National Association of State Mental Health Program Directors
66 Canal Center Plaza, Suite 302
Alexandria, Virginia 22314

Assessment #10

Expenditures

October 1, 2014

This work was developed under Task 2.1.1. of NASMHPD's Technical Assistance Coalition contract/task order, HHSS28342001T and funded by the Center for Mental Health Services/Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services through the National Association of State Mental Health Program Directors.

State Mental Health Agency-Controlled Expenditures for Mental Health Services, State Fiscal Year 2013

Prepared by the NASMHPD Research Institute, Inc., in partnership with the National Association of State Mental Health Program Directors, Inc.

September 26, 2014

Acknowledgements

This work was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) under contract HHSS283201200021I, Task HHSS28342001T, Reference 283-12-2101; and the National Association of State Mental Health Program Directors (NASMHPD), Inc. under Subcontract Number SC-1060-NRI-01.

The authors of this report are Kristin Neylon, Robert Shaw, and Ted Lutterman of the National Association of State Mental Health Program Directors Research Institute (NRI), Inc.

For questions or additional information about the content of this report, please contact the authors at:

NRI
3141 Fairview Park Drive, Suite 650
Falls Church, VA 22042
Phone: 703-738-8160
Email: NRI@nri-inc.org
http://www.nri-inc.org

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Executive Summary

In Fiscal Year 2013 (ending June 30, 2013 for most states), SMHA-controlled expenditures for mental health services and related expenses totaled more than $39.5 billion for the 50 states, the District of Columbia, and Puerto Rico. These expenditures were devoted to providing mental health services in state psychiatric hospitals (25.7% of total expenditures); community-based mental health programs (72.1% of total expenditures); and the administration, training, and research and evaluation of these systems (2.2% of total expenditures). On average, SMHAs expended $124.39 per civilian resident of the United States, with median per capita expenditures of $99.84.

The majority of SMHAs dedicate most of their funding to providing services in community settings; only eight SMHAs (Arkansas, the District of Columbia, Idaho, Kentucky, Louisiana, Mississippi, South Dakota, and Wyoming) spent more on state psychiatric hospital inpatient services than on community-based programs in FY 2013. On average, SMHAs spend 72.1% of their budget, or $89.71 per capita, on community programs, compared to 25.7% of their budget, or $32.00 per capita, on state psychiatric hospital services.

SMHAs expended nearly $24.3 billion (61% of total expenditures) on mental health services for persons aged 18 and older, and nearly $9.6 billion (24% of total expenditures) on mental health services for children aged 0 to 17. Approximately $5.7 billion of SMHA expenditures were not allocated to specific age groups because the SMHA was unable to break out expenditures by age group, or they were dedicated to SMHA administrative, research, training, or other activities not specific to age groups.

SMHAs are also responsible for providing services to forensic patients at state psychiatric hospitals. Forty-five SMHAs reported expending $3.5 billion in FY 2013 on forensic services, an average of $11.04 per capita. Fourteen SMHAs also provided expenditures data on services for sexually violent predators at state psychiatric hospitals; services to this population totaled nearly $546 million in FY 2013, an average of $2.61 per capita.

A variety of factors appear to influence how SMHAs expend funds to provide services, including the location of the SMHA within state government; the organizational distance between the SMHA commissioner and the governor; how SMHAs organize and fund mental health services; and the type of legal action in which the SMHA is involved, if any. SMHAs that are independent departments within the state government spend more per capita ($132.02) than those SMHAs that are under an umbrella agency ($113.03). SMHAs with one level between the commissioner and the governor spend significantly more per capita ($158.07) than those SMHAs whose commissioners report directly to the governor ($107.89). SMHAs that operate county or city-based systems have the highest per-capita expenditures ($147.92) compared to those that operate ($89.41) or fund ($103.14) community-based services. SMHAs that fund services through exclusive fee-for-service payment models spend the most per capita, at $153.27 per person, compared to those that exclusively use managed care ($135.02), and those using a combination of fee-for-service and managed care approach ($114.87). In general, SMHAs involved in legal action (including Class Action Lawsuits, Civil Rights of Institutionalized Persons Investigations, and *Olmstead* Investigations) expend more ($148.10 per capita) than those SMHAs not

involved in legal action ($104.94 per capita); however, expenditures vary significantly based on the type of legal action in which the SMHA is involved.

Since 1981, SMHA expenditures have grown at an annualized rate of 1.7% per year in state psychiatric hospitals, and much faster at 7.6% per year for community-based services. However, when accounting for inflation, SMHAs experienced a negative annualized growth rate of 0.3% between FY 1981 and FY 2013. During this time, the only setting to realize an increase in expenditures is community-based services with a total increase of 2.3%. Expenditures for state psychiatric hospital inpatient services decreased 3.3% over this time, and funding for administrative services declined 2.2%.

Introduction

With the passage of the 2010 Patient Protection and Affordable Care Act (ACA), and the 2008 Mental Health Parity and Addiction Equity Act (MHPAEA), persons with mental illnesses have a greater opportunity to have mental health treatment services reimbursed by public (Medicaid) or private health insurance. Additionally, the MHPAEA and ACA increase demand for the integration and coordination of behavioral and physical health services through the promotion of new service and finance delivery systems, including Health Homes, Accountable Care Organizations, and Dual Eligibility Demonstration Programs. These two new Acts have great potential for changing the financing of services provided by public mental health systems. Given the implementation of the MHPAEA and the ACA, as well as these new potential funding sources for mental health services, Fiscal Year 2013 is an important baseline in public mental health system financing to assess future changes and trends.

SMHAs are the single state government agency responsible for planning and operating state public mental health systems. Each SMHA is unique in how it is structured within the state government and how it organizes, funds, and delivers mental health services. Despite these differences, SMHAs are similar in the types of services they are responsible for providing; how they collaborate with federal, state, and local government agencies to plan for, provide, and ensure the quality of mental health services; and in their role as the public health entity that promotes positive mental health, works to prevent suicides, and achieves early identification and treatment of mental illnesses.

All SMHAs are responsible for ensuring their state's citizens receive appropriate mental health care across a continuum of settings. As part of this responsibility, all SMHAs operate inpatient psychiatric beds for consumers with acute needs who may pose a threat to themselves or others. Most SMHAs are also responsible for the provision and coordination of services to individuals who require forensic mental health services, including those found incompetent to stand trial, guilty by reason of insanity, and guilty but mentally ill, as well as sex offenders and sexually violent predators. SMHAs also ensure that consumers have access to mental health services in their community. While some SMHAs directly administer services, SMHAs most often contract with not-for-profit mental health providers to deliver community-based services; however, it is also common among more heavily-populated states to contract with county or city governments which are then responsible for service delivery in their local areas.

SMHAs collaborate with federal, state, and local agencies to strategize and ensure the highest quality of care for their state's mental health consumers. As part of the federal government's annual Community Mental Health Services Block Grant Plan, SMHAs must plan and develop a comprehensive system of community-based mental health services that are based in research. SMHAs also collaborate with other government agencies to ensure that persons with mental illnesses receive the appropriate services to meet their needs, including health care, mental health treatment, and other related support services (e.g., housing and employment). To measure outcomes and monitor system performance, one of the SMHAs' main priorities is to collect data on the provision of services. The overall goal of this effort is to improve the quality of public mental health services offered by the SMHA.

Another similarity among SMHAs is their role in reducing stigma and informing the public about mental health. SMHAs publish and disseminate information about risks associated with mental health, suicide prevention, and provide access to additional resources for people to seek information and assistance.

State governments have funded and operated mental health services since the founding of the United States; the first psychiatric hospital, Eastern State Hospital in Virginia, was opened by the Virginia Colonial government in 1773. Until the second half of the twentieth century, state mental health systems were almost entirely institutional; state psychiatric hospitals treated more than 500,000 persons in 1950. More recently, states have drastically shifted their focus from providing inpatient services in state psychiatric hospitals, to providing community-based mental health services. State psychiatric hospitals are now primarily used as a safety net for persons who need intensive services in an inpatient setting.

In FY 1981, SMHAs expended $6.1 billion to provide mental health services. Sixty-three percent of these funds were devoted to providing inpatient services in state psychiatric hospitals. By FY 2001, total SMHA expenditures for mental health had grown to $23 billion and SMHAs had shifted most of their funding to the provision of community mental health services (66% of funds for community services, and only 32% for state psychiatric hospital inpatient services). By FY 2013, SMHA expenditures for mental health had grown to an estimated $39.4 billion, and expenditures continued to shift away from psychiatric hospital inpatient services (25.7% of expenditures) toward services provided in the community (72.1% of expenditures).

Methodology

The findings of this report are drawn primarily from the National Association of State Mental Health Program Directors Research Institute's (NRI) FY 2013 SMHA-Controlled Revenues and Expenditures Study (NRI, 2014), with supplemental data derived from prior years of the same study. Data from prior years allow for the identification of trends among SMHA's financing operations. Data for 52 SMHAs are included in this report (all 50 states, plus the District of Columbia and Puerto Rico). As of the writing of this report (September 26, 2014), four SMHAs had not completed their submission of FY 2013 data (California, Florida, New Mexico, and New York). When available and applicable, 2012 data from each of these states are used in lieu of 2013 data. To provide context to the Expenditures data, information from the U.S. Census Bureau's about state populations; and NRI's 2013 State Profiling System about the organization, structure, and policies of SMHAs are also included.

Since 1981, NRI has collaborated with SMHAs from all 50 states and the District of Columbia to document major revenues and expenditures associated with the delivery of public mental health services. The partnership NRI has established with each SMHA is particularly important for conducting this study. Any project seeking to account for billions of dollars could not achieve an accurate portrayal of such funds in the absence of dialogue between NRI project staff and SMHA contacts. This dialogue, conducted via email and telephone, serves to ensure the data received from the SMHAs are accurate and complete. A complete list of SMHA project staff that contributed to the FY 2013 SMHA-Controlled Revenues and Expenditures Study can be found in Appendix A.

The methodology for this effort is predicated on compiling actual, rather than estimated or appropriated, revenues and expenditures under the direct control of SMHAs. The depiction of actual figures is considered necessary for reporting valid and reliable data. Without reference to specific reports that indicate actual expenditures, it is nearly impossible to verify figures or have an accessible database for follow-up analysis.

The funding sources SMHAs directly control include state general funds, state special appropriations, federal mental health block grant funds, Medicaid and Medicare revenues to SMHA-operated or funded programs, other federal funds (such as research and demonstration grants), state-required local government match funds, and various first and third-party funds.

The database that comprises the foundation for this study is based on the development and completion of four Microsoft Excel table shells (Appendix B). Based on figures recorded in each SMHA's archival database, dollar amounts reflecting revenues and expenditures are used to complete each cell in the tables. A glossary that provides uniform definitions of terms and reporting guidance was provided as a reference to states (Appendix C).

Table Shell 1 compiles information about SMHA-controlled mental health expenditures. Expenditures are divided into three categories:

1. State psychiatric hospitals funded and operated by the SMHA
2. Community-based programs that are either directly funded or operated by the SMHA

3. SMHA support activities, including SMHA funding for research, training, prevention programs operated and/or funded by the SMHA, and administrative expenses for the SMHA central office and/or regional units.

Each program category is also divided into several subcategories to capture expenditures on the types of services or activities. These subcategories gather expenditures on inpatient services (licensed hospital beds), other 24-hour care (residential), less than 24-hour care, other or unknown services, central/regional office support, and research and training services. Additionally, expenditures are delineated according to two primary age groups: children and adolescents under age 18, and adults age 18 and over. A section for individuals whose age is unknown is also included.

Table Shell 2 compiles information on revenues received by the SMHA to deliver programs and services that are operated and/or funded by the SMHA, and for which the SMHA has complete administrative control. Revenues of organizations partially funded by the SMHA are not reflected in this table; therefore, the table does not depict revenues for contracted local community mental health centers, county or multi-county mental health and intellectual disability service boards, other local clinics, and other entities, programs, services, or facilities not directly operated by the SMHA.

Revenues are divided into four primary sources: state, federal, local, and other. Each primary source, with the exception of local revenues, is divided into several subcategories to specifically identify the funding source. State revenues are divided into general funds, other state funds, and state Medicaid funds. Federal revenues are divided into Medicaid, Medicare, Social Services Block Grant, Mental Health Block Grant, other SAMHSA funds, and other federal funds. Other revenues are divided into first party, third party, and other.

Table Shell 3 compiles information on the amount of Medicaid Disproportionate Share Funds received by the state for services provided at state psychiatric hospitals.

Table Shell 4 collects data on SMHA expenditures by priority groups at state psychiatric hospitals, including children and adults. The priority groups are composed of forensic patients, sexually violent predators, and voluntary and involuntary (civil) commitments for children and adults. Information about expenditures and the number of patient days for each priority group is collected to determine the cost-per-patient day the SMHA spends on each group.

This study relies on two primary means for accumulating and depicting data: 1) analysis and coding of state revenue and expenditure data, and 2) follow-up discussions with appropriate SMHA officials to verify and clarify figures provided in the tables. The process for obtaining final figures is as follows:

- SMHA staff are contacted and requested to complete each of the four tables distributed by NRI. SMHAs then return the completed tables to their designated NRI project staff member.
- Upon receipt of each SMHA's completed tables, NRI staff members upload the data into a central Revenues and Expenditures database and run quality edit checks. During this process, all errors and data quality issues are identified and an edit report is prepared.

- If no issues are found and data are complete, the SMHAs are notified that they have successfully completed the data submission process. However, if errors are present or unresolved data quality issues exist, the SMHA is sent an edit report that requests the state reevaluate their data and make the appropriate corrections. This process continues until all errors or unresolved issues are addressed.

SMHA-controlled expenditures are compared with SMHA-controlled revenues for mental health services. Expenditures are not required to precisely align with revenues since SMHAs may have carryover funds from year to year, as well as reimbursements that may lag into the following year. During the data edit process, states with large variations between expenditures and revenues are asked to review and verify any differences.

Population data are calculated using information from the U.S. Census Bureau. This report follows the lead of SAMHSA's Center for Mental Health Services and the National Institutes of Mental Health, and uses civilian population estimates that exclude persons serving in the armed forces. The primary reason service members are excluded is because they are more likely to receive services through the Department of Veterans Affairs, or through their particular branch of the armed forces.

When analysis is conducted by geographic region, regions are divided based on the Department of Health and Human Services' ten regions[1]:

1. Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont
2. New Jersey, New York, Puerto Rico, and the Virgin Islands
3. Delaware, the District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia
4. Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee
5. Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin
6. Arkansas, Louisiana, New Mexico, Oklahoma, and Texas
7. Iowa, Kansas, Missouri, and Nebraska
8. Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming
9. Arizona, California, Hawaii, Nevada, American Samoa, the Commonwealth of the Northern Mariana Islands, the Federated States of Micronesia, Guam, the Marshall Islands, and the Republic of Palau
10. Alaska, Idaho, Oregon, and Washington.

