STATE OF MAINE
KENNEBEC, ss.

SUPERIOR COURT
CIVIL ACTION
DOCKET NO. CV-89-088

PAUL BATES, et al.,

Plaintiffs

v.

BRENDA HARVEY, COMMISSIONER, DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants

COURT MASTER'S PROGRESS REPORT PURSUANT TO PARAGRAPH 299

The following report covers the period from December 1, 2009 to June 1, 2010.

Budget Developments Regarding Community Mental Health.

My last progress report, issued December 8, 2009, presented a mixed picture-- a tightening supply of mental health treatment services amidst instances of Departmental progress in achieving compliance with the Consent Decree. The diminished availability of community mental health services resulted from the accumulation of successive reductions in funding imposed in recent years. My report forecast the certainty of even more drastic reductions in service as the result of the recession and revenue deficiencies confronting the State at the beginning of 2010. I advanced the hope that any additional funding reductions for mental health services could be managed to inflict only a temporary setback to the Department's progress in achieving compliance rather than dismantling the progress that has been made. Now that the budget for the remainder of the 2010-11 biennium has been completed, it appears that the Governor and Legislature have provided the Department with the means and the opportunity to maintain progress despite some rather significant reductions in funding and an increase in administrative tasks. For a variety of reasons, including an increased federal match for

MaineCare expenditures and strong advocacy on the part of all interested parties, the impact of the recession on community mental health services, although severe, was not as drastic as it might have been and does not prevent rebuilding.

Many of the proposed budget reductions related to state-funded services that are provided to persons who are not eligible for MaineCare. This group is estimated to represent approximately 20% of the class members and the roughly 12,000+ people in Maine who have severe and persistent mental illness. The curtailment and budget proposal initially called for spending reductions for non-MaineCare services other than housing and medication management of $1,341,864 for FY10 and $4,579,469 for FY11. The reductions eventually enacted totaled $1,341,864 for FY10 and $2,129,331 for FY11. These reductions were softened somewhat by FY11 additional funding for state funded community integration ($345,000) and rental assistance ($405,000) for those who are eligible for MaineCare and those who are not. Although the end result could have been worse, the net effect is that persons without MaineCare will find already scarce mental health services in even tighter supply. The services affected most seriously include ACT, daily living supports, community integration, in home counseling, family services and transportation.

The MaineCare side of the budget was also affected by revenue reductions. A proposed 10% reduction of rates paid under all sections of MaineCare resulted in a 10% reduction for benefits under Section 65 excluding outpatient therapy services, medication management and crisis services, a 4% reduction under Section 17, with the exception of rates for community integration which are reduced by 3%. This results in reductions for FY11 of $494,454 and $575,344 respectively, although actual reductions in expenditures may be somewhat less. Mental health outpatient therapy was reduced by $742,498 by restricting visits to eighteen per year.

Allowance for additional visits was made, however, with authorization based on clinical need. Reductions of $425,159 were achieved by standardizing PNMI rates. The budget changes were accompanied by the creation of separate working groups to address the details of outpatient mental health services and standardizing PNMI rates. In addition the Department is directed to convene a stakeholder advisory group to provide guidance for a transition to managed care for all MaineCare programs, including mental health. A first report is called for by October 1, 2010. The Department was also provided with additional funds and the authority to adjust the MaineCare rates reduced by 10% to "actuarially based rates" where necessary. Finally, the Department is directed to establish a rate structure for two separate levels of crisis services. The higher level of service appears to track the recommendations made by the Consumer Council.

The budget season necessarily diminished the resources made available to the Department for community mental health and added substantially to the administrative tasks assigned to the Department. Impacts and developments in the coming months will be carefully monitored.

The Need To Restore Funding For Class Members And Others Ineligible For MaineCare.

Grant funding, the term that is used to describe the direct funding of mental health services by the State from its general fund, is best understood in contrast with the Medicaid match funding that is involved in Maine's Medicaid program, MaineCare. Since the beginning of my tenure as Court Master, late in 2003, the State has continuously increased its funding for Medicaid match and decreased its grant funding. Reduced to its simplest, the cost shifting dynamic is as follows: If the state spends a million dollars for mental health services through grant funding, it delivers one million dollars of services. If it directs one third of a million to Medicaid match, it delivers the same one million dollars of services because the federal

