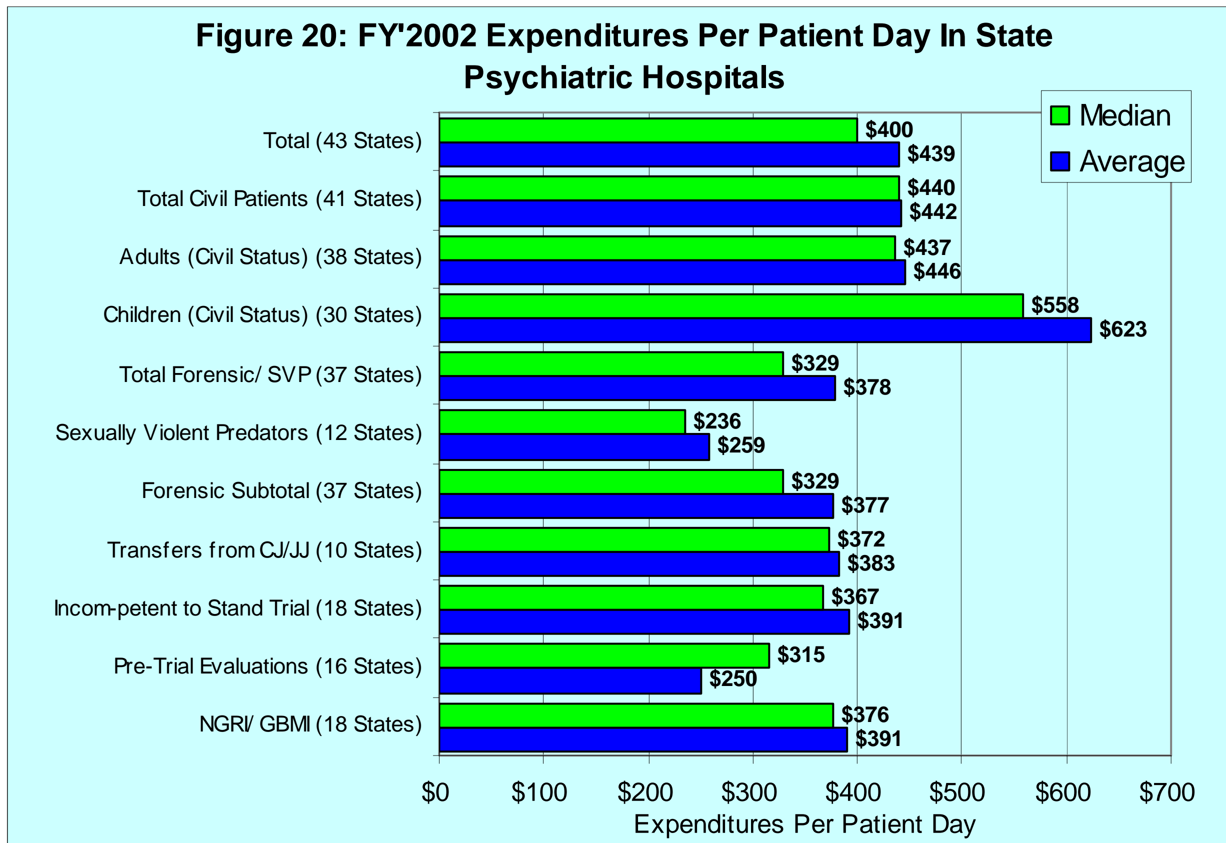


million), while adults averaged 88% ($7.2 billion). Over $395 million (5%) of expenditures not allocated to either adults or children).

State Psychiatric Hospital Expenditures Per Inpatient Day: Forty-three states provided data for state hospital expenditures and patient days. From this data, a per-patient day rate was calculated. For FY 2002, these forty-three states reported 17 million patient days and $6.9 billion state psychiatric hospital expenditures. The average per patient day expenditure was $403.11, the median was $371.62, the lowest was $176.42 (South Dakota), and the highest was $720.83 (New Hampshire).

SMHA-controlled expenditures per patient day varied widely depending on how SMHAs use their state hospitals. Civil patients (both voluntary and involuntary) had the highest average expenditures ($442) per day, followed by "forensic" clients at $371 per day and sexual offenders at $258 per day. Children who were civil status patients had by far the highest costs per day ($602) while adults averaged $421.

Within the category of Forensic patients, those who were in the state psychiatric hospital due to reasons of Incompetence to Stand Trial ($391), Not Guilty by Reason of Insanity or Guilty but Mentally Ill ($391) and Transfers from Criminal Justice ($383) had the highest costs, while patients at the hospital for pre-trial evaluations averaged $250. There is great variation in how states use their state psychiatric hospitals for civil patients. The State Profile System showed that, in 2001, seven states (Alaska, District of Columbia, Kentucky, Missouri, Ohio, Oklahoma, and South Carolina) provided primarily short-term care in their hospitals for youth and two states (Alaska and Kentucky) for adults, while five states (California, Florida, Hawaii, Oregon, and Utah) provided primarily long-term care in their hospitals for youth and six states (California, Florida, Hawaii, Indiana, Oregon, and Pennsylvania) for adults.



Forensic Mental Health Expenditures: The provision of mental health assessments and treatment to persons involved in the criminal justice system is a major responsibility of SMHAs. SMHA expenditures for these forensic mental health services have grown rapidly in recent years. The level of expenditures for forensic service varies substantially across the states. In a few states, the SMHA is not responsible for any forensic services since these services are provided by the state corrections agency and by local jails.

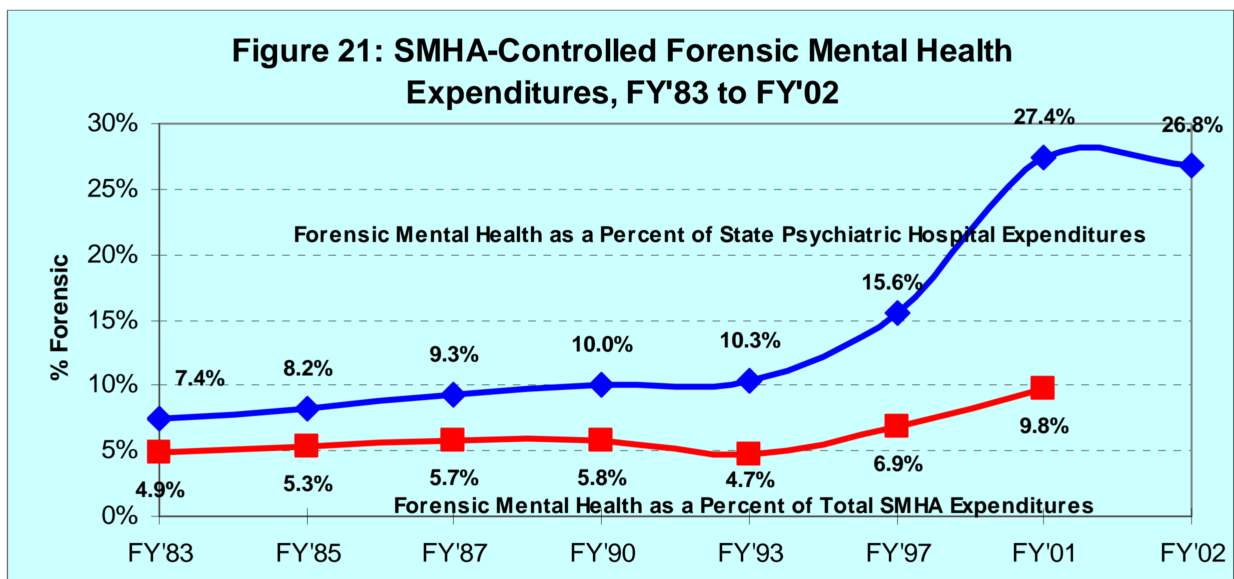
SMHA-controlled expenditures for Forensics were 25% of state hospital expenditures and sexual offender services were an additional 2%.

In FY 2002, SMHA Forensic mental health expenditures were $1.77 billion and services for Sexual Offenders were an additional $164 million. Thus, SMHA-controlled expenditures for Forensics were 25% of state hospital expenditures and sexual offender services were an additional 2%. Forensic and sexual offender services increased by 10% over FY 2001 and adjusted for inflation increased by 5.3%. From FY'90 to FY 2002, there has been an inflation controlled increase in expenditures of 46%.

As shown in Figure 21, expenditures for forensic mental health services are growing as a percent of overall state spending and particularly growing in state psychiatric hospitals. Since FY'83, state hospital forensic expenditures have increased by over four fold, much faster than the rate of increase in total SMHA mental health spending. (Total Forensic expenditures were not compiled for FY 2002.)

Since FY'83, forensic expenditures have increased by over four fold, much faster than the rate of increase in total SMHA mental health spending.

In five states (Arizona, California, Ohio, Oregon, and Wisconsin), Forensic expenditures now exceed half of their state hospital expenditures, and in eight additional states, they exceed 30% of state hospital expenditures. The increased proportion of state psychiatric hospital populations that are forensic clients, who are in the hospital due to their connections with the criminal justice system and courts, suggests a shift in the role of state hospitals in many states to a focus on forensic patients rather than the traditional focus on civil patients (both voluntary and involuntary civil patients).