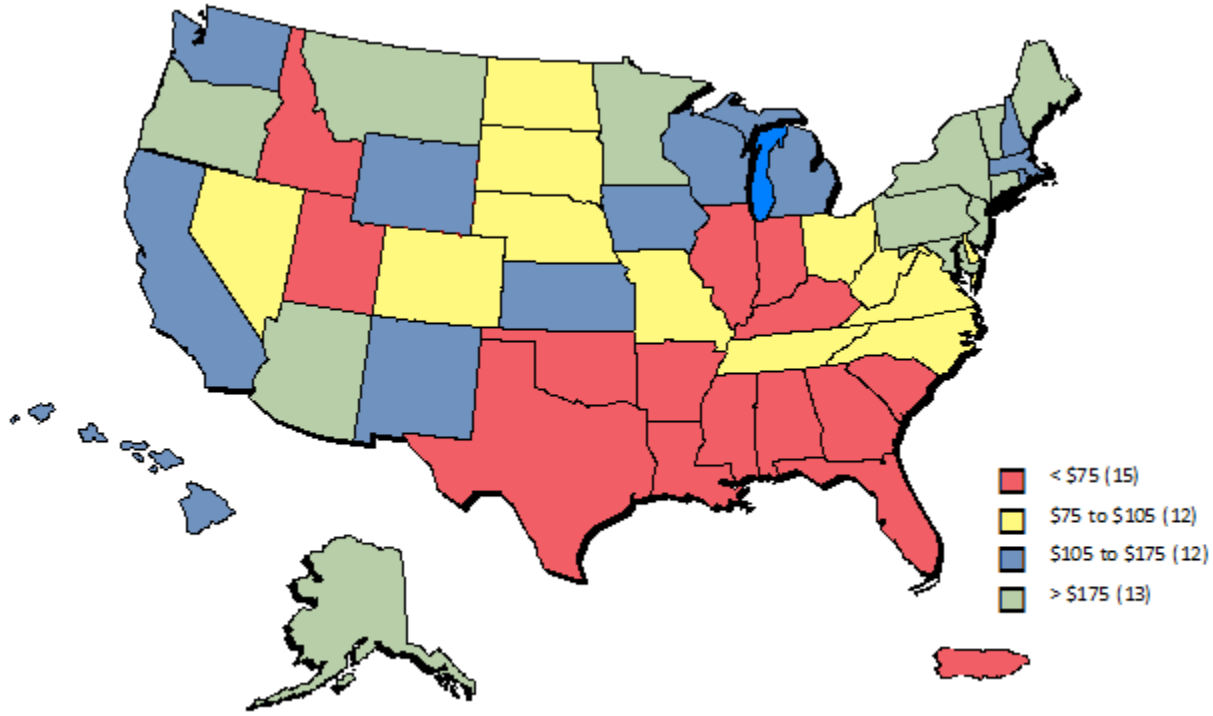
[1] U.S. Department of Health and Human Services. (2014). Office of Regional Operations: ACF Regional Offices. http://www.acf.hhs.gov/programs/oro

Results

SMHA Expenditures in Fiscal Year 2013

SMHAs administer and oversee funds from a variety of sources, including state, federal, and local sources, to finance public mental health services. In Fiscal Year 2013 (ending June 30, 2013 for most states), SMHA-controlled expenditures for mental health services and related expenses totaled more than $39.5 billion for the 50 states, the District of Columbia, and Puerto Rico. These expenditures were devoted to providing mental health care in state psychiatric hospitals ($10.2 billion, or 25.7% of total expenditures); community-based mental health programs ($28.5 billion, or 72.1% of total expenditures); and the administration, training, and research and evaluation of these systems ($850.2 million, or 2.2% of total expenditures). SMHAs expended $124.39 per civilian resident of the United States, with median per capita expenditures of $99.84. SMHA per capita expenditures varied from over $300 in Maine, Alaska, and the District of Columbia, to less than $50 in Arkansas, Florida*, Idaho, Texas, and Puerto Rico.

Figure 1: Total SMHA-Controlled Per-Capita Expenditures for Mental Health Services, FY'13



As Figure 1 shows, 2013 SMHA expenditures varied somewhat by region of the country, with states in the South (including the East South Central, South Atlantic, and West South Central HHS Regions) averaging lower levels of per capita expenditures than states in the Northeast and the West. States in the Midwest (East North Central and West South Central HHS Regions) were generally in the middle two quartiles of SMHA expenditures.

*2012 Revenues and Expenditures data

SMHA Expenditures by Program Type, FY 2013

The majority of SMHAs participating in this study applied more funds to community-based programs than to state psychiatric hospital services; only eight SMHAs (Arkansas, the District of Columbia, Idaho, Kentucky, Louisiana, Mississippi, South Dakota, and Wyoming) spent more on state psychiatric hospital inpatient services than on community-based programs in FY 2013. On average, SMHAs spend 72.1% of their budget, or $89.71 per capita, on community programs, compared to 25.7% of their budget, or $32.00 per capita, on state psychiatric hospital services. Prevention, research, training, and SMHA central office costs averaged slightly more than two percent of their funds, or $2.67 per capita. Table 1 provides a breakdown of expenditures for FY 2013 by program for each of the 10 HHS Geographic Regions.

Table 1: Per Capita SMHA Expenditures for Mental Health Services by Region of Country, FY'13

HHS Region	State Psychiatric Hospitals		Community-Based Programs		Prevention, Research, Training & Administrative		Total
	Per Capita	%	Per Capita	%	Per Capita	%	Per Capita
2 (NJ, NY*, PR)	$76.08	33.9%	$140.16	62.4%	$8.26	3.7%	$224.50
3 (DE, DC, MD, PA, VA, WV)	$37.34	19.0%	$155.17	79.0%	$3.87	2.0%	$196.39
9 (AZ, CA*, HI, NV)	$31.11	18.4%	$136.14	80.6%	$1.59	0.9%	$168.84
1 (CT, ME, MA, NH, RI, VT)	$31.02	18.5%	$130.44	77.7%	$6.41	3.8%	$167.87
10 (AK, ID, OR, WA)	$38.89	28.4%	$95.62	69.8%	$2.48	1.8%	$136.99
U.S. Average	*$32.00*	*25.7%*	*$89.71*	*72.1%*	*$2.67*	*2.2%*	*$124.39*
7 (IA, KS, MO, NE)	$32.87	29.1%	$78.22	69.2%	$2.00	1.8%	$113.09
5 (IL, IN, MI, MN, OH, WI)	$22.71	21.7%	$80.50	76.8%	$1.62	1.5%	$104.83
8 (CO, MT, ND, SD, UT, WY)	$26.67	26.5%	$73.06	72.5%	$1.01	1.0%	$100.73
4 (AL, FL*, GA, KY, MS, NC, SC, TN)	$23.79	38.5%	$36.74	59.4%	$1.31	2.1%	$61.84
6 (AR, LA, NM*, OK, TX)	$17.83	36.6%	$29.36	60.3%	$1.51	3.1%	$48.70

**2012 expenditure and population data used to calculate these states' expenditures.*

SMHAs in the West (HHS Region 9), Mid-Atlantic (HHS Region 3), and New England (HHS Region 1) regions had the highest percentage of expenditures for community mental health services in FY 2013, while SMHAs in the Southern regions (HHS Regions 4 and 6) had the highest percentage of expenditures dedicated to inpatient services in state psychiatric hospitals. Table 2 provides information on expenditures by state psychiatric hospitals, community mental health programs, and SMHA central offices, by state.

Table 2: SMHA-Controlled Expenditures by Type of Program (in Millions), FY'13

State	State Psychiatric Hospitals			Community-Based Programs			Prevention, Research, Training, & Administration			Total SMHA Expenditures		Notes
	Total	%	Rank	Total	%	Rank	Total	%	Rank	Total	Rank	
AL	$99.3	28%	26	$243.0	69%	29	$7.7	2%	26	$350.0	28	
AK	$31.7	13%	46	$204.6	84%	30	$6.3	3%	31	$242.6	33	
AZ	$68.7	5%	31	$1,269.2	94%	5	$17.9	1%	14	$1,355.8	5	
AR	$49.8	38%	37	$76.6	58%	43	$6.3	5%	32	$132.6	45	a
CA*	$1,316.8	20%	1	$5,065.5	79%	1	$45.1	1%	3	$6,427.4	1	ac
CO	$114.2	22%	24	$397.8	77%	20	$4.9	1%	34	$516.9	23	ab
CT	$184.1	24%	18	$542.7	70%	15	$50.9	7%	2	$777.7	14	ac
DE	$34.3	39%	45	$52.2	59%	46	$2.4	3%	40	$89.0	47	c
DC	$83.4	42%	30	$72.1	36%	45	$42.0	21%	4	$197.4	38	
FL*	$319.4	45%	8	$377.9	53%	24	$20.3	3%	12	$717.6	18	
GA	$210.4	36%	16	$378.7	64%	23	$0.0	0%	50	$589.1	21	b
HI	$59.8	33%	33	$111.1	62%	42	$7.9	4%	25	$178.8	41	
ID	$26.3	50%	49	$23.7	45%	52	$2.7	5%	38	$52.7	52	
IL	$237.5	26%	12	$671.2	72%	10	$22.2	2%	10	$930.9	12	
IN	$153.2	33%	19	$305.5	66%	26	$5.4	1%	33	$464.1	24	
IA	$41.3	9%	41	$394.2	90%	21	$4.3	1%	35	$439.8	26	
KS	$96.7	27%	28	$262.4	73%	27	$0.9	0%	46	$360.0	27	
KY	$116.3	48%	23	$113.6	47%	41	$11.0	5%	22	$240.9	34	
LA	$108.7	43%	25	$127.5	50%	37	$10.7	4%	23	$255.6	31	
ME	$46.9	10%	38	$399.9	87%	19	$11.5	3%	20	$458.3	25	b
MD	$240.0	23%	11	$784.2	74%	9	$31.0	3%	7	$1,055.2	9	b
MA	$91.7	12%	29	$625.1	85%	12	$21.0	3%	11	$737.8	16	a
MI	$250.6	19%	9	$1,029.9	80%	6	$6.4	0%	30	$1,286.9	6	
MN	$118.7	12%	22	$837.4	87%	8	$7.7	1%	27	$963.7	10	
MS	$128.5	77%	20	$34.7	21%	49	$3.2	2%	37	$166.4	44	a
MO	$245.6	41%	10	$332.5	56%	25	$20.0	3%	13	$598.8	20	
MT	$29.9	14%	48	$177.4	84%	31	$3.4	2%	36	$210.7	35	
NE	$45.1	27%	39	$119.5	72%	39	$2.5	2%	39	$167.1	43	
NV	$66.1	27%	32	$175.9	71%	32	$6.4	3%	29	$248.4	32	
NH	$54.1	30%	35	$127.0	69%	38	$1.9	1%	42	$183.0	39	
NJ	$551.9	30%	3	$1,279.8	69%	4	$25.4	1%	9	$1,857.2	4	
NM*	$24.3	9%	50	$248.1	91%	28	$0.0	0%	51	$272.4	30	
NY*	$1,296.9	25%	2	$3,732.3	71%	2	$239.2	5%	1	$5,268.4	2	b
NC	$319.9	34%	7	$614.1	65%	13	$11.6	1%	19	$945.6	11	
ND	$12.9	20%	51	$50.4	80%	47	$0.1	0%	49	$63.3	51	
OH	$215.5	19%	15	$902.6	78%	7	$41.3	4%	5	$1,159.4	7	a
OK	$40.9	20%	42	$150.8	74%	35	$11.3	6%	21	$203.0	37	
OR	$235.7	33%	13	$477.2	66%	16	$9.0	1%	24	$721.9	17	
PA	$349.1	10%	5	$3,304.5	90%	3	$12.9	0%	18	$3,666.5	3	a
PR	$31.1	45%	47	$37.7	55%	48	$0.0	0%	52	$68.8	50	
RI	$36.8	33%	43	$72.2	65%	44	$2.3	2%	41	$111.3	46	***
SC	$98.1	36%	27	$164.3	59%	34	$13.8	5%	17	$276.2	29	
SD	$43.2	61%	40	$27.0	38%	51	$0.6	1%	47	$70.8	48	
TN	$125.7	22%	21	$426.9	75%	18	$13.9	2%	16	$566.5	22	
TX	$387.5	36%	4	$650.4	61%	11	$32.0	3%	6	$1,069.9	8	b
UT	$53.5	26%	36	$150.5	73%	36	$1.2	1%	44	$205.2	36	b
VT	$11.1	6%	52	$165.0	90%	33	$6.5	4%	28	$182.6	40	
VA	$339.9	45%	6	$385.8	51%	22	$28.3	4%	8	$754.0	15	b
WA	$218.4	28%	14	$553.4	70%	14	$14.7	2%	15	$786.5	13	

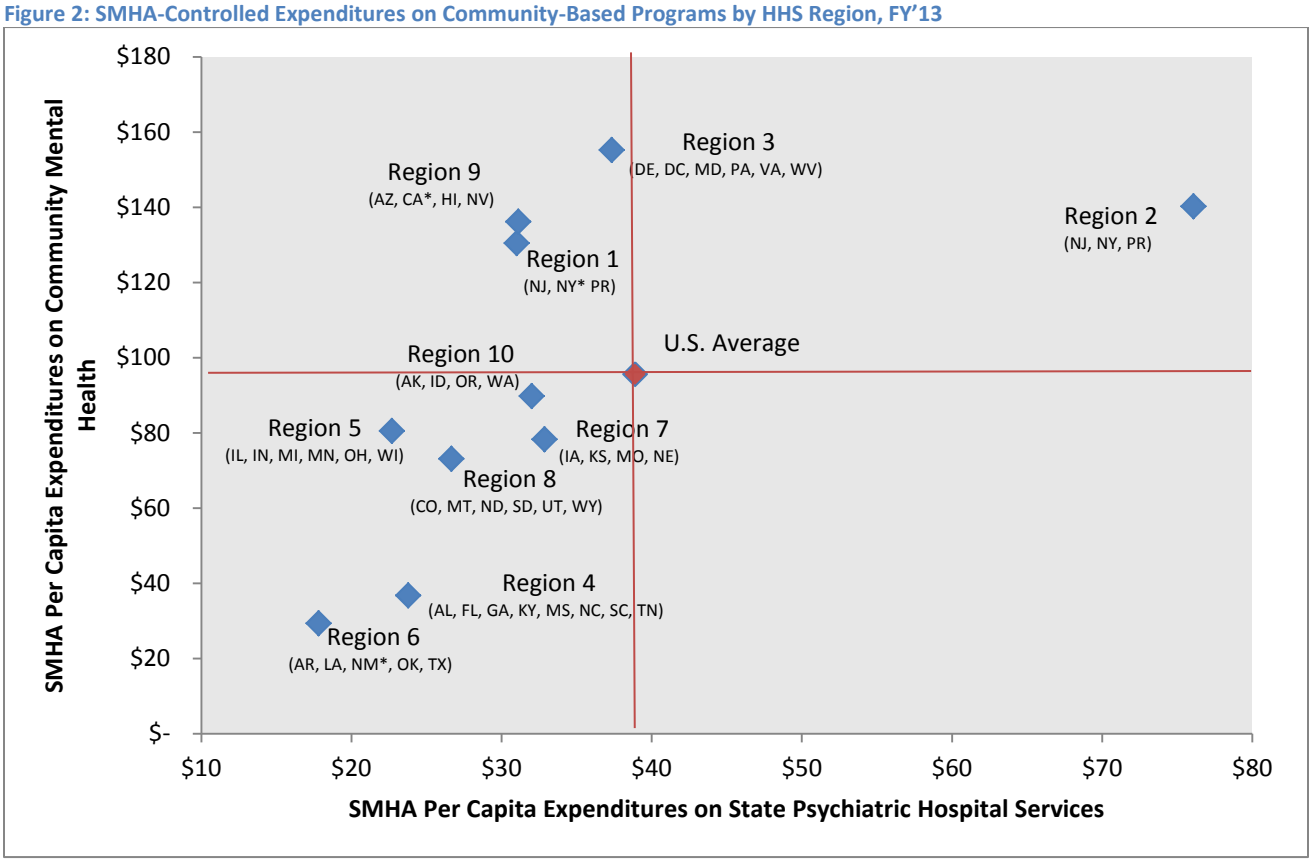
State	State Psychiatric Hospitals			Community-Based Programs			Prevention, Research, Training, & Administration			Total SMHA Expenditures		Notes
	Total	%	Rank	Total	%	Rank	Total	%	Rank	Total	Rank	
WV	$56.8	32%	34	$117.7	67%	40	$0.5	0%	48	$175.0	42	a
WI	$201.2	31%	17	$446.4	69%	17	$1.3	0%	43	$648.9	19	b
WY	$36.3	53%	44	$31.4	46%	50	$1.1	2%	45	$68.8	49	a
Total	$9,351	24%		$29,249	72%		$838	2%		$39,449		

*2012 data were used for these states' calculations.
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 are not included in SMHA-controlled expenditures
***Rhode Island does not have a state psychiatric hospital. Reported figures are expenditures dedicated to psychiatric services at a state-run hospital (Eleanor Slater Hospital)

County-based system	SMHA Directly Operates	SMHA Directly Funds	Unknown

Figure 2 compares SMHA expenditures on state psychiatric hospital inpatient services to SMHA expenditures for community-based programs for each of the 10 HHS regions and the national average. Although there is a relatively weak relationship between the two variables, the more an SMHA spends on community programs, the more it also appears to spend on state psychiatric hospital inpatient services.

