# M00L
# Behavioral Health Administration
**Department of Health and Mental Hygiene**

## *Operating Budget Data*

**($ in Thousands)**

| | FY 13 Actual | FY 14 Working | FY 15 Allowance | FY 14-15 Change | % Change Prior Year |
|---|---|---|---|---|---|
| General Fund | $758,426 | $797,769 | $814,710 | $16,941 | 2.1% |
| Contingent & Back of Bill Reductions | 0 | -13,803 | -2,690 | 11,112 | |
| **Adjusted General Fund** | **$758,426** | **$783,966** | **$812,019** | **$28,054** | **3.6%** |
| Special Fund | 58,189 | 50,514 | 46,032 | -4,482 | -8.9% |
| Contingent & Back of Bill Reductions | 0 | 0 | -8 | -8 | |
| **Adjusted Special Fund** | **$58,189** | **$50,514** | **$46,024** | **-$4,490** | **-8.9%** |
| Federal Fund | 383,690 | 443,499 | 513,293 | 69,794 | 15.7% |
| Contingent & Back of Bill Reductions | 0 | 0 | -39 | -39 | |
| **Adjusted Federal Fund** | **$383,690** | **$443,499** | **$513,254** | **$69,755** | **15.7%** |
| Reimbursable Fund | 10,984 | 10,431 | 8,332 | -2,099 | -20.1% |
| **Adjusted Reimbursable Fund** | **$10,984** | **$10,431** | **$8,332** | **-$2,099** | **-20.1%** |
| **Adjusted Grand Total** | **$1,211,288** | **$1,288,410** | **$1,379,630** | **$91,220** | **7.1%** |

- There are two significant fiscal 2014 deficiency appropriations that add funding to the Behavioral Health Administration (BHA): $27.8 million in federal funds based on expectations of higher costs associated with individuals newly eligible for Medicaid under the Affordable Care Act (ACA); and $3.6 million in general funds for overtime costs at the Clifton T. Perkins Hospital Center.

- Cost containment actions also withdraw $13.8 million in general funds from the BHA budget, including $8.4 million from the community mental health services fee-for-service (FFS) budget based on the assumption that services currently funded with State-only funds will be available to individuals newly enrolled in the ACA Medicaid expansion eligibility category and thus covered by federal funds. Other major cost containment actions include reductions

Note: Numbers may not sum to total due to rounding.

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to employee/retiree health insurance ($3.3 million) and retirement reinvestment contributions ($1.5 million).

- The fiscal 2015 BHA allowance includes continued growth in community FFS mental health funding fueled mainly by the annualization of costs anticipated for the new ACA expansion population and a 4% community provider rate adjustment effective January 1, 2015.

- Funding for substance abuse grant services is lower in fiscal 2015 compared to fiscal 2014, again based on the notion that some services currently provided to individuals through these grants will be provided through Medicaid because of the expanded reach of that program under ACA expansion.

## *Personnel Data*

| | FY 13 Actual | FY 14 Working | FY 15 Allowance | FY 14-15 Change |
|---|---|---|---|---|
| Regular Positions | 2,919.45 | 2,919.45 | 2,916.45 | -3.00 |
| Contractual FTEs | 209.02 | 191.00 | 203.18 | 12.18 |
| **Total Personnel** | **3,128.47** | **3,110.45** | **3,119.63** | **9.18** |

***Vacancy Data: Regular Positions***

| | | |
|---|---|---|
| Turnover and Necessary Vacancies, Excluding New Positions | 159.18 | 5.46% |
| Positions and Percentage Vacant as of 12/31/13 | 233.95 | 8.01% |

- The personnel allocation for BHA is reduced by 3 regular positions in the fiscal 2015 budget. These positions are transferred to the Medical Care Program Administration as part of the creation of a behavioral health unit in the administration.

- Contractual employment increases in fiscal 2015 but is still below the most recent actual.

- The overall vacancy rate in BHA remains high, especially given the fact that most of the positions in this budget are for 24/7 State-operated psychiatric facilities.

# *Analysis in Brief*

## Major Trends

***Substance Abuse Prevention:*** The number of people served by prevention programming grew by 9,000 (2.4%) in fiscal 2013 compared to fiscal 2012. The growth was in single service programming.

***Substance Abuse Treatment:*** State-funded admissions to treatment and the number of unique admissions to treatment fell for the second consecutive year, down to 42,426 and 33,354, respectively. Treatment completion rates also fell in fiscal 2013, down from 57.4 to 55.9%. Among the reasons for the drop in completion rates are erosion in data compliance as the substance abuse system moves to a new service delivery model.

***Community Mental Health Fee-for-service System: Enrollment and Utilization Trends:*** Enrollment growth in the FFS community mental health system slowed to 6% in fiscal 2013. Growth is expected to pick up in fiscal 2014 with the expansion of Medicaid under the ACA. The mix of service utilization continues to show a decline in the utilization of inpatient and residential treatment center (RTC) services, with growth in outpatient services.

***Community Mental Health Fee-for-service System: Expenditure Trends:*** Expenditure growth has slowed in recent years, despite continued growth in enrollment as well as the provision of modest provider rate increases. The changing service utilization mix noted above has been key to these spending trends.

***Outcomes for Community Mental Health Services:*** Outcome measures derived from interviews with clients served in outpatient settings continue to show improvement in functioning for adults, although less so for children. Data on adult employment continues to be troubling.

## Issues

***Behavioral Health Integration: Next Steps:*** The integration of State mental health and substance abuse agencies and budgets is occurring, and details on how specialty mental health and substance abuse services will be managed in the future are emerging. More details will follow in the next few weeks with the release of a request for proposals for a vendor to administer many, but not all, specialty mental health and substance abuse services effective January 1, 2015.

***Continuity of Care:*** In the 2013 interim, the Governor charged the Department of Health and Mental Hygiene (DHMH) with leading a panel aimed at improving continuity of care for individuals with serious mental illness. Particular focus is given to the recommendation in which the panel told the Secretary of DHMH to convene another workgroup to examine the implementation of an outpatient civil commitment program.

## Recommended Actions

1. Add language making rate increases included in the fiscal 2015 budget effective July 1, 2014.

2. Add language restricting the use of funds for any outpatient civil commitment program until a report is submitted.

3. Add language restricting funding in the Medical Care programs Administration for specialty mental health services to that purpose.

## Updates

***Use of Fiscal 2014 Expanded Crisis Services Funding:*** The fiscal 2014 budget included additional funding for crisis services. The department's allocation of that funding is reviewed.

***Psychiatric Bed Registry:*** In November 2012, a collaborative group of State and hospital sector agencies launched a new psychiatric bed registry. The effort has not been as successful as had been hoped.

***Transition-age Youth:*** A report in response to a 2013 *Joint Chairman's Report* (JCR) request on services available to transition-age youth included a number of recommendations to improve current services.

***RTC Outcomes:*** A lack of consistently applied valid outcomes across the State's public and private RTCs has meant that there is no way to properly assess the relative merits of these institutions. The development of such a set of outcomes remains unfinished, but progress is being made.

***Individuals with Serious Mental Illness and Aging in Place:*** A 2013 JCR response reviews some of the issues concerning older individuals who have serious mental illness and the ability to keep treating those individuals in community-based settings.

# M00L
# Behavioral Health Administration
### Department of Health and Mental Hygiene

## *Operating Budget Analysis*

### Program Description

The Behavioral Health Administration (BHA) is responsible for the treatment and rehabilitation of the mentally ill; individuals with drug, alcohol, and problem gambling addictions; and those with co-occurring addiction and mental illness. BHA reflects a merger of the Mental Hygiene Administration (MHA) and the Alcohol and Drug Addiction Administration (ADAA). The organizational chart for the combined BHA is shown in **Appendix 4**.

For fiscal 2014, funding for MHA and ADAA was formally combined by budget amendment. In fiscal 2015, funding for Medicaid-eligible services for the mentally ill was moved from MHA into the Medical Care Programs Administration (MCPA). However, for the purpose of reviewing the fiscal 2015 budget, the funding that is budgeted in MCPA is reflected in this analysis.

The newly created BHA will continue to perform the functions previously undertaken by MHA and ADAA. Namely:

- **For Mental Health Services –** planning and developing a comprehensive system of services for the mentally ill; supervising State-run psychiatric facilities; reviewing and approving local plans and budgets for mental health programs; providing consultation to State agencies concerning mental health services; establishing personnel standards; and developing, directing, and assisting in the formulation of educational and staff development programs for mental health professionals. In performing these activities the State will continue to work closely with local core service agencies (CSA) to coordinate and deliver mental health services in the counties. There are currently 19 CSAs, some organized as part of local health departments, some as nonprofit agencies, and 2 as multi-county enterprises.

- **For Substance Abuse Services –** developing and operating unified programs for substance abuse research, training, prevention, and rehabilitation in cooperation with federal, State, local, and private agencies.

## Performance Analysis: Managing for Results

## 1. Substance Abuse Prevention

State prevention services are provided through two types of programs:

- **Recurring Prevention Programs –** *i.e.*, with the same group of individuals for a minimum of four separate occasions and with programming that is an approved Substance Abuse and Mental Health Services Administration evidence-based model. In fiscal 2013, a total of 318 recurring prevention programs were offered across the State, a drop of 10 from the prior year.

  Statewide, the successful completion rate for these types of programs is reported at 84%, a number that has varied little over the past decade. There is variation by county among programs in terms of successful completion. In fiscal 2013, for example, the successful completion rate varied from 89% in Washington and Kent counties to 80% in St. Mary's County. It should be noted that since programming varies from one jurisdiction to the next, there is no universal definition of what is considered a "successful completion."

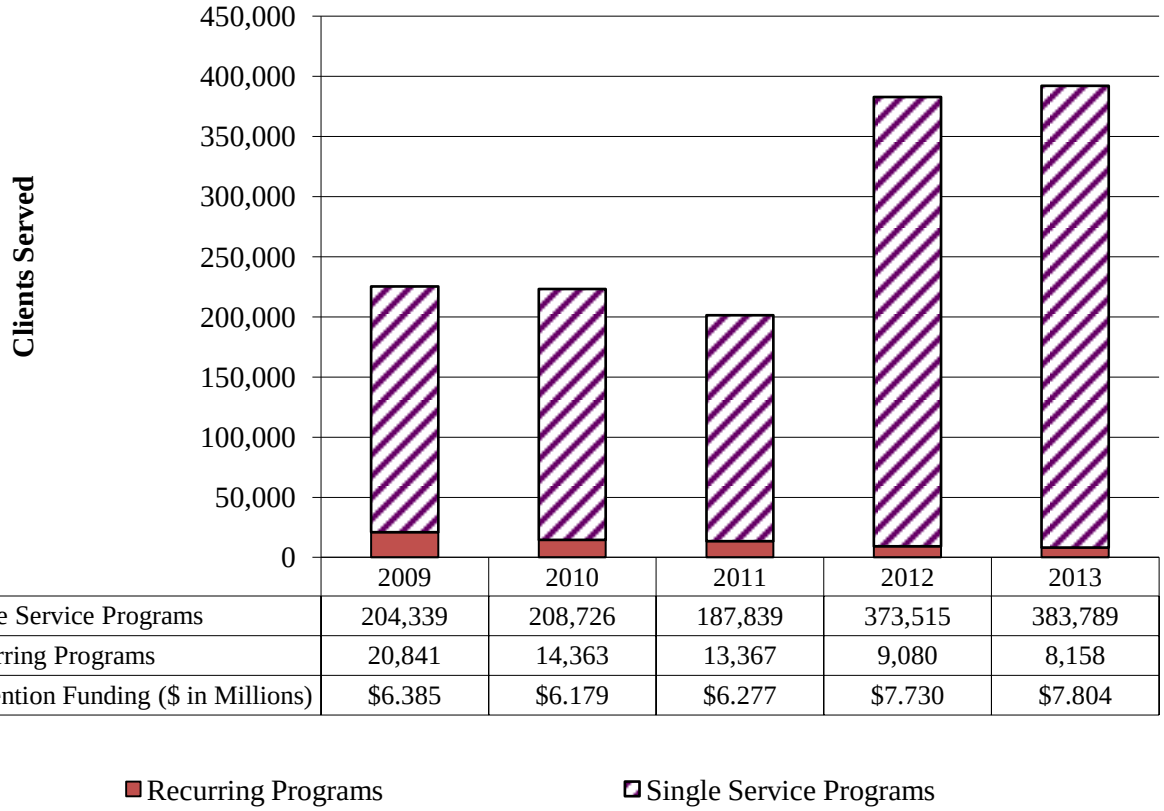
- **Single Service Programs –** such as presentations, speaking engagements, training, *etc*., that are provided to the same group on less than four separate occasions. Participant numbers are either known or estimated. In fiscal 2013, 1,277 single service prevention activities were offered in Maryland, an increase of 24 from the prior year.

As shown in **Exhibit 1**, prevention programming served almost 392,000 participants in fiscal 2013, 9,000 (2.4%) higher than served in fiscal 2012. Recurring programs continue to see a drop in people served, down over 900 (10.0%) between fiscal 2012 and 2013, although that decline is much less than the prior year. Conversely, the number of participants served in single service programs grew by over 10,000 between fiscal 2012 and 2013, or 2.8%.

In essence, after the significant growth in single service programming between fiscal 2011 and 2012 to reflect the change in program focus from individual-based programming to population-based programming/activities, prevention programming has somewhat stabilized in terms of activities funded. The change in focus required jurisdictions to spend 50% of their prevention award on "environmental strategies," *i.e.*, the establishment of, or changes to, written and unwritten community standards, codes, and attitudes influencing the incidence and prevalence of the abuse of alcohol, tobacco, and other drugs. Environmental strategies tend to be primarily single service activities, limiting the funding available for recurring programs. The broader reach of environmental programming, including mass media campaigns, boosts exposure to single service activities.

Prevention funding continues to increase slightly because of the availability of federal Strategic Prevention Framework State Incentive Grant funds. This grant is due to expire at the end of fiscal 2014, although an extension has been requested for fiscal 2015.

**Exhibit 1**
**BHA-funded Prevention Programs**
**Served by Program**
**Fiscal 2009-2013**




| | 2009 | 2010 | 2011 | 2012 | 2013 |
|---|---|---|---|---|---|
| Single Service Programs | 204,339 | 208,726 | 187,839 | 373,515 | 383,789 |
| Recurring Programs | 20,841 | 14,363 | 13,367 | 9,080 | 8,158 |
| Prevention Funding ($ in Millions) | $6.385 | $6.179 | $6.277 | $7.730 | $7.804 |

BHA: Behavioral Health Administration

Note: Funding includes prevention block grant funds and, beginning in fiscal 2010, Strategic Prevention Framework Grant funds.

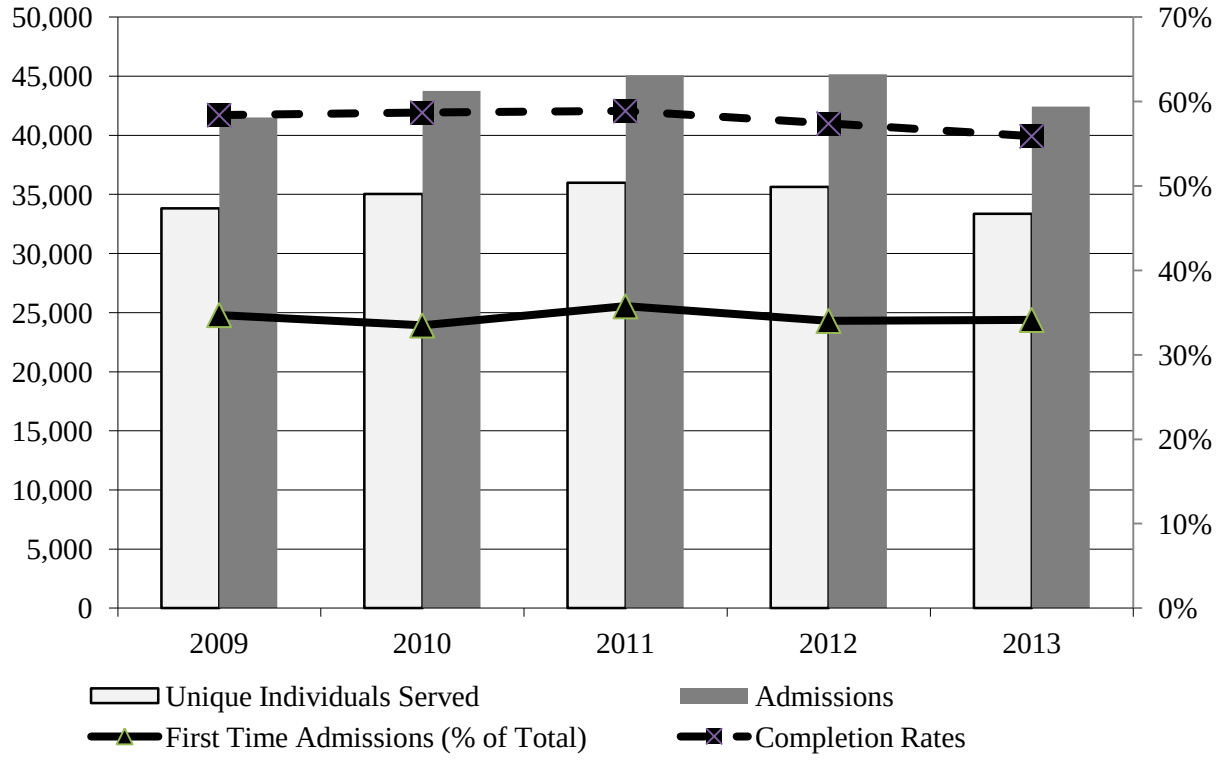
Source: Behavioral Health Administration

It should be noted that BHA's Managing for Results includes a prevention measure, the first time a prevention measure has been included. Specifically, by fiscal 2015 the objective is to reduce the percent of Maryland citizens in the 12 to 20 age range who have used alcohol in the past month to 24.5%. This data is derived from the National Survey on Drug Use and Health. In the most recent survey, for 2011 to 2012, this figure was 25.0% (the same as in the 2010 to 2011 survey and slightly below the 2009 to 2010 survey number of 25.1%).