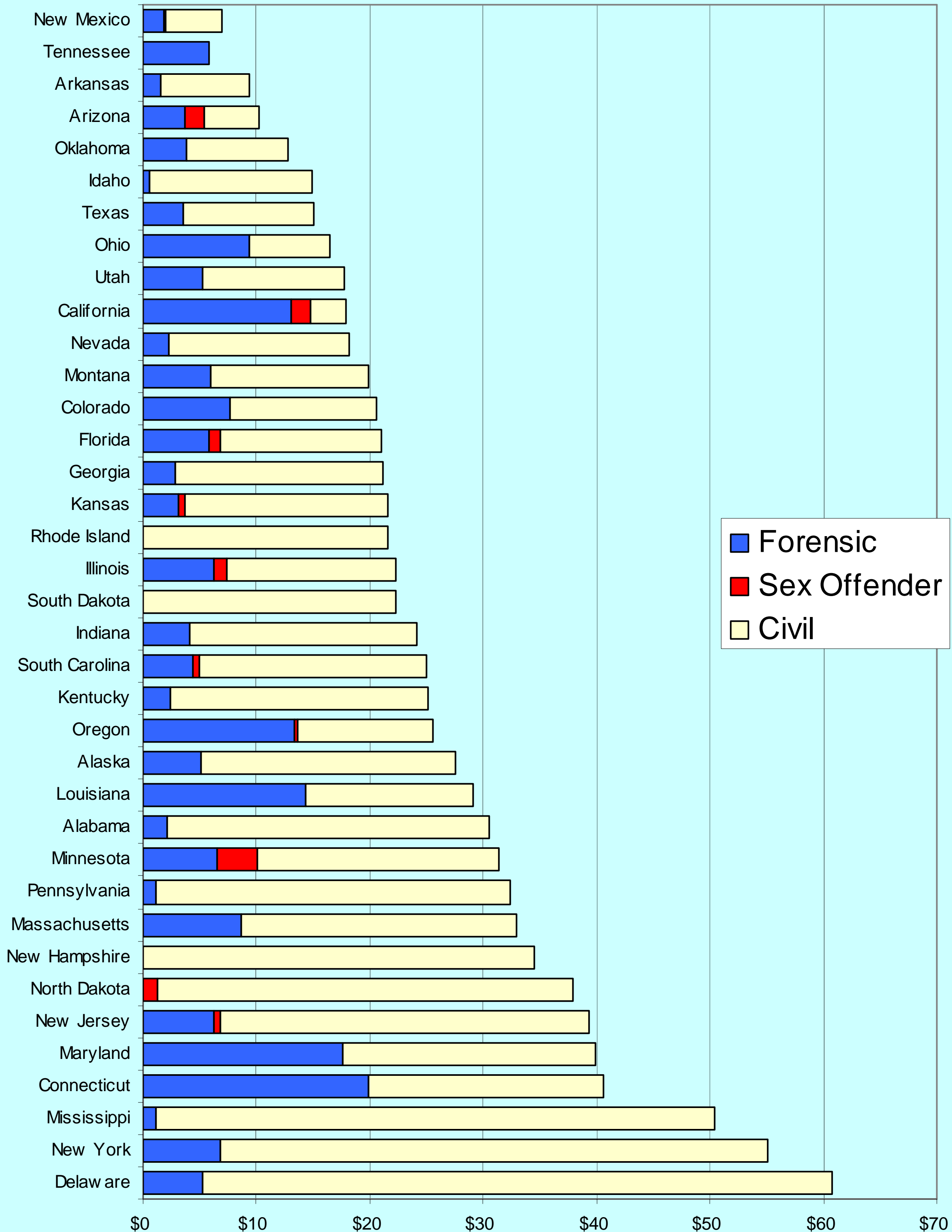


Figure 22: State Psychiatric Hospital Per Capita Expenditures for Forensic and Civil Patients, FY 2002, Selected States
New Mexico
Tennessee
Arkansas
Arizona
Oklahoma
Idaho
Texas
Ohio
Utah
California
Nevada
Montana
Colorado
Florida
Georgia
Kansas
Rhode Island
Illinois
South Dakota
Indiana
South Carolina
Kentucky
Oregon
Alaska
Louisiana
Alabama
Minnesota
Pennsylvania
Massachusetts
New Hampshire
North Dakota
New Jersey
Maryland
Connecticut
Mississippi
New York
Delaware
$0
$10
$20
$30
$40
$50
$60
$70
Forensic
Sex Offender
Civil

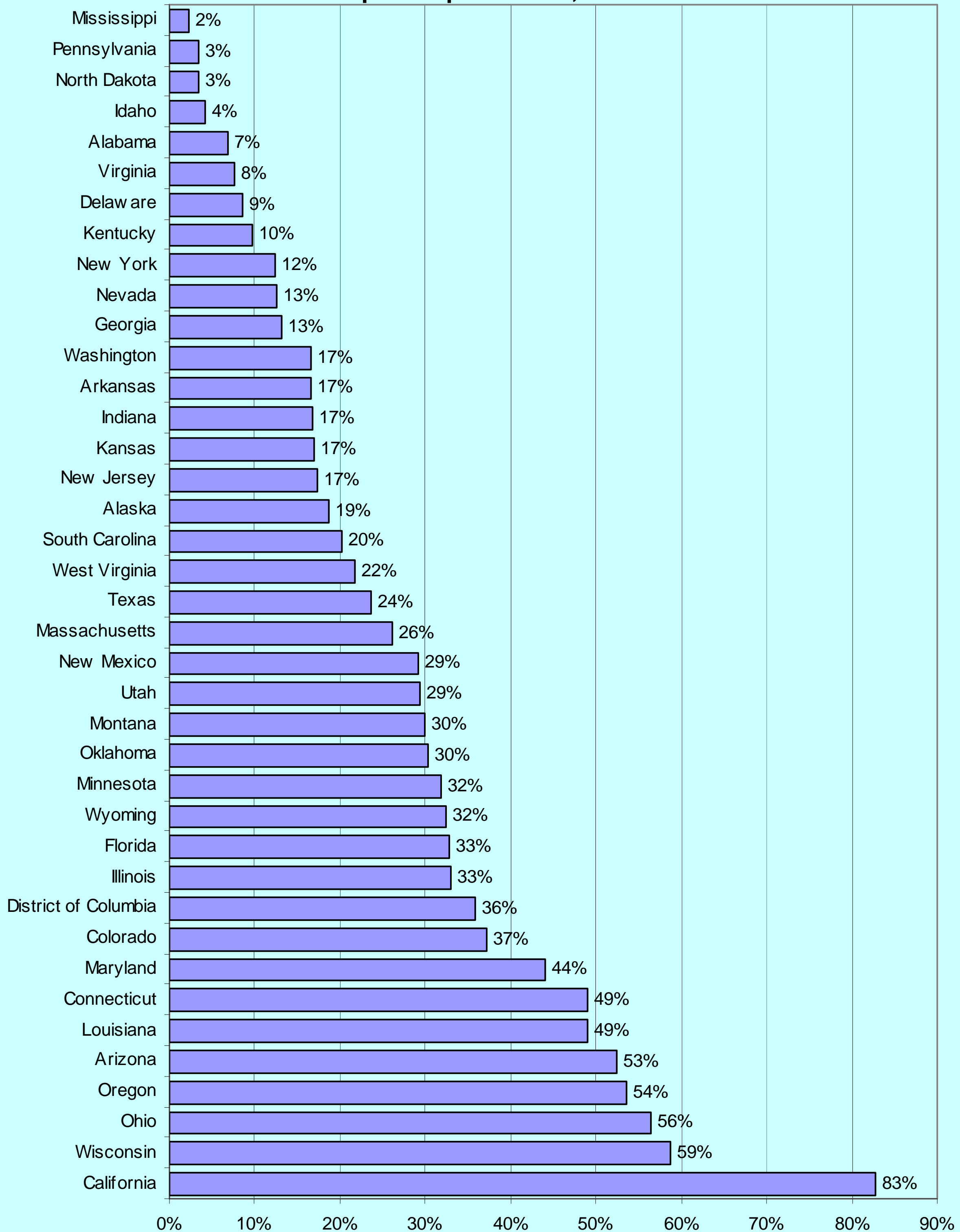


Figure 23: State Psychaitric Hospital Expenditures for Forensic and Sex Offender Services as a Percent of Total State Psychiatric Hospital Expenditures, FY'02
Mississippi
2%
Pennsylvania
3%
North Dakota
3%
Idaho
4%
Alabama
7%
Virginia
8%
Delaware
9%
Kentucky
10%
New York
12%
Nevada
13%
Georgia
13%
Washington
17%
Arkansas
17%
Indiana
17%
Kansas
17%
New Jersey
17%
Alaska
19%
South Carolina
20%
West Virginia
22%
Texas
24%
Massachusetts
26%
New Mexico
29%
Utah
29%
Montana
30%
Oklahoma
30%
Minnesota
32%
Wyoming
32%
Florida
33%
Illinois
33%
District of Columbia
36%
Colorado
37%
Maryland
44%
Connecticut
49%
Louisiana
49%
Arizona
53%
Oregon
54%
Ohio
56%
Wisconsin
59%
California
83%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%

Figures 22 and 23 show how each of the states use their state hospitals for forensic and non-forensic services. Figure 22 shows the per capita expenditures by states. Figure 22 depicts what percent of state hospital expenditures were devoted to forensics.