Figure 2: SMHA-Controlled Expenditures on Community-Based Programs by HHS Region, FY'13



Expenditures by Client Age Group

SMHAs expended nearly $24.3 billion (61% of total expenditures) on mental health services for persons aged 18 and older, and nearly $9.6 billion (24% of total expenditures) on mental health services for children aged 0 to 17. Approximately $5.7 billion of SMHA expenditures were not allocated to specific age groups because the SMHA was unable to break out expenditures by age group, or they were dedicated to SMHA administrative, research, training, or other activities not specific to age groups. Per capita expenditures for children's mental health services averaged $129.80 per child*, while per capita expenditures for adults averaged $99.71 per adult. Table 3 provides a breakdown of type of expenditure by age group and state for FY 2013.

Table 3: SMHA-Controlled Mental Health Expenditures by Age Group and State, FY'13

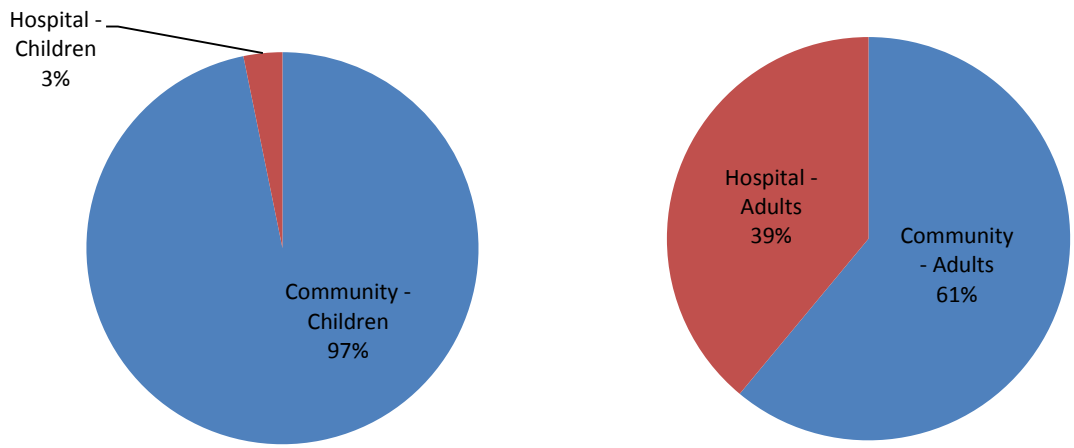
State	Children & Adolescents (Age 0-17)			Adults and Older Adults (Age 18 and Up)			Unallocated by Age			Total SMHA Expenditures	
	Total (Millions)	Per Capita	%	Total (Millions)	Per Capita	%	Total (Millions)	Per Capita	%	Total (Millions)	Per Capita
AL	$31.3	$28.2	9%	$174.0	$46.9	60%	$144.7	$30.0	41%	$350.0	$72.6
AK	$106.3	$565.1	44%	$130.0	$248.5	54%	$6.3	$8.8	3%	$242.6	$341.1
AZ	$448.7	$277.5	33%	$889.2	$178.2	66%	$17.9	$2.7	1%	$1,355.8	$205.2
AR	$12.3	$17.4	9%	$65.4	$29.2	49%	$56.8	$19.3	42%	$134.5	$45.6
CA*	$2,020.0	$220.2	31%	$3,782.0	$130.4	59%	$625.4	$16.4	10%	$6,427.4	$168.4
CO	$168.7	$136.3	33%	$343.0	$86.0	66%	$4.9	$0.9	1%	$516.9	$98.8
CT	N/A	N/A	0%	$726.8	$259.4	93%	$50.9	$14.2	7%	$777.7	$216.8
DE	N/A	N/A	0%	$86.6	$120.5	97%	$2.4	$2.6	3%	$89.0	$96.5
DC	$30.1	$269.7	15%	$125.4	$235.8	64%	$42.0	$65.2	21%	$197.4	$306.9
FL*	$88.6	$22.0	12%	$608.8	$39.4	85%	$20.3	$1.0	3%	$717.6	$36.8
GA	$111.0	$44.6	19%	$478.2	$64.3	81%	N/A	N/A	N/A	$589.1	$59.3
HI	$32.2	$104.8	18%	$138.7	$132.1	78%	$7.9	$5.8	4%	$178.8	$131.8
ID	$12.3	$28.8	23%	$37.7	$31.9	72%	$2.7	$1.7	5%	$52.7	$32.8
IL	$219.6	$72.6	24%	$689.1	$70.1	74%	$22.2	$1.7	2%	$930.9	$72.4
IN	$108.3	$68.3	23%	$350.4	$70.3	75%	$5.4	$0.8	1%	$464.1	$70.7
IA	$145.9	$201.5	33%	$289.6	$122.5	66%	$4.3	$1.4	1%	$439.8	$142.4
KS	$139.0	$192.0	39%	$181.3	$84.5	50%	$39.7	$13.8	11%	$360.0	$125.5
KY	$51.0	$50.3	21%	$178.8	$53.2	74%	$11.1	$2.5	5%	$240.9	$55.1
LA	$28.8	$25.9	11%	$216.1	$61.9	85%	$10.7	$2.3	4%	$255.6	$55.5
ME	$194.6	$745.0	42%	$252.1	$236.6	55%	$11.5	$8.7	3%	$458.3	$345.4
MD	$295.2	$219.6	28%	$652.7	$143.2	62%	$107.3	$18.2	10%	$1,055.2	$178.8
MA	$87.3	$62.6	12%	$629.5	$118.9	85%	$21.0	$3.1	3%	$737.8	$110.3
MI	$232.7	$103.6	18%	$1,047.8	$137.0	81%	$6.4	$0.7	0%	$1,286.9	$130.1
MN	$291.2	$227.7	30%	$664.8	$160.6	69%	$7.7	$1.4	1%	$963.7	$177.9
MS	$31.8	$43.2	19%	$131.3	$58.7	79%	$3.2	$1.1	2%	$166.4	$56.0
MO	$80.9	$57.9	14%	$497.9	$107.6	83%	$20.0	$3.3	3%	$598.8	$99.4
MT	$102.6	$458.1	49%	$104.7	$132.9	50%	$3.4	$3.4	2%	$210.7	$208.3
NE	$13.4	$28.8	8%	$151.2	$108.2	90%	$2.5	$1.4	2%	$167.1	$89.8
NV	$19.9	$30.1	8%	$222.1	$104.9	89%	$6.4	$2.3	3%	$248.4	$89.4
NH	$43.2	$159.5	24%	$137.8	$131.1	75%	$1.9	$1.5	1%	$183.0	$138.4
NJ	$297.8	$147.3	16%	$1,463.9	$213.1	79%	$95.5	$10.7	5%	$1,857.2	$208.9
NM*	$143.4	$282.5	53%	$129.0	$82.5	47%	N/A	N/A	N/A	$272.4	$131.5
NY*	$262.7	$62.0	5%	$1,590.0	$103.3	30%	$3,415.7	$174.0	65%	$5,268.4	$268.4
NC	$388.2	$169.8	41%	$541.9	$72.7	57%	$15.5	$1.6	2%	$945.6	$97.1
ND	$3.7	$22.5	6%	$59.6	$107.7	94%	$0.1	$0.2	0%	$63.3	$88.5

*The SMHAs of Connecticut, Delaware, and Rhode Island have no responsibility for providing children's mental health services. A separate state agency is responsible for these services. The child/adolescent populations from these states are removed from this calculation.

State	Children & Adolescents (Age 0-17)			Adults and Older Adults (Age 18 and Up)			Unallocated by Age			Total SMHA Expenditures	
	Total (Millions)	Per Capita	%	Total (Millions)	Per Capita	%	Total (Millions)	Per Capita	%	Total (Millions)	Per Capita
OH	$431.4	$162.8	37%	$686.7	$77.06	59%	$41.3	$3.56	4%	$1,159.4	$100.3
OK	$21.8	$23.0	11%	$169.9	$58.9	84%	$11.3	$3.0	6%	$203.0	$53.0
OR	$149.1	$173.9	21%	$563.8	$183.6	78%	$9.0	$2.3	1%	$721.9	$183.8
PA	$1,929.4	$710.5	53%	$1699.5	$169.1	46%	$37.6	$2.9	1%	$366.5	$287.2
PR	$9.1	$11.2	13%	$59.6	$21.3	87%	N/A	N/A	N/A	$68.8	$19.02
RI	N/A	N/A	N/A	$109.4	$131.3	98%	$1.7	$1.6	2%	$111.3	$106.1
SC	$68.4	$63.4	25%	$194.0	$53.1	70%	$13.8	$2.9	5%	$276.2	$58.4
SD	$14.4	$69.1	20%	$36.0	$56.8	51%	$20.4	$24.3	29%	$70.8	$84.1
TN	$179.0	$120.0	32%	$373.6	$75.0	66%	$13.9	$2.2	2%	$566.5	$87.5
TX	$132.1	$18.8	12%	$905.7	$47.0	85%	$32.0	$1.2	3%	$1,069.9	$40.7
UT	$61.2	$68.3	30%	$129.3	$64.7	63%	$14.7	$5.1	7%	$205.2	$70.9
VT	$82.0	$668.3	45%	$94.1	$187.0	52%	$6.5	$10.4	4%	$182.6	$291.7
VA	$121.2	$65.0	16%	$604.5	$96.3	80%	$28.3	$3.5	4%	$754.0	$92.6
WA	$135.0	$84.6	17%	$504.2	$94.7	64%	$147.3	$21.3	19%	$786.5	$113.7
WV	$2.4	$6.3	1%	$112.2	$76.3	64%	$60.4	$32.6	35%	$175.0	$94.4
WI	$6.7	$5.1	1%	$194.5	$43.9	30%	$447.7	$78.0	69%	$648.9	$113.1
WY	$1.0	$7.5	2%	$66.7	$150.9	97%	$1.1	$1.9	2%	$68.8	$118.8
Total	$9,587.1	$129.8	24%	$24,271.1	$99.7	61%	$5,680.7	$17.9	14%	$39,539	$124.1
County-based system			SMHA Directly Operates			SMHA Directly Funds			Unknown		

Children primarily receive services in community settings. On average, SMHAs that provide services to children*, expend 97% of their children's budget on services to children in the community, while only 3% of the children's budget is allocated to children's services in state psychiatric hospitals. SMHAs also tend to expend more funds on community services for adults (61% of SMHA adult budgets) in lieu of adult services in state psychiatric hospitals (39% of adult budgets). Figure 3 provides a breakdown of SMHA's children and adult budgets.

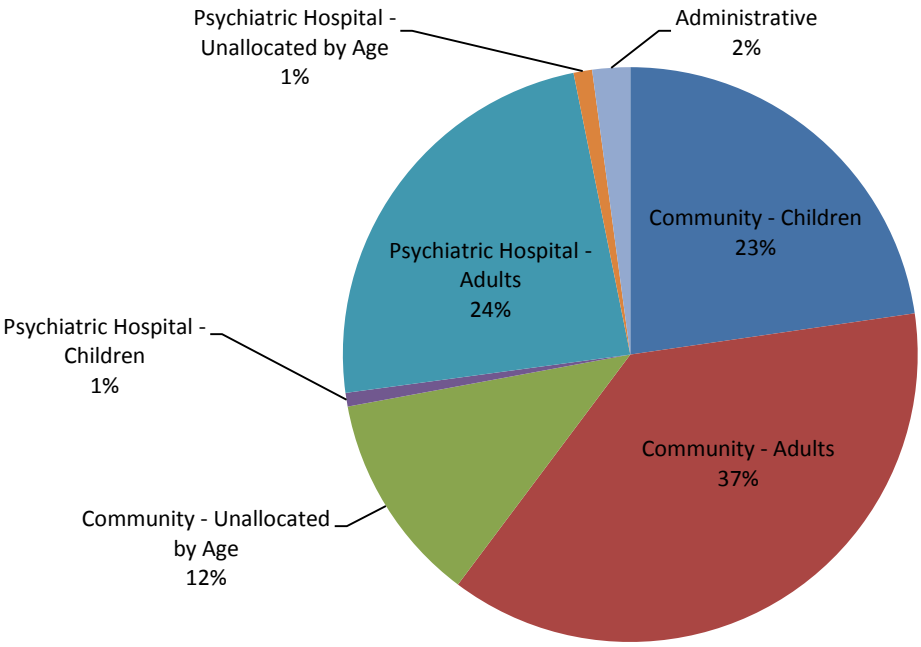
Figure 3: Percentage of SMHA Expenditures by Age Group and Setting, FY'13



*The SMHAs of Connecticut, Delaware, and Rhode Island have no responsibility for providing children's mental health services; a separate state agency is responsible for these services. Also, New York and Wisconsin did not provide a break-down of expenditures by setting (community or hospital) for children. These five states are removed from this calculation.

Figure 4 provides a breakdown of total SMHA budget allocations by setting and age group*.

Figure 4: SMHA Budget Allocations by Setting and Age Group, FY'13



Expenditures on State Hospital Inpatient Services for Forensic Patients & Sexually Violent Predators

Forty-five SMHAs reported expenditures on state psychiatric hospital inpatient services for forensic patients in FY 2013. Thirty-five percent ($3.46 billion) of total SMHA expenditures on state psychiatric hospitals were dedicated to serving this population. On average, SMHAs spent $11.04 per capita for forensic consumers, with a median per capita expenditure of $7.05. The range of expenditures for forensic consumers was wide, with $90.60 per capita in the District of Columbia, and $0.06 per capita in Iowa. Table 4 provides a breakdown of expenditures for forensic patients for each of the 10 HHS Regions, ranked in order of per capita expenditures (highest to lowest).

Table 4: SMHA Expenditures for Forensic Services in State Psychiatric Hospitals by HHS Region, FY'13

HHS Region	Number of SMHAs Responding	Total Forensic Expenditures (in Millions)	Per Capita Forensic Expenditures	Percentage of State Psychiatric Hospital Expenditures on Forensic Services
9	3 (AZ, CA, NV)	$1,013.3	$20.84	70%
10	4 (AK, ID, OR, WA)	$219.1	$16.64	43%
1	2 (CT, MA)	$137.5	$13.38	48%
3	6 (DE, DC, MD, PA, VA, WV)	$357.9	$11.84	32%
U.S. Average	***45***	***$3,462.2***	***$10.89***	***35%***
2	3 (NJ, NY, PR)	$338.9	$10.58	14%
5	6 (IL, IN, MI, MN, OH, WI)	$529.1	$10.17	41%
7	4 (IA, KS, MO, NE)	$126.3	$9.13	28%
8	4 (CO, MT, UT, WY)	$97.4	$8.63	41%
6	5 (AR, LA, NM, OK, TX)	$290.4	$7.31	41%
4	8 (AL, FL, GA, KY, MS, NC, SC, TN)	$352.3	$5.66	24%

Sixteen SMHAs reported state hospital expenditures of $545 million for sexually violent predators, representing five percent of the SMHA's psychiatric hospital inpatient expenditures. On average, these SMHAs spent $2.61 per consumer, with a minimum of $0.36 per capita in Pennsylvania, and a maximum of $12.01 per capita in Nebraska. Table 5 provides expenditure data on sexually violent predators for the 16 states responding.