## 2. Substance Abuse Treatment

As shown in **Exhibit 2**, the number of admissions to treatment and the number of unique individuals admitted to treatment, which had fallen marginally from fiscal 2011 to 2012, fell more sharply between fiscal 2012 and 2013; admissions falling from 45,168 to 42,426 (6.1%) and the number of unique individuals admitted falling from 35,634 to 33,354 (6.4%).

**Exhibit 2**
**State-funded Treatment Programs – Various Data**
**Fiscal 2009-2013**




Source: Department of Legislative Services; Behavioral Health Administration

In the analysis of the fiscal 2014 budget, the administration attributed these declines between fiscal 2011 and 2012 to an increase in length of stay within a treatment episode which increased the average number of daily active patients but reduced the ability to accept admissions. At the time, the administration indicated that preliminary data for fiscal 2013 saw admissions once again rising. Clearly, this did not happen, with admissions falling sharply. The number of episodes of care did increase slightly from fiscal 2012 to 2013, supporting the argument made last year concerning the ability to accept admissions. However, the administration also notes that data reporting compliance on the part of providers may not be as robust as in prior years.

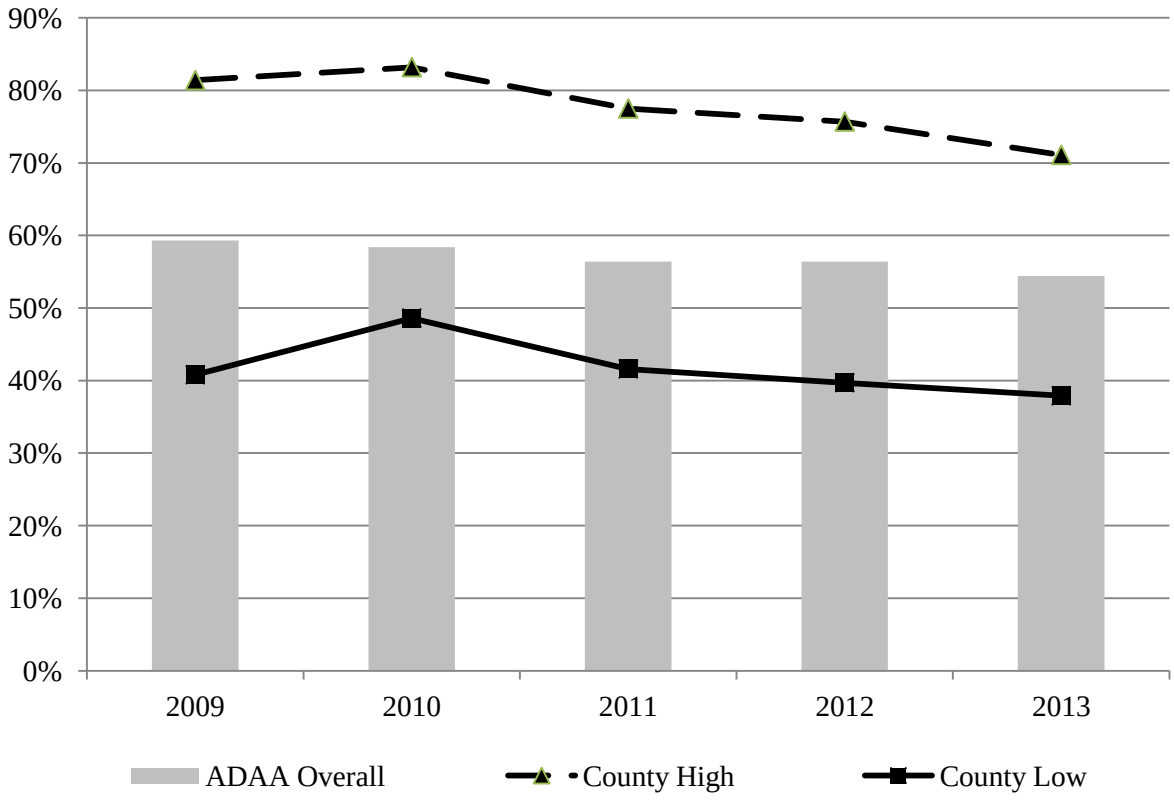
Lack of data reporting compliance is attributed to the gradual erosion of compliance with Statewide Maryland Automated Record Tracking (SMART) reporting requirements due to the merger of ADAA with MHA. Specifically, as the State moves toward the proposed administrative service organization (ASO) model (for a greater discussion, see Issue 1 in this analysis) for mental health and substance abuse services, providers are not entering patient data into the SMART system. Further, grant funding was closely tied to reporting in the SMART system. With more individuals having Medicaid coverage, this also appears to be limiting compliance with reporting requirements.

Completion rates (program completion and discharge without the need for further treatment or program completion with appropriate referral to the next level of treatment), which tended to vary little from year-to-year, fell from 57.4 to 55.9% between fiscal 2012 and 2013. While data issues may again play a part in this drop, the administration also notes the impact of an increase in heroin-related treatment cases. In fiscal 2012, 28.0% of discharges following treatment were for heroin use; this jumped to 32.0% in fiscal 2013. Completion rates associated with heroin-related treatment cases are generally 20.0% lower than these for nonheroin-related treatment cases.

In terms of outcomes, traditionally, a key outcome measure is the retention rate within a program. Research, as well as Maryland experience, demonstrates a strong relationship between retention rates and successful outcomes. In outpatient treatment, for example, keeping a person in a program for longer than 90 days is considered an important benchmark. As shown in **Exhibit 3**, the gradual improvement in the retention rate beyond 90 days in ADAA-funded Level I (outpatient) programs that had dated back to fiscal 2003 stopped in fiscal 2009 and has fallen since that time, including a decline from 56.4% in fiscal 2012 to 54.4% in fiscal 2013.

There continues to be a wide variation between programs in fiscal 2013. For fiscal 2013, the highest retention rate for State-supported programs is 71.1% (Kent County). While Kent County also had the highest retention rate in fiscal 2012, at 75.7%, it is somewhat lower in fiscal 2013. The lowest retention rate is 37.9% (Prince George's County), which represented a sharp drop for this county from 47.7% in fiscal 2012.

**Exhibit 3**
**Level I Retention Rates**
**Retained More Than 90 Days (Percent)**
**Fiscal 2009-2013**




ADAA: Alcohol and Drug Addiction Administration

Source: Behavioral Health Administration

Additional outcome data drawn from treatment programming is shown in **Exhibit 4** as follows:

- There has been a slow but generally steady increase in the percentage of admissions to State-supported treatment programs among individuals who had used substances 30 days prior to admission to treatment. Over the same period shown in the exhibit, up until fiscal 2012, there had been a fairly consistent decline in those reporting substance use 30 days prior to discharge. However, between fiscal 2011 and 2012 this number increased to 40.0%, and it jumped dramatically to 45.6% in fiscal 2013. This also results in a significant drop in the change between substance use at admission and discharge. The administration attributes this to the increase in heroin-related admissions.

**Exhibit 4**
## State-funded Treatment Programs
### Various Treatment Outcomes for Most Treatment Types
### Fiscal 2009-2013

| | Substance Abuse | | | Employed | | | Criminal Justice Involvement (Arrested in Prior 30 Days) | | |
|---|---|---|---|---|---|---|---|---|---|
| | 30 Days Prior to Admission | 30 Days Prior to Discharge | % Change | At Admission | At Discharge | % Change | Prior to Admission | Prior to Discharge | % Change |
| 2009 | 78.0% | 40.0% | -48.7% | 27.1% | 35.2% | 29.9% | 8.0% | 3.2% | -60.0% |
| 2010 | 78.3% | 38.7% | -50.6% | 24.3% | 32.0% | 31.7% | 8.4% | 2.9% | -65.5% |
| 2011 | 78.5% | 37.4% | -52.4% | 23.5% | 30.9% | 31.5% | 8.0% | 3.4% | -57.5% |
| 2012 | 78.3% | 40.0% | -48.9% | 23.0% | 30.4% | 32.2% | 8.7% | 3.5% | -59.8% |
| 2013 | 79.3% | 45.6% | -42.5% | 23.1% | 30.4% | 31.6% | 8.2% | 3.9% | -52.4% |

Note: Data on substance abuse usage excludes persons reported as being in a controlled environment 30 days prior to treatment and detoxification patients; data on employment and criminal justice involvement excludes patients in short-term residential placements and detoxification.

Source: Behavioral Health Administration

There is a fairly significant disparity in this data by individual jurisdiction. Substance abuse within 30 days of admission ranges from a low of 48.1% in Caroline County to 92.1% in Montgomery County. Substance abuse within 30 days prior to discharge ranges from a low of 12.8% in Frederick County (also the jurisdiction with the lowest level in fiscal 2012) to 67.7% in Baltimore City. Jurisdictional differences can be attributed to such things as variation in reporting standards; variation between providers on reporting of substance use prior to treatment; and differences in the mix of levels of care being reported.

- Data on employment continues to be discouraging. Although in fiscal 2013 the percentage of people who were employed both at admission to treatment and at discharge were higher than in fiscal 2012, both data points are still a long way from pre-recession levels.

  The jurisdictional data makes for even grimmer reading in certain areas of the State. For example, although Baltimore City has an above average increase between the number of persons employed at admission to treatment and when discharged from treatment (58.8%), it has the lowest level of persons employed at admission, 10.2%, which rises only to 16.2% at discharge. The variation in terms of employment at admission and discharge is quite marked across the State. Talbot County, for example, has 43.4% employed at admission to treatment and 51.3% employed at discharge. Variation across subdivisions is attributed to patient mix (*i.e.*, the degree to which they might serve adolescents or indigents), local economic factors, and the levels of care offered (many residential programs, for example, integrate employment into program goals and develop relationships in the community around job placement). The administration also notes that much of the change in jurisdictional performance in fiscal 2013 relates to the surge in heroin cases. These individuals tend to have much lower levels of employment at admission (half that of nonheroin cases).

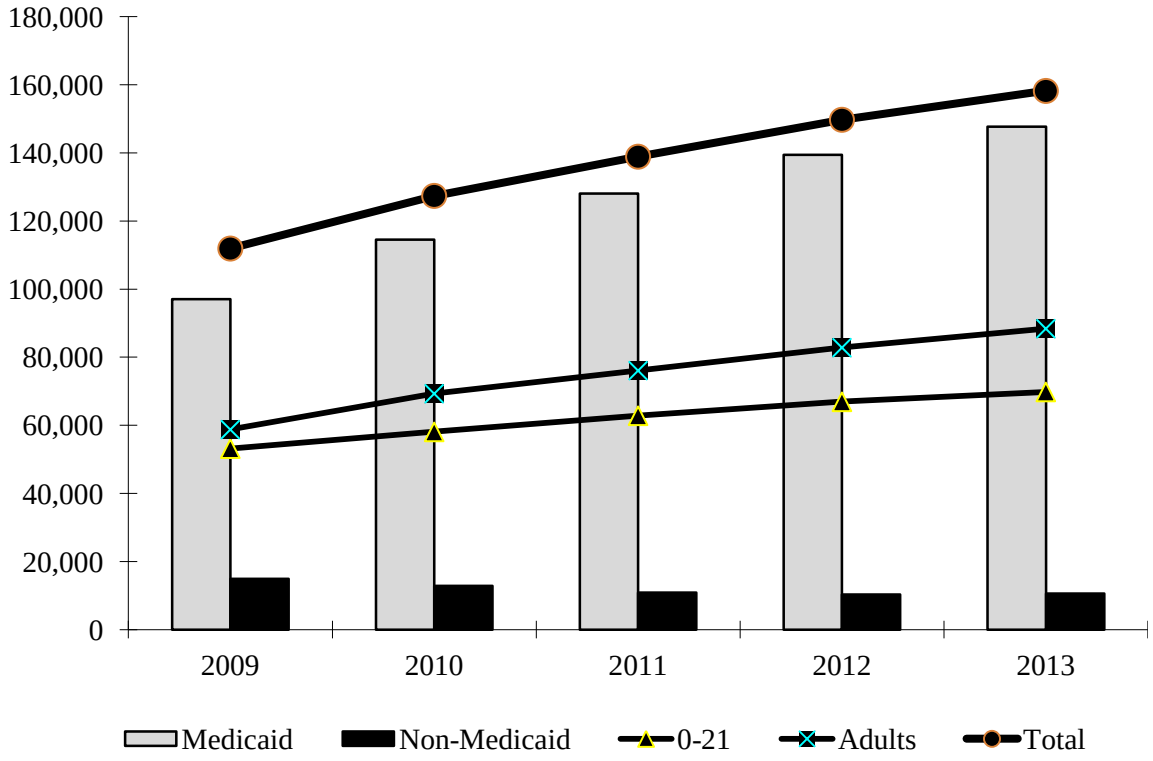
- The relative change in the level of criminal justice involvement 30 days prior to treatment compared to 30 days prior to discharge showed a drop between fiscal 2012 and 2013. Criminal justice involvement at admission was lower, and the level of involvement at discharge higher. Again, the impact of heroin cases is believed to be a factor in that persons in treatment for heroin use tend to have higher levels of criminal justice involvement during treatment.

  Again, the differences by jurisdiction can be quite wide. Talbot County (18.1%) had the highest percentage of individuals who were arrested 30 days prior to admission, compared to St. Mary's County with only 4.5%. In terms of persons arrested 30 days prior to discharge, St. Mary's County had only 1.1% of clients arrested, compared to 8.0% in Kent County. Two jurisdictions, Harford and Queen Anne's counties, saw more people arrested within 30 days prior to discharge than prior to admission.

## 3. Community Mental Health FFS System: Enrollment and Utilization Trends

As shown in **Exhibit 5**, total enrollment in the fee-for-service (FFS) community mental health system (Medicaid and non-Medicaid) has increased at an average annual rate of 9.0% between fiscal 2009 and 2013. Consistent with the growth in the Medicaid program overall, the recession, as well as Medicaid expansion to parents of children in Medicaid up to 116% of the federal poverty level (FPL) beginning in fiscal 2009, has resulted in enrollment growth accelerating in recent years, rising by 14.0% between fiscal 2009 and 2010. However, enrollment growth in the FFS community mental health system, as with Medicaid, is beginning to slow, with growth of 9.0% between fiscal 2010 and 2011, 7.5% between fiscal 2011 and 2012, and 6.0% between fiscal 2012 and 2013.

**Exhibit 5**
**Community Mental Health Services Enrollment Trends**
**Fiscal 2009-2013**




Note: Data for fiscal 2013 is incomplete. Enrollment counts may be duplicated across coverage types. Enrollment in the Baltimore City capitation project is included.