Expenditures for Psychiatric Medications and New Generation Atypical Antipsychotic Medications: In FY 2002, 43 states reported $295 million of expenditures in state psychiatric hospitals for psychiatric medications. These expenditures averaged 4.4% of state psychiatric hospital expenditures. 86% of state hospital medications were paid for by state dollars and 14% we paid for by Medicaid.

During the dozen years from FY 1990 to FY 2002, many new pharmacological agents were developed that are effectively used by SMHAs to treat mental illnesses. Many of the new generation medications are substantially more expensive than earlier medications. In FY 2002, 34 states reported $776 million in expenditures on atypical antipsychotic medications, 15% in state psychiatric hospitals and 85% through community programs. These atypical medications represented 2.5% of state hospital expenditures and 8.2% of community expenditures.

Payment for atypical medications varied by type of program. In state hospitals, state dollars paid for 88% of atypical medications and Medicaid paid for 12%. In community mental health programs, Medicaid paid for 83% ($547million) and other SMHA dollars paid for 17% ($112 million). Atypical medications include: clozapine, olanzopine, quietapine, risperidone, and other atypicals.

From FY 2001 to FY 2002, 29 states were able to report total atypical medication expenditures for both years. These states reported an increase of over 10% in expenditures for atypical medications (up 6% in inflation adjusted expenditures). From FY 1997 to FY 2002, 19 states reported data for both years and atypical antipsychotic expenditures increased by 268% over the 5 years in these states (an increase of about 30% per year). Even controlling for inflation, atypical antipsychotic expenditures increased by 203% from FY 1997 to FY 2001.

References:

[1] THE FISCAL SURVEY OF STATES: DECEMBER 2003, National Governors' Association (NGA) and the National Association of State Budget Officers (NASBO): December 2003

[2] New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care in America: Executive Summary. DHHS, Pub. No. SMA-02-3831. Rockville, MD: 2003 p. 1

[3] J. Atay, and R. Manderscheid, A. Male, and J. DeLozier, Additions and Resident Patients At End of Year, State and County Mental Hospitals, by Age and Diagnosis, by State, United States, 2000. CMHS, Rockville, MD: SAMHSA 2002

[4] THE FISCAL SURVEY OF STATES: National Governors' Association (NGA) and the National Association of State Budget Officers (NASBO): APRIL 2004, page IX.

[5] Inflation-adjusted expenditures adjust all expenditures to a base year of 1990. The Medical Component of the Consumer Price Index is used as the adjustor.

[6] R.G. Frank, H.H.Goldman, and M.Hogan, "Medicaid and Mental Health: Be Careful What You Ask For: Growth in Medicaid Mental Health Spending Has Ironically Resulted in Less Money for the Mental Health Care Safety Net," Health Affairs (Jan/Feb 2003):101:113

Methods

The methodology that formed the basis of this effort was predicated on the compilation of actual (rather than estimated) revenues and expenditures under the direct control of the SMHA. The depiction of actual (rather than estimated figures) was considered necessary if valid and reliable data were to be reported. Without reference to specific financial reports depicting actual expenditures, it is difficult, if not impossible, to both verify figures and have an accessible database for follow-up and/or analysis.

The database that comprised the foundation for the study was predicated on the development and completion of five table shells. Table shells 1 through 5 are included in Appendix B: Glossary. Based upon revenue and expenditure figures recorded in each states archival database, dollar amounts reflecting the states revenues and expenditures were utilized to complete each cell in the tables.

Definitions for each of the terms contained on the table shells are found in the Glossary that provided the states and project staff with uniform definitions of terms that corresponded to the row and column headings on the table shells.

Table shell 1, representing each state's mental health agency-controlled mental health expenditures, indicates the three categories for describing expenditures. First, efforts were made to distinguish expenditures by the primary program categories within which expenditures were incurred. For purposes of this study, three program were identified: (1) expenditures for state mental hospitals funded and operated by the SMHA; (2) SMHA expenditures incurred on behalf of community-based programs. These programs could either be directly funded (and operated) by the state mental health agency or represent grant or contract or other state local fiscal arrangements whereby funds are transferred from the SMHA to independent local programs and/or provider agencies; and (3) state mental health agency support activities to include SMHA funding for research, training, prevention programs operated and/or coordinated by the SMHA, and SMHA administrative expenses for the SMHA central office and/or subordinate regional units.

Each of the program categories (administrative auspices) was then subcategories into types of specific services or activities. Finally, efforts were also made to delineate expenditures according to two primary age groups: children and adolescents under age 18, adults age18 and over, and individuals age unknown.

Table shell 2 was used for depicting revenues that were accrued directly by the SMHA and for which the SMHA had complete administrative control. These revenues represent funds accrued by the SMHA for mental health programs or services. Revenues of organizations that may be partially funded (versus operated and funded) by SMHA funds are not reflected in the revenue tables. Therefore, the tables do not depict revenues for contracted local community mental health centers, county or multi-county mental health and mental retardation service boards, other local clinics, and/or other entities, programs, services, or facilities not directly operated by the SMHA.

As indicated in table shell 2, depiction of revenues is by primary source (state, federal, local, and other) and by subcategories of revenue accounts within each of these three general source classifications. Specific definitions for each of the revenue sources and accounts are contained in the Glossary. Revenues are depicted according to the three major program auspices (i.e., state mental hospitals, community-based pro-

grams, and SMHA support activities) used in the SMHA-controlled mental health expenditures table.

Table 3 focuses on the types and numbers of patients served in state psychiatric hospitals. Expenditures (and number of patient days) are compiled for both various types of forensic services, sexual offenders services, and civil patients.

Table 4 compiles information on the expenditure by state for the new generation "atypical" anti-psychotic medications. These atypical medications include: Clozaril, olanzopine, risperidone, quietapine, and ziprasidone.

Table 5 compiles information on the amount of Medicaid Disprortionate Share funds received by states for services provided at state psychiatric hospitals.

States were also asked to provide comments or explanations for any changes in their system or in their data reporting capacities. A state-by-state listing of reported notes is included as Appendix A in this report starting on page 78.

In addition, a set of standard footnotes were collected from states regarding major difference in state reporting. These notes are marked by a letter code in the right column of each output table. The notes are:

A = Medicaid revenues for community programs are not included in SMHA-controlled expenditures.

B = SMHA-controlled expenditures include funds for mental health services in jails or prisons

C = Children's mental health expenditures not included in SMHA-controlled expenditures

NR = No response from state to the footnote questions.

Output Format Process

The Project utilized two primary means for accumulating and depicting data: (a) analysis and coding of state revenue and expenditure data; and (b) follow-up discussion with appropriate SMHA officials to clarify items in the state's database, request supplemental budget documents, and/or request review of allocations made to the various table cells.

Generally, the following steps were followed to obtain final revenue and expenditure figures:

(1) SMHA staff were contacted and requested to either forward FY 2002 revenue and expenditure data archival documents and/or to make initial dollar allocations to cells on the tables and forward these data to the NRI. States were sent Microsoft Excel files to enter facilitate entering data. Data edits comparing each state's data from the prior (FY 2001) study were built into the spreadsheets.

(2) The net expenditure figures (representing only mental health programs) were then separated into Administrative Auspice and Service/Activity categories. These mental health expenditures were then allocated on the FY 2002 SMHA Controlled Mental Health Expenditures table (Table shell 1). Mental health revenue figures were entered on the FY 2002 SMHA-Controlled Mental Health Revenues table (Table shell 2).

(3) Following preliminary completion and/or review of the data tables by NRI project staff, the data tables, footnotes, glossary, and cover letter (including special questions and notes) were sent to each state SMHA contact person. These persons were requested to respond to any questions and verify the data tables.

(4) Following feedback from the SMHA, project staff entered the verified data into the NRI database for storage, retrieval, and analysis

(5) A draft set of the Final Report tables showing data from all 50 states was sent to the SMHA Commissioners and SMHA contact person for their review. With the draft final tables, any outstanding data issues for each state were raised in this mailing. States were requested to verify their data and send any necessary corrections or updates to the NRI. The NRI made the changes requested by the states and prepared this final report.

Population data was calculated using data from the U.S. Census Bureau. This report follows the lead of CMHS and NIMH and uses "Civilian" Population estimates (which exclude persons serving in the Armed Forces).

The close relationship between the NRI and each SMHA was particularly important for conducting the study. Any project seeking to account for literally billions could not achieve an accurate portrayal of such funds in the absence of dialogue between project staff and SMHA contact persons. This dialogue (via letter, e-mail, and phone) served to ensure the data received from SMHAs were accurate and complete to the extent possible. Data for each cell in all tables could not always be obtained. Some SMHAs did not have an accounting system for FY 2002 that portrayed the allocation of revenues/expenditures using the Project's glossary and table formats.