Table 5: SMHA Expenditures on Sexually Violent Predators in State Psychiatric Hospitals, FY'13

State	Total State Hospital Expenditures	Total Expenditures on Sexually Violent Predators	Percentage of Hospital Expenditures on Sexually Violent Predators	Per Capita Expenditures on Sexually Violent Predators
AZ	$68,700,000	$9,000,000	13%	$1.36
CA*	$1,316,825,581	$210,605,673	16%	$5.56
DC	$83,413,313	$638,437	1%	$0.99
FL	$319,433,236	$31,715,745	10%	$1.65
IA	$47,300,000	$9,400,000	20%	$3.04
IL	$237,500,000	$22,900,000	10%	$1.78
KS	$96,700,000	$22,700,000	23%	$7.91
MO	$263,095,494	38,900,000	15%	$6.45
ND	$21,954,890	$5,483,839	25%	$7.66
NE	$48,009,165	$23,364,135	49%	$12.01
NJ	$551.934,000	$24,641,000	4%	$2.77
NY	$1,852,700,000	$49,900,000	3%	$2.55
PA	$349,100,000	$4,600,000	1%	$0.36
SC	$105,300,000	$13,800,000	13%	$2.92
VA	$339,900,000	$28,100,000	8%	$3.45
WI	$201,200,000	$50,000,000	25%	$8.71
Total	**$5,903,065,679**	**$545,748,829**	**9%**	
Avg.	**$368,941,605**	**$34,109,302**		**$2.61**

Understanding Variations in SMHA Expenditures

From state to state, SMHA expenditures vary considerably, reflecting a similar trend among overall state government spending. 2012 data from the National Association of State Budget Officers and the National Governors' Association show that total government expenditures varied by a factor of 9.6, SMHA spending varied by a factor of 10.4, and Medicaid expenditures varied by a factor of 7.3. Spending variations for major state agencies in FY 2012 are reflected in Table 6.[2] This section looks at how SMHA organization, structure, and policies may account for some of these variations.

Table 6: High-Low Per Capita Variations in State Agency Spending, FY'12

Agency:	Total State Gov't	SMHA	K-12 Education	Higher Education	Public Assistance	Medicaid	Corrections	Transport.	Capital	All Other
U.S. Average	$5,995	**$129**	$1,092	$684	$72	$1,254	$169	$540	$435	$2,185
Median	$5,379	**$106**	$1,035	$581	$44	$1,205	$154	$437	$289	$1,716
Minimum	$1,736	**$33**	$412	$78	$4	$276	$52	$154	$22	$494
Maximum	$16,600	**$338**	$2,493	$1,659	$358	$2,026	$504	$2,782	$4,175	$7,443
High/Low Ratio	**9.6**	**10.4**	**6.1**	**21.4**	**96.8**	**7.3**	**9.7**	**18.1**	**189.9**	**15.1**

Location of the SMHA within State Government

The way an SMHA is organized within the state government appears to influence how much SMHAs spend per capita. SMHAs that are independent departments within the state government spend more per capita than those SMHAs that are under an umbrella agency. On average, independent agencies spend $132.02 per capita, while those under an umbrella agency only spend $113.03 per capita. Of those under umbrella agencies, SMHAs that are located within the state's Health Department spend the least amount per capita, at $97.07 per person; and SMHAs under the state's Department of Health and Human Services spend the most per capita, at $122.57 per person. A breakdown of per capita spending by location within state government is provided in Table 7 (49 SMHAs responding).

Table 7: Per Capita Expenditures by Location within State Government. FY'13

Location of SMHA in State Government	Number of SMHAs	Total SMHA Expenditures	Community-Based Programs		State Psychiatric Hospital Services		Administrative Expenses	
		Per Capita	Per Capita	%	Per Capita	%	Per Capita	%
Independent Agency	**14**	**$132.02**	**$84.40**	**64%**	**$42.47**	**32%**	**$5.15**	**4%**
Under Umbrella Agency:	**35**	**$113.03**	**$84.79**	**75%**	**$26.44**	**23%**	**$1.80**	**2%**
Health & Human Services	9	$122.57	$90.82	77%	$29.33	22%	$2.43	1%
Human Services	19	$119.24	$91.31	72%	$26.41	26%	$1.51	2%
Health Department	7	$97.07	$69.96	74%	$25.08	24%	$2.02	2%

Organizational Distance between SMHA Commissioner and the Governor

The number of organizational layers between an SMHA's commissioner and the state's governor also appears to influence expenditures. SMHAs with one level between the commissioner and the governor spend significantly more per capita ($158.07 per person) than those SMHAs whose commissioners report directly to the governor ($107.89 per person), and those with two layers between the commissioner and the governor. SMHAs with two layers between the commissioner and the governor spend the least amount per capita, at $80.78 per person. Table 8 breaks out per capita expenditures by organizational levels between the SMHA commissioner and governor and by type of expenditure (51 SMHAs responding).

[2] *Source:* National Association of State Budget Officers. (2013). State *Expenditure Report: Examining Fiscal 2011 – 2013 State Spending.* http://www.nasbo.org/publications-data/state-expenditure-report.

Table 8: Per Capita Expenditures by Commissioner's Distance from Governor, FY'13

Number of Layers between SMHA Director and the Governor	Number of SMHAs	Total SMHA Expenditures	Community-Based Programs		State Psychiatric Hospital Services		Administrative Expenses	
		Per Capita	Per Capita	%	Per Capita	%	Per Capita	%
Reports Directly to Gov.	9	$107.89	$78.57	73%	$26.51	25%	$2.81	3%
One Layer	24	$158.07	$112.25	71%	$41.82	26%	$4.00	3%
Two Layers	15	$80.78	$55.20	68%	$23.91	30%	$1.68	2%
Three or More Layers	3	$146.26	$114.25	78%	$30.64	21%	$1.37	1%

County/City Government and Community-Based Services

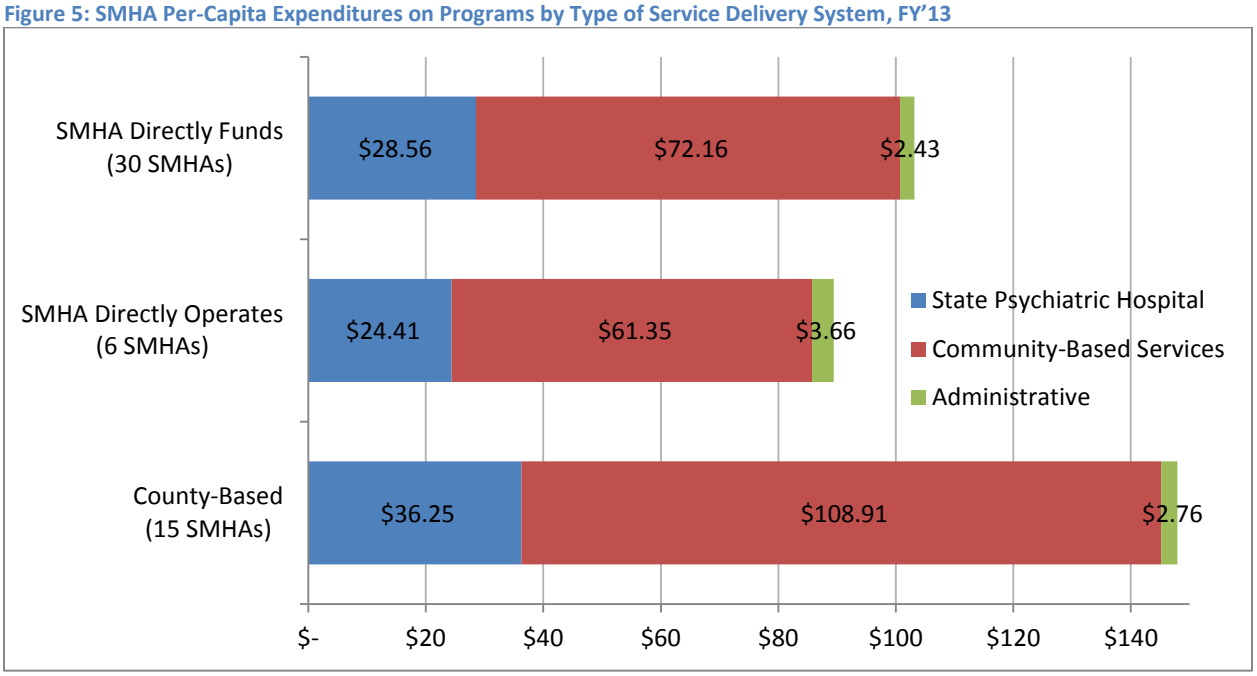
SMHAs organize and fund community mental health services through a variety of mechanisms. The three primary methods include: SMHA-operated community mental health services (state employees), SMHA-funded county/city governments or boards to organize and delivery community mental health services, and SMHA-contracted community mental health service providers (most often non-profit organizations).

Six SMHAs directly operated community mental health services in FY 2013 (Connecticut, Idaho, Illinois, Nevada, North Dakota, and South Carolina). On average, these SMHAs spend the lowest total per capita expenditures ($89.41 per person). States that directly operate community mental health services also tend to rely more heavily on state general funds, and less on Medicaid and other reimbursements for services. These SMHAs also have the highest reported administrative costs, averaging $3.66 per person, which may be due to the SMHA having to directly pay for administration and personnel expenses associated with community programs operated by the SMHA. The total population of these five states represents seven percent of the total U.S. population.

The 15 SMHAs that fund city and county governments to provide services have the highest average per capita expenditures overall ($147.92), and highest per capita expenditures for community-based services ($108.91). These states tend to be larger states (California, Iowa, Michigan, Minnesota, Nebraska, New York, North Carolina, Ohio, Oregon, Pennsylvania, Texas, Utah, Virginia, Washington, and Wisconsin), and collectively represent 52% of the total U.S. population.

The majority of SMHAs (30) directly fund community providers to deliver services. These states average the second highest total per capita expenditures at $103.14 per person, and represent 38% of the total U.S. population. On average, these states have lower per capita expenditures for community programs ($72.16 per person) than city/county-based states, and spend the least of all three on administrative costs ($2.43 per capita). Figure 5 depicts the differences in per-capita spending for each type of SMHA organization for 51 states*.

Figure 5: SMHA Per-Capita Expenditures on Programs by Type of Service Delivery System, FY'13



**It is unknown what type of service delivery system Puerto Rico employs. Puerto Rico expends $8.60 per capita for state psychiatric hospitals, and $9.74 per capita for community-based services.*

SMHA Involvement with Medicaid

The responsibility an SMHA has for setting rates for mental health services and administering Medicaid benefits for mental health also seems to affect SMHA expenditures. In most states, Medicaid mental health services are funded through a combination of fee-for-services and managed care (31 SMHAs), followed by fee-for-services only (15 SMHAs), and managed care only (4 SMHAs). The states which fund services through an exclusive fee-for-services payment model have higher average per-capita expenditures ($153.27 per person) than those that exclusively use a managed care only model ($135.02 per person), and those using a combination of fee-for-service and managed care ($114.87 per person). Table 9 provides per capita expenditures by type of expenditure for each of the three payment models (50 SMHAs responding).

Table 9: Per Capita Expenditures by Type of Payment Model, FY'13

Type of Payment Model	Number of SMHAs	Total SMHA Expenditures	Community-Based Programs		State Psychiatric Hospital Services		Administrative Expenses	
		Per Capita	Per Capita	%	Per Capita	%	Per Capita	%
Fee-for-Service Only	15	$153.27	$114.42	75%	$36.37	24%	$2.48	2%
Managed Care Only	4	$135.02	$103.98	77%	$28.51	21%	$2.52	2%
Combination Fee-for-Service & Managed Care	31	$114.87	$80.83	70%	$31.21	27%	$2.84	3%

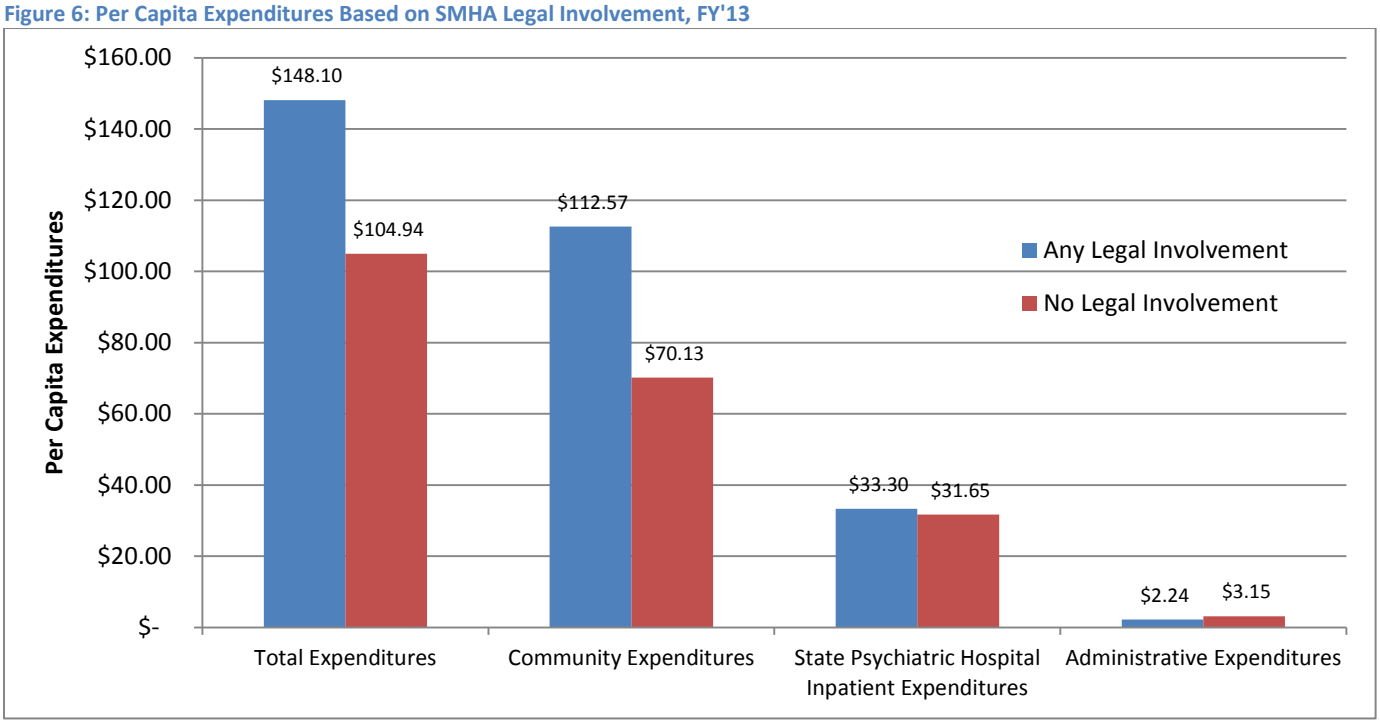
Legal Actions

The United States has several laws in place to protect the rights of disabled persons, including the Civil Rights of Institutionalized Persons Act (CRIPA), and the *Olmstead* Decision. CRIPA, passed in 1980, is aimed at protecting the rights of institutionalized persons, including those with a mental illness receiving treatment in an institutional setting. The 1999 U.S. Supreme Court *Olmstead* Decision interprets Title II of the Americans with Disabilities Act (ADA) to mean that persons with disabilities, including mental illnesses, are entitled to receive services and live in the most integrated settings appropriate for their care. Both the Department of Justice and

state Protection and Advocacy Attorneys are able to charge the SMHA with violations of these laws. To ensure compliance with the CRIPA and ADA statutes, SMHAs have worked to modify their mental health service systems to maximize the ability of individuals with mental illnesses to live in their own communities while receiving necessary mental health services and supports.