Source: Department of Legislative Services; Department of Health and Mental Hygiene

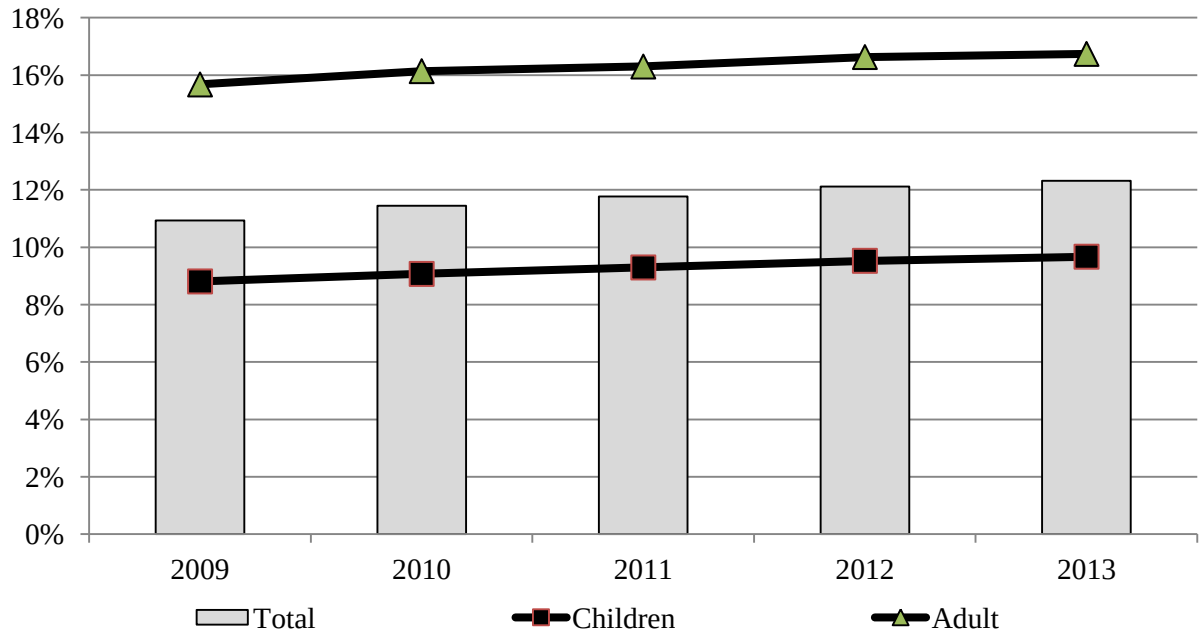
As with Medicaid generally, the expansion of Medicaid eligibility under the federal Affordable Care Act (ACA) is expected to increase enrollment in the public mental health system and will also make all specialty mental health services available to individuals previously enrolled in primary adult care (PAC).

The exhibit underscores the relative importance of enrollment growth in the Medicaid program over non-Medicaid/uninsured clients. Recent growth is almost exclusively in the Medicaid-eligible category (11% between fiscal 2009 and 2013 and 6% between fiscal 2012 and 2013), with the non-Medicaid population falling by 8% over the period shown, although increasing slightly (2%) between fiscal 2012 and 2013.

The exhibit also shows that enrollment growth over the period has been driven by adults (11% between fiscal 2009 and 2013), reflecting the fiscal 2009 Medicaid expansion to parents of children in Medicaid and also, to some extent, the recent strong growth in the PAC program. This compares to 7% for children and adolescents. Adults make up 56% of total enrollment in fiscal 2013, compared to 53% in fiscal 2009. Enrollment growth from fiscal 2012 to 2013 among adults was 3% higher than among children and adolescents. The ACA expansion, effective January 1, 2014, will only serve to reinforce this trend.

The percentage of Medicaid enrollees utilizing FFS community mental health services, the penetration rate, again grew slightly between fiscal 2012 and 2013. The rate grew from 9.5 to 9.7% among children enrolled in Medicaid/Maryland Children's Health Program and from 16.6 to 16.7% among adults. As shown in **Exhibit 6**, the penetration rate in both children and adults has grown steadily over the past 5 years.

**Exhibit 6**
**Community Mental Health Services Penetration Rate**
**Fiscal 2009-2013**

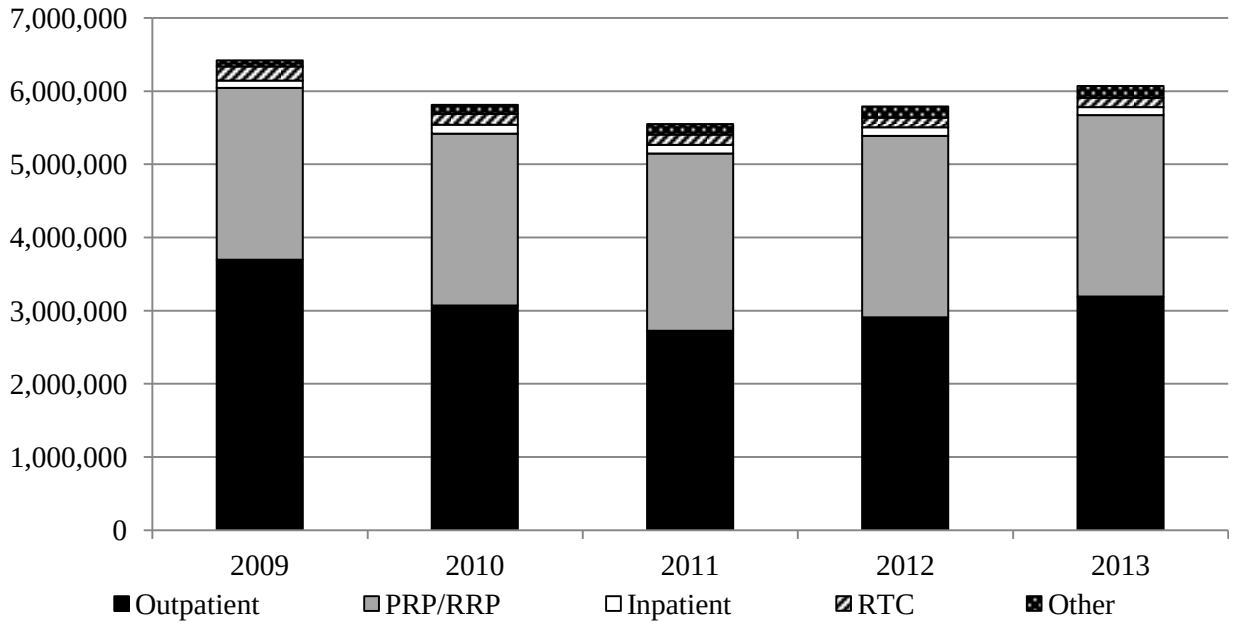



Note: Data for fiscal 2013 is incomplete.

Source: Department of Legislative Services; Department of Health and Mental Hygiene

In terms of utilization of services, trends are shown in **Exhibit 7**. The exhibit shows that over the five-year period, total service units were down slightly (1%). This decline was driven by a drop in outpatient services (4% over the period). This drop was due to a clamp-down on the use of intensive outpatient services, (prompted by perceived inappropriate overutilization of this service) and RTC service units (11%). The number of service units delivered began to grow again in fiscal 2012, and grew by 5% between fiscal 2012 and 2013. However, growth was uneven among different service types: inpatient and RTC service unit counts fell by 4% and 5% respectively; Psychiatric Rehabilitation Program and Resident Rehabilitation Program (RRP) service unit counts were flat; strong growth shown in outpatient service units (10%).

**Exhibit 7**
**Community Mental Health**
**Fee-for-service Service Utilization Trends (Units of Service)**
**Fiscal 2009-2013**




PRP: Psychiatric Rehabilitation Program
RRP: Resident Rehabilitation Program
RTC: Residential Treatment Center

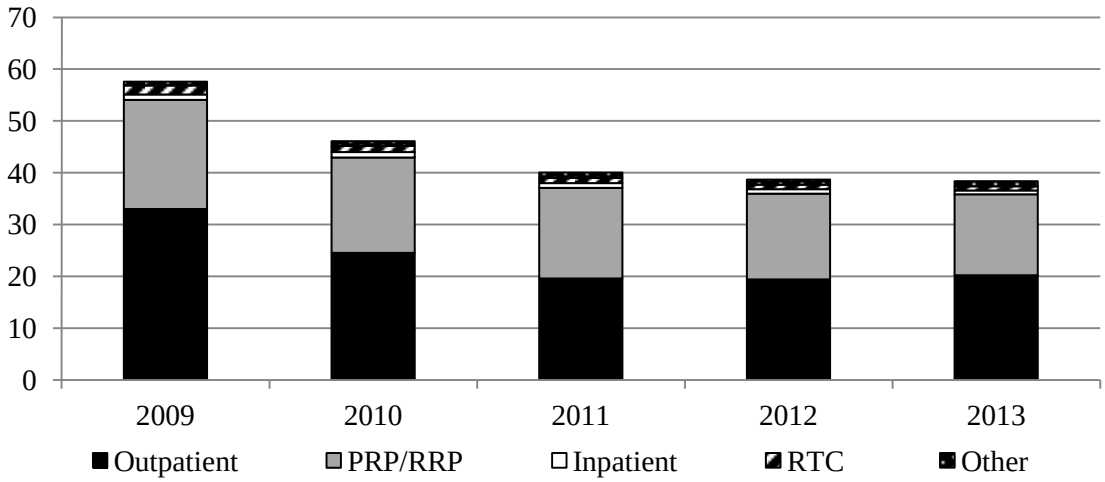
Note: Data for fiscal 2013 is incomplete. Total service unit data includes service units for the Baltimore City capitation project.

Source: Department of Legislative Services; Department of Health and Mental Hygiene

It is worth noting the difference between the enrollment growth in the system between fiscal 2009 and 2013 and contrasting that with the total service units provided in the same period. This difference translates into a decline in the average number of services per capita in almost all service categories (see **Exhibit 8**). This decline is due to a combination of factors:

- specific efforts to reduce utilization of certain services, for example:
  - inpatient (through strengthening of diversion programs, limiting length-of-stay, and improving discharge planning);
  - RTC (limiting use for short-term diagnostic and evaluation services rather than longer treatment stays, plus developing community alternatives to RTC placement); and
  - intensive outpatient (as noted prior); and
- The fact that new enrollees appear to require fewer services generally.

**Exhibit 8**
**Community Mental Health**
**Fee-for-service Service Utilization Trends (Services per Capita)**
**Fiscal 2009-2013**




PRP: Psychiatric Rehabilitation Program
RRP: Resident Rehabilitation Program
RTC: Residential Treatment Center

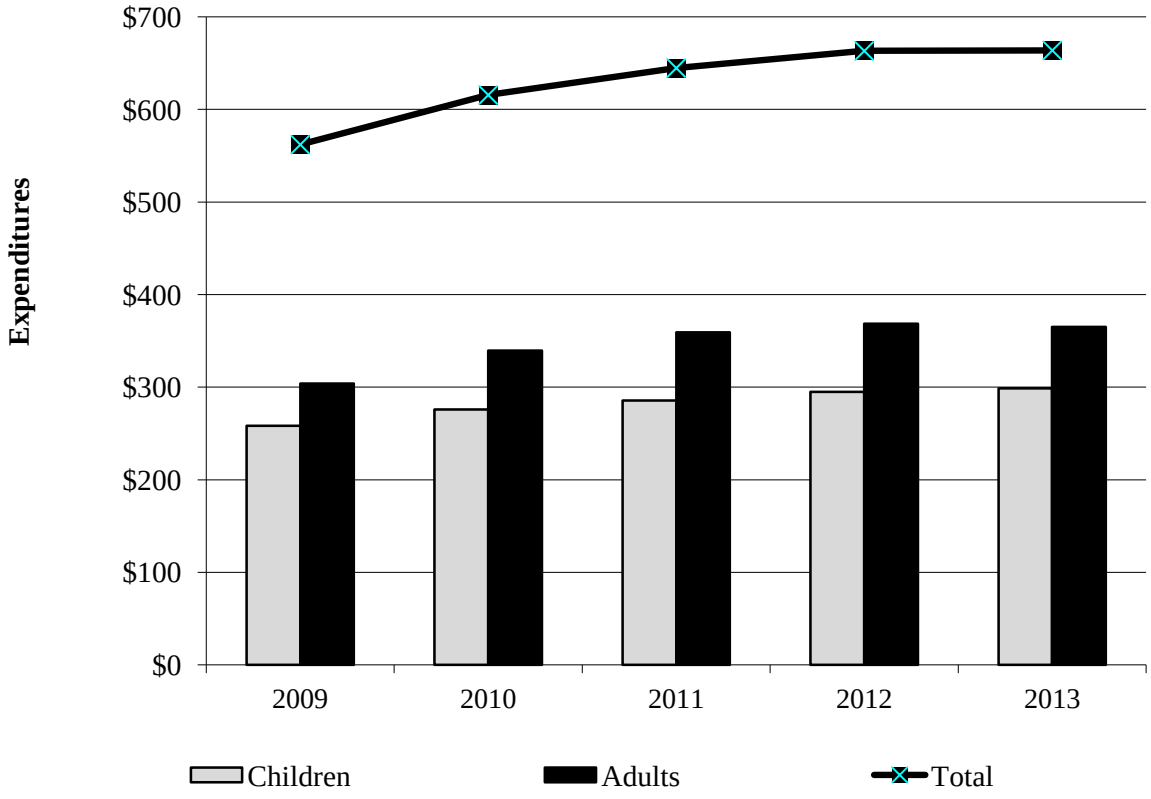
Note: Data for fiscal 2013 is incomplete. Total service unit data includes service units for the Baltimore City capitation project.

Source: Department of Legislative Services; Department of Health and Mental Hygiene

## 4. Community Mental Health FFS System: Expenditure Trends

Expenditure patterns broadly mirror enrollment growth (**Exhibit 9**). Expenditure growth over the fiscal 2009 to 2013 period is 4.1%. In the middle of the period, growth was somewhat higher (8.0% between fiscal 2009 and 2010) but has begun to slow and is projected at only 1.2% between fiscal 2012 and 2013).

**Exhibit 9**
**Community Mental Health**
**Fee-for-service Expenditures**
**Fiscal 2009-2013**
**($ in Millions)**

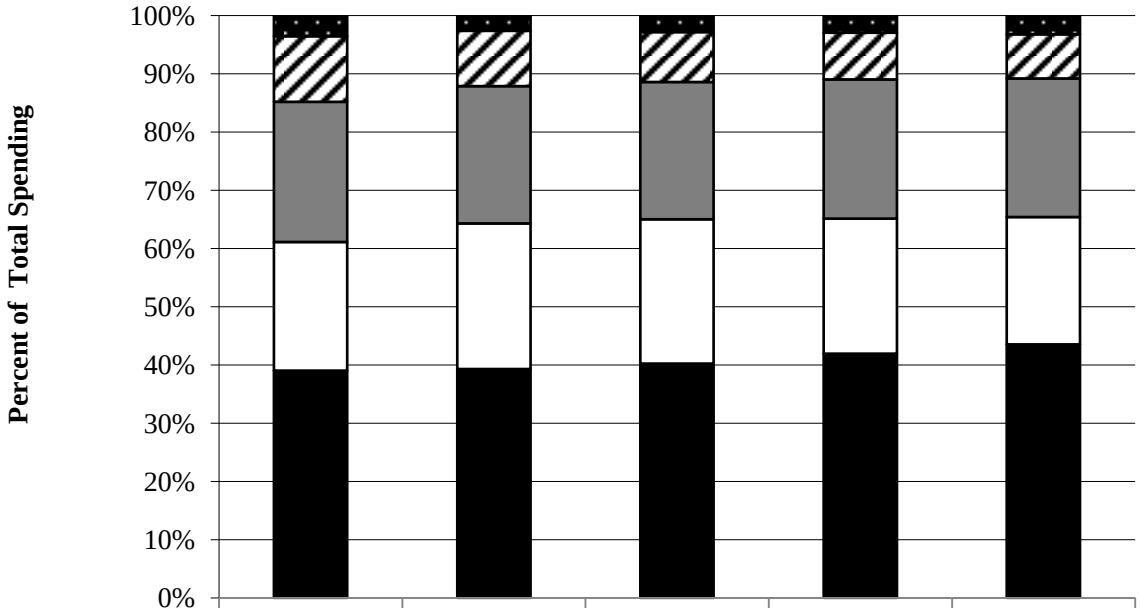



Note: Data for fiscal 2013 is projected from the most recent expenditure data. Total expenditures exclude funding for the Baltimore City capitation project.