STATE FOOTNOTES FY 2002 DATA

Alabama: Alabama recomputed the 2001 figures. Patient days were reduced in FY02 as a result of closing long-term care beds as part of the Wyatt Settlement Agreement and, partly, as a result of utilizing new generation medications when appropriate. Pharmacy costs were reduced in FY02 as a result of the department joining a larger general purchasing organization for drug purchases and changes to the Indigent Drug Program, which shifted some participants to publicly funded Pharmacy Assistance Program.

Alaska: The Department of Health and Social Services and the Mental Health Division have undergone a large amount of restructuring over the last five or more years. Many programs that existed in 2001 have changed, moved to a different division or been done away with. Many new programs have arisen in 2002 as well as the changes in the budget structure.

Arizona: Arizona revised their FY 2001 numbers. The difference between expenditures and revenue is due to tobacco litigation funds counted as revenue in FY'01 and spent in FY'02. The difference between total expenditures for state hospitals and revenue for state hospitals is due to revenue that was collected, but the hospital cannot keep and is returned to the General Fund. The difference between total expenditures for community programs and revenues for community programs is a $5.2 million Fund Seep in FY'02 and $2 million that was carried forward to FY'03. The remainder is tobacco litigation funds counted as revenue in FY'01 but spent in FY'02. The increase in total state hospital and inpatient expenditures, including state hospital forensic expenditures, is a result of the addition of $9.4 million Sexually Violent Predator (SVP) Program. The decrease in total pharmacy expenditures is due to other medications not included in FY'02. The increase in expenditures for atypical medications is due to ADHS reporting of drugs changing from one year to the next. The decrease in state general/other revenue is due to $70 million in tobacco litigation funds allocated in FY'01 and available for disbursement over a three-year period. The increase in state Medicaid revenue is due to the passage of an Arizona voter based proposition which increased Medicaid eligibles dramatically in FY'02; Arizona shifted costs of Medicaid system to federal funds. The increase in total revenue for state hospitals is due to increased billing revenues and new funding for Restoration to Competency.

Arkansas: None

California: California revised their FY 2001 figures.

Colorado: Some children's services moved from Child Welfare appropriation to mental health appropriation. Medication expenditures overall increased from $21,886, 860 to 23,529,375 because they did not have information on atypical medications in FY 2001. The increase in state hospital Medicaid revenue is due to payments going directly to them instead of CMHCs for the hospital clients B per legisla-

tive intent to not double count Medicaid at CMHCs, and then state hospital when paid by CMHCs. The state hospital Federal Medicaid revenues were shown in the "other revenues" in FY 2001 and appropriately in the Medicaid line for FY 2002. The other community mental health programs Federal revenue increase is due to additional Federal grants. The larger community program grants appropriated in the administration section were not shown as either revenues or expenditures in FY 2001. As stated above, are shown in FY 2002 (moved from administration to community).

Connecticut: The Adult and Elderly Services figures are inconsistent year over year. FY'01 includes administrative costs. The FY'02 number excludes these costs. The DSH amounts are included in the General Fund line on Table 2, not in the Medicaid line. Medicaid revenues reflect fee for service revenue.

Delaware: Medicaid and Medicare revenue is deposited directly to the state general fund and not used to support expenditures.

District of Columbia: FY 2002 was the beginning a major reorganization for the Department of Mental Health (DMH). The Department was divided into three components. The DMH Authority (Admin), Saint Elizabeths Hospital (Inpt care), and Community Services Agency (Community care). State Inpatient care continues to decrease while the Community Services increase. At the same time, the Community Services changed from a traditional Outpatient Treatment mode of care to a Rehabilitation model. As a result, expenditures including Administrative Costs increased and revenue decreased, while capacity was built in the DMH Community Agency and Community Contract Providers.

Hospital is continuing to downsize and community programs are becoming less dependent on hospital provided services, such as pharmaceuticals, facility maintenance, etc. Funds and functions were shifted to cover authority costs.

In FY'02, the Prevention category was not included so those expenditures are included in community mental health expenditures.

In FY'02, the hospital discontinued providing inpatient services for children. Private community hospitals provided these services at no cost to DMH. Also, out-of-state residential care for youths continues to decrease and DMH began billing Medicaid for child services for the first time.

Along with the hospital downsizing, DMH changed billing systems and procedures. DMH did not bill for Medicaid at the hospital for six months. DMH billed for per diem outpatient clinic visits from October 2001 to March 2002. Beginning March 2002 until September 2003, Medicaid Rehabilitation Option services were billed and accrued.

The increase in mental health block grant revenue is due to carry over funds from FY'01.

The decrease in Federal other revenue is due to changes in Medicare regulations. DMH lost Medicare revenue. DMH did not bill Medicare for nine months. Also, the number of Federal consumers funded by the Federal Government is decreasing each year with no increase in the billing rate.

The decrease in Federal Other revenue-State Hospitals is due to changes in Medicare Part B regulations. Saint Elizabeths Hospital, along with other state hospitals, lost revenue for inpatient charges.

The decrease in Federal Other revenue-Community Mental Health is due to Medicare regulations for outpatient billing and affiliations reduced billing for the first two quarters. Beginning April 1, 2002, DMH switched to a Rehab. Model of Treatment which is not covered by Medicare. DMH did not bill for six months. The budget was supplemented with local funds.

The decrease in other revenue is due to downsizing and changes in populations/ coverage (self and commercial coverage).

The decrease in total revenues for state hospitals is due to downsizing, Medicare regulations, changes in populations/coverage, no rate increase and changes in billing procedures accounts for the decrease in revenues.

Florida: The difference between FY'01 and FY'02 expenditures is due to two factors. In FY'01, $93 million in DSH funds were not included in expenditures, but were included in FY'02. In FY'02 actual budget allocations and expenditures were used rather than the statewide allotments and expenditures from the Florida Accounting Information Resource (FLAIR). This accounts for extra federal and state funds that were received by the SMHA that were not counted in previous years. Forensic patient days and expenditures do not include sexually violent predators. The total expenditures for civil patients does include the DSH total in FY'02, but the FY'01 total did not include DSH funds.

Georgia: Federal Medicaid is part of the Department of Community Health's budget. Some community-based programs in Other/Unknown are also funded by Federal Medicaid (in Ga. Department of Community Mental Health Budget). State matching funds are reflected in the totals. Based on FY'02 blended rate of 59.17%, an additional $42,823,178 would be paid to providers, which is not reflected in the above.

Hawaii: None

Idaho: None

Illinois: Distribution of FY'02 MCO funds ($109.1 million combined GRF and FFP) across program categories impacts program growth reflected between FY'01 and >02 in residential and non-residential categories. State Medicaid Revenues, State Reve-

nues Total, Federal Medicaid Revenues, and Federal Total Revenues - FY'01 response reflected all community in-patient psychiatric funds in the Federal Medicaid line. FY'02 response allocates these funds between the Federal and State Medicaid lines. Other Revenues - FY'01 response excluded first party, third party, and other revenues. FY'02 response includes these sources.

<u>Indiana:</u> The increase in expenditures for inpatient (licensed) hospital beds is due to nursing differentials; state employee raises for all staff and increased benefits costs. Indiana=s MRO paid is up and the Mental Health Fund Recovery is down. The revenues for Medicaid also include Medicare funds. Other Federal revenue includes DSH. The increase in research/training is because of new administrative/research initiatives, such as new ACT technical assistance center, consumer survey, office of consumer affairs, actuarial work (required every four years), and rapid response team.

<u>Iowa:</u> Iowa revised their FY 2001 numbers.

<u>Kansas:</u> The increase in community expenditures is due to a rate increase. Administration costs for FY 2002 decreased primarily due to budget cuts. DSH has been declining for the last several years. The increase in forensic expenditures is due partly to the expansion of this program. Medicaid revenue increased due to rate increases.

<u>Kentucky:</u> None

<u>Louisiana:</u> $1,674,900 reported in Block grant expenditures / Support Activities were utilized for statewide activities in the Community; only $254,100 was related to administrative support. Funds were accounted for in the Mental Health Central office's budget. The agency has been reorganized to include additional administrative functions and some of the statewide federal grant support is included. Children's mental health services were calculated in previous years by the census as of the last day of the fiscal year. For Fiscal year 2002, patient days were utilized as a basis for calculating children/adolescent and adult cost which we consider would be more accurate.

State mental health hospitals are prescribing more of the atypical anti-psychotic medications, which are more expensive accounting for the increase in state hospital pharmacy expenditures. The only expenditures reported for community mental health were the atypicals. Other medications for community are $643,000 in Medicaid & $3,446,000 in state funds. There has been a significant increase in the price of medications to treat physical illness particularly our elderly population. There was an increase in the appropriation for forensic expenditures to satisfy a lawsuit imposed on the department for admitting forensic clients.

The increase in civil patients days are probable due to an increase in the adult population served. With the increase in civil patient day, a commensurate decrease in

cost per patient day is expected. The State of Louisiana has been experiencing an influx of forensic clients in the mental health system; currently 47% of our civil beds are occupied by forensic clients, which increases the expenditures related to this population. Some of the community mental health block grant expenditures are reported in the Administration program. Federal other revenues for state hospitals decreased due to the expiration of some of the federal grants.