When grouping SMHAs with any type of legal action and comparing them to those without any legal involvement, there appears to be a significant difference in spending between the two groups. In FY 2013, states involved in any legal investigation expended, on average, $43.16 more per capita than states not involved in any legal action. See Figure 6.

Figure 6: Per Capita Expenditures Based on SMHA Legal Involvement, FY'13



However, when separating SMHAs based on the type of legal action they are facing, results are mixed on whether or not they spend more than those SMHAs without any legal action. While SMHAs under a class action lawsuit spent the most in FY 2013, with an average of $160.37 per capita, SMHAs under CRIPA or *Olmstead* investigations actually expended less per capita than those states not under CRIPA or *Olmstead* investigations. Table 10 breaks out expenditures of states involved in legal actions, and compares them to those not under any legal action.

Table 10: Per-Capita Expenditures Based on SMHA Legal Involvement, FY'13

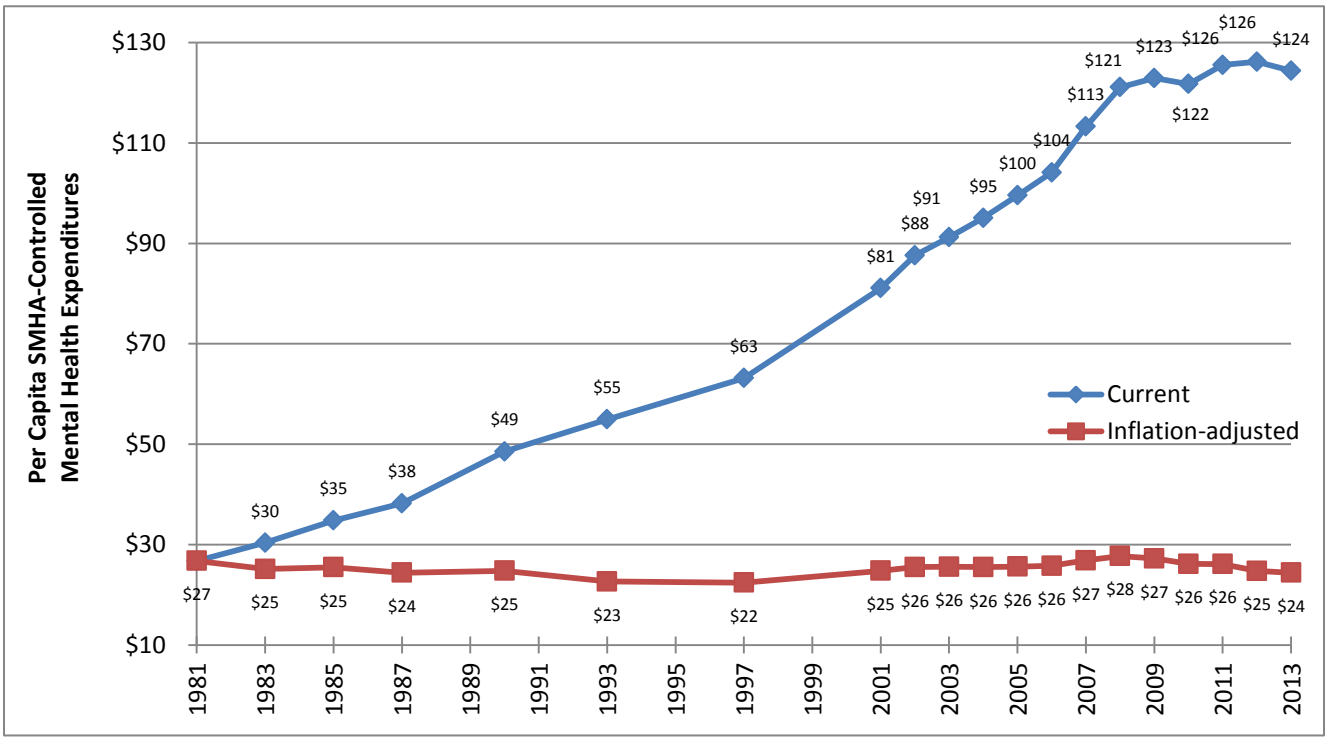
Type of Legal Action	Yes, Has Legal Involvement				No, Has No Legal Involvement				Difference in Total Per Capita Spending
	Number of SMHAs	Total Per Capita Expenditures	% on Community	% on State Hospital	Number of SMHAs	Per Capita Expenditures	% on Community	% on State Hospital	
Any Legal Action	23	$148.10	76%	22%	27	$104.94	67%	30%	$43.16
Class Action Suit	15	$160.37	78%	21%	35	$105.23	67%	30%	$55.14
CRIPA	2	$110.07	57%	38%	46	$125.97	72%	25%	($15.90)
Any *Olmstead*	15	$114.56	67%	30%	35	$128.95	73%	25%	($14.39)
Consent Decree	11	$122.67	72%	26%		$126.07	72%	26%	($3.40)

Trends in Mental Health Expenditures

Since 2001, per capita SMHA-controlled expenditures for mental health services have increased from $91.00 in FY 2001, to $124.39 in FY 2013. Not accounting for inflation, SMHA expenditures have grown 4.9% since 1981 at an annualized rate of 1.7% per year in state psychiatric hospitals, and much faster at 7.6% per year for community-based services. This rate of increase might have been much higher had the 2008 economic recession not occurred. Between FY 2001 and FY 2008, SMHAs saw a 23.5% increase in expenditures to state psychiatric hospital inpatient services (an average increase of 2.7% per year), and a 62.7% increase in expenditures for community-based programs (an average increase of 6.3% per year). Between FY 2008 and FY 2013, SMHA funding for state psychiatric hospital inpatient services decreased 7%, while expenditures for community-based programs increased by a total of 5.4% - sluggish compared to the seven years prior to the recession.

When accounting for inflation, SMHAs experienced a negative annualized growth rate of 0.3% between FY 1981 and FY 2013. During this time, the only setting to realize an increase in expenditures is community-based services with a total increase of 2.3%. Expenditures for state psychiatric hospital inpatient services decreased 3.3% over this time, and funding for administrative services declined 2.2%. Although the inflation-adjusted growth rates for state psychiatric hospital expenditures and administrative expenditures were negative prior to the 2008 recession (-7.5% and -4.5%, respectively between FY 2001 and FY 2008), the economic downturn exacerbated this problem. Between FY 2008 and FY 2013, expenditures for state psychiatric hospitals decreased 20.3% (annualized rate of -3.2%), expenditures for community-based programs declined 9.7% (annualized rate of -1.4%) and administrative expenditures were reduced by 13.4% (annualized rate of -2.0%). See Figure 6 for trends in per capita expenditures.

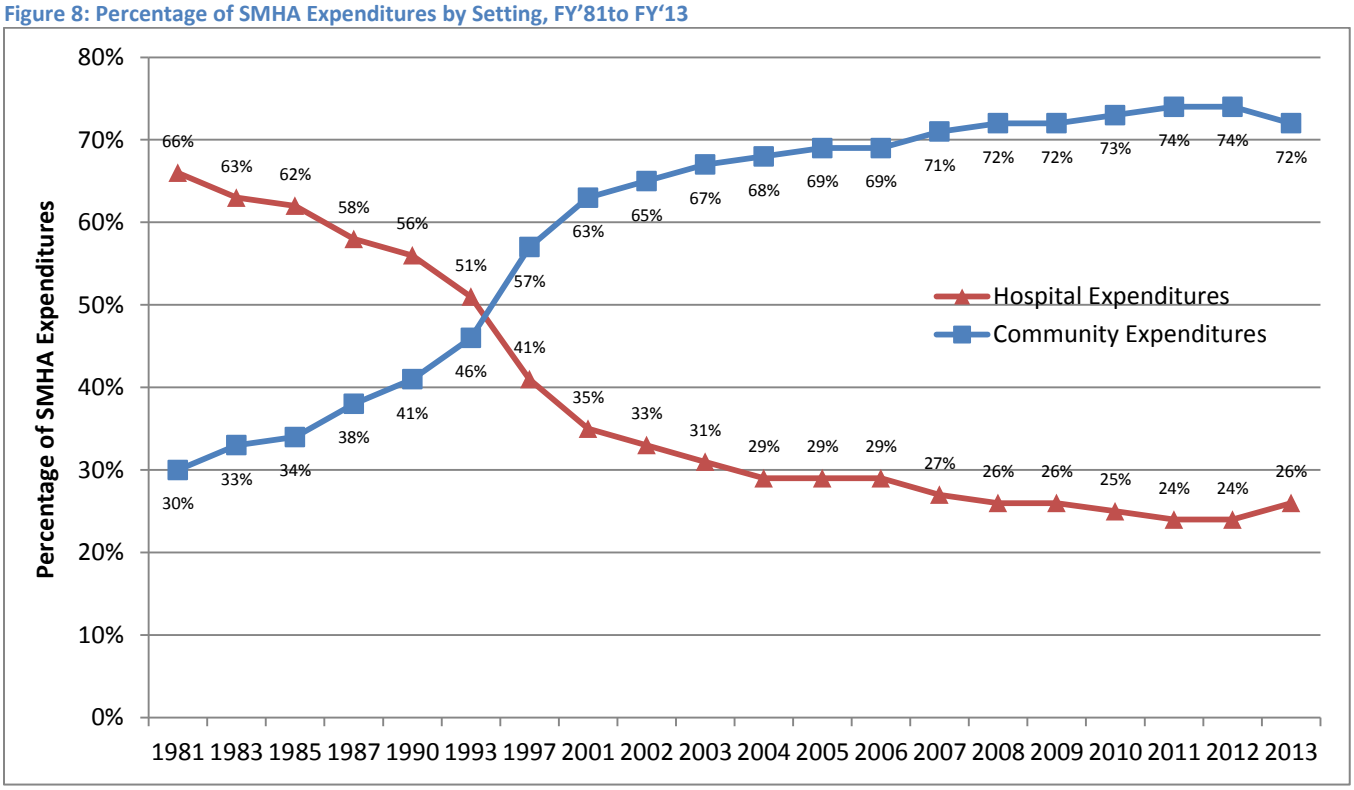
Figure 7: Trends in SMHA Per Capita Expenditures, FY'81 to FY'13



Shift from Psychiatric Hospital Inpatient to Community-Based Services

As a percentage of overall SMHA expenditures, expenditures on community-based programs have gradually increased, and expenditures on state psychiatric hospitals have gradually decreased since 1981, when the Revenues and Expenditures study was initiated and data became available. Since 1993, expenditures for community based services have exceeded expenditures for state psychiatric hospitals, a major reversal from the 1980s when SMHAs expended 63% of their funds in state psychiatric hospitals, and only 33% for community mental health services. Not accounting for inflation, Figure 7 depicts this trend in allocation of SMHA expenditures to state psychiatric hospitals for inpatient services and for community mental health services. .

Figure 8: Percentage of SMHA Expenditures by Setting, FY'81to FY'13



Conclusion

In Fiscal Year 2013, SMHA-controlled expenditures for mental health services and related expenses totaled more than $39.5 billion for the 50 states, the District of Columbia, and Puerto Rico. These expenditures were devoted to providing mental health services in state psychiatric hospitals; community-based mental health programs; and the administration, training, and research and evaluation of these systems. On average, SMHAs expended $124.39 per civilian resident of the United States, with median per capita expenditures of $99.84.

The majority of SMHAs dedicate most of their funding to providing services in community settings (24% of expenditures). Most SMHAs focus their efforts, and expenditures, on providing services to adults age 18 and over (61% of expenditures). SMHAs also expend funds to provide services to civilian and forensic consumers in state psychiatric hospitals (72% of expenditures).

Significant variations in expenditures occur across states, and may be influenced by the SMHA's organization, strategies employed for funding mental health services; and the type of legal action in which the SMHA is involved, if any.

While SMHA expenditures in real dollars have grown 4.9% since 1981, when accounting for inflation, SMHAs actually experienced a negative annualized growth rate of 0.3% between FY 1981 and FY 2013. During this time, the only setting to realize an increase in expenditures is community-based services with a total increase of 2.3%.

Appendix A: SMHA Contacts

Alaska
Nancy Cooperrider
Administrative Operations Manager II
Alaska Division of Behavioral Health
907-465-8202
nancy.cooperrider@alaska.gov

Alabama
Koye Adedokun
Chief Financial Officer
Department of Mental Health
334-242-3996
koye.adedokun@mh.alabama.gov

Arkansas
Julie Carpenter
Assistant Director for Finance
Division of Behavioral Health Services
501-686-9463
julie.carpenter@arkansas.gov

Serhan Al-Serhan
Research Project Analyst
Division of Behavioral Health Services
501-686-9037
serhan.al-serhan@arkansas.gov

Arizona
Debbie Gann
Finance Manager
State of Arizona
602-364-4719
debbie.gann@azdhs.gov

California
Jenkins Kumeh
Chief
California Department of Health Care Services
916-323-3571
jenkins.kumeh@dhcs.ca.gov

Colorado
Andrew Martinez
Associate Director of Business and Support
Division of Behavioral Health
303-866-7154
andrew.martinez@state.co.us

Connecticut
Chris Beauty
Fiscal Services
Department of Mental Health and Addiction Services
860-418-6977
christopher.beauty@ct.gov

District of Columbia
Antoinette Alexander
Program Management Specialist
Department of Behavioral Health
202-671-3064
antoinette.alexander@dc.gov

Delaware
Darlene Plummer
Senior Fiscal Administrative Officer
Division of Substance Abuse and Mental Health
302-255-9430
darlene.plummer@state.de.us

Florida
Adam Wasserman
Operations Review Specialist
Department of Children and Family Services
850-717-4791
adam_wasserman@dcf.state.fl.us

Georgia
John Quesenberry
Director of Information Management
Department of Behavioral Health and Developmental Disabilities
404-232-1295
jwquesenberry@dhr.state.ga.us

Hawaii
Brian Higgins
Chief Financial Officer
Division of Adult Mental Health
808-586-4688
brian.higgins@doh.hawaii.gov

Iowa
Ben Cleveland
515-281-5374
bclevel@dhs.state.ia.us

Idaho
Cynthia Clapper
Program Specialist
Adult Mental Health
208-334-5527
clapper@dhw.idaho.gov

Casey Moyer
Program Manager
Division of Behavioral Health
208-334-4916
moyerc@dhw.idaho.gov

Illinois
Mary Smith
Associate Director
Division of Mental Health
312-814-4948
marye.smith@illinois.gov

Indiana
Donna Rutherford
Controller
Division of Mental Health and Addiction
317-232-7862
donna.rutherford@fssa.in.gov

Kansas
George Van Hoozer
CSP Program Oversight Manager
Department for Aging and Disability Services
785-296-7706
george.vanhoozer@kdadas.ks.gov

Kentucky
Rachel Cox
Department for Behavioral Health,
Developmental and Intellectual Disabilities
502-564-4860
rachel.cox@ky.gov

Louisiana
Deanne Mills
Account Manager III
Office of Behavioral Health
225-342-9265
deanne.mills@la.gov

Massachusetts
Karen Brady
Director of Budget and Reimbursement
Department of Mental Health
617-626-8035
karen.brady@state.ma.us

Maryland
Susan Bradley
Chief, Office of Management Information
Systems and Data Analysis
Department of Health and Mental Hygiene
410-402-8409
susan.bradley@maryland.gov

Marion Katsereles
Chief Financial Officer
Department of Health and Mental Hygiene
410-402-8409
marion.katsereles@maryland.gov

Maine
Jay Yoe
Director
Office of Quality Improvement
207-624-7988
jay.yoe@maine.gov

Michigan
Cynthia Kelly
Director
Bureau of State Hospitals and Behavioral Health
Administrative Operations
517-335-0263
kellyc@michigan.gov

Minnesota
Jerry Storck
651-431-2237
jerry.t.storck@state.mn.us

Missouri
Kate Wieberg
573-751-9215
kate.wieberg@dmh.mo.gov

Mississippi
Kenneth Leggett
Bureau Director for Administration
Department of Mental Health
601-359-6231
kenneth.leggett@dmh.state.ms.us