Source: Department of Legislative Services; Department of Health and Mental Hygiene

Reflecting the changes in service utilization noted prior, there has been a corresponding change in expenditure patterns between different services (**Exhibit 10)**. Not surprisingly, between fiscal 2012 and 2013, expenditures on inpatient and RTC care shrank, by 4.7 and 4.6%, respectively. In dollar terms, growth in the FFS mental health budget was driven almost entirely by spending on outpatient services.

**Exhibit 10**
**Community Mental Health Service Expenditures by Service Type**
**Fiscal 2009-2013**




| | 2009 | 2010 | 2011 | 2012 | 2013 |
|---|---|---|---|---|---|
| Other | $20,257,023 | $16,175,298 | $18,332,842 | $19,701,889 | $21,615,258 |
| RTC | $64,345,414 | $58,561,029 | $55,193,989 | $53,238,979 | $50,775,830 |
| PRP and RRP | $137,319,566 | $144,952,130 | $152,065,342 | $158,376,085 | $159,831,333 |
| Inpatient | $126,266,048 | $154,038,002 | $159,737,593 | $153,797,591 | $146,601,964 |
| Outpatient | $222,634,947 | $241,974,085 | $259,472,425 | $278,169,109 | $292,205,693 |

PRP: Psychiatric Rehabilitation Program
RRP: Resident Rehabilitation Program
RTC: Residential Treatment Center

Note: Data for fiscal 2013 is incomplete.

Source: Department of Legislative Services; Department of Health and Mental Hygiene

## 5. Outcomes for Community Mental Health Services

Outcome data from MHA's Outcomes Measurement System continues to be limited to outpatient clinics. The data presented in **Exhibit 11** is restricted to clients with at least two data points (generally six months but up to several years apart) and with the same questionnaire type (*i.e.*, the same age group) for those responses. The data compares the initial interview with the most recent interview and compares results from the fiscal 2009, 2010, 2011, 2012, and 2013 cohorts. While this is not an unduplicated sample, there continue to be strong gains in improved functioning for adults. Net improvement in functioning for children fell in fiscal 2013, as it did in fiscal 2012, but rates remained above those reported for 2009.

Data on adult employment in fiscal 2013, while improved over fiscal 2012, remains a concern. The percent of unemployed adults with serious mental illness receiving treatment in outpatient settings in both observations is 63.1%, similar to unemployment levels for persons discharged from substance abuse treatment. Clearly, lack of employment is a major barrier to recovery in both treatment settings.

**Exhibit 11**
**Community Mental Health Services**
**Outpatient Fee-for-service Selected Outcomes**
**Fiscal 2009-2013**

| | Reported in 2009 | Reported in 2010 | Reported in 2011 | Reported in 2012 | Reported in 2013 |
|---|---|---|---|---|---|
| **Adult Outcomes** | | | | | |
| Net Improvement in Functioning (Percent of Total Observations) | 10.2% | 12.0% | 13.8% | 21.8% | 24.6% |
| Increase in Employment Between Observations | -4.1% | -5.5% | -2.2% | -1.7% | -0.1% |
| Persons Unemployed in Both Observations | 59.5% | 61.4% | 74.0% | 63.5% | 63.1% |
| Homelessness in Both Observations | 5.3% | 6.6% | 5.5% | 5.5% | 5.0% |
| **Children and Adolescents Outcomes** | | | | | |
| Net Improvement in Functioning (Percent of Total Observations) | 8.8% | 14.3% | 16.0% | 15.3% | 14.2% |

Source: Department of Legislative Services; Behavioral Health Administration

## Fiscal 2014 Actions

### Proposed Deficiency

There are two deficiency appropriations that impact the BHA budget:

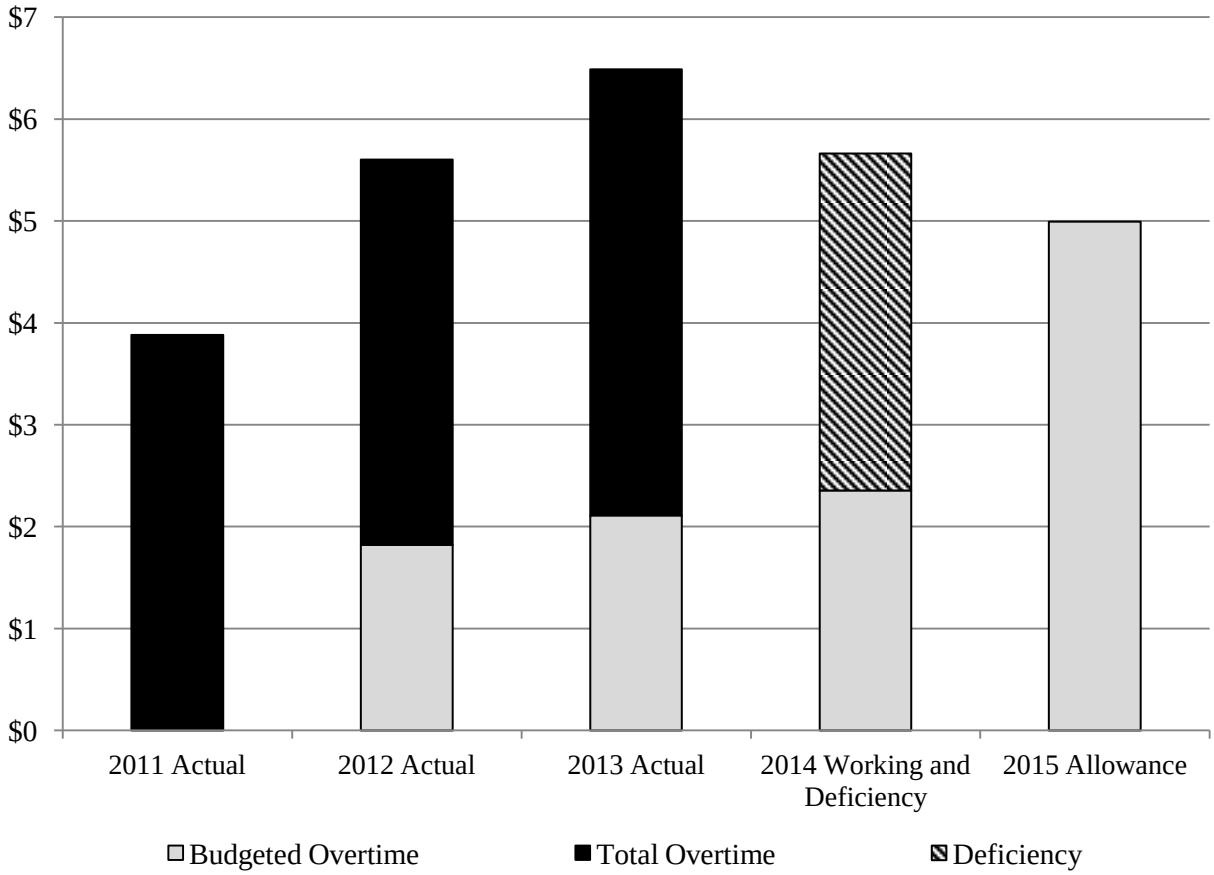
- **The Addition of $27,812,291 in Federal Medicaid Funds –** This additional funding is attributed to higher than originally estimated expenditure growth under the recent Medicaid expansion to 138% FPL, effective January 1, 2014.

- **The Addition of $3,569,729 in General Funds for Overtime at the Clifton T. Perkins Hospital Center –** In 2011, two patients were murdered by other patients at Clifton T. Perkins Hospital Center, the State's sole maximum security psychiatric hospital. These incidents followed another patient-on-patient murder that occurred in 2010. After an independent consultant review, the most visible response from the administration was the addition of 65 positions in fiscal 2012 through double-pinning and contractual employment (with positions and funding formally added in fiscal 2013) and an additional 28 positions in fiscal 2013, for a total of 93 new positions. These new positions were intended to improve patient monitoring through implementation of a new staffing standard established at the facility without a reliance on mandatory overtime and to reduce nonmandated levels of overtime.

The Clifton T. Perkins Hospital Center has generally been able to fill the new positions provided to it. The vacancy rate at the facility as of December 31, 2013, for example, was 6.1%. While still high, that compares to 7.8% in fiscal 2011 when the facility had 86 fewer positions. Despite these additional resources, as shown in **Exhibit 12**, overtime at the facility has continued to grow to almost $6.5 million in fiscal 2013. The fiscal 2014 working appropriation, when combined with the 2014 deficiency appropriation, is still below that level. BHA can be expected to manage any additional shortfall, as it normally does, through recycling eligible salary expenses at Perkins and other facilities. For fiscal 2015, budgeted overtime at the facility increases to almost $5 million, although budgeted turnover is also higher at 6.8%.

According to the administration, although it is certainly paying attention to overtime expenditures, the events of 2011 and 2012 appear to have injected an understandable degree of caution into the operations at Perkins, with the result that overtime has remained high, even with higher staffing levels.

**Exhibit 12**
**Clifton T. Perkins Hospital Center**
**Overtime**
**Fiscal 2011-2015**
**($ in Millions)**




Source: Department of Legislative Services; Behavioral Health Administration

## Cost Containment

There are a number of withdrawn appropriations that somewhat offset the increase in deficiency appropriations noted above:

- $8,330,075 in general funds is withdrawn from the FFS community mental health budget. The reduction is justified based on an assumption that previously State-funded services will be available now to individuals who will be enrolled in Medicaid under the ACA expansion. It should be noted that language does allow the agency to reallocate this reduction to other

programs across the whole department. The ability of the FFS community mental health budget alone to withstand this reduction is discussed below.

- General funds totaling $642,410 are withdrawn from Springfield and Spring Grove hospital centers. However, these reductions are back-filled by equal amounts of special funds available from the Strategic Energy Investment Fund (discussed further in the Maryland Energy Administration budget analysis).

- The BHA budget is also reduced by its share of two statewide reductions to employee/retiree health insurance ($3,348,353); and reductions to retirement reinvestment ($1,481,898). These actions are fully explained in the analyses of the Department of Budget and Management (DBM) – Personnel and the State Retirement Agency (SRA), respectively.

## Proposed Budget Growth Is Driven by Growth in FFS Community Mental Health Services, Primarily Due to Medicaid Expansion under the ACA

As shown in **Exhibit 13**, after adjusting for fiscal 2014 cost containment, the fiscal 2015 allowance for BHA increases by $91.2 million, or 7.1%. After taking into account all of the other adjustments proposed for fiscal 2014, the budget still increases, but by $59.2 million, or 4.5%.

In addition to the absolute growth in the BHA budget, there are also some important changes in fund availability. As shown in Exhibit 13, budget growth is dominated by an increase in federal funds. This is primarily funding that relates to the expansion of Medicaid to 138% of the FPL under the ACA, effective January 1, 2014. The drop in special funds predominantly relates to several factors, including no funding in fiscal 2015 from the Community Health Resources Commission Fund (revenue from the CareFirst premium tax exemption), compared to almost $6.5 million in fiscal 2014. There is also no funding from the Dedicated Purpose Account (DPA) in fiscal 2015 to offset federal sequestration that impacted substance abuse funding (a drop of $1.6 million), although revenues from the Problem Gambling Fund do increase by over $2.3 million.

The decline in reimbursable funds is primarily due to a $1.5 million change in fund source for substance abuse services provided at the Whittsit Center in Kent County. These funds, budgeted as general funds in MHA, were transferred to ADAA where they were budgeted as reimbursable funds. With the merger of the two agencies' budgets, the budget transfer (and thus the reimbursable funds) are no longer required. The actual level of funding for the Whittsit Center is unaffected.

## Exhibit 13
## Proposed Budget
### DHMH – Behavioral Health Administration
### ($ in Thousands)

| How Much It Grows: | General Fund | Special Fund | Federal Fund | Reimb. Fund | Total |
|---|---|---|---|---|---|
| 2014 Working Appropriation | $783,966 | $50,514 | $443,499 | $10,431 | $1,288,410 |
| 2015 Allowance | 812,019 | 46,024 | 513,254 | 8,332 | 1,379,630 |
| Amount Change | $28,054 | -$4,490 | $69,755 | -$2,099 | $91,220 |
| Percent Change | 3.6% | -8.9% | 15.7% | -20.1% | 7.1% |

**Where It Goes:**

| | | |
|---|---|---|
| **Personnel Expenses** | **$11,179** | |
| Annualization of fiscal 2014 cost-of-living adjustment and increment | | $5,958 |
| Overtime earnings (Clifton T. Perkins Hospital Center) | | 2,620 |
| Retirement contributions | | 1,900 |
| Fiscal 2015 increment and other regular salary compensation | | 1,270 |
| Workers' compensation assessment | | 984 |
| Miscellaneous adjustments | | 198 |
| Turnover adjustments | | 179 |
| Social Security contributions | | 178 |
| Other fringe benefit adjustments | | 158 |
| New position (one contractual conversion, all federal funds) | | 80 |
| Transferred positions (four to Medicaid for behavioral health unit) | | -245 |
| Employee and retiree health insurance | | -2,099 |
| **Community Mental Health Services** | | |
| ***Fee-for-Service Expenditures*** | ***$94,637*** | |
| Expansion under the Affordable Care Act (ACA) (federal funds) | | 78,701 |
| Community provider rate adjustment, 4% effective January 1, 2105 (nonrate-regulated services only) | | 10,080 |
| Enrollment and utilization (excluding ACA Expansion) | | 5,855 |
| ***Grants and Contracts*** | ***-$1,872*** | |
| Grants and contracts rate adjustment, 4% effective January 1, 2015 | | 1,036 |
| Administrative Services Organization contract | | 255 |
| Community Mental Health Services Block Grant (federal funds) | | 253 |
| Healthy Transitions (federal grant expires September 30, 2014) | | -386 |

| | | |
|---|---|---|
| Maryland Cares (federal grant expires September 30, 2014) | | -734 |
| **Where It Goes:** | | |
| Local Core Service Agency Grants and Contracts | | -795 |
| Whittsit budget adjustment following merger of the Mental Health Administration and the Alcohol and Drug Abuse Administration (reimbursable funds) | | -1,501 |
| **Substance Abuse Services** | **-$14,855** | |
| Prevention (federal funds) | | 307 |
| Local treatment grants (including treatment funded through the Problem Gambling Fund) | | -2,762 |
| Deletion of funding transferred to Medicaid for the funding of substance abuse service in the Primary Adult Care program and to support rates in the Medicaid program generally | | -12,400 |
| **State-run Psychiatric Facilities** | **$1,328** | |
| Food and food service contract expenditures | | 549 |
| Contractual employment (still below most recent actual) | | 524 |
| Fuel and utilities (align to most recent actual) | | 474 |
| Enhanced security services at Crownsville Hospital Center based on a recent increase in vandalism | | 164 |
| Medical care (primarily the pharmacy contract at Springfield with the University of Maryland School of Pharmacy) | | 163 |
| Equipment repair | | 121 |
| Drug costs | | -667 |
| **Program Direction** | **$696** | |
| Transfer of funding from the Developmental Disabilities Administration for evaluation services for individuals with intellectual disability and mental disorders and in forensic evaluations | | 696 |
| **Other** | | 107 |
| **Total** | | **$91,220** |

Note: The fiscal 2014 working appropriation reflects negative deficiencies and contingent reductions. The fiscal 2015 allowance reflects back of the bill and contingent reductions. Numbers may not sum to total due to rounding.

## Personnel Expenditures

Personnel expenses increase by $11.2 million. Virtually all of the personnel expenses are for operations at the State-run psychiatric facilities. Over half of this increase, almost $6.0 million, is for the annualization of the fiscal 2014 cost-of-living adjustment (COLA) (3% effective January 1, 2014) and fiscal 2014 increment (effective April 1, 2014). As noted above, overtime at the Clifton T. Perkins Hospital Center is budgeted $2.6 million higher in fiscal 2015 compared to the 2014 working

appropriation. However, if the 2014 deficiency appropriation is taken into account, the fiscal 2015 budget is $669,000 below the anticipated 2014 overtime need.

Even after accounting for the fiscal 2015 contingent reduction in retirement contributions due to the reduction in retirement reinvestment ($1,508,888 in total funds), total retirement contributions still increase by $1.9 million. Funding for the fiscal 2015 increment, effective July 1, 2014, adds a further $1.3 million to personnel costs.

The most significant reduction in personnel expenses, including the impact of a back of the bill reduction, is a $2.1 million reduction in employee and retiree health insurance costs.