Maine: None

Maryland: None

Massachusetts: Massachusetts recomputed their FY 2001 figures to match the definitions that were employed in the FY 2002 report. Expenditures and revenues from state operated CMHC inpatient units and the mental health inpatient units that the Department operates in the Commonwealth's Public Health hospitals were reassigned to the community based/inpatient category for FY 01. Also some FY 01 child/adolescent dollars for Intensive Residential Treatment Programs were reclassified under state hospitals.

Michigan: None

Minnesota: Expenditures for administration include costs for planning, evaluation and some technical assistance.

Survey instructions changed from FY01 to FY02 regarding State psychiatric Hospitals. In FY01 Residential Treatment operated as part of any state mental hospital's community/outpatient program were not to be included in Community-Based Programs. In FY02 all mental health services that are provided off the hospital grounds were reported as in the Community. This change resulted in a shift of $4,232,867 in FY02 Residential from State Psychiatric Hospitals to SMHA-Controlled Community expenditures in the Residential area.

For Children's Community Residential- approx. $10 million was included in FY02, but not in FY01, because it was not under SMHA control in FY01 but was included in FY02 because of new Medicaid revenues (Federal & Local Share).

Survey instructions changed from FY01 to FY02. FY 02 did not include Other Medications for Community Mental Health. The only comparison for medications between FY 01 and FY 02 for medications should be only for Atypical medications.

Mississippi: None

Missouri: SMHA controlled mental health expenditures have been increased by actual fringe benefits in the amount of $45,513,004 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 $4,356,813 of estimated 2002 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.

Included in SMHA revenues and expenditures are $42,518,693 of the federal Medicaid portion (FFP) that the Missouri Department of Social Services pays private community mental health programs for Medicaid services. This was done to normalize for the future inclusion of this federal authority in the SMHA's budget by the state legislature in FY 2004.

SMHA FY 2000 expenditures were used to estimate the FY 2002 expenditures for the following:
SMHA Owned and Operated Psychiatric Inpatient Facilities for Less than 24 Hour Care; SMHA Owned and Operated Psychiatric Inpatient Facilities for Adult Other Ambulatory; 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 SMHA expenditures and apportioned to each respective division.

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 $135,290,291 is collected by the SMHA and transferred to the General Revue fund: $97,23848 is attributed to state psychiatric hospitals; $38,051,539 is attributed to community programs.

SMHA controlled mental health revenues have been increased by actual fringe benefits in the amount of $45,513,004 associated with the SMHA. These are included in revenues even though
fringe benefits are appropriated to and paid for by another state agency.

SMHA has excluded $4,368,561 of apportioned Office of Director revenues (costs) that support the division that are one time costs associated with the future upgrade and redesign of SMHA information systems.

Disproportionate Share Medicaid: The Disproportionate Share State Match represents the certified state match of in-kind expenditures. This certified State Match is ap-

propriated by the State of Missouri as General Revenue to the SMHA to operate state inpatient facilities. The Federal share is Disproportionate Share Medicaid received by the State of Missouri is not all controlled by the SMHA. Of the $109,269,595 amount, the SMHA retained $19,811,800 and $89,817,795 was transferred to the Missouri General Revenue Fund.

Montana: FY 2001 pharmacy expenditures did not include figures from the state hospital.

Nebraska: SMHA Controlled Expenditures Medicaid revenues for community programs in FY 2002 were limited to the Medicaid Rehabilitation Option.

The large one-year change on Forensic Mental Health Expenditures is due to no capacity to break out the Forensic data.

The large one-year change in pharmacy expenditures is due to the inclusion of Medicaid in the reported data.

Nevada: None

New Hampshire: Not all of FFY02 Block Grant was spent in SFY02 because the fiscal years do not coincide.

New Jersey: New Jersey has changed the methodology used to calculate "state mental health authority dollars". The FY 2002 expenditures grand total based on updated methodology, which when applied to FY2001 survey, would have yielded FY2001 grand total expenditures of $932,219,000---a "real" increase of 11% from FY2001 to FY2002, NOT 36% as reflected in the figures reported.

Research & Training costs are NOT part of administration, but are imbedded within State Hospital & Community Services Expenditures.

In FY2001, New Jersey reported $29,110,937 in forensic expenses. These are the expenses of the single state entity "Anne Klien Forensic Psychiatric Hospital". But in FY2002, $53,100,000 expenses are for all forensic patients in different state hospitals including Anne Klien Hospital.

Not all of the FFY02 Block Grant was expended in SFY02 because the fiscal years do not coincide and the block grant allows spending over a two-year period.

New Mexico: Revenues reported for the state psychiatric hospital include hospital revenues for more than just mental health services. The state hospital provides long-term care and other non-mental health services.

New York: The amount reported for Forensic services in the FY2001 survey ($153,900,966) included approximately $24 million related to an outpatient service operated by OMH that provides mental health services to individuals in State prisons and county jails. The cost of this program has been reported under the category of expenditures for "less than 24 hour care in community programs" for this FY 2002 survey.

North Carolina: None

North Dakota: None

Ohio: Virtually all of the community Medicaid medication expenses are not funded through the SMHA (they are funded through the Ohio Department of Job and Family Services, the state Medicaid authority). The very small amount of hospital Medicaid medications are covered in an all-inclusive rate.

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

Oklahoma: A portion of DSH funds received in FY 2002 reverted to the State Department of Mental Health and Substance Abuse Services, not all of which were expended in FY 2002.

Oregon: There are no state medical expenses through the State Mental Health Authority. All medical expenses are paid through the Oregon Health Plan.

Pennsylvania: FY 2002 State Mental Health Agency Controlled Mental Health Expenditures include MH/MA Capitation & FFS

Rhode Island: Please note that the DSH amount reported in 2001 was overstated.

South Carolina: None

South Dakota: South Dakota's SMHA does not actually receive general fund revenues into their department the actual expenses that we incur from the State's general fund budget are simply covered by the State Treasury to the amount / limit of our general fund expenditure authority.

Tennessee: "Community Mental Health Programs", "Medicaid $ including state match", through TennCare Partners, spent a total $384.2 million on all types of psychotropic drugs during FY 2001-2002. The breakout for "Atypical Antipsychotics" is not available.

Texas: There may be some Medicaid federal expended for Atypical or other drugs. It is not possible to determine the Medicaid portion for the Facility drug expenditures.

Utah: The State Mental Health Agency in Utah is not the State Medicaid agency. To make Utah information more comparable with information from other states, Medicaid funds "not controlled by the SMHA" but expended for mental health clients at Utah public mental health centers were included on revenue and expenditure for FY 2001 and FY 2002.

Vermont: None

Virginia: None

Washington: Other Community Based Programs include programs provided to clients, which are not treatments (examples included are transportations, family supports, parental support, training, etc.) Data is not separated into the given forensic categories for FY 2002 State Mental Health Agency State Hospital Expenditures by Priority Groups inquiry. FY 2001 Children's MH Services expenditures include community expenditures for unknown age of $46,321,043.

West Virginia: Some of the expenditures were classified differently in FY 2002 than in FY 2001. For example, DSH is reported differently. Also, in FY 2002 a contract with Medicaid was not renewed - which caused a reduction in administrative expenditures.

Wisconsin: Amounts for Community-based Programs and Administration are for Calendar Year 2002. Due to budgeting methodology for State-County contracts, Wisconsin cannot accurately allocate funds the Counties budget to specific target populations. Services for Forensic patients and Sexually Violent Predators are not part of the County-administered mental health system.

Wyoming: None

GLOSSARY

Funding Sources and Expenditures of State Mental Health Agencies: Fiscal Year 2002

Inquiries and/or questions should be directed to:

Robert Shaw, M.A.
NASMHPD Research Institute, Inc.
66 Canal Center Plaza, Suite 302
Alexandria, VA 22314
Phone: (703) 739-9333 ext. 124
Fax: (703) 548-9517
Email: robert.shaw@nri-inc.org

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INTRODUCTION

This Fiscal Year 2002 Revenue/Expenditure Study is the ninth in a series that now includes information on State Mental Health Agency (SMHA) expenditures and revenues for FY'81, FY'83, FY'85, FY'87, FY'90, FY’93, FY’97 and FY’01. This Glossary includes instructions and definitions to help States in completing the tables.

This study will provide a comprehensive database of comparable information about the SMHAs that the NASMHPD Research Institute (NRI) and States can utilize for national policy making, local and state planning, and advocacy. The data will be used by NRI and by the SMHA Profiling System as a basis for the financial component, by a group of mental health services researchers working with NRI to help us better understand the funding of public mental health systems, and by individual states to assist in their own legislative budget process. The data will also fulfill the requirements for Table 7 of the Center for Mental Health Services Uniform Reporting System.

Tables 1 through 5 depict the mental health expenditures (Table 1) and revenues (Table 2) that are under the control of the SMHA. These funds include all State general funds to the SMHA, the federal mental health block grant, local funds when required to match State dollars, and other funds that the SMHA controls as well as the total expenditures and revenues of the community mental health system.