government matches the expenditure by a factor of two for one. If a service can be placed under Medicaid, the State can shift two thirds of the cost to the federal budget. Maine has pursued this policy so aggressively that, in terms of its reliance on Medicaid, it is by far the most Medicaid centric state in the country. According to NRI, a research division of the National Association of Mental Health Program Directors, in 2006, the latest year with complete figures, the Department received 91% of its mental health revenues, both state and federal, from the Medicaid side of the budget, while it received only 9% from grant funding. Most states take a more balanced approach. On average other states received only 44% of their revenue from Medicaid and 46% of their revenue from general funds. Although maximizing federal participation is a useful strategy and endorsed by the consent decree, Maine has gone too far in "Medicaiding" its mental health care costs at the expense of grant funding. By shifting costs too aggressively, it has destroyed, or at least diminished, the safety net of services that were previously available for the low income population that is ineligible for MaineCare.

The reason that most states maintain a more balanced approach between Medicaid and general fund spending for mental health care than Maine is because Medicaid covers only a portion of the population of low income people with mental disorders. Medicaid cost shifting does not result in the services being delivered to the same people. MaineCare coverage details are complex but most adults are ineligible if they have income that exceeds 100% of the federal poverty level of $903 a month. The disqualifying amount varies a bit depending on whether the income is earned or unearned. Adults are also ineligible if they have assets in excess of $2,000 and are receiving SSI, or a total of $10, 000 in assets for those without SSI. Thus, a rather modest asset, social security, retirement, or disability benefit will render an adult ineligible. Some adult mental health clients whose income exceeds the income limits, are able to become

eligible by virtue of the Spend Down provisions. A person with a disability and with incurred medical bills may deduct a portion of their income and thereby become eligible for a period of time, usually six months. The medical bills do not have to be paid but must be incurred. For example, a mental health client with disqualifying income or assets may become eligible for MaineCare because of the medical expense incurred but not paid as the result of admission to a psychiatric hospital.

The precise number of people with severe and persistent mental illness in Maine who are ineligible for MaineCare, with or without a spend down, has not been accurately quantified. Using an incident level of 1.7 and projecting from national statistics, the Department estimates that there are approximately 1,289 such persons whose income would fall at or below 200% of the federal poverty level. It estimates the additional cost of providing services to this population at $7,378,454 per year. An alternative method, which I favor, for estimating the cost of restoring the service needs of the non-MaineCare population is to consider the few hundred persons that the Department reported as affected by the cuts in grant funded services since the beginning of FY08 and to seek to restore the major service cuts imposed, taking into account as well the Department's request for additional service funding that was not acted upon.

According to the documents presented by the Department to the Court on May 16, 2008, which documents were offered to assure the Court that the needs of the non-MaineCare clients could be met despite a cut of $1,000,000 in grant funding, the Department experienced approximately a $2,000,000 reduction in general funding for services in FY09 as compared with FY08. In addition in FY09, the Department submitted a supplemental budget request to fund additional services for non-MaineCare clients in the annual amount of $2,664,250. That request

was not acted upon. I find that the funds required for restoring mental health services to non-MaineCare clients in conformance with the consent decree is $4,664,250.

The non-MaineCare population is a low income population, nearly identical to the MaineCare population and it experiences mental health issues at a rate higher than the general population. Those who are denied necessary mental health services often reappear in the criminal justice system, jails, homeless settings and hospitals, both community and state. Once committed to Riverview Psychiatric Center their discharge is often delayed unnecessarily because of the unavailability of housing and mental health services in the community. Simple justice, public protection and the prudent management of Maine's psychiatric hospitals requires that necessary mental health services for the non-MaineCare population be restored.

Accordingly it is my suggestion that the Department submit budget requests for additional funds for FY12, and thereafter, to restore mental health services to persons ineligible for MaineCare. At a minimum, the additional amount should be $4,664,250. In addition to the findings set forth above, my suggestion is also premised upon the findings set forth in my recommendation dated December 22, 2008, the related findings set forth in earlier progress reports and the current information contained in daily waitlist reports maintained by APS Healthcare and the unmet needs data collected by the Department. My suggestion also reflects the profound concern expressed by the Consumer Council System of Maine in its first annual report "over the nearly non-existent public mental health services available to people who are not MaineCare-eligible." The Council observes: "This state of affairs cannot continue. It is unconscionable to deny services to any person with severe and persistent mental illness who cannot otherwise afford care."

The Need for Increased BRAP funding.