In addition to funding for the fiscal 2015 COLA, 2% effective January 1, 2015, DBM's budget also contains funding for various Annual Salary Review (ASR) increases for positions in the Department of Health and Mental Hygiene (DHMH) that will largely benefit BHA, including:

- a $3,000 hiring and $3,000 retention bonus for registered nurses at the department's 24/7 facilities;
- a one-grade increase for psychologists; and
- a one-grade increase for direct care assistants.

These ASR increases are effective January 1, 2015.

## Community Mental Health Services

### FFS System

Total spending in the FFS system increases by $94.6 million, of which $78.7 million is federal funding attributed to the annualization and additional growth in expenditures associated with the new ACA expansion population. A provider rate increase of 4%, effective January 1, 2015, for nonrate-regulated community providers adds almost $10.1 million. It should be noted that the Department of Legislative Services (DLS) baseline estimate for the community provider rate increase for fiscal 2015 was 4%, effective for the full year. This was based on the interpretation of the statute governing this rate increase that had prevailed prior to this particular budget: namely, that it was a mandated annual increase based on a formula determined by increases in certain cost centers in State government, and then translating those increases to comparable cost centers identified for community providers. For this budget, the Administration has noted that it does not believe the statute to be a mandate, and hence the increase (and the timing of the increase) is discretionary.

The remaining funding, $5.9 million, is to cover enrollment and utilization for enrollees, excluding the ACA expansion. This represents a 0.8% increase in funding. Given anticipated enrollment growth of 3.30% in the Medicaid program as a whole, excluding the ACA expansion

population, in fiscal 2015, and also taking into consideration the need for rate adjustments for rate-regulated providers and residential treatment centers (RTC), at first blush this appears problematic.

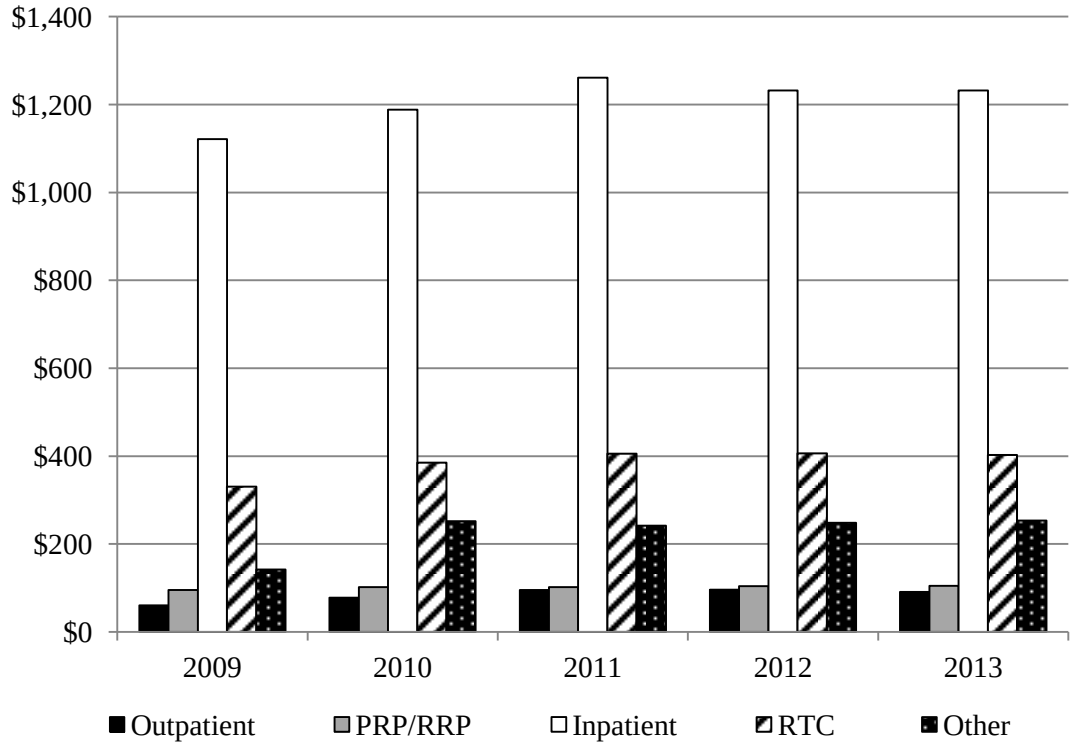
It should be noted that enrollment and utilization funding for Medicaid-eligible individuals, excluding the ACA expansion population, is actually slightly higher than the overall 0.8% increase because the fiscal 2015 budget provides $1.5 million fewer general funds for services for the uninsured than in fiscal 2014. Nonetheless, in order to be able to keep within this budget there needs to be:

- a reduction in demand for services for the uninsured, predominantly through the enrollment of this population in Medicaid through ACA expansion, although perhaps to a lesser extent through enrollment in qualified health plans in the Maryland Health Benefit Exchange (MHBE). Funding for the uninsured is currently limited to those below 200% of the FPL and one or more of the following: being served in the public mental health system in the past two years; currently receiving Social Security Disability Insurance (SSDI) for mental health reasons; currently homeless; having been released from prison, jail, or a correctional facility in the past 3 months; having been released from a Maryland-based psychiatric hospital in the past 3 months; or currently receiving services as required under an order of conditional release. Funding has shrunk over the past few years, and it is unclear the extent to which additional reductions will be realized. The bulk of the individuals enrolling in the new ACA expansion category were already in the PAC program and eligible for some, although not all, specialty mental health services.

- the maintenance of existing utilization trends, and in particular maintaining the decline in utilization of high cost inpatient and RTC services. As shown in **Exhibit 14**, although the number of inpatient and RTC services is far fewer than for other service types, the average costs per service is much higher. Thus, savings in this area from relatively small reductions in service utilization can be disproportionately higher.

- no demand for State-funded services (such as residential rehabilitation) among the new ACA expansion population. The budget makes no allowance for the use of these State-funded services by this new population on the grounds that they are unlikely to be as sick as the current population.

**Exhibit 14**
**Fee-For-Service Community Mental Health Services.**
**Average Cost Per Service**
**Fiscal 2009-2013**

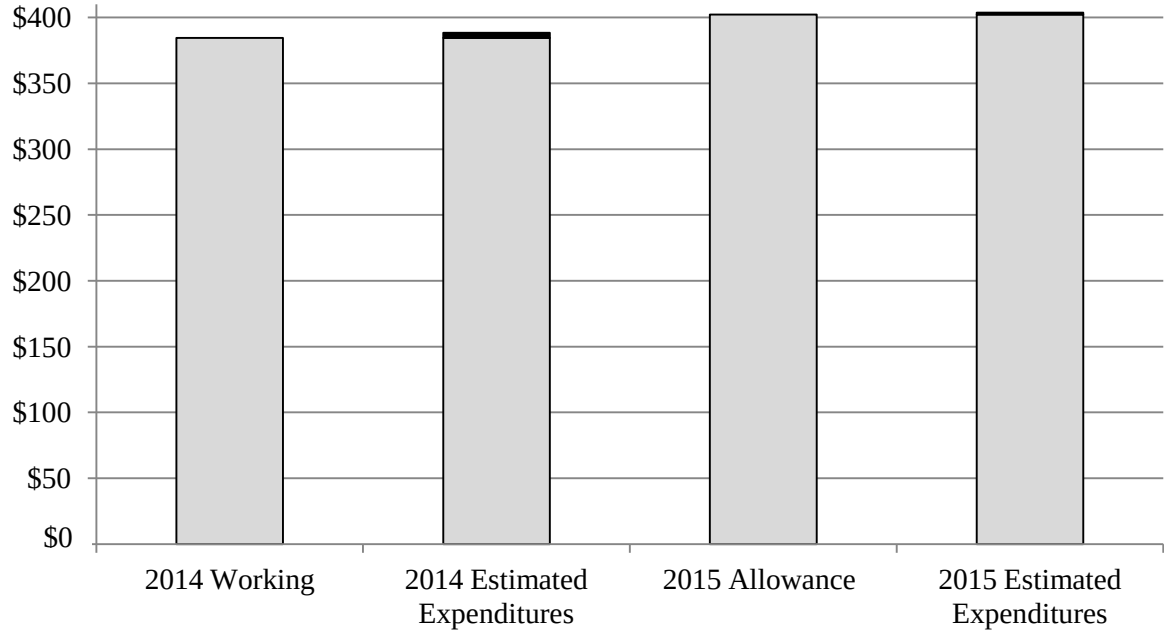



PRP: Psychiatric Rehabilitation Program
RRP: Resident Rehabilitation Program

Source: Department of Legislative Services; Behavioral Health Administration

The DLS estimate of demand for FFS community mental health services excluding the ACA population is provided in **Exhibit 15**. Based on the most recent projections of spending for fiscal 2013 and using projected enrollment growth, provider rate increases, and current utilization trends, it appears that the fiscal 2014 FFS budget is slightly underfunded ($4.0 million) in terms of State funding after taking into consideration the $8.3 million fiscal 2014 withdrawn appropriation. However, it should be noted that current fiscal 2013 accrual levels appear to be slightly above the level needed to closeout fiscal 2013, so flexibility in terms of funding availability remains.

**Exhibit 15**
**Fee-for-service Community Mental Health Services**
**State Fund Adequacy Analysis**
**Fiscal 2014-2015 Estimated**
**($ in Millions)**




Source: Department of Legislative Services; Behavioral Health Administration

In terms of the fiscal 2015 budget, the DLS projection is for a deficit of $1.4 million in State funding. For both fiscal 2014 and 2015, given the overall level of State funding, this represents a variance of only 1.0 and 0.3% respectively. In both cases, the big unknown remains the actual impact of the expansion of Medicaid under ACA and, to a lesser degree, the take-up of insurance options through the exchange among those currently utilizing uninsured services. In theory, many of the individuals currently served in the uninsured program qualify for subsidized insurance through the exchange or for expanded Medicaid. Practically speaking, this is a population that has traditionally been difficult to enroll in Medicaid, let alone the private insurance market. At the very least, the uninsured funding will be needed as a bridge to Medicaid/enrollment in qualified health plans.

Furthermore, there are a number of Medicaid-eligible services, such as psychiatric rehabilitation programming, that are not covered by qualified health plans. The program will also continue to serve those that do not qualify for Medicaid (noncitizens and undocumented aliens) as well as certain Medicare dual-eligibles. Finally, as discussed below in Issue 1, the administration is proposing to potentially expand access to uninsured services by raising income limits.

## Community Mental Health Grants and Contracts

There are two important changes to the funding for community mental health grants and contracts. This funding is primarily for services that are not considered appropriate to deliver through the FFS system and is typically spent through grants and contracts with CSAs. First, the fiscal 2015 budget includes over $1 million to support a 4% rate increase effective January 1, 2015, for services funded through grants and contracts. At the same time, there is a $795,000 reduction in the base funding for grants and contracts. At this time, the administration does not have a plan to allocate that reduction.

## Substance Abuse Services

Funding for substance abuse services through BHA falls by $14.9 million from fiscal 2014 to 2015. The most significant drop is the absence of funding that has been transferred in recent years from ADAA to Medicaid. This funding supported both substance abuse services for people enrolled in the PAC program as well as higher reimbursement rates for substance abuse services provided to other Medicaid enrollees. The fiscal 2014 budget reduced the amount of the transfer, recognizing the end of the PAC program effective January 1, 2014, with those individuals transferring to Medicaid as part of the ACA expansion funded 100% with federal funds. The fiscal 2015 budget phases out the transfer completely. At this point, all funding for Medicaid-eligible substance services for Medicaid recipients is budgeted in MCPA. Funding for Medicaid-ineligible services (*e.g.*, most residential treatment), remains in the BHA budget for both Medicaid-eligible individuals as well as the uninsured/underinsured.

Although the elimination of the funding for PAC is properly characterized in Exhibit 13 as a reduction in the funding for substance abuse services available in the BHA budget, since those services will still be available and funded in MCPA, this particular reduction in funding does not impact service delivery.

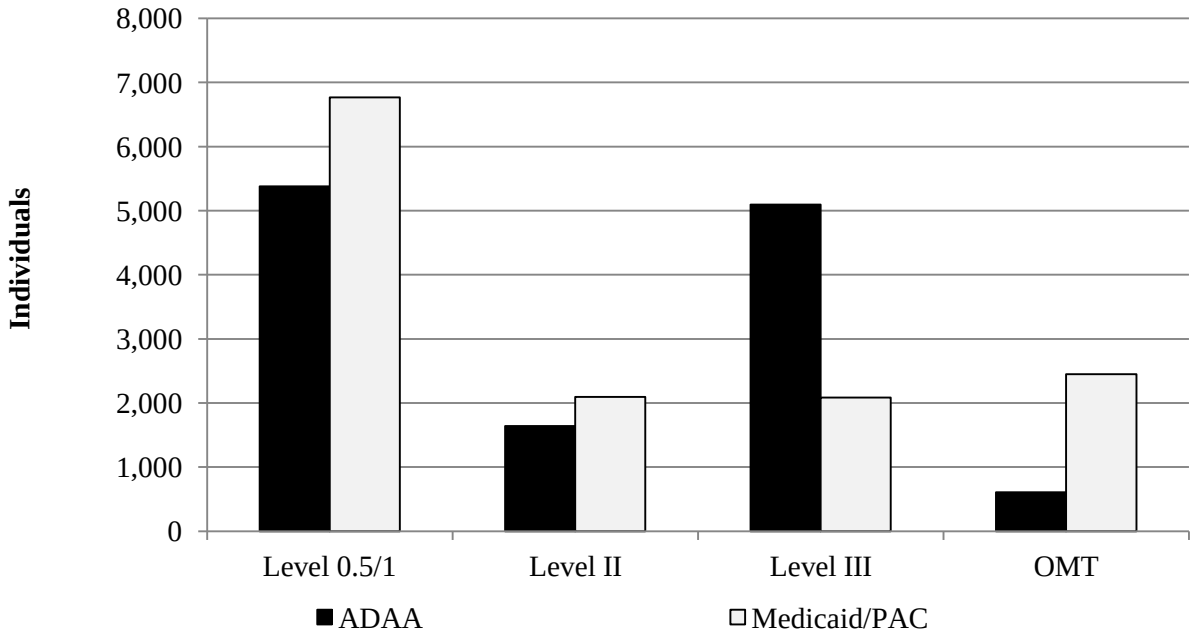
In terms of other treatment funding, there is a $2.8 million reduction compared to fiscal 2014. This drop is driven by a decline in available federal Substance Abuse Prevention and Treatment Block Grant funds ($3.6 million) plus the fiscal 2014 funding from the Dedicated Purpose Account discussed above. While there is some partial back-filling because of higher Problem Gambling Fund dollars available for treatment (based on the opening of the new facility in Baltimore and an assessment on table games Problem Gambling Fund revenues are expected to increase from $2.8 million in fiscal 2014 to $5.2 million in fiscal 2015) plus some additional general fund support, overall, available funding is lower.

The administration argues, as it did last year, that this reduction should not impact service delivery because the grant-based substance abuse system will see a reduction in demand as a result of PAC recipients being able to access the full range of Medicaid-eligible services through Medicaid as opposed to the partial range funded under PAC, and also as individuals who were previously accessing services as uninsured/underinsured become eligible for services in Medicaid under the

ACA expansion or through the MHBE. However, akin to the discussion on community mental health services, the extent to how much this will actually occur is difficult to quantify.

For example, **Exhibit 16** illustrates the primary source of payment by individuals reported at discharge from treatment in fiscal 2013. This data also gives a sense of where potential savings could come from under expanded Medicaid coverage and MHBE enrollment, although because the data lists payment source by the level of care at discharge, that source could reflect multiple levels of care in a treatment episode. As shown in the exhibit, ADAA funding will likely continue to dominate funding for Level III (residential) services for which Medicaid funding is generally ineligible, while savings may be possible in all other levels of care. However, it is impossible to know the extent to which savings will be generated.

**Exhibit 16**
**Primary Source of Payment for Individuals Reported at Discharge by ASAM Level of Care**
**Fiscal 2013**




Level 0.5:/I: Early Intervention/Outpatient
Level II: Intensive Outpatient/Partial Hospitalization
Level III: Residential

ADAA: Alcohol and Drug Addiction Administration
ASAM: American Society of Addiction Medicine
OMT: Opioid Maintenance Therapy
PAC: Primary Adult Care

Note: Multiple levels of care may have been involved in the episode.