Montana
Karen Antonick
406-444-9311
kantonick@mt.gov

North Carolina
Wanda Mitchell
Budget Director
Division of Mental Health
919-733-7013
wanda.mitchell@dhhs.nc.gov

North Dakota
Linda Mertz
Liaison Accountant
Department of Human Services
701-328-4016
lmmertz@nd.gov

Nebraska
Karen Harker
Fiscal and Federal Performance Administrator
Division of Behavioral Health
402-471-7796
karen.harker@nebraska.gov

New Hampshire
Peter Reid
603-271-5066
pried@dhhs.state.nh.us

New Jersey
Laura Pierce-Foglia
laura.pierce-foglia@dhs.state.nj.us

Lynn Kovich
Division of Mental Health and Addiction
Services
609-777-0711
lynn.kovich@dhs.state.nj.us

New Mexico
Cynthia Shelton
Behavioral Health Policy Analyst
Human Services Department, Behavioral Health
Collaborative
505-476-9293
cynthiaa.shelton@state.nm.us

Nevada
Dave Caloiaro
Clinical Program Planner III
Division of Public and Behavioral Health
775-684-5970
dcaloiaro@mhds.nv.gov

Debi Galloway
Division of Public and Behavioral Health
dgalloway@health.nv.gov

Luana Ritch
775-684-5912
lritch@mhds.nv.gov

Kurt Green
Northern Nevada Adult Mental Health Services
775-688-2030
kgreen@nnamhs.state.nv.us

New York
Leesa Rademacher
Director of Intergovernmental Relations
Office of Mental Health
518-474-4403
leesa.rademacher@omh.ny.gov

Ohio
Holly Jones
Department of Mental Health
614-644-8559
holly.jones@mh.ohio.gov

Oklahoma
Juarez McCann
Chief Financial Officer
Department of Mental Health and Substance Abuse Services
405-522-1427
Juarez.mccann@odmhsas.org

Oregon
Silke Blaine
Budget Administrator
Adult Mental Health
503-945-6198
silke.blaine@state.or.us

Alisa Webb
503-945-6553
alisa.i.webb@state.or.us

Pennsylvania
Susan Snyder
Pennsylvania Bureau of Information Systems
717-787-2773
sussnyder@pa.gov

Puerto Rico
Felícita Cintrón-Díaz
Planner
Mental Health and Anti-Addiction Services Administration
787-763-7575, ext. 1094
fcintron@assmca.pr.gov

Rhode Island
Steven Dean
Office of Finance and Contract Management
401-462-0486
steven.dean@bhddh.ri.gov

South Carolina
William Wells
Department of Mental Health
843-212-8977
wtw14@scdmh.org

South Dakota
Brenda Tidball-Zeltlinger
Deputy Secretary
Department of Social Services
605-773-3165
brenda.tidball-zeltinger@state.sd.us

Bill Regynski
Budget and Finance Director
605-773-5182
bill.regynski@state.sd.us

Jeri Winkler
jeri.winkler@state.sd.us

Tennessee
Gene Wood
Budget Director
Department of Mental Health and Substance Abuse Services
615-532-6676
gene.wood@tn.gov

Texas
Rebecca Salisbury
Division Budget Analyst
Mental Health and Substance Abuse Division
512-206-5730
rebecca.salisbury@dshs.state.tx.us

Utah
Paul Korth
Administrative Services Director
Division of Substance Abuse and Mental Health
801-538-9844
pkorth@utah.gov

Charles Bentley
Financial Manager II
Department of Human Services
Office of Fiscal Operations
801-538-9844
cbentley@utah.gov

Virginia
Ken Gunn
Director
Office of Budget and Financial Reporting
Department of Behavioral Health Services
ken.gunn@dbhds.virginia.gov

Vermont
Heidi Hall
Department of Mental Health
802-828-1721
heidi.hall@state.vt.us

Washington
Melissa Clarey
Chief
DBHR Finance
360-725-1675
melissa.clarey@dshs.wa.gov

Wisconsin
Dan Zimmerman
Bureau of Prevention, Treatment and Recovery
Division of Mental Health and Substance Abuse Services
608-266-7072
daniel.zimmerman@wisconsin.gov

West Virginia
Melissa Mullins
Bureau of Behavioral Health and Health Facilities
304-356-4990
melissa.d.mullins@wv.gov

Wyoming
Lisa Petersen
Knowledge-Management, Analysis and Technology
Mental Health and Substance Abuse Services Division
301-777-5850
lisa.petersen@wyo.gov

Appendix B: FY 2013 Revenues and Expenditures Table Shells

Table 1

State: Wyoming

FY 2013

FY 2013 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)*				$0
	Other 24 Hour (Residential)				$0
	Less than 24 hour care (provided at the state hospital)				$0
	Service Setting Not Available				$0
	Subtotal	$0	$0	$0	$0
SMHA-Controlled Expenditures of Community-Based Programs	Inpatient (Licensed Hospital beds)				$0
	Other 24 Hour (Residential)				$0
	Less than 24 hour care				$0
	Other/Unknown: (please describe)				$0
	Subtotal	$0	$0	$0	$0
Administration	Central/regional office support				$0
	Prevention				$0
	Research/Training				$0
	Admin/Central Subtotal			$0	$0
GRAND TOTAL *		$0	$0	$0	$0

** See Table 4 for a breakdown of these expenditures*

NA = Services provided but exact expenditures not available.

Please answer the following three questions:

1. Are Medicaid revenues for community programs included in SMHA-Controlled expenditures? _____

2. Do SMHA-Controlled expenditures include funds for mental health services in jails or prisons? _____

3. Are children's mental health expenditures included in SMHA-Controlled expenditures? _____

Table 2

State: Wyoming

FY 2013

FY 2013 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				$0
	Other State				$0
	State Medicaid				$0
	Subtotal	$0	$0	$0	$0
Federal Revenues	Medicaid				$0
	Medicare				$0
	Soc. Svcs. Block				$0
	MH Block Grant				$0
	Other SAMHSA				$0
	Other Federal				$0
	Subtotal	$0	$0	$0	$0
Local Revenues					$0
Other Revenues	First Party				$0
	Third Party				$0
	Other Revenue				$0
	Subtotal	$0	$0	$0	$0
GRAND TOTAL		$0	$0	$0	$0

NA = Services provided but exact revenues not available.

Table 3

FY 2013 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	$0

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

Table 4

State: Wyoming

FY 2013

FY 2013 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 (#)	Calculated cost per patient day
Forensic				
Sexually Violent Predators				
Civil (Voluntary and involuntary)	Children			
	Adults			
	Civil Subtotal	$0	0	
GRAND TOTAL *		$0	0	

* Total should match total inpatient expenditures on Table 1

NA = Services provided but exact expenditures not available.

NEW TABLE **Table 5 (OPTIONAL table)**

State: Wyoming

FY 2013 Total Medicaid Expenditures

FY 2013

If your state is able to report the total Expenditures of your State Medicaid agency for mental health services, please report these expenditures here:

to the nearest $100,000

	Inpatient Hospital	Other 24-Hour Care	Less Than 24 Hour Care	Pharmacy	Total
Total Medicaid Expenditures for Mental Health					$0
SMHA-Controlled Medicaid Expenditures for Mental Health					$0
Non-SMHA-Controlled Expenditures by Medicaid	$0	$0	$0	$0	$0

2. Are all Medicaid claims included in your analysis or are some Medicaid claims missing? ☐ Yes ☐ No

2a. If some are missing, what is missing?

2a1. Managed Care Claims ☐ Yes ☐ No

2a2. Fee-for-service Claims ☐ Yes ☐ No

2a3. Pharmacy data ☐ Yes ☐ No

2a4. Disproportionate Share (DSH) ☐ Yes ☐ No

3. Do the Medicaid expenditures include payments for psychiatric medications (pharmacy)? ☐ Yes ☐ No

3a. Please describe how you determined which medications to include as mental health:

4. What factors does your SMHA consider in determining if a claim is a MH Claim? *(check all that apply. E.g., if you use a combination of diagnoses and procedure codes, check both items)*

4.a Primary Diagnosis ☐ Yes ☐ No

4.b. Provision of service by a mental health clinician ☐ Yes ☐ No

4.c. Mental Health specific procedure code ☐ Yes ☐ No

4.d Prescription for a psychiatric medication ☐ Yes ☐ No

4.e. Other: _____

5. Please describe how your SMHA estimated total Medicaid payments for Mental Health:

Appendix C: Glossary – Funding Sources & Expenditures of SMHAs, Fiscal Year 2013

NASMHPD RESEARCH INSTITUTE, INC.

GLOSSARY

Funding Sources and Expenditures

of State Mental Health Agencies:

Fiscal Year 2013

Please submit data no later than **June 13, 2014**

Inquiries and/or questions should be directed to:

Azeb Berhane, M.A.

NASMHPD Research Institute, Inc.

3141 Fairview Park Drive

Falls Church, VA 22042-4539

Phone: (703) 738-8167

Fax: (703) 738-8185

Email: azeb.berhane@nri-inc.org

April 2014

INTRODUCTION

This Fiscal Year 2013 Revenue/Expenditure Study is the nineteenth 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, FY'01, FY'02, FY'03, FY'04, FY'05, FY'06, FY'07, FY'08, FY'09, FY'10, FY'11, and FY'12. 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 NASMHPD, the NASMHPD Research Institute, Inc. (NRI) and states can utilize for budgeting, planning, and policy making, at the local, state, and national levels. These data are also used by many individual states to assist in their own budget processes. The data will also fulfill the requirements for Table 7 of the Center for Mental Health Services' (CMHS) Uniform Reporting System (URS) that is part of each state's required Mental Health Block Grant Implementation Report.

Tables 1 through 4 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. **Table 5 (optional)** depicts the total Medicaid expenditures (SMHA-controlled and non-SMHA controlled Medicaid dollars) that are devoted for mental health services. This new optional table has been added to permit SMHAs that have information about the total mental health related expenditures for their state Medicaid agency to submit this information to provide a more robust depiction of the mental health service system in their state.

The term "SMHA-controlled" expenditures refers to the expenditure of funds by the SMHA or programs funded by the SMHA (such as community mental health providers), where the SMHA has some direct control over the expenditures of these funds. All state general revenues that flow through the SMHA to local providers should be included within the funds considered SMHA-controlled. Federal funds that go directly through the SMHA, such as the Mental Health Block Grant, PATH Homeless Grants, and other funds that the SMHA allocates to local providers (or county/city governments) should be counted as SMHA-controlled. In many SMHAs, the SMHA has a role in working with the state Medicaid Agency to establish rates for mental health services, develop Medicaid options or Waivers for mental health services, or is otherwise involved in the use of Medicaid to pay for mental health services at the SMHA-funded system. In these instances, the SMHA should include these Medicaid (or other funds) within the resources it considers SMHA-controlled. Some SMHAs may allocate State General Fund and other expenditures to local mental health providers as part of a system where

the expected amount of Medicaid (or Medicare or other funds) help determine how much State funds are provided. Again, in these instances, the Medicaid (and other funds) should be counted as SMHA-controlled. In instances where Medicaid (or other funds) is billed by local providers to another state government agency (such as Medicaid) and the SMHA has no involvement in the Medicaid program, then these funds should **not** be counted as SMHA-controlled.

An additional factor to be considered by SMHAs in determining the scope of their system to define as SMHA-controlled is to consider the mental health providers and system that are included in the development of the state's Mental Health Block Grant Plan and Implementation report and the mental health services reported to CMHS under the Uniform Reporting System (URS). The NRI's Revenues and Expenditures data on SMHA-controlled expenditures should correspond to the services and clients reported within the URS as part of the SMHA system (e.g., if clients from community providers receiving services paid for by Medicaid are reported to CMHS through the URS and are part of the state's Mental Health Block Grant Plan, then the expenditures and revenues for these services should be reported here as SMHA-controlled.

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'12 study have been included that compare FY'12 and FY'13 data.

STUDY PROCESS

Each state should complete the attached tables as completely as possible. Please e-mail your completed data to Azeb Berhane at azeb.berhane@nri-inc.org. If you need a copy of the Table shells please contact Ping Wu at ping.wu@nri-inc.org.

Please utilize the built-in data edits to ensure accurate data reporting. If any item is flagged by the built-in data edits please review your data before returning it to NRI. If your data is accurate, then please submit explanations (data notes) for each flagged item. After each state has submitted data, NRI will run additional 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 approval before NRI issues the final report. A copy of the final report will be sent to each SMHA Director and the state contact person for this project.

INSTRUCTIONS

Data reported on the Tables should include expenditures/revenues for **mental health only.** Expenditures for mental retardation/intellectual 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 age 17
Adult/Elderly	age 18 and older
Age unknown	please use this category only if you cannot breakout 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.

Please report data for each major Administrative Auspice (State Psychiatric Hospitals, Community Mental Health, and SMHA Administration). If you are unable to depict expenditures for a services that are part of your system, a "NA" should be used in the tables to show that "services are provided, but that exact expenditures (or revenues) are

not allocatable." If the service is not provided in your state, then a zero ($0) should be used in the tables to show no expenditures for that service.

> (For example, if your state funds Community mental health centers to provide Residential and Ambulatory Services, but the expenditure data submitted to you by local providers does not supply the detail needed to break out expenditures between Residential and Ambulatory Services, then place an "NA" in the appropriate cells for both Residential and Ambulatory Services and put the actual expenditure amounts in the Other/Unknown row).

Round dollar amounts to the nearest $100,000.

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).**

Footnotes

Please provide footnotes as necessary. Footnotes should document the source of the figures reported. They will be a useful reference if questions arise about the data requiring assessment of the reported figures.

Fiscal Year 2013 is your state's fiscal year that ended in calendar year 2013. For example, for most states, Fiscal Year 2013 ended on June 30, 2013.

TABLES 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/ intellectual disabilities, alcohol abuse, or drug abuse programs are not to be included on this table.

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

In order to provide some contextual information for users of the data, please respond "yes" or "no" to the three questions at the bottom of Table 1.

Note: If the SMHA has earmarked funds for dual diagnosis services, they should be included in this table.

TABLE 2: SMHA-CONTROLLED MENTAL HEALTH REVENUES

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

- SMHA-Controlled revenues dedicated to state psychiatric 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.

The glossary section 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 for 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: DISPROPORTIONATE SHARE MEDICAID

Table 3 compiles information about Disproportionate Share Medicaid Revenues received by the State for mental health services provided at State psychiatric hospitals.

TABLE 4: STATE MENTAL HEALTH AGENCY STATE HOSPITAL EXPENDITURES BY PRIORITY GROUPS

Table 4 compiles additional data on mental health expenditures in state psychiatric hospitals reported on Table 1 for some of the priority populations that SMHAs are serving. Categories to report include forensic clients, sexually violent predators, and civil commitments. For each of these priority population groups, please use the SMHA's definition. If you have to estimate the expenditures, please note on the table that these figures are estimates.

Note: Totals from this table must match the total inpatient expenditures for state psychiatric hospitals reported on Table 1, row 1. Please include data for both children and adults.

TABLE 5: TOTAL MEDICAID EXPENDITURES (OPTIONAL)

Table 5 compiles data on total expenditures of the state's Medicaid agency for mental health services for those states that are able to report.

A number of states have indicated to NRI that they are routinely working with their State Medicaid Agency's data to track all mental health services paid for by Medicaid. States have developed these counts of total State Medicaid expenditures for mental health by analyzing Medicaid paid claims for mental health services (identified by an analysis of mental health procedure codes, mental health providers, and/or to persons with a mental health diagnosis listed on the claim form).