In addition to the shortage of mental health services, there has been a longstanding shortage of rental assistance. A wait list has been in effect since at least 2007. The most recent quarterly report shows some improvement and contains the finding that $1.4 Million would need to be added to the FY11 base in order to eliminate the waitlist.

Commendably, the Legislature and the Administration added $405,000 for BRAP in FY11. It is my suggestion that the Department, at a minimum, submit budget requests of $995,000 for additional BRAP funding for FY12 and beyond. Adequate BRAP funding is an essential component of Maine's mental health system.

Riverview Psychiatric Center.

In my last progress report, I suggested that the direct care staff at RPC be exempted from the hiring freeze and that the budget of the hospital be maintained without reduction and expended only at the hospital. The Administration and the Legislature accomplished each of these goals. As a result, progress in general continues at RPC. In addition, I also urged that the hospital engage in a vigorous management and training effort to focus more clearly on client-centered and recovery-oriented treatment. At present the hospital is engaged in Leadership Effectiveness Training and it should be completed in the near future. In March, I worked with the Superintendent and the Director of the Office of Adult Mental Health to seek to identify changes within the hospital that would strengthen its program to achieve an improved recovery orientation. The hospital is currently evaluating a recovery program used in Connecticut. Results will be assessed in the coming months.

Many performance indicators reflect favorably on the operation of the hospital. The rate of client injuries, staff injuries, elopement, medication errors and readmissions within 30 days after discharge are below the national mean. There has been a marked improvement in AIMS testing for side effects to psychotropic medication. I continue to have concerns, however, about the incidence of restraint and seclusion, client satisfaction and delay in filing institutional reports. The incidence of restraint and seclusion remains above the national mean. To some extent, the increased incidence can be attributed to the challenges of dealing with particular forensic clients, but nonetheless it persists more generally. The restraint figures assume added importance because they do not include manual holds of less than five minutes. The use of manual holds requires monitoring under RPC's plan despite the fact that it is not presently reported for purposes of national comparison. With respect to client satisfaction, the Superintendent uses the monthly client forum as a means of determining the causes of client dissatisfaction and provides appropriate follow up. Timely filing of institutional reports has improved somewhat but still requires attention.

The availability of community services continues as the most persistent and serious problem of the hospital. The discharge of hospital clients, particularly those without MaineCare, is frequently delayed because of the unavailability of housing, services or both. With regard to civil clients, the number of people stuck in the hospital has been reduced significantly but the timeliness of discharges still falls short of the Department's standard. During the most recent quarter, 51.4 percent of the clients were discharged within 7 days of discharge readiness in comparison with the target of 75 percent. 64.9 percent were discharged with 30 days instead of the targeted 90 percent and 83.8 percent were discharged within 45 days instead of the targeted 100 percent. Although these discharge figures are commendable under the circumstances, and

represent a significant improvement from years past, they are still a cause for concern. As community resources become scarce, discharge performance slips, just as it has from the last quarter.

Forensic clients at Riverview face significant delays once cleared for discharge or release by the Courts. Typically, release, partial or otherwise, is conditioned on placement in a group home or supported apartment, with round the clock staffing. In addition, the client is assigned to supervision by an ACT team. At present, the only ACT team available is located in Augusta and serves a catchment area of 25 miles. Accordingly, the group home or supported apartment must also be in the Augusta area. Such housing placements are in short supply, particularly in the Augusta area. When MaineCare funding is not available, the discharge or release process is often daunting and delayed. At the present time, there are three clients awaiting placement after receiving court clearance two months ago. In an effort to relieve the situation, the staff at Riverview is considering proposing to the Court in individual cases, the use of community ACT teams and housing in locations other than Augusta.

The intense treatment available at Riverview is a precious and limited resource. The discharge process, both civil and forensic, is seriously complicated by availability of community resources. The prudent use of Maine's only tertiary mental health facility for both civil and forensic clients requires the restoration of adequate and improved community services to all low income mental health clients whether eligible for MaineCare or not.

Conclusion.

Undoubtedly, Maine still faces difficult economic times and there is a prospect for future budget gaps that will require filling. The extension of the increased federal match for MaineCare expenditures is presently pending before Congress. If the extension is not enacted, further cuts

will follow. It is important, however, to begin the work that is necessary to restore past accomplishments in the mental health system and achieve final compliance with the Consent Decree. The resolution of this long-standing challenge is well within the grasp and means of our State.

DATED: June 25, 2010

Daniel E. Wathen, Court Master