Source: Department of Legislative Services; Behavioral Administration

Although not an increase, it should also be noted that additional general funds are made available to maintain the Access to Recovery initiative. Access to Recovery is a federally funded program that began in fiscal 2011 and was the initial focus of substance abuse recovery support service funding in the State budget. Federal funding for this project expires in September 2014. The fiscal 2015 budget includes $2.4 million in general funds to maintain funding for the program at $3.2 million in fiscal 2015. State funding for its own recovery support services program remains at $11.7 million in fiscal 2015.

It should be noted that committee narrative in the 2013 *Joint Chairmen's Report* (JCR) requested BHA to submit a report on these recovery services expansions, which have dominated any growth in substance abuse funding in recent budgets. At the time of writing, no report has been received.

Finally, despite the integration of the two State agencies, unlike for mental health community providers, there is no provision for a rate increase for substance abuse community providers in the fiscal 2015 budget. As the agency attempts to integrate service providers, this discrepancy will need to be resolved.

# *Issues*

## 1. Behavioral Health Integration: Next Steps

For the past several years, DHMH has been examining the issue of integrating mental health and substance abuse care. The need to do this was prompted by observations that the current service delivery system for mental and substance abuse services was fragmented and suffered from a lack of connection (and coordination of benefits) with general medical services; had fragmented purchasing and financing systems with multiple, disparate public funding sources, purchasers, and payers; had uncoordinated care management including multiple service authorization entities; and had a lack of performance risk with payment for volume not outcomes.

As a result of long deliberations, the State chose to move forward with a carve-out of behavioral health services from the managed care system with added performance risk. Specifically, all substance abuse/specialty mental health services will be carved out from managed care organizations (MCO) and delivered as FFS through an ASO (the current MHA model). The ASO contract will include incentives/penalties for performance against set targets.

### Changes to State Administrative and Financial Structures and a Proposal for Management Change

Since the 2013 session, the most visible signs of integration have been:

- the merger of ADAA and MHA into the newly created BHA; and

- the configuration of funding streams in the fiscal 2015 budget so that funding for Medicaid-eligible specialty mental health and substance abuse services for Medicaid-eligible individuals is located in the Medicaid program (the latter still embedded in the MCO/Medicaid FFS budget), with funding for the uninsured/underinsured and for Medicaid-ineligible services located in BHA.

However, at the time of writing, the department had yet to issue the request for proposals (RFP) for the new ASO contract, a contract which is supposed to go into effect on January 1, 2015. The RFP is anticipated in February/March, 2014.

Although the lack of a RFP means it remains somewhat unclear how the funding included in the budget for the second half of fiscal 2015 will be managed, a report recently issued in response to language included in the fiscal 2014 budget bill does offer some additional insight. Some of the important changes include:

- **Revised Eligibility Criteria for the Uninsured –** Under the proposed system, income eligibility for uninsured services will be set at 250% of the FPL, with certain additional

criteria, including having applied for Medicaid or insurance through the MBHE, having a valid Social Security number, and being a Maryland resident. Some temporary exceptions to the criteria apply, which are similar to those currently in place for eligibility for uninsured specialty mental health services access.

Temporary exceptions include receiving SSDI for mental health reasons; being under 18 years of age; homelessness; release for incarceration in the past three months; pregnancy; being an intravenous drug user; having HIV/AIDS; discharge from a Maryland-based psychiatric hospital within the past three months; release from a Maryland-based Level III facility within the past 30 days; receiving services as required by court order or referral from drug or probate court; or receiving services as required under an order of conditional release.

This revised eligibility criteria has a higher income limit than is currently in place for specialty mental health services (200% FPL) and eliminates the sliding-fee scale currently in place for substance abuse services (which imposes a $5 fee for most services for individuals with incomes below 100% of the FPL and a percentage charge for service for individuals above 100% of the FPL).

- **Changes to Authorization, Payment and Data Collection Mechanisms –** For specialty mental health services, the model remains virtually the same as the current system. For all specialty mental health services, clinical policy decisions over authorization will be made by with BHA, with the ASO controlling administrative authorization, payments, and data collection. This does represent one small change in that the CSAs currently have an authorization role for some services. That may change under the new system, although the CSAs are still expected to have an oversight role.

  The most significant changes will be for substance abuse services, as shown in **Exhibit 17**.

**Exhibit 17**
## Proposed Authorization, Payment and Data Collection Mechanisms for Substance Abuse Services

| Service Type | Eligibility Group | Authorizations | Payment | Data Collection |
|---|---|---|---|---|
| Medicaid-reimbursable services | Medicaid | ASO (currently through the MCOs) | FFS through the ASO (currently part of the MCO capitated rate) | ASO (currently through MCO) |
| Medicaid-reimbursable services | Uninsured | ASO (currently authorized by local authorities) | FFS through the ASO (currently through grants) | ASO (currently through SMART) |
| Non-Medicaid reimbursable services | Medicaid or Uninsured | Local jurisdictions (same as currently) | Local jurisdictions through grants (same as currently) | ASO (currently through SMART) |

ASO: administrative service organization
FFS: fee-for-service
MCO: managed care organizations
SMART: Statewide Maryland Automated Record Tracking

Source: Department of Legislative Services; Behavioral Administration

- One of the more interesting aspects of this proposed arrangement is that for non-Medicaid reimbursable substance abuse services (for example, most residential services), funding will stay with the local jurisdiction. While the administration believes that this funding will eventually migrate to the ASO, it argues that this approach avoids potential destabilization of the system that could occur if all the funding for substance abuse services were withdrawn from local jurisdictions. However, this does not appear to fit with idea of ending fragmented management of services or funding streams.

- Also of interest is that Medicaid-reimbursable substance abuse services (for example, outpatient services) for the uninsured will now be provided fee-for-service through the ASO. Effectively, this creates treatment on demand for eligible individuals, much different from the current grant-based system.

- Financial incentives and penalties for performance will be built into the ASO contracts. Specific incentives, and the relative financial weighting, are not known at the time of writing, but will encompass both administrative performance as well as consumer outcomes.

- The ASO will be responsible not only for coordination with local agencies but also with MCOs to ensure appropriate referrals from MCOs and coordination between MCOs and behavioral health providers.

- Provider training will be required in terms of developing and enhancing provider competency in the areas of mental health and substance abuse services and how to seek authorizations and payment through the ASO.

- The State is also moving forward with an initiative for providers to either be independently licensed to provide care or be part of a program that is accredited by a national accreditation body. This is expected to be part of a statutory change that, at the time of writing, had not yet been introduced.

## The Cost of a New ASO Contract

In terms of the cost associated with implementing a new ASO contract, **Exhibit 18** details estimated costs for fiscal 2015 (assuming a January 1, 2015 implementation date). These costs are above and beyond the existing ASO contract. Actual costs will depend on bids made as part of the RFP process. The fiscal 2015 budget does not assume any of these new costs associated with the proposed ASO contract. The hope is that, long-term, better integration of care will be able to generate savings that offset these additional costs.

**Exhibit 18**
**Projected New Costs Associated with the Proposed Behavioral Health ASO Contract Fiscal 2015 (Six Months of Costs Only)**
**($ in Millions)**

| Costs/Lost Revenue/Savings | General Funds | Total Funds |
|---|---|---|
| **Costs/Lost Revenue** | | |
| Adding Medicaid-covered substance abuse services to administrative service organization (ASO) contract. Based on estimated spending on these services in managed care organizations (MCO) and Medicaid fee-for-service ($269 million), multiplied by 1.7% (conservative cost of benefit for ASO costs). | $1.15 | $2.30 |
| Adding certain substance abuse services provided to the uninsured to the ASO contract (outpatient services valued at $27.8 million), multiplied by 1.7%. | 0.24 | 0.24 |
| New ASO requirements for mental health services not in current ASO contract (to cover performance risk and data-sharing requirements not currently included in ASO contract). | 0.52 | 0.89 |
| Lost revenue from the Rate Stabilization Fund (carve-out of substance abuse services from MCOs reduces overall premium tax receipts paid by MCOs which in turn reduces the revenues paid to the Rate Stabilization Fund that are used to support Medicaid services) that will need to be back-filled with additional general funds | 1.28 | 1.28 |
| **Offsets** | | |
| MCO rate adjustment to reflect lower administrative costs | -1.15 | -2.30 |
| **Net New Costs** | **$2.04** | **$2.41** |

Source: Department of Legislative Services; Behavioral Administration

## 2. Continuity of Care

During the 2013 interim, at the direction of the Governor, DHMH established a Continuity of Care Advisory Panel to explore ways to enhance continuity of care for individuals with serious mental illness. Based on work done by the panel and workgroups established by the panel, a wide-ranging set of recommendations outlined in **Exhibit 19** were included in a report issued in

## Exhibit 19
## Summary of Recommendations Made by the Continuity of Care Advisory Panel

| Areas of Recommendation | Recommendations |
|---|---|
| Accessibility of Mental Health Records | Update comparison of federal and State privacy laws and regulations and specifically reference mental health records. |
| | Encourage mental health providers to utilize CRISP programs and add representation to the CRISP board. |
| | Ensure economic incentives are in place for behavioral health providers to utilize Electronic Health Records. |
| Service Availability | Continue to monitor access to services, especially in certain areas, e.g. crisis services and residential housing. |
| Workforce Training | Conduct workforce training in certain areas, *e.g.*, cultural competency and training for language interpreters who work in health care settings. |
| Mental Health Literacy | Develop mental health literacy materials so that consumers better understand choices when making health care decisions. |
| Additional Research | Conduct additional research in a number of areas: how to address the behavioral health workforce shortages (including the use of telemedicine) and how to overcome language barriers in health care settings, as well as a long list of other topics, such as expansion of mental health courts and overcoming regional disparities in services. |
| Delegated Decisionmaking | Amend the Health Care Decisions Act to allow a surrogate to authorize the treatment of a mental disorder. |
| | Change guardianship requirements and provide more education on what is covered by guardianship. |
| | Make various changes with regard to advance directives. |
| Services for Court-Involved Individuals | Expand the scope of clinical review panels to allow decisions made at DHMH facilities to apply to individuals in the custody of the Department of Public Safety and Correctional Services for a limited time. |
| | Expand the Community Forensic Aftercare Program. |
| Involuntary Commitment | Better define the current dangerousness standard and promote consistent application, including the development of appropriate training programs. |
| | The Secretary of DHMH should convene a workgroup to further examine the implementation of an outpatient civil commitment program. |

CRISP: The Chesapeake Regional Information System for our Patients
DHMH: Department of Health and Mental Hygiene

Source: Continuity of Care final report. January 2014.

January 2014. The panel made additional recommendations to be considered by agencies other than DHMH (for example, numerous recommendations in the housing area) as well as recommendations to expand existing efforts where DHMH is already actively engaged in addressing barriers to continuity of care (for example, expanding the Loan Assistance Repayment Program and speeding Medicaid enrollment).

## Outpatient Civil Commitment

The topic that evoked the most discussion during the deliberations of the panel and its workgroups was outpatient civil commitment. Given the depth of feeling around this issue, the extent of discussion was not surprising. Nor was it surprising that the workgroups involved in the process came to no consensus on this issue. However, as noted above, the panel did ultimately make a recommendation.

Outpatient civil commitment is a civil law mandate ordering an individual to obtain psychiatric treatment against one's will or risk sanctions up to and including forced hospitalization. Unlike involuntary inpatient commitment, outpatient commitment allows an individual to remain in the community versus confinement in a hospital. However, failure to adhere to outpatient civil commitment requirements can ultimately result in forced hospitalization.

There are various types of outpatient commitment: conditional release from hospital (40 states); alternative to hospitalization (33 states); and preventive outpatient commitment (10 states) for individuals not yet meeting inpatient criteria but with the intent of preventing deterioration that would lead to hospitalization. In total, 45 states have one or more forms of outpatient commitment. Maryland is one of 5 states (together with Connecticut, Maine, Massachusetts, and New Mexico) that have no outpatient civil commitment statute.

The arguments for and against outpatient civil commitment are summarized in **Exhibit 20**.

**Exhibit 20**
## Summary of Arguments For and Against Outpatient Civil Commitment (OCC)

| Arguments For | Arguments Against |
|---|---|
| OCC is less damaging than being left untreated | OCC is unconstitutional |
| OCC increases treatment exposure and medication adherence | OCC is overly coercive |
| OCC leads to a better quality of life | OCC relies on deception |
| OCC reduces violence | OCC is anti-therapeutic |
| OCC is better than inpatient or criminal justice confinement | OCC is disempowering |
| OCC leads to less inpatient or criminal justice confinement | OCC is stigmatizing |
| | OCC is discriminatory |
| | OCC involves inadequate services |

Source: *The Criminalization of Mental Illness: Crisis and Opportunity for the Justice System* (2013) cited by J. P. Morrissey in a presentation to the Continuity of Care Panel (October 2013).

In addition to a presentation of the arguments for and against outpatient civil commitment, the Continuity of Care Panel was presented with a review of the evidence on outpatient civil commitment from three major studies from the United States (two based on data from New York and one from data in North Carolina), including an assessment of the strengths and limitations of those studies. The review of the studies concluded that there was some moderate evidence in support of outpatient civil commitment reducing hospital use and increasing engagement in services, but there was only weak support for the notion that outpatient civil commitment reduces criminal justice involvement.

Similarly, the panel was presented with a review of a 2013 study looking at potential cost savings from outpatient civil commitment, again from New York and again including strengths and limitations of the study. From a budget perspective, this study was particularly interesting. The study had two major findings:

- Outpatient civil commitment requires a substantial investment of resources but can reduce overall service costs for persons with serious mental illness.

- For those who did not qualify for outpatient civil commitment, voluntary participation in intensive community-based services may reduce overall costs over time.

However, the review presented to the panel on this study concluded that the strength of evidence for both findings was weak and concluded that there is little evidence from this study that indicates that states can save money from outpatient civil commitment.

The panel's recommendation on outpatient civil commitment was for the Secretary of DHMH to convene a workgroup to further examine the implementation of an outpatient civil commitment program in Maryland. As part of this examination, the workgroup would assesses the cost to DHMH and other State agencies, including the feasibility of securing federal participation for services provided through any program. If this workgroup wanted to move forward with an outpatient civil commitment program it would also recommend appropriate legislation, as it is generally thought statutory change is required for such a program.

**Given the potential fiscal impact of any implementation of an outpatient civil commitment program in Maryland, DLS recommends adding language requiring that if the Secretary chooses to appoint a workgroup to develop an outpatient civil commitment program, a report detailing the budget implications of any program recommended by that workgroup be submitted prior to the program's implementation.**

# *Recommended Actions*

1. Add the following language:

   Provided that any funding included in the fiscal 2015 Department of Health and Mental Hygiene budget for provider rate increases shall be used to fund the level of rate increase that is supportable with that funding on a twelve-month basis effective July 1, 2014. Further provided that this restriction does not apply to any calendar 2015 rate increase for Managed Care Organizations (MCO).

   **Explanation:** The fiscal 2015 budget for the Department of Health and Mental Hygiene includes a variety of rate increases. Some of these increases are effective July 1, 2014; others are effective January 1, 2015. The fiscal 2016 general fund cost simply to maintain the rate levels that go into effect January 1, 2015, is approximately $24 million. The language does not reduce the funding included in the budget for proposed rate increases, but rather requires the funding to be used to support whatever rate increases are supportable for the full fiscal year. For example, funding in the budget to support a rate increase of 5.0% effective January 1, 2015 would instead be used to fund a rate increase of 2.5% effective July 1, 2014. It should be noted that MCO rates are set on a calendar year basis. Funding for any calendar 2015 rate increase is not included in the fiscal 2015 budget. However, the language makes it clear that it does not apply to any MCO rate increase.

2. Add the following language:

   Further provided that no funding appropriated in this budget may be used to implement a program of outpatient civil commitment until the Department of Health and Mental Hygiene submits a report to the Senate Finance and Budget and Taxation committees and the House Health and Government Operations and Appropriations committees detailing the specifics of any program, including a detailed cost estimate. The committees shall have 45 days to review and comment.

   **Explanation:** A recent Continuity of Care Advisory Panel, appointed at the direction of the Governor, submitted a report in January 2014 which included a recommendation to further examine the implementation of an outpatient civil commitment program. The language simply requires the Department of Health and Mental Hygiene (DHMH) to submit a report to the appropriate policy and budget committees prior to the implementation of any program in fiscal 2015.

| **Information Request** | **Author** | **Due Date** |
|---|---|---|
| Outpatient civil commitment | DHMH | 45 days prior to the expenditure of any funding on an outpatient civil commitment program |

3. Add the following language:

All appropriations for program M00Q0110 Medicaid Behavioral Health Provider Reimbursements are to be used for the purposes herein appropriated, and there shall be no budgetary transfer to any other program or purpose except that funding may be transferred to programs M00L01.02 Community Services and M00L01.03 Community Services for Medicaid State Fund Recipients, to cover shortfalls in fee-for-service community mental health funding for Medicaid-ineligible services or services to the uninsured. Funds not expended for these purposes shall revert to the General Fund or be cancelled.

