STATE OF MAINE
KENNEBEC, ss.

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

PAUL BATES, et al.,

Plaintiffs

v.

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 August 1, 2012 to January 15, 2013.

Riverview Psychiatric Center

Although the hospital faces significant challenges, at this point it continues to operate satisfactorily and continues to receive adequate staff and budget support. Commendably, the budget curtailment announced by the Governor on December 27, 2012, that included significant cuts in mental health services in other areas, imposed only a minor reduction in the hospital's budget for auditing services. The proposed supplemental budget for FY 13 and biennial budget for FY 14 and 15, announced on January 7, 2013, however, address only a portion of the critical budgetary needs that the hospital faces in the immediate future. The maintenance of an adequate budget for the hospital will certainly be an issue in the Legislative session that is just now beginning.

The hospital is challenged by the continued increase in the number of forensic admissions. At the time of my last report, it was not clear whether the increase was a temporary situation or represented a more lasting shift in the demand for hospital services. It is now clear that an actual shift has occurred and the hospital is appropriately seeking to maximize the effective use of the available forensic capacity. For a time in October and November, forensic admissions were waitlisted and no civil admissions were permitted. Although the rate of forensic admissions has slowed slightly in recent weeks and civil admissions have resumed, the balance between forensic and civil clients remains skewed. As of January 8, 2013, the forensic population was 51 and the civil was 24, with 11 of the forensic clients housed on the civil side of the hospital. Under normal circumstances, the population is ordinarily divided roughly in half between forensic and civil.

The increase in forensic admissions has a profound impact on the general funding structure that supports the hospital. Stated simply, the hospital budget is derived primarily from Federal Disproportionate Share funding (DSH) and the State General Fund. It is now recognized that, at a minimum, forensic clients transferred from jails or prisons, clients admitted for court-ordered evaluations, and clients found incompetent to stand trial do not qualify as

uncompensated care for purposes of the DSH funding. The last session of the Legislature appropriated $3,176,972 in General Funds to replace the anticipated reduction in DSH funding.

The actual shift in forensic population that has occurred since July 1, 2012 suggests that the DSH funding anticipated for FY 13 should be reduced by an additional $2,296,811 and be replaced by a corresponding increase in General Fund appropriations. Unless the population balance corrects itself, a similar increase may be required for FY 14 and 15. The budgets proposed for FY 13, 14 and 15 make no provision for offsetting the loss of DSH funding. Other needs that are not included in the proposed budget include $1,085,944 required in FY 13 to pay a DSH audit for 2009 and $250,000 for each of the three years for the anticipated cost of replacing an obsolete electronic medical record platform. Hopefully, these requests will be considered during the coming Legislative session even though they do not appear in the proposed budgets.

The hospital presented a $325,920 request for FY 13 and a $216,857 request for each of FY 14 and 15 to cover the cost of ACT team services that are usually required when a forensic client who has been found not criminally responsible is approved for community placement by the court system. In authorizing community placement, judges are appropriately sensitive to concerns for public safety. Often the release will be ordered only on condition that the client is housed in a Private Non-Medical Institution (PNMI) and participates in Riverview's ACT team program. Because both services are considered 24/7 services, they cannot be billed concurrently for Medicaid reimbursement. The net result is that the hospital's ACT team services must be supported primarily with State funds. Hence the request, and without additional funding the hospital's capacity to house forensic clients would quickly be eclipsed. The requested funds are a vital part of the hospital's response to the increased demand for forensic services. The proposed budget includes the amount requested for FY 13 and for each of the following two years.

Considering the budget request that is included in the proposed budget and the requests that are not included, it is evident that in the coming Legislative session, the State's resolve to maintain the progress that warranted the withdrawal of the Court's active supervision of the hospital will be tested.

Developments in Community Mental Health

My last report regarding community mental health focused on two aspects of the consent decree that require completion: (1) the funding that is necessary to assure the availability of core mental health services, and (2) the measures the Department might take in order to improve the time necessary for assigning a case worker, and to accomplish the complete separation of housing from services except in residential treatment facilities.

Funding.