This new Optional Table 5 has been added for those states where the SMHA has analyzed or has access to an analysis of the total expenditures by the state Medicaid Agency for mental health services (provided under either a fee-for-service or managed care arrangement). If this additional Medicaid information is available, states are asked to report on Table 5 how much of the Medicaid is included in the revenues and expenditures reported as "SMHA-controlled" on Tables 1 and 2, and how much is additional Medicaid expended for mental health services beyond the SMHA system.

We expect that the Medicaid reported on Table 5 as "SMHA-controlled" should be identical or close to the amounts of Medicaid reported on Table 2 as total "SMHA-controlled" revenues from Medicaid.

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.

GLOSSARY OF TERMS

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 psychiatric hospitals) hospitals that either directly or indirectly receive, 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 in an inpatient setting 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**:**

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

SKILLED NURSING FACILITY (SNF): A residential facility offering services characteristic of the Intermediate Care Facility (ICF) with the addition of 24-hour, seven day per week nursing services required for complex patient medical conditions. These facilities usually have no less than one registered licensed nurse per 15 patients. SNF 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.

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 refers to services provided in less than 24-hour care setting and not overnight. It 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; 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.

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.

STATE REVENUES: Depict only State funds that are received by or controlled by the SMHA. For mental health programs that are operated by the SMHA (such as state psychiatric hospitals or SMHA-operated community mental health centers) depict all state revenues that are used to fund the mental health provider. For mental health providers that are funded by the SMHA, report all state government funds that the SMHA distributes to the mental health provider (or city/county government) to pay for mental health services.

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:

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.

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

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.

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

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."

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. Forensic Services may include:

- NGRI/GBMI: “Not guilty by reason of insanity" (NGRI) and/or "guilty but mentally ill" (GBMI)
- 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.

Appendix D: 2013 State Revenues and Expenditures Footnotes

Alabama:

- The decrease in *Total State Hospital Expenditures* from FY13 to FY12 is due to hospital closures.
- The increase in *Total Medicaid: State Hospitals (State + Fed.)* from FY13 to FY12 is due to accounting correction for developmental disability program.
- The increase in *MH Block Grant Revenues* from FY13 to FY12 is due to more clients served in the community.
- The decrease in *Other Revenues* from FY13 to FY12 is due to non-recurring proceeds from BP grant funds.
- The decrease in *Total Revenues: State Hospitals* and *Civil Patients: Patient Days* from FY13 to FY12 is due to hospital closures.

Alaska:

- None.

Arizona:

- *The total expenditures* is not equal to *the total revenues* are due to revenue & expenditures may not always occur in the same fiscal year. Revenue reported in a prior report may be spent in the following fiscal year.
- Less than 95% of the Mental Health Block Grant must go toward community mental health services and more than 5% may go toward SMHA Support Activities is due to expenditures in SFY13 reflect multiple awards in MHBG block grants, but each grant year is within the 95/5 rule.

Arkansas:

- None

California:

- The increase in *State Medicaid Revenues* from FY2011 to FY2012 is due to ARRA was no longer in existence after 2010 the State Medicaid rate increase. This resulted in the increase in State Medicaid revenues in 2012.
- The decrease in *Total Administration* from FY2011 to FY2012 is due to dollars reflecting state hospital expenditures only and excludes community mental health dollars.
- The increase of *Other Revenues* from FY2011 to FY2012 is due to increase of collection of county revenues is associated with recognition of increased state hospital bed costs.

Colorado:

- Less than 95% of the Mental Health Block Grant must go toward community mental health services and over 5% may go toward SMHA Support Activities is due to Central office expenditures include 5% Administrative Block Grant and Direct Block Grant expenses.
- For FY2012, *Administration expenses* were not included because Mental Health expenditures were blended with Substance Abuse expenditures as a result of restructuring. In Fiscal Year 2013, Colorado is reporting combined central office administration expenses.
- *Medicaid revenues* for community programs are not included in SMHA-Controlled expenditures: with the exception of $44,228 supporting the Child Mental Health Treatment Act and $378,623 in Administration.
- *SMHA-Controlled expenditures* are including funds for mental health services in jails or prisons: in Colorado, the Department of Corrections and local county jails have separate behavioral

budgets. The State Mental Health authority provides a limited amount (approximately $3.4M) to fund Mental Health Services for Juvenile and Adult Offenders.

- *Children's mental health expenditures* included in SMHA-Controlled expenditures: the SMHA budget includes some children's mental health expenditures. However, mental health expenditures also occur throughout other state and local budgets [such as Child Welfare, Youth Corrections, Medicaid Capitation, CHP+ (Children's Health Plan +) and local county departments of social services.)

Connecticut:

- *The total expenditures* is not equal to *the total revenues* are due to Medicaid, Medicare, Third Party revenue are posted to the State of CT General Fund and not DMHAS.
- The decrease in *Total Medicaid Revenues (State plus Federal), Total Medicaid: Community (State + Federal), State Medicaid Revenues, Federal Medicaid Revenues and Federal Revenues Total* from FY13 to FY12 are due to Billing delayed pending revised Medicaid State plan amendments.
- *Disproportionate Share Medicaid (DSH) tota*l reported on Table 3 is great than *total Medicaid to State Hospital*s reported on Table 2 is due to Medicaid, Medicare, Third Party revenue are posted to the State of CT General Fund and not DMHAS.

Delaware:

- *Medicaid revenues for community programs* are only included for group homes and ACT/ICM.
- *The total expenditures* is not equal to *the total revenue* is due to 6.3M of revenues were spent/expenditures processed in FY14 (continuing approach and DSH); $1,089.7 Medicaid, Medicare, self-pay deposited into state general fund not SMHA to spend; $2.9M in salary reductions due to vacancies.
- *Medicaid revenues for community programs* are only a portion of the DSH funds are allocated to our state hospital
- *The total expenditures for community programs* is not equal to *the total revenues for community programs* is due to Medicare, self-pay, and other third party revenues are deposited into the general fund - not the SMHA account to be spent - federal funds were not all expended (block grant has two year spending authority - trauma grant will get carryover award Salary surplus in Community Mental Health due to vacancies ($750k); $5.8m expended in FY14 in continuing appropriations and outstanding invoices processed in FY14 for FY13.
- The decrease in *Total Medicaid Revenues (State plus Federal)*, *Total Medicaid: Community (State + Federal)* and *Federal Medicaid Revenues* are due to change from CCCP model to ACT/ICM resulted in $5M less Medicaid for those programs - also experiencing high rate of uninsured clients in community system.
- The decrease in *Forensic Patients: Expenditures* from FY13 to FY12 is due to better cost allocation/capturing in FY13.
- The decrease in *Forensics: Cost per pt. day* from FY13 to FY12 is due to better cost allocation/capturing in FY13: these costs per day are not inclusive of allocated department/division costs to reconcile with SMHA expenditures.

District of Columbia:

- The decrease in *MH Block Grant Revenues* from FY13 to FY12 was due to FY12 MHBG reflects carryover dollars.

- The decrease in *Total Medicaid Revenues (State plus Federal), Total Medicaid: Community (State + Federal), Federal Medicaid Revenues, Civil (non-Forensic) Patients: Expenditures, Civil Patients: Patient Days* and the increases in *Total DSH, Forensic Patients: Expenditures* were due to significant decrease in budget in FY 2013.

Florida:

- *The total expenditure of the state mental health authority* is not equal to *the total revenues* is due to unfunded budget from federal grants that ended and high staff turnover.
- *The total expenditure for community program* is not equal to *the total revenues for community programs* is due to unfunded budget from federal grants that ended.
- *The total Inpatient expenditures for state hospitals* is not match *the total expenditures* is due to unfunded budget for bond payment that was transferred to different program component.
- *Medicaid revenues for community programs* are partial included in SMHA-Controlled expenditures is due to we reported Medicaid revenues only focus on Medicaid funds allocated to the Florida Department of Children and Families (DCF; the State Mental Health Authority). The Florida Agency for Health Care Administration (AHCA) is the Florida Medicaid Authority. AHCA's costs for behavioral health services, funded through Medicaid revenue, are not reported to DCF, and DCF does not have timely access to AHCA data.

Georgia:

- The increases in *Total Medicaid Revenues (State plus Federal), Total Medicaid: Community (State + Federal)* and *Federal Medicaid Revenues* are due to these increases relates Title XIX Associated with AW Holdings in the amount of $2.8M & Integrated Health Resources in the amount of $1.4M.

Hawaii:

- None.

Idaho:

- The decrease in *Civil Patients: Patient Days* from FY13 to FY12 is due to there was a bathroom remodel that lasted all year dropping patient days down 3000 beds (from 29,000 to26,000)

Illinois:

- The decrease in *Total Medicaid: State Hospitals (State + Fed.)* and increase in *Total DSH* from FY13 to FY12 is due to closure of two State operated hospitals.

Indiana:

- The decrease in *Other Revenues* from FY13 to FY12 is due to collected lower revenue in 2013 compared to 2012.

Iowa:

- Less than 95% of the Mental Health Block Grant must go toward community mental health services and more than 5% may go toward SMHA Support Activities Community Programs are due to statewide training and technical assistants costs are included in the support activities.

- The increase in *Total Medicaid: State Hospitals (State + Fed.)* from FY13 to FY12 is due to Psychiatric Medical Institute for Children Unit per diem increased during FY2013.
- The increase in *State Medicaid Revenues* from FY13 to FY12 is likely caused by adjustments to the Iowa state payment structure beginning in FY2012.
-

Kansas:

- *Disproportionate Share Medicaid (DSH)* reported on Table 3 is not equal to or less than total Medicaid to State Hospitals reported on Table 2 is due to state mental hospital costs include more medical services than just DSH payments.
- The decrease in *Total Administration* from FY13 to FY12 is due to executive reorganization into Kansas Department of Aging and Disability resulted in a decrease in FTE and overhead costs.
- The increase in *Sexually Violent Predators: Expenditures and Sexually Violent Predators*: Cost per pt. day is due to Program Expansion.

Kentucky:

- *Disproportionate Share Medicaid (DSH) reported* on Table 3 is not equal to or less than total Medicaid to State Hospitals reported on Table 2 is due to Medicaid receipts for patients outside of the 22-64 age range.
- The decrease in T*otal Revenues* is due to First Party & Third Party collections decreased during SFY2013. Revenue from patients and insurance fluctuate from year to year.
- The decrease in *Forensic Patients: Patient Days* from FY13 to FY12 is due to patient days decreased during FY13 at KCPC due to units being close for.
- The increase in *Forensics: Cost per pt. day* from FY13 to FY12 is due to fixed cost remained the same during FY13, although there were fewer patients due to units being closed for renovations.

Louisiana:

- The decrease in *Total State Hospital Expenditures* from FY13 to FY12 is due to closure of Southeast LA State Hospital.
- The decrease in *Children's MH Services* from FY13 to FY12 is due to transfer of children's bed from the public hospital to private.
- The decrease in *Total Medicaid Revenues (State plus Federal)*, *Total Medicaid: Community (State + Federal), Federal Medicaid Revenues* and *Federal Revenues Total* from FY13 to FY12 are due to Medicaid services for the community are provided by a state management organizational and transfer of children's beds from public hospital to private.
- The decrease in *Total Medicaid: Community (State + Federal)* is due to Medicaid Services are provided by a state management organization.
- The increase in *MH Block Grant Revenues* from FY13 to FY12 is due to increase in service.
- The increase *in Other Revenues* from FY13 to FY12 is due to more dollars are generated through the state management organization.
- The decrease in *Total Revenues: State Hospitals* from FY13 to FY12 is due to transfer of children's bed from the public hospital to private.

Maine:

- Notes: Blended FMAP (2013): Federal=62.57%; State=37.43% Children's Targeted Case Management - 13.12 (Procedures - Z9422, Z9423, T1017-UC)Community Support Services: Community Integration (H2015,H2019), Assertive Community Treatment (CBB10,H0039,H0040), Skills-Training & Development (H2014,H2014-HQ,H2026), Ongoing Support -Employment (H2025);Daily Living Supports: (H2017); Community Rehabilitation Services (H2018); Day Support (H2012), Daily Living Support (H2017), Therapeutic Behavioral Health services (H2019);Community Rehabilitation Services (CRS) Mental Health Services: Crisis Intervention (H2011), Crisis Stabilization Unit (H0018, H0019),Outpatient (H2000,H2000-HH,H2000-HQ,H2000-HQHH,H2020,H0004,H0004-HH,HQ,HQ-HH, H0015), Medication Management (H2010,H2010-GT),Psychological/Neuro-psych. Services (see DIG procedure crosswalk) New procedures require breakout by age Children Birth to 17 Years; Adults - 18 years and older Children's Home & Community Based Services, Children's Assertive Community Tx, Community Rehabilitation Services (CRS)- see DIG crosswalk for procedure codes. PNMI - Residential/Group Services: (Children's & Adults) - Proc. Adult MI: RMI, RMI2, RML, RML2; Child: RTS, RTSL, H0019, T0020-HE, T1020-HE and limited to individuals with a MH diagnosis. Note: Child PNMI services include all residential services, including: Intensive residential treatment programs and therapeutic foster care. Psych. Inpatient Units in Community Hospitals: St Mary's Hospital, Northern ME Medical Center, Pen-Bay Hospital, ME General Hospital, Maine Medical Center, Mid-Coast Hospital, and Southern ME Medical Center (Children & Adults with Psych. ICD-9 Dx) receiving treatment in category of service (General Hospital 01).Private Psych. Inpatient Facilities (IMD): Spring Harbor Hospital, Acadia Hospital (Children Only) category of service (Psych. Inpatient - 02) Note: Psychiatric Inpatient expenditures are based on estimated payments. Identification of mental health service users in Residential Facilities and Inpatient Psychiatric Facilities required the use of ICD-9 Dx codes:(291 Thru 314.99)State Psychiatric Institutes: Riverview Psychiatric Institute; Dorthea Dix Psychiatric Institute: Data obtained from Psychiatric Institute Financial Data State hospital expenditures include: federal and state disproportionate share expenditures and general fund only expenditures from the two hospitals.
- Note: The breakdown *of State hospital expenditures* by specific populations in table 4 is not available.
- *MH Administration: Expenditures* include: State General funds for all Central/Regional Office support activities including personnel costs.
- Data Sources: MaineCare Paid Claims System: Paid Claims Data Expenditures based on date of service for State Fiscal Year 2013 (July 1, 2012 to June 30, 2013) State Grant Funds: Obtained from ME-DHHS Administrative Data Systems - (Advantage ME System) Psychiatric Facility Data.
- The decrease in *Forensics: Cost per pt. day* from FY12 to FY13 is due to in 2012 the large increase in forensic population resulted in high acuity levels thus to increased overall and per patient expenditures. In 2013, the population returned to a more typical level.
- The increase in *Civil (non-Forensic) Patients: Expenditures*, *Civil Patients: Patient Days* and *Civil Patients: Cost per pt. day* are due to in 2012 the increase in forensic patients necessitated the use of civil beds. In 2013 with a return to a more typical ratio (forensic: civil) expenditures attributed to civil patients increased accordingly.

Maryland:

- None.

Massachusetts:

- Expenditures and state revenues data source is the FY 2013 Resource Inventory. Where applicable a 25.98% fringe benefit rate has been added to personnel expenses.
- *Other 24-Hour (Residential)* adult state psychiatric hospital expenditures represent the residential component of Community Based Flexible Supports (CBFS) services located on the campus of Taunton State Hospital.
- Expenditures for CBFS services have been placed under the *other expenditures* category. CBFS does not have a residential component; however, a significant portion of the activity within this service is not residential. CBFS is funded through a bundled rate and the DMH is not able to break-out the expenditure for the residential and day components.
- The differences in *revenues and expenditures* are partly a function of the way the data are collected and Massachusetts' system. Funding MH services in Massachusetts is not based on retained revenue and revenues are not a one to one offset of expenditures. Our general fund revenues represent the amount DMH is appropriated each year to run its programs. Without getting into too much detail and the specifics of individual services/programs, it is simple to say that generally any revenues we bring in through the year go back to the general fund.
- DMH did not collect any *DSH* in FY2013
- The increase in *Total Medicaid: State Hospitals (State + Fed.)* from FY13 to FY12 is due to a change in room and board charge plus the capturing of prior year reimbursement in FY13.
- The increase in *other revenues* from FY13 to FY12 is due to additional rental receipts and interest.