**Explanation:** The language restricts the use of Medicaid behavioral health provider reimbursements to that purpose with limited exceptions.

# *Updates*

## 1. Use of Fiscal 2014 Expanded Crisis Services Funding

Through a supplemental budget appropriation, the fiscal 2014 budget bill included $2.0 million in funding for crisis response services and $1.5 million for crisis intervention teams. However, no detail was provided as to how this funding would be allocated. In response to budget bill language, DHMH submitted a report outlining its proposed allocation of this funding.

### Crisis Response Systems

In order to evaluate how the additional funding provided in the supplemental budget would be allocated, the report notes that an effective crisis system should consist of three broad components:

- immediate triage and crisis response, primarily through 24/7 crisis hotlines and other online supports;

- community response crisis services, including mobile crisis teams, trauma response/critical incident stress management teams, urgent care services, emergency respite services, crisis beds, and emergency department/detention center diversion services; and

- longer term crisis services, including care coordination and stabilization services and referrals/linkages to long-term services.

Currently, CSAs in local jurisdictions offer many elements of an effective crisis system, and the systems vary from jurisdiction to jurisdiction based on local need. Funding is primarily provided by the State (just under $12.8 million) with some additional local support. Nonetheless, gaps in the system are still present. The additional $3.5 million in crisis funding is intended to fill some of these gaps.

CSAs have proposed various crisis program expansions with the available new funding reflecting local needs and existing programming. The most commonly anticipated expansions include

- implementation or expansion of mobile crisis teams (typically comprised of mental health professionals, including psychiatrists, social workers, and nurses, who can be dispatched to community locations to provide immediate assessment, intervention, and treatment);

- development or expansion of crisis intervention teams (local initiatives designed to improve the way law enforcement and the community respond to people experiencing mental health crises; these teams are built on strong partnerships between law enforcement, mental health provider agencies, and individuals and families affected by mental illness); and

- expansion of urgent care psychiatric hours to allow rapid access to licensed behavioral health clinicians in nonhospital settings.

## Proposed Allocation of Funding

In allocating the available funding, DHMH adopted an approach based on two broad principles:

- A portion of the funding for both crisis response services and crisis intervention teams will be allocated based on utilization of inpatient care in the public mental health system, specifically using the average inpatient bed days for fiscal 2011 and 2012 in a jurisdiction as a percentage of total bed days. This measure is used as a proxy for demand for crisis services. **Exhibit 21** details average inpatient bed days by jurisdiction.

- A portion of funding for the crisis response services and crisis intervention teams will be allocated evenly between each CSA on the basis that a core level of funding is required in each CSA in order to enhance or develop a minimum amount of new crisis services in that CSA.

**Exhibit 21**
## Inpatient Bed Days in the Public Mental Health System
**Average for Fiscal 2011 and 2012**

| | 2011 | 2012 | Two-year Average | % of Total |
|---|---|---|---|---|
| Allegany | 8,637 | 7,960 | 8,299 | 1.81% |
| Anne Arundel | 27,276 | 25,929 | 26,603 | 5.81% |
| Baltimore County | 61,627 | 63,014 | 62,321 | 13.62% |
| Calvert | 5,647 | 4,886 | 5,267 | 1.15% |
| Carroll | 11,096 | 9,549 | 10,323 | 2.26% |
| Cecil | 6,515 | 7,597 | 7,056 | 1.54% |
| Charles | 5,777 | 5,183 | 5,480 | 1.20% |
| Frederick | 9,960 | 8,838 | 9,399 | 2.05% |
| Garrett | 1,847 | 2,044 | 1,946 | 0.43% |
| Harford | 13,478 | 15,735 | 14,607 | 3.19% |
| Howard | 18,274 | 18,015 | 18,145 | 3.97% |
| Mid-Shore | 3,135 | 3,002 | 3,069 | 0.67% |
| Montgomery | 51,033 | 53,243 | 52,138 | 11.40% |
| Prince George's | 46,364 | 48,087 | 47,226 | 10.32% |
| St. Mary's | 3,989 | 4,224 | 4,107 | 0.90% |
| Washington | 8,801 | 8,457 | 8,629 | 1.89% |
| Wicomico/Somerset | 10,477 | 10,430 | 10,454 | 2.28% |
| Worcester | 2,405 | 1,292 | 1,849 | 0.40% |
| Baltimore City | 164,496 | 156,742 | 160,619 | 35.11% |
| **Total** | **460,834** | **454,227** | **457,531** | **100.00%** |

Source: Department of Health and Mental Hygiene

In addition to these two broad principles, an added dimension to the proposed allocation of funding is an earmark of $385,000 in crisis response funding for the Mid-Shore CSA (the single CSA for Caroline, Dorchester, Kent, Queen Anne's, and Talbot counties). This earmark was part of a commitment given to the Mid-Shore by DHMH as part of the Health Enterprise Zone (HEZ) application made by Caroline and Dorchester counties and approved by the Maryland Community Health Resources Commission. Although the HEZ was approved assuming this funding, no funding was specifically provided in the fiscal 2014 budget.

With this earmark in mind, the funding allocations proposed by DHMH are:

- $2.0 million in crisis response services funding to be distributed as follows: $1.0 million divided among the CSAs (except for the Mid-Shore CSA) based on inpatient bed days; $615,000 divided equally among the CSAs (except for the Mid-Shore CAS); and $385,000 for the Mid-Shore CSA; and

- $1.5 million in crisis intervention team funding to be distributed as follows: $500,000 divided among all of the CSAs based on inpatient bed days; and $1.0 million divided equally among all of the CSAs.

Resulting CSA allocations are summarized in **Exhibit 22**.

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**Exhibit 22**
## Proposed Crisis Response Service and Crisis Intervention Team Enhanced Funding
**Fiscal 2014**

| | Crisis Response Services | Crisis Intervention Teams | Total |
|---|---|---|---|
| Allegany | $52,427 | $61,700 | $114,127 |
| Anne Arundel | 92,703 | 81,703 | 174,406 |
| Baltimore County | 171,297 | 120,737 | 292,034 |
| Calvert | 45,755 | 58,387 | 104,142 |
| Carroll | 56,881 | 63,912 | 120,793 |
| Cecil | 49,693 | 60,343 | 110,036 |
| Charles | 46,225 | 58,620 | 104,845 |
| Frederick | 54,849 | 62,903 | 117,752 |
| Garrett | 38,448 | 54,758 | 93,206 |
| Harford | 66,307 | 68,594 | 134,901 |
| Howard | 74,092 | 72,460 | 146,552 |
| Mid-Shore | 385,000 | 55,985 | 440,985 |
| Montgomery | 148,892 | 109,609 | 258,501 |
| Prince George's | 138,082 | 104,241 | 242,323 |
| St. Mary's | 43,203 | 57,119 | 100,322 |
| Washington | 53,154 | 62,062 | 115,216 |
| Wicomico/Somerset | 57,169 | 64,055 | 121,224 |
| Worcester | 38,234 | 54,652 | 92,886 |

| | Crisis Response Services | Crisis Intervention Teams | Total |
|---|---|---|---|
| Baltimore City | 387,588 | 228,160 | 615,748 |
| **Total** | **$2,000,000** | **$1,500,000** | **$3,500,000** |

Note: See text for additional details.

Source: Department of Legislative Services; Department of Health and Mental Hygiene

## Observations

DLS would make two observations about the funding allocations proposed by DHMH:

- The earmark of $385,000 in crisis response services funding to the Mid-Shore CSA significantly skews the overall distribution of funds. Although the Mid-Shore CSA has only 0.67% of the inpatient bed days utilized in the public mental health system, it will receive 12.6% of the total available funding, second only to Baltimore City.

- DHMH has indicated that it will be including language in the annual grant agreements between the State and the CSAs that this additional funding is intended to enhance existing funding for crisis services and cannot be used to supplant any local funding currently provided for these services.

In summary, the funding allocation methodology used by DHMH to allocate the $3.5 million in new mental health crisis funding seeks to achieve a balance between distributing funding based on likely demand while at the same time allowing every CSA to provide some new amount of meaningful crisis-related services. The earmarking of $385,000 in crisis response services funding to the Mid-Shore CSA distorts the resulting distribution. However, as noted above, the fiscal 2014 budget did not provide any specific new funding to cover the commitment made by DHMH as part of the approved HEZ in Dorchester and Caroline counties. Absent this earmark, fulfilling this commitment would likely result in the need to make reductions to other existing CSA grants.

## 2. Psychiatric Bed Registry

In November 2012, a new Psychiatric Bed Registry (PBR) was launched by the Maryland Institute for Emergency Medical Services Systems in conjunction with MHA, the Maryland Hospital Association, and the Maryland Chapter of the American College of Emergency Physicians. The development of this new PBR is the latest effort to resolve a long-standing concern that patients entering emergency departments for voluntary or involuntary evaluation and treatment face delays in accessing inpatient treatment. Some of this is attributed to a lack of knowledge of the availability of inpatient psychiatric beds.

The PBR can:

- track available inpatient psychiatric beds across the State, to include direct contact information;
- log in information about psychiatric patients in need of a bed to help match patients to beds; and
- provide real-time information about the number of psychiatric patients presenting to hospital emergency departments.

At this time, participation in PBR is voluntary, and most emergency departments and inpatient psychiatric units are not participating. As of October 31, 2013, only 13% of acute general hospitals and 26% of private psychiatric hospitals were participating.

In discussing the disappointing take-up of the PBR with the different groups involved, the following issues emerged:

- the lack of participation is somewhat self-fulfilling in that unless everybody participates, the PBR has limited utility;
- hospital staff time is limited and entering the information needed for the PBR is an additional burden, and the burden may not be worth it, particularly if hospitals are not participating;
- the information shown on the PBR may not be sufficiently real-time;
- even when using the PBR, hospitals still must call to confirm that a bed is actually available and to make the arrangements for patient transfer, limiting the apparent utility of participating in the PBR;
- State facilities do not participate in the registry, and some groups believe that they should participate; and

- there were also some technical issues with the PBR.

In spite of the disappointing initial take-up and the issues that have yet to be resolved, the plan is to re-focus attention on the PBR in spring 2014 and probably re-launch the registry.

## 3. Transition-age Youth

The 2013 JCR asked for an update on mental health services available to transition-age youth. The report submitted by the department reviewed both service availability as well as identifying service gaps. The report also included a national literature review on best practices. Since there is no standard definition of transitioning youth, the report adopts the widest ranges identified in that literature: ages 14 to 30 years.

Transition into adulthood for most individuals can be a difficult process. For individuals with serious mental illness this can be more difficult, because the skills needed to make the transition are impaired, and the identification of a disability (and accompanying treatment) is delayed. This often translates into poorer outcomes in areas such as employment, homelessness, and criminal justice involvement. Likewise, accessing mental health services as a transition-age youth is often more difficult because, for example, they "age out" of children's services; accessing adult services can be more difficult; adult services may not be tailored to their specific needs; and eligibility for adult services may be stricter than for children's services.

In recognition of these concerns, there have been efforts nationally to implement developmentally appropriate programming for this transition-age population. Similarly, Maryland began funding a range of locally determined age-specific transition-age youth programming in 1999 based on competitive proposals received from the CSAs. The intent was to provide young adults, who would otherwise have been ineligible for adult services, with a range of services appropriate to their needs. Most of these programs and services have been sustained, although not necessarily at the same level of funding.

BHA is now in the process of aligning these programs and services around a framework consistent with a national evidence-based model: Transition into Independence Process (TIP). TIP is an individualized process fashioned around several guidelines: teaching community skills; encouraging completion of secondary education; providing exposure to community-life experiences; promoting movements into post-school employment, educational opportunities, independent living situations, and community life; transcending age barriers that typically exist between child and adolescent and adult services; and respecting the self-determination of young people.

The report also noted gaps in existing services based on surveys conducted for this report:

- Lack of housing was mentioned as the top concern. This is a concern for individuals with serious mental illness generally.

- Programs specifically for transition-age youth. Reasons offered for the need for this kind of programming included: potential hesitancy among transition-age youth to participate in programming with adults perceived as having more significant disabilities; adult programming not being developmentally appropriate; and participation in adult programming may feel stigmatizing.

- Coordinated and consistent transition services. Fragmentation of services in the adult mental health system is frequently cited as a challenge to providing quality care and supports to the transition-age youth population.

- Lack of linkage between child and adult systems underscores the concerns about fragmentation of services.

- Services for transition-age youth with mild or moderate mental health conditions.

- Barriers to service delivery including eligibility barriers (diagnostic criteria, age, and restrictions regarding private health insurance), and funding.

The report makes four recommendations:

- Establish eligibility and medical necessity criteria spanning the adult and child mental health systems to provide continuous access to transition-age youth and develop a Medicaid funding authority to support these services.

- Evaluate the role of Medicaid expansion and health care reform in reimbursing the array of transition services.

- Establish systems that facilitate continuity of care.

- Enhance core competencies of practitioners to provide developmentally appropriate and empirically supported practices.

## 4. RTC Outcomes

As noted above, spending on RTC services in the FFS mental health system has been shrinking in recent years, as the State seeks to develop community-based alternatives to RTC care. This has led to significant downsizing of capacity at private RTCs and the two remaining State-operating RTCs, or Regional Institute for Children and Adolescents (RICA), RICA – Gildner and RICA – Baltimore. It should be noted that the RICAs do not provide services through the FFS mental health system and spending for services at those facilities are not reflected in the RTC data presented above.

Given the overall decline in RTC utilization, the question has arisen about why the State continues to operate two different systems of RTC-level care: one inside the FFS system and one outside of it. Debates have swirled on relative costs of care (with the RICAs considered more expensive on a per diem basis), as well as the relative quality of care. While arguments were made around quality of care, there was no data around which to make definitive analysis since there were no common outcomes used across the RTCs, public and private. The 2013 JCR asked for the development of consistent and meaningful measures for use by all RTCs.

A stakeholder group was convened in the 2013 interim and agreed to a uniform set of measures to monitor short-term outcomes in three domains: adaptive functioning; symptom severity; and family satisfaction. The group is also considering a fourth domain, family involvement, if a valid method can be found to measure it. The group is currently in the process of developing operational definitions for each domain and determining the screening and assessment instruments that will provide a standardized approach to evaluating outcomes. The report confirmed that there was a high degree of variability among the specific measures and methods used by RTCs to track outcomes across the four chosen domains.

In terms of long-term outcomes, the initial recommendation is to use public mental health system data for youth prior to and post discharge from an RTC in areas such as RTC readmission and psychiatric inpatient hospitalization, although there has been no finalization of the outcome measures.

There was still concern among some RTCs about the ability to track outcomes including insufficient resources to track outcomes post discharge, an inability to monitor longer-term outcomes for youth with private insurance, the cost and training considerations associated with new screening and assessment instruments, and variability among RTC program populations (for example, by age, gender, and diagnosis, as well as other characteristics, such as delinquency history and the presence of physical disabilities.) Nonetheless, the stakeholder group remains engaged to determine suitable instruments to allow for standardized measurement in the three short-term domains identified.

Next steps in this process involve all RTCs to adopt core outcome measures for each domain, although programs will have flexibility to use existing or additional instruments and measures if they choose to. Once measures and instruments are finalized, a training and implementation deadline will be developed, and benchmarks will be established for each outcome domain. A plan will be developed for collecting and analyzing data and for the organization of a third-party evaluation team. Work is expected to continue through 2014.

## 5. Individuals with Serious Mental Illness and Aging in Place

With an aging population, a concern has been how to keep individuals with serious mental illness in community-based care as they age. The 2013 JCR asked the department to report on this issue. The report, which focused on the residential services component in the public mental health system, RRPs, noted that as part of its recent Mental Health Transformation project, three issues needed to be addressed for this population: developing a medical services model for consumers who can remain safely in the RRPs; defining at what point a consumer can no longer stay safely in the

RRP model; and working with other agencies to provide ways to transition consumers to other settings. The Mental Health Transformation report made a number of recommendations to address these issues (regular monitoring, care coordination, staff training on care issues) as well as identifying new programming, most of which included adding additional nursing support. However, little progress appears to have been made to implement any new programming at any significant level.