Edit Checks have been built into the Excel file to help you review the data prior to submission. A few data items from the FY 2001 study have been included that compare the FY 2001 and FY 2002 data.

Changes to the Tables: A Commissioners’ Advisory Group met and reviewed the study process and data compilation tables. They made the following recommendations:

1. Simplify and reduce the number of tables compiled. We have significantly reduced the burden of data compilation required by the states in this iteration of the study. The only Table remaining unchanged is Table 2.

2. **Please report data rounded to the nearest $100,000.** Since the report is documenting expenditures of over $23.billion, the advisory group recommends data be reported rounded to the nearest hundred thousand dollars rather than the exact dollar. For example, report Hospital Inpatient Expenditures for Adults of $74,321,200,000 instead of $74,321,219,274.43.

3. The Advisory Group to the project has recommended that the NRI now require that the final data tables be signed by the commissioner after all edits have been made.

Study Process
Each State should complete the attached tables as completely as possible. Computer spreadsheet templates are included on enclosed diskettes in Microsoft Excel format. You may use these to enter data or use the attached paper forms and return them to the NASMHPD Research Institute. If you use the Excel diskettes, you can e-mail your completed data directly to the NRI at robert.shaw@nri-inc.org.

Please review your data before returning it to the NRI. After each State has submitted its data, the NRI will enter the data into the computer and run data edits. All errors and unresolved issues will be followed up with the State. A draft report depicting your data and information from all other States will be sent back to you for your State's review and commissioner's signature of approval before NRI issues the final report. Two copies of the final report will be sent to each Sate, one to the SMHA Director, and one to the State contact person for this project.

Footnotes
Please provide footnotes as necessary. Footnotes should document the source of the figures reported in this survey. They will be a useful reference if questions arise about the data requiring assessment of the reported figures. Sample footnotes are provided at the back of this Glossary.

GLOSSARY OF TERMS

Data reported on the Tables should include expenditures/revenues for **mental health only.** Expenditures for mental retardation/developmental disabilities, alcohol abuse, or drug abuse programs should **NOT** be included. **If the SMHA has earmarked funds for dual diagnosis services, they should be included.**

Age group breakdowns are:

Children/Adolescents	through 17 years
Adult/Elderly	age 18 and older
Age unknown	please use this category only if you cannot break out expenditures by any age group distinctions.

Note: If exact expenditures are not available by these age categories, please estimate how the expenditures would have been spent based on your client caseload statistics. If you must report estimated age group expenditures, please so note on the tables. Please only use the "Age Unknown" column (Table 1) as a last resort if you are unable to either report actual age group related expenditures or to estimate age group expenditures.

FISCAL YEAR is your State's fiscal year that ended in that calendar year. For example, for most states, Fiscal Year 2002 ended on either June 30, 2002 or September 30, 2002.

If you are unable to depict expenditures for a category where services were provided, a "NA" should be used in the tables to show that "services are provided, but that exact expenditures (or revenues) are not allocatable.

A zero ($0) should be used in the tables to show no expenditures or revenues in that category.

Capital Improvement expenditures and/or revenues to be used for capital improvements should not be included.

Fringe Benefit costs associated with State Mental Health Agency employees should be included, even if they are paid by another State agency. Please note this with a footnote. For example, if a State Department of Administration actually pays for employee fringe benefits, and these fringe benefits are 20% of salaries, please increase the SMHA expenditures by the fringe benefit rate (a 20% increase in personnel costs).

TABLE SHELLS FOR DOCUMENTING SMHA REVENUES AND EXPENDITURES

TABLE 1: SMHA-CONTROLLED MENTAL HEALTH EXPENDITURES

All mental health expenditures controlled by the SMHA are depicted in this table. The glossary provides definitions of each item. Expenditures for mental retardation/developmental disabilities, alcohol abuse, or drug abuse programs are not to be included on this table.

TABLE 2: SMHA-CONTROLLED MENTAL HEALTH REVENUES

All funds received and controlled by the SMHA for mental health programs are depicted in this table. The glossary provides definitions to explain the allocations to the appropriate cells in the table. SMHA funds received and dedicated to MR/DD, alcohol abuse, or drug abuse services should not be included.

Include all funds that the State receives due to services provided by SMHA operated programs. Thus, Medicaid, Medicare, and First/Third Party funds collected by the State for services provided at the SMHA **should be depicted** even if the funds revert directly to the state General Fund.

TABLE 3: STATE MENTAL HEALTH AGENCY STATE HOSPITAL EXPENDITURES BY PRIORITY GROUPS

Table 3 compiles additional data on expenditures in state psychiatric hospitals reported on Table 1 for various priority populations that many SMHAs are serving. Categories to report include forensic clients, sexually violent predators, pre-trial evaluations, and civil commitments.

TABLE 4: SMHA EXPENDITURES FOR PHARMACY

Table 4 compiles information on the expenditures by states for the atypical anti-psychotic medications and total pharmacy expenditures.

TABLE 5: DISPROPORTIONATE SHARE MEDICAID

Table 5 compiles information about Disproportionate Share Medicaid Revenues received for care provided at State psychiatric hospitals.

EDIT CHECKS: The "Edit Checks" worksheet lists some data edits that will help you review data prior to submission. Please reconcile edits before sending the data to NRI.

TABLE 1: FISCAL YEAR 2002 SMHA-CONTROLLED MENTAL HEALTH EXPENDITURES

STATE PSYCHIATRIC HOSPITALS

This category includes all SMHA funded-and-operated organizations operated as hospitals that provide primarily inpatient care to mentally ill persons from a specific geographical area and/or statewide. These hospitals may provide a variety of treatment and rehabilitative services. They may be designated as "mental health institutes," "centers," "State hospitals" "State forensic hospitals," "State psychiatric centers," or similar titles. A State operated community mental health center that operates inpatient beds should only be included if the center is licensed by the State as a hospital (otherwise, it should be included in community-based programs).

Only expenditures for inpatient, other residential and less than 24-hour care services that occur on a state hospital campus should be reported. All mental health services that are provided off the hospital grounds should be reported as part of the "SMHA Community-Based Programs" section on Tables 1 and 2.

Less than 24-hour care includes such services as: case management, partial care, and emergency services that are provided at a state hospital.

COMMUNITY-BASED PROGRAMS

This category includes services, programs, and activities provided in settings that are based in the community. These types of organizations include community mental health centers (CMHCs), outpatient clinics, partial care organizations, partial hospitalization programs, PACT programs, consumer run programs (including club houses and drop in centers), and all Community Support Programs (CSP). Include any services provided by state hospitals that are provided off the grounds of state hospitals.

Also county, city, general, and/or all other (non-State operated mental hospitals) hospitals that receive, either directly or indirectly, SMHA funds to provide inpatient, outpatient, residential, or other services, should also be reported as "SMHA-controlled community expenditures." These programs should be counted as community expenditures, even if the payments to such hospitals are made directly from the SMHA and do not pass through community-based programs (e.g., community mental health center, county level mental health board, clinic, etc.).

INPATIENT: Services offered and provided through a community-administered program to include diagnosis, treatment, and care to mentally ill individuals on a comprehensive 24-hour basis. Such services may be directly operated by the community-administered agency and/or such agency may, in turn, purchase inpatient services from another public or private agency or facility. Inpatient care may be offered in one or more of the following settings:

- Within the inpatient unit of a community mental health center or clinic.

- Via general medical/surgical beds within a public or private community-administered general hospital.

- By an established, organizationally separate, psychiatric unit, ward, or facility with assigned staff for inpatient care, operating within a public or private community-administered general hospital.

- A designated, public (including county and/or city mental hospital) or private "psychiatric hospital" in which the majority of the facility's resources are devoted to inpatient care of mentally ill persons.

OTHER 24 HOUR CARE: "Other 24 hour care" refers to a setting, other than hospital "inpatient" setting, that provides congregate overnight living. A variety of services along a continuum of living arrangements may be offered, ranging from basic room and board with minimal supervision through 24 hour medical, nursing, and/or intensive therapeutic programs. Activities include: diagnosis, treatment, and care to mentally ill individuals, either on a residential treatment or residential support services basis. "Residential treatment" is overnight care in conjunction with an intensive treatment program. "Residential support" is overnight care in conjunction with supervised living and other support services. Depending upon the nomenclature used in the State, residential settings may include, but may not be limited to, any and all of the following:

1. RESIDENTIAL TREATMENT**:**

SKILLED NURSING FACILITY (SNF): A residential facility offering services characteristic of the ICF with the addition of 24-hour, seven day per week nursing services required for complex patient medical conditions. These facilities usually have no fewer than one registered licensed nurse per 15 patients. Must have at least one or more medically-related health services such as physical services, physical, occupational or speech therapy, diagnostic and laboratory services, and/or medication.

INTERMEDIATE CARE FACILITY (ICF): A residential facility providing room, board, social and rehabilitative services, and nursing services to include treatment, medication, and counseling. One registered or licensed nurse per 40 patients is usually minimal

RESIDENTIAL TREATMENT CENTER FOR EMOTIONALLY DISTURBED CHILDREN: An organization that provides individually planned programs of mental health treatment services in conjunction with residential care for its patients/clients. It serves children and youth primarily under the age of 18.