Michigan:

- The decrease in *MH Brock Grand* from FY13 to FY12 is due to spending reductions due to Federal Sequestration.
- The increase in *Other Revenues* from FY13 to FY12 is due to one-time use of restricted revenue carry forward.

Minnesota:

- Less than 95% of the *Mental Health Block Grant* must go toward community mental health services and more than 5% may go toward SMHA Support Activities Community Programs are due to Community Programs do not include training and planning and prevention (95% is just for non-administration.)
- The increase in *Total Administration* from FY13 to FY12 is due to a major Psychiatric consultation contract ($846,916) to provide psychiatric consultation to primary care prescribers' accounts for a large increase.
- The increase in *Total Medicaid: State Hospitals (State + Fed.)* from FY13 to FY12 is due to it appears to be just higher Medicaid billings from previous year based on data that we received.
- The increase in *Other Revenues* from FY13 to FY12 is due to in previous years we only included fees and charges that counties reported for residential services, this year we included other community services as well.

Mississippi:

- The decrease in *Total Community MH Expenditures*, *Grand total for SMHA controlled-expenditures*, *Children's MH Services, Adult and elderly services , Total Medicaid Revenues (State plus Federal), State Medicaid Revenues, Federal Medicaid Revenues, State Revenues*

Total, Federal Revenues Total, Total Revenues and Total Revenues: Community MH from FY13 to FY12 are due to Medicaid Match for community programs removed from State Department of Mental Health Budget and put in the MS Division of Medicaid's Budget.

- The increase in *Forensic Patients: Expenditures* from FY13 to FY12 is due to costs reported reflects increase in expenditure amount for forensic unit.

Missouri:

- SMHA Controlled Mental Health Expenditures:
    - SMHA controlled mental health expenditures include fringe benefit costs associated with the SMHA. These are included in expenditures even though fringe benefits are appropriated to and paid for by another State agency.
    - SMHA has excluded $1,107,871 of estimated 2013 costs for psychiatric services provided to the inmates of the Department of Corrections from the SMHA owned and operated adult psychiatric inpatient facilities. These individuals have not been committed to the SMHA for care. Instead this is a program where the SMHA has entered into an agreement with the Department of Corrections to assist with inmates exhibiting behavioral problems while they are in the custody of the Department of Corrections.
    - SMHA Administration includes administrative expenditures of the Division of Behavioral Health - Comprehensive Services and the apportioned costs of the Office of Director that support the division. Office of Director Costs that support the Division of Behavioral Health - Alcohol and Drug Abuse and the Division of Developmental Disabilities are excluded from Table 1.
- SMHA Controlled Mental Health Revenues
    - SMHA revenues do not equal SMHA expenditures due to revenues that are collected by the SMHA but transferred back to the State of Missouri General fund. A total of $153,851,791 is collected by the SMHA and transferred to the General Revenue fund: $153,328,257 is attributed to state psychiatric hospitals; $2,191,538 is attributed to community programs.
- Disproportionate Share Medicaid (DSH)
    - Federal Revenues includes DSH Payments, per diem payments, and Add-on Payments; Total DSH payment includes federal and state and revenue is federal only.
    - The Disproportionate Share State Match represents the certified state match of in-kind expenditures. This certified State Match in Table 3 is appropriated by the State of Missouri as General Revenue to the SMHA to operate state inpatient facilities.
    - The Federal share of the Disproportionate Share Medicaid received by the State of Missouri is not controlled by the SMHA. The $134,334,153 is collected by the SMHA and transferred to the Missouri General Revenue Fund.
- The increase in *Total Medicaid: Community (State + Federal)* and *State Medicaid Revenues* from FY13 to FY12 are due to Increase Medicaid billable services; Continuation of department initiatives to serve more consumers in the community instead of state operated facilities.
- The decrease in *Other Revenue* from FY13 to FY12 is due to Third party payments were less in FY13.
- The increase in *Sexually Violent Predators Expenditure* from FY13 to FY12 is due to Opened more SORTS wards.

Montana:

- The increase in *Forensic Patients: Expenditures* and *Forensic Patients: Patient Days* were higher because of two group homes being closed for remodeling.

Nebraska:

- The decrease in *Total Medicaid: State Hospitals (State + Fed.)* and *Total DSH* from FY13 to FY12 is due to a reduction in billable days due to a change in licensing at a youth facility. DSH revenue is distributed proportionally across several hospitals and varies year to year depending on the percentage of uncompensated care experienced at each location.
- The increase in *Total Medicaid: Community (State + Federal)* and *State Medicaid Revenues* are due to usage of Secure Residential Services by Medicaid eligible individuals increased more than 205% from the prior reporting year, accounting for the variance.

New Hampshire:

- None.

Nevada:

- The large one year change on all *the revenues and expenditures* data from FY13 to FY12 were due to previous years report failed to include all revenue sources beyond State General Fund.

New Jersey:

- The large one year change on *MH Block Grant Revenues* from FY13 to FY12 is due to the fact that the Mental Health Block Grant funds can be obligated and expended over a two-year time period and therefore, on occasion, there will be differences in expenditures from year to year.
- The decrease in *Total Medicaid: State Hospitals (State + Fed.)* from FY13 to FY12 is due to the closure of a State Psychiatric Hospital on June 30, 2012.

New York:

- None.

New Mexico:

- Dept. of Health has determined that the NM State Hospital does not qualify for DSH payments as it is not a General Acute Care Hospital.
- The total expenditures are not nearly equal to the total revenues and the decrease in State Medicaid Revenues from FY2011 to FY2012 is due to inadvertent differences in reporting methodology.

North Carolina:

- The decrease in *Total Community MH Expenditures, Grand total for SMHA controlled-expenditures, Children's MH Services, Total Medicaid Revenues (State plus Federal), and Total Medicaid: Community (State + Federal), State Medicaid Revenues, Federal Medicaid Revenues, Federal Revenues Total, Total Revenues* and increase in *Other Revenues* are due to Managed Care Organization (MCO) waiver - Medicaid encounter data not currently available.

North Dakota:

- None.

Ohio:

- Table 1: The FY 13 Admin amount for Central office support is much larger than in FY 12. That is attributed to some Medicaid "close-out" activities that occurred in our budget in FY 13.
- Table 2: The Revenue to Community Administered Programs is much lower than FY 12 because it does not include revenues for community Medicaid.

Oklahoma:

- The decrease in *Total State Hospital Expenditures* from FY13 to FY12 was due to Children's Recovery Center (CRC) was included with hospitals in FY12.
- The increase in *Total Medicaid Revenues (State plus Federal)* from FY13 to FY12 was due to Medicaid collections and DSH was reduced in FY13.
- The decrease in *Total Medicaid: State Hospitals (State + Fed.)* from FY13 to FY12 was due to Enhanced Tiered Payment System (ETPS).
- The increase in Federal *Medicaid Revenues* and *Total Medicaid: Community (State + Federal)* from FY13 to FY12 was due to ETPS revenue was received during FY13.
- The decrease in *Other Revenues* from FY13 to FY12 was due to other revenue was erroneously recorded in FY12. This is properly accounted for in the state revenues section.
- The decrease in *Total Revenues: State Hospitals*, increase *in Civil (non-Forensic) Patients: Expenditures* and *Civil Patients: Patient Days* from FY13 to FY12 were due to Recovery Center (CRC) was moved from hospitals to community programs section and children's was included with hospitals in FY12. CRC was moved from hospitals to community programs section.
- The decrease in *Total DSH* from FY13 to FY12 was due to DSH collections were reduced.

Oregon:

- The increase in *Other Revenues* from FY13 to FY12 is due to onetime transfer in from Oregon Housing Trust Fund principal.
- The decrease in *Total DSH* from FY13 to FY12 is due to FY12 reported 5 quarters, FY13 reported 3 quarters.
- The increases in *Civil (non-Forensic) Patients: Expenditures* and *Civil Patients: Patient Days* from FY13 to FY12 is due to In FY 2012 all Nero/Gero ward were counted as Forensic, in FY 2013 it was recognized that most are actually Civil.

Pennsylvania:

- The increases in *Forensic Patients: Expenditures and Sexually Violent Predators*: Expenditures from FY13 to FY12 are due to Total patient days and average cost went up.

Puerto Rico:

- Additional expenses were added on the "*Other 24 Hour (Residential) services for Adults*" for amount of $2,451,491.00 increasing the expenses in comparison to the previously submitted report (table 1).
- The difference between *revenues and expenditures* shown to the Grand Total in table 1 and 2 is the result of a Public Policy on Puerto Rico regarding fiscal austerity. Due to the economic austerity measures a voluntary early retirement plan was established and we were not authorized to hire new personnel. The adjustments resulted on savings in programmatic and financial aspects shown on this report.

- Table 4: The following was used to calculate the total amount of Patient Days: Total amount of Hospital Expenditures during FY2013, divided by 365 days, divided by number of available licensed hospital bed.
- The decrease in *Total Community MH Expenditures, State Revenues Total and Total Revenues: Community MH* from FY13 to FY12 are due to P.R. is in an economic recession for the last years, including 2013, as a result, the government has reduction in revenues and budget for services. Community Mental Health appropriations were reduced which impact expenditure in all services.
- The increase in *Civil Patients: Patient Days* and decrease in *Civil Patients: Cost per pt. day* from FY13 to FY12 is due to the patient days were reduced in public facilities Forensic and the State General Psychiatry, the cost was proportionally reduced. It was different in the private facilities were beds increase in patients days.

Rhode Island:

- The decrease in *Total Administration* from FY13 to FY12 is due to reduction of two federal grants which contribute to admin.

South Carolina:

- The decrease in *MH Block Grant Revenues* from FY13 to FY12 is due to South Carolina utilized the spending flexibility given to allow states to address their unique needs.
- The increase in *Sexually Violent Predators: Expenditures* from FY13 to FY12 is due to the census at our Sexually Violent Predator Treatment Center has increased.

South Dakota:

- *The total expenditure* is not equal to *the total revenues* is due to timing and Monthly Title XIX receivable.
- *The total inpatient expenditures for state hospital(s)* in Table 1 is not match the total expenditures on Table 4 is due to age unknown data reported in Table 1.
- The decrease in *Total Administration* from FY13 to FY12 is due to Suicide Prevention Grant ended.
- The increase in *MH Block Grant Revenues* from FY13 to FY12 is due to Timing of Revenue Posting between SFY.
- The decrease in *Other Revenues* from FY13 to FY12 is due to decrease in fees.

Tennessee:

- None.

Utah:

- The difference between total DSH and State plus federal Medicaid to state hospitals reported on Table 2 can be explained: The DSH payments are reported on both tables 2 and 3. DSH represents a small portion of the total Medicaid dollars received by the Utah State Hospital. The majority of the Medicaid received by the Utah State Hospital is for the care of youth and children. The edit appears to presume that the majority (if not all) of the Medicaid funding received by a State Hospital should be DSH. In the case of the Utah State Hospital, that presumption leads to a highly inaccurate conclusion.

Texas:

- The increases in *Total Medicaid Revenues (State plus Federal), Total Medicaid: State Hospitals (State + Fed.), Total Medicaid: Community (State + Federal), State Medicaid Revenues, Federal Medicaid Revenues, Other Revenues, Forensic Patients: Expenditures, Forensic Patients: Patient Days* from FY13 to FY12 are due to there were increases in funding from prior FY2012 data reporting.

Vermont:

- The decrease in *Total State Hospital Expenditures* and *Total Revenues: State Hospitals* from FY13 to FY12 are due to Vermont State hospital (VSH) closed in FY12 due to Hurricane Irene. Services being provided by State hospital replacement and other community inpatient hospitals in FY13.
- The increase in *Total Community MH Expenditures* from FY13 to FY12 are due to DMH expanded community mental health services in an effort to reduced psych inpatient need post Hurricane Irene.
- The increase in *Total Medicaid Revenues (State plus Federal)*, *Total Medicaid: Community (State + Federal, State Medicaid Revenues* and *Total Revenues: Community MH* are due to DMH used GF that was supporting the closed VSH to expand Medicaid eligible community services.

Virginia:

- The Virginia Department of Behavioral Health and Developmental Services serves not only those in need of mental health services but those needing substance use disorder services and services associated with intellectual disability (formerly known as mental retardation). Due to this, certain allocations of costs within our Central Office were required in order to properly assign strictly mental health costs to mental health services.

- The Commonwealth of Virginia funds its community programs with a variety of fund sources. State General Fund pass through dollars, Medicaid dollars and Federal pass through amounts are controlled by the Commonwealth. Funding from our local governments is not controlled by the Commonwealth and is not included in the survey. If this fund source were included, our state expenditures for mental health community programs would be higher.
- Tables 1 and 2: Expenditures Exceed Revenues by $900,000:
    - This difference is the result of actual revenues generated by our MH facilities (Medicaid, Medicare, Third Party reimbursement, patient income, etc.) being less than needed to support our Special Revenue Fund appropriation. Although expenditures were in line with the appropriation, revenues generated to support the appropriation declined due to declining overall census, particularly our geriatric census. This decline is due to emphasis upon community programs as opposed to inpatient oriented state mental health facilities.
- Table 2: Medicaid for State Hospitals Declined in FY 2013:
    - See previous explanation for Table 1 and Table 2 Expenditures Exceed Revenues by $900,000. The drop in geriatric census is a critical factor in the drop.
- Table 2: Increase in Central Office Support
    - The increase in Central Office support is primarily due to the funding and staffing associated with the development and implementation of our Electronic Health Record System. This project is currently underway at most of our facilities.

- Table 4: Sexually Violent Predators
    - The increase in both expenditures and patient days is attributable to an ever increasing sexually violent predator patient population.

Washington:

- None.

West Virginia:

- The decrease in *Children's MH Services* from FY13 to FY12 is due to a timing difference between when grant funds are awarded and when they are drawn down by providers. Also several smaller grants that were targeted for these services ended in FY 2012.
- The increase in *Other Revenues* from FY13 to FY12 is due to there was an increase in First Party and Other Revenue from the state operated hospitals for FY 2013.
- The increase in *Forensic Patients: Expenditures* and *Forensics: Cost per pt. day* from FY13 to FY12 is due to West Virginia's state owned hospitals were able to run a more comprehensive query and report for total forensic charges (a Cyber query report) which resulted in higher numbers for FY 2013. In previous years, the numbers may not have been all inclusive.

Wisconsin:

- The increase in *Total Administration* from FY13 to FY12 is due to total admissions costs varies annually, the 2013 number is more in line with previous years, most notably 2010 in which expenditures totaled $1,270,000. A reduction was previously observed in 2012.
- The increase in *Total Medicaid: State Hospitals (State + Fed.)* from FY13 to FY12 is due to Medicaid billing does vary annually, there is still an overall reduction from the $8,500,000 reported in 2010.
- The increase in *Local Revenues* from FY13 to FY12 is due to amount reports includes local county contributions. Counties are reporting that they are allocation more money than in previous years. Some of this increase may also be accounted for by underreporting in 2012 and annual variation. Overall there has been an increase in spending in Wisconsin on community based programs.
- The decrease in *Civil Patients: Patient Days* and *Civil Patients: Cost per pt. day* from FY13 to FY12 is due to there is an increase in spending on community based mental health programs which are leading to a reduced need for inpatient stays. This has been a trend since 2010 where there was a reported 77,257 inpatient days. This decrease in inpatient days likely is associated with the increased cost per day as fewer days increases the average cost per day.

Wyoming:

- Wyoming State Hospital does not serve clients under 18 for state hospital expenditures data.
- Wyoming State does not receive Federal funds for state hospital data.