The new health homes that have been developed and recently began operations may also offer an opportunity to improve care coordination for persons with serious mental illness as well as other chronic health conditions. This may offer an opportunity for older individuals with serious mental illness and other chronic health problems to get the care needed that keeps them out of an institutional setting, although the Maryland model is specifically designed for an older population.

Appendix 1

# *Current and Prior Year Budgets*

## Current and Prior Year Budgets
### Behavioral Health Administration
### ($ in Thousands)

| | General Fund | Special Fund | Federal Fund | Reimb. Fund | Total |
|---|---|---|---|---|---|
| **Fiscal 2013** | | | | | |
| Legislative Appropriation | $763,270 | $52,627 | $393,503 | $10,696 | $1,220,097 |
| Deficiency Appropriation | -2,221 | 0 | 2,387 | 0 | 166 |
| Budget Amendments | -2,604 | 7,250 | 1,013 | 907 | 6,565 |
| Reversions and Cancellations | -19 | -1,688 | -13,213 | -619 | -15,539 |
| **Actual Expenditures** | **$758,426** | **$58,189** | **$383,690** | **$10,984** | **$1,211,288** |
| **Fiscal 2014** | | | | | |
| Legislative Appropriation | $793,710 | $48,910 | $443,420 | $10,431 | $1,296,471 |
| Budget Amendments | 4,059 | 1,604 | 79 | 0 | 5,742 |
| **Working Appropriation** | **$797,769** | **$50,514** | **$443,499** | **$10,431** | **$1,302,213** |

Note: The fiscal 2014 working appropriation does not include deficiencies or contingent reductions. Numbers may not sum to total due to rounding.

## Fiscal 2013

The fiscal 2013 legislative appropriation for BHA was decreased by just over $8.8 million. This change is derived as follows:

- Deficiency appropriations added $166,000 derived as follows:

  - Just over $2.2 million in general funds were removed from BHA. This reflected the removal of $7.2 million due to anticipated cost savings primarily from reduced inpatient hospital utilization that was partially offset by $5.0 million to cover the increased cost of Clifton T. Perkins Hospital Center employee overtime and patient off-grounds hospitalization.

  - The reduction in general funds was more than offset by an increase of almost $2.4 million in federal funds for a variety of program activities including $250,000 for the Maryland Launching Individual Futures Together targeted at youth ages 13 to 17 years in Baltimore County with serious emotional disturbances and co-occurring substance abuse needs; $250,000 for the Maryland Linking Actions for Unmet Needs in Children's Health Project to promote the wellness of young children from birth to 8 years in Prince George's County by addressing physical, social, emotional, cognitive, and behavioral aspects of development; $1,377,216 in block grant funds to provide mental health services to dually diagnosed individuals in community services ($924,655) and to provide short-term intensive mental health crisis services for children, adolescents, and adults in community settings ($452,561); and $509,770 in federal funds to be utilized by CSAs and the University of Maryland to develop and implement a statewide system of care that meets the co-occurring substance abuse and mental health needs of Maryland's children and their families.

- Budget amendment added almost $6.6 million. Specifically:

  - General fund amendments reduced the budget by $2.6 million. Small increases based on reallocation of general funds and realignment of telecommunications funding during closeout being more than offset by reductions based on the transfer of positions and funding to Medicaid to create a new behavioral health unit ($200,000), health insurance realignment during closeout ($900,000), and the transfer of funds out of BHA to other agencies (principally to Developmental Disabilities Administration (DDA)) as part of the department's general fund closeout process ($1.7 million).

  - Special fund amendments added $7.25 million. This funding was primarily from two amendments: $6.25 million in special funds derived from revenue generated from the CareFirst premium tax exemption to support community mental health services as authorized by Chapter 1 of the 2012 First Special Session, the Budget Reconciliation and Financing Act of 2012; and $944,000 to support the fiscal 2013 COLA.

- An increase in federal funds of just over $1.0 million, almost all of which ($975,000) represented transfers of federal fund appropriation into BHA as part of the closeout process.

- A variety of reimbursable fund amendments added $907,000.

- The budget increases from deficiency appropriations and budget amendments were more than offset by reversions and cancellations of just over $15.5 million. Specifically:

  - general fund reversions of $19,000;

  - special fund cancellations of almost $1.7 million derived from a variety of special fund sources;

  - federal fund cancellations of just over $13.2 million. The bulk of this was lower than expected federal fund Medicaid attainment; and

  - reimbursable fund cancellations of $619,000.

## Fiscal 2014

To date, BHA's fiscal 2014 appropriation has been increased by $5.7 million. Significant increases include:

- $3,562,952 ($3,484,541 general funds, $4,165 special funds, and $74,246 federal funds) to fund the fiscal 2014 COLA, increments, and ASR increases that were not included in the original BHA allowance.

- $1.6 million in special funds from the DPA intended to offset reductions in available Substance Abuse Prevention and Treatment Block Grant funding as a result of federal sequestration. This funding will be used as follows:

  - $200,000 to support the statewide tobacco cessation training initiative, specifically providing training to mental health and substance abuse providers to address tobacco cessation needs of patients. Individuals with behavioral health disorders have high rates of smoking and staff are often uninformed about best practices.

  - $200,000 to support naloxone training in local jurisdictions. Awards will be made through a competitive process. Funds will support community training that allows individuals to receive a prescription for naloxone as part of the administration's overdose prevention activities.

  - $200,000 to support behavioral health activities in the Public Health Administration.

- $1,000,000 to be awarded to jurisdictions proportionate to the amount removed through sequestration with the recommendation (though not requirement) that jurisdictions use this funding to support residential services.

- The addition of $623,000 in general funds as a result of the transfer of 7 positions and associated funding from DDA's Secure Evaluation and Therapeutic Treatment Center unit to consolidate forensic activities in BHA's Office of Forensic Services.

**Object/Fund Difference Report**
**DHMH – Behavioral Health Administration**

| Object/Fund | FY 13 Actual | FY 14 Working Appropriation | FY 15 Allowance | FY 14 - FY 15 Amount Change | Percent Change |
|---|---|---|---|---|---|
| **Positions** | | | | | |
| 01 Regular | 2,919.45 | 2,919.45 | 2,916.45 | -3.00 | -0.1% |
| 02 Contractual | 209.02 | 191.00 | 203.18 | 12.18 | 6.4% |
| **Total Positions** | **3,128.47** | **3,110.45** | **3,119.63** | **9.18** | **0.3%** |
| **Objects** | | | | | |
| 01 Salaries and Wages | $ 218,819,580 | $ 228,616,187 | $ 237,702,428 | $ 9,086,241 | 4.0% |
| 02 Technical and Spec. Fees | 10,978,995 | 9,223,058 | 9,747,151 | 524,093 | 5.7% |
| 03 Communication | 470,131 | 484,886 | 468,188 | -16,698 | -3.4% |
| 04 Travel | 204,711 | 269,648 | 293,090 | 23,442 | 8.7% |
| 06 Fuel and Utilities | 10,238,928 | 9,994,246 | 10,468,511 | 474,265 | 4.7% |
| 07 Motor Vehicles | 655,199 | 812,743 | 763,735 | -49,008 | -6.0% |
| 08 Contractual Services | 955,395,088 | 1,038,446,114 | 1,108,572,033 | 70,125,919 | 6.8% |
| 09 Supplies and Materials | 12,705,529 | 13,181,372 | 13,056,073 | -125,299 | -1.0% |
| 10 Equipment – Replacement | 628,678 | 249,820 | 261,180 | 11,360 | 4.5% |
| 11 Equipment – Additional | 260,672 | 0 | 47,178 | 47,178 | N/A |
| 12 Grants, Subsidies, and Contributions | 374,921 | 411,885 | 428,209 | 16,324 | 4.0% |
| 13 Fixed Charges | 555,975 | 522,834 | 559,826 | 36,992 | 7.1% |
| **Total Objects** | **$ 1,211,288,407** | **$ 1,302,212,793** | **$ 1,382,367,602** | **$ 80,154,809** | **6.2%** |
| **Funds** | | | | | |
| 01 General Fund | $ 758,425,941 | $ 797,768,540 | $ 814,709,929 | $ 16,941,389 | 2.1% |
| 03 Special Fund | 58,188,902 | 50,514,078 | 46,032,389 | -4,481,689 | -8.9% |
| 05 Federal Fund | 383,689,858 | 443,499,354 | 513,293,084 | 69,793,730 | 15.7% |
| 09 Reimbursable Fund | 10,983,706 | 10,430,821 | 8,332,200 | -2,098,621 | -20.1% |
| **Total Funds** | **$ 1,211,288,407** | **$ 1,302,212,793** | **$ 1,382,367,602** | **$ 80,154,809** | **6.2%** |

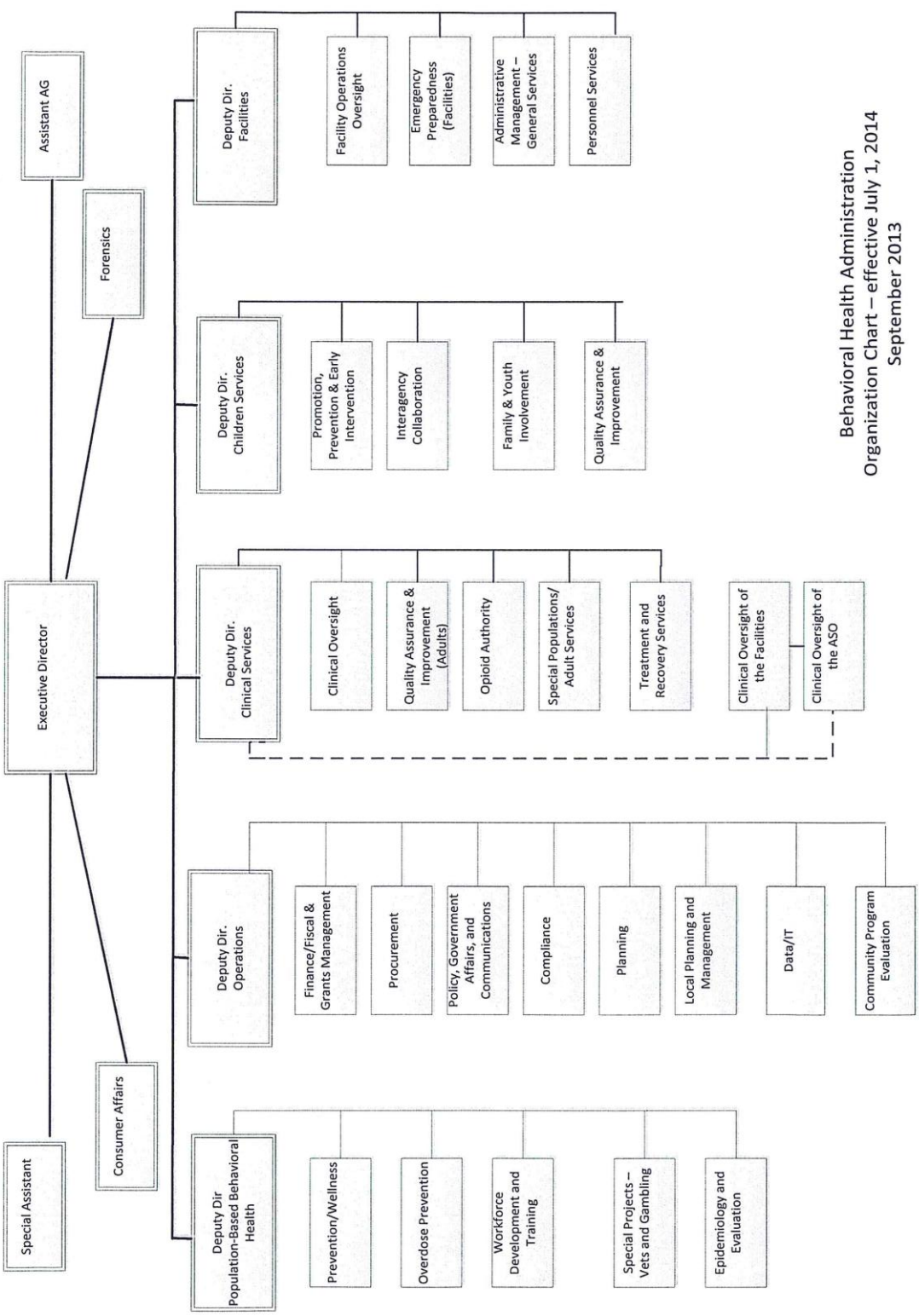
Note: The fiscal 2014 appropriation does not include deficiencies. The fiscal 2015 allowance does not include contingent reductions.

**Fiscal Summary**
**DHMH – Behavioral Health Administration**

| Program/Unit | FY 13 Actual | FY 14 Wrk Approp | FY 15 Allowance | Change | FY 14 - FY 15 % Change |
|---|---|---|---|---|---|
| 01 Mental Hygiene Administration | $ 944,067,341 | $ 1,029,951,727 | $ 316,883,026 | -$ 713,068,701 | -69.2% |
| 04 Thomas B. Finan Hospital Center | 18,536,128 | 18,971,098 | 19,469,686 | 498,588 | 2.6% |
| 05 Regional Institute For Children and Adolescents – Baltimore City | 12,935,190 | 13,130,746 | 13,627,464 | 496,718 | 3.8% |
| 07 Eastern Shore Hospital Center | 17,604,403 | 18,744,219 | 19,030,571 | 286,352 | 1.5% |
| 08 Springfield Hospital Center | 69,224,133 | 72,518,501 | 74,494,418 | 1,975,917 | 2.7% |
| 09 Spring Grove Hospital Center | 76,673,540 | 79,476,190 | 80,643,287 | 1,167,097 | 1.5% |
| 10 Clifton T. Perkins Hospital Center | 59,599,181 | 56,411,041 | 61,944,820 | 5,533,779 | 9.8% |
| 11 John L. Gildner Regional Institute for Children and Adolescents. | 10,873,894 | 11,355,330 | 11,661,306 | 305,976 | 2.7% |
| 15 Institutional Operations | 1,774,597 | 1,653,941 | 2,364,249 | 710,308 | 42.9% |
| 01 Medical Care Programs Administration: Community fee-for-service mental health services for Medicaid-eligible individuals | 0 | 0 | 782,248,775 | 782,248,775 | 0% |
| **Total Expenditures** | **$ 1,211,288,407** | **$ 1,302,212,793** | **$ 1,382,367,602** | **$ 80,154,809** | **6.2%** |
| General Fund | $ 758,425,941 | $ 797,768,540 | $ 814,709,929 | $ 16,941,389 | 2.1% |
| Special Fund | 58,188,902 | 50,514,078 | 46,032,389 | -4,481,689 | -8.9% |
| Federal Fund | 383,689,858 | 443,499,354 | 513,293,084 | 69,793,730 | 15.7% |
| **Total Appropriations** | **$ 1,200,304,701** | **$ 1,291,781,972** | **$ 1,374,035,402** | **$ 82,253,430** | **6.4%** |
| Reimbursable Fund | $ 10,983,706 | $ 10,430,821 | $ 8,332,200 | -$ 2,098,621 | -20.1% |
| **Total Funds** | **$ 1,211,288,407** | **$ 1,302,212,793** | **$ 1,382,367,602** | **$ 80,154,809** | **6.2%** |

Note: The fiscal 2014 appropriation does not include deficiencies. The fiscal 2015 allowance does not include contingent reductions.

Appendix 4


Behavioral Health Administration
Organization Chart – effective July 1, 2014
September 2013
Executive Director
Assistant AG
Forensics
Special Assistant
Consumer Affairs
Deputy Dir. Facilities
Facility Operations Oversight
Emergency Preparedness (Facilities)
Administrative Management – General Services
Personnel Services
Deputy Dir. Children Services
Promotion, Prevention & Early Intervention
Interagency Collaboration
Family & Youth Involvement
Quality Assurance & Improvement
Deputy Dir. Clinical Services
Clinical Oversight
Quality Assurance & Improvement (Adults)
Opioid Authority
Special Populations/ Adult Services
Treatment and Recovery Services
Clinical Oversight of the Facilities
Clinical Oversight of the ASO
Deputy Dir. Operations
Finance/Fiscal & Grants Management
Procurement
Policy, Government Affairs, and Communications
Compliance
Planning
Local Planning and Management
Data/IT
Community Program Evaluation
Deputy Dir Population-Based Behavioral Health
Prevention/Wellness
Overdose Prevention
Workforce Development and Training
Special Projects – Vets and Gambling
Epidemiology and Evaluation