The funding situation presents a mixed picture at this point. Two years ago, with my concurrence and encouragement, the Department persuaded the Legislature that $4.6 million dollars was required to restore the necessary grant-funded mental health services that had been eliminated in prior years for non-MaineCare clients. Implemented effectively and maintained from year to year, those funds would have gone a long way toward establishing reasonable

compliance. The funds requested were appropriated for FY 12 but any funding for FY13 required a report from the Commissioner and further action by the Legislature. The report was unavailing and no funds were appropriated for FY13. The Department did succeed in carrying over $850,000 in unexpended funds from FY 12 to FY13. Needless to say, that reduced amount would not have been sufficient and it has been eliminated and aggravated by a total reduction of $1.8 million in grant-funded mental health services as a result of the Governor's December 27, 2012, curtailment order. I have learned only recently that one provider may be compelled to discharge within the next month as many as 750 clients from medication management services as a result of the unavailability of grant funding. Many of these clients are class members, all are being deprived of a core mental health service. The curtailment hastened this dire result but the root cause is the Legislature's failure to continue the additional grant funding from FY 12 to FY 13.

In compliance with its obligation to advocate for funds needed to achieve compliance, the Department requested $3,814,818 for mental health services in the Supplemental Budget for FY13 and $4,664,250 for each of the following two years. The proposed budget includes an additional $2,000,000 for FY 13, (leaving the curtailed amount in effect) and an additional $2,000,000 for FY 14 alone. The net increase of $2,200,000 over an approximate year and one half would be helpful but would not be adequate to address the need or achieve reasonable compliance. There is no assurance, for example, that the new funds would be sufficient to restore the medication management services referred to above.

Process Improvement.

In response to questions posed in my last report, the Office of Substance Abuse and Mental Health Services (SAMHS) has provided a work plan for improving the time that it takes providers to respond to a request from a person with severe and persistent mental illness for the assignment of a caseworker. SAMHS has also provided a work plan for determining the degree to which housing and services may be tied together in community placements other than residential treatment facilities.

The prompt assignment of a caseworker for class members and non-class members is the simplest and most basic obligation that the Department assumed under the terms of the consent decree. The Department agreed in 1990 that class members would have a caseworker assigned within 2 days of a request if hospitalized and 3 days if not hospitalized, and that non-class members would have one assigned within 7 days of a request. That is a promise that has never been even remotely fulfilled. Today, twenty two years later, there are 204 persons with MaineCare coverage on a waitlist for the assignment of a caseworker. The average time they have been waiting, depending on the provider they have selected, ranges from 30 to 60 days, with some waiting for more than 100 days. In addition, there are 188 persons without MaineCare coverage on the waitlist. The average time they have been waiting ranges from 40 to 80 days, with some waiting for 150 and up to 300 days.

The work plan submitted by the Department with respect to the assignment of caseworkers involves an improved process for monitoring the performance of individual providers, a procedure for follow up and technical assistance if necessary and the possibility of sanctions. My own inquiries persuade me that that there are a variety of factors that affect

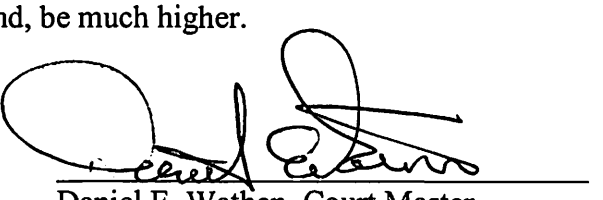
provider performance including a high no-show rate, capacity issues and, most importantly, the availability of grant funding. I am meeting on a monthly basis with SAMHS management and it will take approximately a year to see the results of their current effort at enhanced contract management and process improvement. Those results will be undoubtedly be influenced by the absence of adequate funding for mental health services, particularly for those ineligible for MaineCare. Nonetheless, the process improvement effort may demonstrate that given proper funding, the Department is capable of attaining a degree of reasonable compliance with the most basic obligations of the Consent decree.

The Department is moving promptly to ascertain if there is any remaining tying arrangement between housing and services. Officials of SAMHS are conducting a housing inspection and survey during this month of January for all clients receiving community rehabilitation services. The full results of that survey should be available in February and will form the basis for any required plan of correction.

Conclusion

Continued budgetary support of Riverview Psychiatric Center is absolutely essential in maintaining the improvements that have been achieved. With respect to community mental health services, despite the efforts made in past years, Maine's mental health system is still broken. A person with severe and persistent mental illness should not have to wait months simply to be assigned a caseworker nor should they lose vital medication management services. The cost of improving the delivery of core mental health services in the community, approximately $4 million per year, should be a high priority and is well within our collective means. The true cost of continuing to short fund the treatment needs of a sizable group of people with serious mental illness may, in the end, be much higher.

Dated: January 25, 2013



Daniel E. Wathen, Court Master