2. HOUSING WITH SUPPORT SERVICES:

GROUP HOME: A residential facility providing post-institutional care or alternative to institutional care to include counseling, rehabilitation, supervised living, personal care, and other supportive services.

SUPPORTIVE LIVING FACILITY: A long-term residential facility that provides room, board, and possibly mental health care.

HALFWAY HOUSE: A residential facility providing short-term supervised living and/or care.

BOARD AND LODGING HOME/DOMICILIARY: Providing only room and board.

UNSUPERVISED AND SUPERVISED APARTMENTS: Providing only room and board; and/or minimal supervision.

LESS THAN 24 HOUR CARE:

This category includes outpatient, partial care, emergency, case management services, and prevention programs.

OUTPATIENT: Mental health services provided to clients on an hourly basis, on an individual or group basis, and usually in a clinic setting. Services such as screening, crisis intervention, outreach, and psychiatric treatment can be included. Outpatient services may be diagnostic, therapeutic, or adjunctive. Include expenditures for “wrap around” services here.

PARTIAL CARE/DAY TREATMENT: Structured programs of treatment, activity, or other mental health services provided in clusters of three or more hours per day. These programs are often called day treatment, partial hospitalization, psychosocial rehabilitation, or activity centers.

EMERGENCY: Programs that provide immediate and short-term services to cover patients experiencing psychiatric emergency or crisis situations. This covers telephone counseling, immediate services, and referral services

CASE MANAGEMENT: Functions as an outreach intervention for clients with the primary purpose of: a) assisting clients in accessing financial, housing, medical, employment, social, transportation, and other essential community resources; b) assisting community agencies in offering responsive services to the client population; c) assisting community agencies in offering responsive services to the client population; or d) mobilizing assistance from family, neighbors, and self-help groups on behalf of clients.

PREVENTION AND PROMOTION PROGRAMS: Mental health primary prevention programs are designed to directly reduce the incidence of mental disorders, the high-risk precursors of disorders; and the adverse consequences of high-risk precursors and/or early manifestations of the disorders themselves.

Prevention services may vary widely but are generally associated with primary and early intervention, secondary prevention, and/or tertiary prevention activities and may also include such promotion services as information, education, literature distribution, media campaigns, clearinghouse activities, speaker's bureaus, and school or peer group situations. These services may be directed at any portion of the population. No inpatient expenditures of any kind are to be included in this category.

ADMINISTRATION

> CENTRAL/REGIONAL OFFICE SUPPORT: Include expenditures for the administration of the SMHA including central and regional offices defined as SMHA activities that provide centralized policy direction and administrative management for all operational segments of the SMHA program. Functions usually include policy formulation, planning, budgeting, coordination, and evaluation. Supplemental/support activities may include fiscal administration, legal services, management information systems, purchasing, licensure, development of standards, and monitoring. SMHAs may operate from one central office or through a regional structure. Expenditures depicted herein will include the expenditures of the total central and/or regional structure.

The infrastructure of the SMHA may include separate administrative components for the planning, coordination, and development of community-administered programs, State psychiatric hospitals, and/or other programs. Expenditures for these SMHA divisions and/or components should be included in the total "SMHA Administration" figure.

RESEARCH/TRAINING: Include identifiable research activities funded and/or funded-and-conducted by the SMHA. Research activities may: a) constitute one or more components within a state psychiatric hospital(s), community program, or independent facility; b) comprise an entire program entity or facility (e.g., a Children's Psychiatric Research Institute); and/or c) be conducted at the SMHA central office.

Training refers to identifiable staff training and human resource development (HRD) activities or facilities funded and/or funded-and-operated by the SMHA. Training activities may: a) be conducted as part of the state hospital(s); within community-administered programs, or independently run through an SMHA regional or central office; and/or (b) comprise an entire program entity facility (e.g., a Mental Health Training Institute). Please include all funds from federal HRD grants as well as all state funds devoted towards training activities.

Only TOTALS are required for the "Administration" line items.

Note:

If the SMHA has earmarked funds for dual diagnosis services, they should be included in Table 1.

Table 1

State: ______________________

FY 2002 State Mental Health Agency Controlled Mental Health Expenditures (to the nearest $100,000)

Administrative Auspice	Service	*Under Age 18* Children	*Age 18 and Over* Adults	Any Age Unknown	*(all ages)* TOTAL
State Psychiatric Hospitals	Inpatient (Licensed Hospital beds)*				
	Other 24 Hour (Residential)				
	Less than 24 hour care (provided at the state hospital)				
	Subtotal				
SMHA-Controlled Expenditures of Community-Based Programs	Inpatient (Licensed Hospital beds)				
	Other 24 Hour (Residential)				
	Less than 24 hour care				
	Other/Unknown: (please describe)				
	Subtotal				
Administration	Central/regional office support				
	Research/Training				
	Subtotal				
GRAND TOTAL *					

** See Table 3 for a breakdown of these expenditures*

NA = Services provided but exact expenditures not available.

TABLE 2: FISCAL YEAR 2002 SMHA-CONTROLLED MENTAL HEALTH REVENUES

Revenues specifically dedicated to each of the three Administrative Auspice Types should be depicted on this table which will match revenue source with the type of setting in which these revenues are ultimately expended. These include:

- SMHA-Controlled revenues dedicated to state mental hospital programs;
- SMHA-Controlled revenues for Community-Based Programs; and
- SMHA-Controlled revenues dedicated to SMHA support activities of Research, Training, Prevention, and SMHA Administration.

STATE REVENUES: DEPICT ONLY STATE FUNDS THAT ARE RECEIVED BY OR CONTROLLED BY THE SMHA.

GENERAL APPROPRIATIONS: Funds provided directly to the SMHA by the state legislature.

OTHER STATE REVENUES: Includes any other funds from State sources other than the General Funds. These funds may include:

- SPECIAL REVENUES: Funds "dedicated" or "earmarked" for a specific purpose or objective and designated as such in SMHA revenue documents.
- INTERDEPARTMENTAL: Funds received by the SMHA from another State government agency or entity (via fund transfer, contract, memorandum of agreement).

STATE MEDICAID: Funds constituting the SMHA and local portion/share of the Federal-State Medicaid match formula.

****

FEDERAL REVENUES: DEPICT ONLY FEDERAL FUNDS THAT ARE ENABLED BY SMHA OPERATED PROGRAMS.

MEDICAID: Funds that constitute the Federal portion/share of the Federal-State Medicaid match formula and are received by SMHA operated organizations through the SMHA. Report all Medicaid received by the State for services provided at state mental hospitals, even if these funds revert directly to the State general revenue fund.

If the SMHA is responsible for Medicaid funding of community mental health services or if the SMHA operates community-based programs, please report these Medicaid funds in the Community-based Programs column. For SMHA-funded organizations, only report Medicaid funds on this table if they are SMHA-controlled. Otherwise, please report the Medicaid receipts of these programs on Table 5.

MEDICARE: Report all Medicare revenues paid to the state for SMHA-owned-and-operated mental health programs, even if these funds revert directly to the State general revenue fund and are not available for mental health programs. For SMHA-funded organizations, only report Medicare funds on this table if they flow through the SMHA. Otherwise, please report the Medicare receipts of these programs on Table 5.

SOCIAL SERVICES BLOCK GRANT: Includes Title XX program funds that go through the SMHA or are expended by SMHA-operated mental health organizations.

MH BLOCK GRANT: The Community Mental Health Services Block Grant received by the SMHA and passed on to community mental health programs.

OTHER SAMHSA: Funds received from the Center for Mental Health Services (CMHS), or the Substance Abuse and Mental Health Services Administration (SAMHSA), and the U.S. Department of Health and Human Services.

These funds include CSP, CASSP, HRD, PATH (homeless) grants and research and other demonstration grants from CMHS or SAMHSA.

OTHER FEDERAL: Funds from any and all other Federal sources not included above. This would include funds from the National Institute of Mental Health (NIMH), Education Programs such as P.L. 94-142 (funds received from the Federal "Education for all Handicapped Children Act" for mental health services, workers, and teachers in special education settings) and P.L. 89-313 (Federal tuition assistance funds for basic aid for children in mental institutions), the Veterans Department, the Indian Health Service, and other federal agencies.

****

LOCAL REVENUES:Funds from local jurisdictions, such as counties, parishes, cities, or multi-county agencies, provided through cash receipts, "in-kind," and/or match funds. Only list local funds that are required by the SMHA as a state match on Table 2. For Local Revenues that are not "SMHA-controlled" please report the funds on Table 5.

****

OTHER REVENUES

FIRST AND THIRD PARTY PAY

1st PARTY: revenues provided through direct payments made by the service recipient.

3rd PARTY: payment for service provided by a source that is neither the receiver nor provider of the service.

Report all First and Third Party funds generated by SMHA operated mental health organizations, even if the funds revert directly to the general treasury. For SMHA-funded organizations, report First and Third Party Funds if they are "Controlled by the SMHA." If the funds are received independent of the SMHA, then report these funds on Table 5.

OTHER REVENUES: Any and all other revenues not included above.

Table 2

State: ________________

FY 2002 State Mental Health Agency Controlled Mental Health Revenues

(to the nearest $100,000)

Revenue Source	Revenue Account	State Mental Hospital Programs	Revenues to Community Administered Programs	SMHA Support Activities	TOTAL
State Revenues	General				
	Other State				
	State Medicaid				
	Subtotal				
Federal Revenues	Medicaid				
	Medicare				
	Soc. Svcs. Block				
	MH Block Grant				
	Other SAMHSA				
	Other Federal				
	Subtotal				
Local Revenues					
Other Revenues	First Party				
	Third Party				
	Other Revenue				
	Subtotal				
GRAND TOTAL					

NA = Services provided but exact expenditures not available.

TABLE 3: FISCAL YEAR 2002 SMHA EXPENDITURES BY PRIORITY GROUPS

Table 3 compiles additional data on the mental health expenditures in state psychiatric hospitals reported on Tables 1 for some of the priority populations that SMHAs are serving. Categories include: forensic clients, sexually violent predators, and civil commitments. For each of these priority population groups, please use your SMHA's definition. If you have to estimate the expenditures, please note on the table that these figures are estimates.

Totals from this table must match the total inpatient expenditures for state psychiatric hospitals found on Table, row 1.

Please include both children and adults.

FORENSIC SERVICES: Forensic services are related to: a) mental health support to state correctional system operations; b) mental health support to court system operations; and/or c) mental health support to local jail facilities. Specific forensic activities may include, but are not limited to: a) diagnosis of individuals placed in an inpatient unit for short-term psychiatric observation; b) provision of diagnostic and treatment support for correctional populations on an inpatient basis; providing security up to maximum levels; and provision of security staff in secure units for the rehabilitation and management of behaviorally problematic individuals.

> NGRI/GBMI: "Not guilty by reason of insanity" (NGRI) and/or "guilty but mentally ill" (GBMI) have been referred by legal and law enforcement agencies for emergency psychiatric evaluations; and persons who are to be evaluated for dangerousness. Provision of Forensic services may occur within any of the separate state mental hospital services, other hospital programs, community-based programs, and/or through the SMHA administrative offices.
>
> PRE-TRIAL EVALUATIONS: Evaluation for competency to stand trial and/or insanity at the time of trial.
>
> INCOMPETENT TO STAND TRIAL: Defendants who are being treated by the SMHA facility until they are found competent for their trial to proceed.
>
> TRANSFERS FROM CRIMINAL JUSTICE/JUVENILE JUSTICE: Services to adult or juvenile prisoners who have been transferred to the state hospital to receive services.

SEXUALLY VIOLENT PREDATORS: An increasing population in many state mental health systems is persons deemed to be "Sexually Violent Predators". These persons have been convicted of a sexual offence and been sent to the mental health system for treatment and control.

CIVIL COMMITMENTS: Admissions to a state psychiatric hospital, either voluntarily or involuntarily that does not involve the court system.

Table 3

State: ________________________

FY 2002 State Mental Health Agency State Hospital Expenditures by Priority Groups

State Hospital Inpatient (include both children and adults)		Expenditures ($) to the nearest $100,000	Patient Days (#)
Forensic	NGRI/GBMI		
	Pre-Trial Evaluations		
	Incompetent to stand trial		
	Transfers from Criminal Justice/Juvenile Justice		
	Subtotal		
Sexually Violent Predators			
Civil (Voluntary and involuntary)	Children		
	Adults		
	Subtotal		
GRAND TOTAL *			

* Total should match total inpatient expenditures on Table 1

NA = Services provided but exact expenditures not available.

TABLE 4: SMHA EXPENDITURES FOR PSYCHIATRIC MEDICATIONS AND "ATYPICAL" ANTIPSYCHOTICS

Table 4 compiles information on the expenditures by states for "atypical" anti-psychotic medications. The Atypical Medications that should be included are: clozaril, olanzapine, risperidone, quietapine, and ziprasidone.

TABLE 5: DISPROPORTIONATE SHARE1TABLE 8MEDICAID DISPROPORTIONATE SHARE MEDICAID

Table 5 shows Medicaid Disproportionate Share payments received by the State for mental health services provided by SMHA programs.

Table 4

State: ____________

FY 2002 Expenditures for Psychiatric Medications and "Atypical" Antipsychotics (to the nearest $100,000)

	State Psychiatric Hospitals		Community Mental Health Programs		TOTAL
	Medicaid $ including state match	Other state funds	Medicaid $ including state match	Other state funds	
Atypical Antipsychotics					
All Other Medications					
TOTAL PHARMACY					

NA = Services provided but exact expenditures not available.

Table 5

FY 2002 Disproportionate Share Medicaid (to the nearest $100,000)

How much Disproportionate Share Medicaid was received by the State for care provided by State Psychiatric Hospitals?

Federal Share	
State Match	
Total DSH	

Were these DSH Funds reported on Tables 1 & 2 above? ___ Yes ___ No

SAMPLE FOOTNOTES

STATE OF: "SAMPLE"

FY 2002 SMHA CONTROLLED MENTAL HEALTH EXPENDITURES TABLE 1

SERVICE	FACILITY/PROGRAM PAGE IN	AMOUNT STATE REPT.	
STATE MENTAL HOSPITAL PROGRAMS: $40,994,695			
Inpatient Adult	Morrisville Children's Center	$10,700,000	A16
	Holly Oak Psychiatric Hospital	8,500,000	B39
	Manor Garden Psychiatric Center	7,900,000	B42
Inpatient Child/Adol.	Children=s Unit at Holly Oak 3,5700000	B41	
Other 24 Hour – Residential- Adult	SNF: Holly Oak	4,600,000	A57
	SNF: Manor Garden	6,900,000	A52
Other 24 Hour – Residential- Child/Adol.	Group homes at Holly Oak and Manor Garden	900,000	A66
Partial Hosp.- Child/Adol.	Holly Oak Outpatient Clinic	100,000	A57
Partial Hosp.- Adult	Manor Garden Outpatient Clinic	300,000	A58
Partial Hosp.- Child/Adol.	Holly Oak Child Case Mgmt.	100,000	B105
Partial Hosp.- Adult	Manor Garden Case Mgmt.	200,000	B107

SMHA-CONTROLLED EXPENDITURES OF COMMUNITY-BASED PROGRAMS: $31,200,000

Service	Provider	Amount	Code
24 hour care-			
Child/Adol.	Oakland County CMHC	600,000	A93
24 hour care-			
Adult	Oakland County CMHC	2,300,000	A93
24 hour care-			
	Jane Adams Outpatient Clinic	330,000	A94
Child/Adol.	Oakland County CMHC	600,000	A94
24 hour care-			
	Jane Adams Outpatient Clinic	900,000	A97
Adult	Oakland County CMHC	600,000	A97
	Leeland Group Homes, Inc.	700,000	A97
<24 hour	Jane Adams Outpatient Clinic	1,000,000	A89
Child/Adol.	Oakland County CMHC	1,100,000	A89
	Center For Well Being, Inc.	1,400,000	A89
<24 hour -	Jane Adams Outpatient Clinic	2,000,000	A90
Adult	Oakland County CMHC	2,200,000	A90
	Center For Well Being, Inc.	1,400,000	A90
	Jane Adams Outpatient Clinic	1,100,000	A97
	Oakland County CMHC	1,300,000	A97
	Center For Well Being, Inc.	600,000	A97
<24 hour.-	Jane Adams Outpatient Clinic	500,000	A89
Child/Adol.	Oakland County CMHC	500,000	A89
	Center For Well Being, Inc.	200,000	A89
<24 hour.-	Jane Adams Outpatient Clinic	2,000,000	A90
Adult	Oakland County CMHC	1,200,000	A90
	Center For Well Being, Inc.	400,000	A90
	Jane Adams Outpatient Clinic	100,000	A97
	Oakland County CMHC	1,000,000	A97
<24 hour -			
Child/Adol.	Oakland County CMHC	100,000	A89
<24 hour -	Jane Adams Outpatient Clinic	500,000	A90
Adult	Oakland County CMHC	300,000	A90
<24 hour -	Jane Adams Outpatient Clinic	400,000	A89

Child/Adol.	Oakland County CMHC	300,000	A89
	Center For Well Being, Inc.	100,000	A89
<24 hour - Adult	Jane Adams Outpatient Clinic	1,000,000	A97
	Oakland County CMHC	1,000,000	A97
	Center For Well Being, Inc.	200,000	A97
<24 hour - Child/Adol.	Contract to Hillbrook, Inc.	45,000	A88

ADMINISTRATION: $3,700,000

SMHA Administration-	Central Office Budget	2,900,000	A12
Research-	Research Center on Serious Mental Illness	600,000	B44
Training-	Manpower Dev./Training Grant	200,000	B47

BUDGET DOCUMENTS:

A = "FY'02 Department of Mental Health Annual Expenditures", 2002.
B = "Cost-Finding in State Hospitals" (Internal working paper, Dept of MH).