M00L
Behavioral Health Administration
Department of Health and Mental Hygiene

Operating Budget Data

($ in Thousands)

	FY 14 Actual	FY 15 Working	FY 16 Allowance	FY 15-16 Change	% Change Prior Year
General Fund	$785,711	$810,538	$870,342	$59,804	7.4%
Deficiencies and Reductions	0	-6,955	-7,762	-807	
Adjusted General Fund	**$785,711**	**$803,583**	**$862,580**	**$58,998**	**7.3%**
Special Fund	50,596	47,553	48,465	912	1.9%
Deficiencies and Reductions	0	3,000	-17	-3,017	
Adjusted Special Fund	**$50,596**	**$50,553**	**$48,448**	**-$2,105**	**-4.2%**
Federal Fund	445,517	529,024	738,645	209,621	39.6%
Deficiencies and Reductions	0	0	-93	-93	
Adjusted Federal Fund	**$445,517**	**$529,024**	**$738,552**	**$209,528**	**39.6%**
Reimbursable Fund	9,323	8,332	7,944	-388	-4.7%
Adjusted Reimbursable Fund	**$9,323**	**$8,332**	**$7,944**	**-$388**	**-4.7%**
Adjusted Grand Total	**$1,291,148**	**$1,391,493**	**$1,657,525**	**$266,032**	**19.1%**

Note: The fiscal 2015 working appropriation reflects deficiencies and the Board of Public Works reductions to the extent that they can be identified by program. The fiscal 2016 allowance reflects back of the bill and contingent reductions to the extent that they can be identified by program.

- Total funding for the Behavioral Health Administration (BHA) increases by $266.0 million (19.1%) over the fiscal 2015 working appropriation, mainly due to the transfer of funds for substance use disorder services from Medicaid to BHA.

- Cost containment actions remove a total of $6.8 million in fiscal 2015 and $30.8 million in fiscal 2016, with the largest action in 2016 including $23.0 million in rate reductions for community providers in the mental health services system.

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

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- Funding for substance abuse services is mainly flat between fiscal 2015 and 2016. There is an increase of $211.0 million for BHA, but this funding is due to the transfer of substance abuse services from Medicaid to the behavioral health carve-out. There is a corresponding decrease in funding in the Medicaid budget.

Personnel Data

	FY 14 Actual	FY 15 Working	FY 16 Allowance	FY 15-16 Change
Regular Positions	2,919.45	2,911.85	2,912.35	0.50
Contractual FTEs	216.13	207.98	214.47	6.49
Total Personnel	**3,135.58**	**3,119.83**	**3,126.82**	**6.99**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	172.41	5.92%
Positions and Percentage Vacant as of 12/31/14	193.75	6.65%

- The fiscal 2016 allowance contains an additional 0.5 positions for BHA Program Direction related to tobacco compliance programming.

- Contractual employment increases in fiscal 2016 but is still below the most recent actual.

- The overall vacancy rate for BHA has declined between fiscal 2015 and 2016. However, expected turnover is increased in the allowance by 0.46%.

Analysis in Brief

Major Trends

Substance Abuse Prevention: The number of people served by prevention programming grew by 9,784 (2.5%) compared to fiscal 2013. The growth was in single service programming.

Substance Abuse Treatment: State-funded admissions to treatment and the number of unique individuals served in treatment has fallen yet again between fiscal 2013 and 2014, with the number of admissions falling from 43,524 to 39,318 (9.7%) and the number of unique individuals admitted falling from 34,161 to 31,202 (8.7%). However, this fall in admissions could be due to the erosion of 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 fee-for-service (FFS) community mental health system was 7% in fiscal 2014, which matched the enrollment growth over a five-year period from fiscal 2010 through 2014. The mix, however, has skewed heavily towards the adult population with the expansion of Medicaid under the federal Affordable Care Act (ACA). Growth in total service units also outpaced enrollment growth at 11% in fiscal 2014, with heavy use in outpatient and crisis services.

Community Mental Health FFS System: Expenditure Trends: Expenditures grew at 4.0% in fiscal 2014, outpacing the growth over the last five years of 2.8%. Again, this trend mirrors the growth in both service units and enrollment. Much of the growth is due to the ACA expansion population, which in fiscal 2014 is 100.0% federally funded.

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 as well as children in fiscal 2014. Data on adult employment continues to be troubling.

Issues

Behavioral Health Integration – Implementation and Issues: The integration of State mental health and substance abuse agencies and services is continuing, with FFS payments for both services being carved-out under a single administrative service organization since January 1, 2015. However, more needs to be done to streamline the payment system for substance abuse services for the uninsured population as well as to develop regulations regarding the licensure and accreditation process for behavioral health service providers. **The agency should comment on what substance abuse services for the uninsured it plans to migrate to a FFS system and what services it plans to leave on a grant-based structure, when it plans to do so, and why some services, if any, will remain grant based while others are migrated to a FFS. The agency should also comment on its plans for reimbursing for residential detoxification services conducted in an institution for mental diseases, and when it expects regulations concerning accreditation and licensing to be implemented.**

The Heroin Epidemic: What to Do?: The use of heroin and heroin-related substances has reached an all-time high in the State, becoming the first substance to surpass alcohol as the primary reason for individuals being admitted to substance abuse treatment since reporting began in the 1970s. While there have been numerous efforts focused on reducing the rate of overdose deaths related to these substances, funding for substance abuse treatment services remains flat in the fiscal 2016 allowance. **The agency should comment on how it plans to combat heroin use and overdose deaths going forward, and what further options may be necessary for treatment and prevention of heroin use in both the near and long-term future.**

Treatment and Service Options for Court-involved Individuals: The 2014 *Joint Chairmen's Report* (JCR) requested that a workgroup be convened by the department that included various stakeholders in order to review the average wait times for residential placement in State-run psychiatric facilities as well as for treatment under the 8-507 orders, to review and report on the availability of staff and services for court-involved individuals, and to report on any recommendations based on an analysis of this data.

A report was submitted by the workgroup, which contained an analysis of this data and numerous recommendations. **The agency should comment on the potential fiscal impact of the workgroup's recommendations. The Department of Legislative Services also recommends that the withheld allotment in the fiscal 2015 budget be released.**

Recommended Actions

		Funds
1.	Add language requesting a report on the spending of funds related to the Synar penalty.	
2.	Add budget bill language authorizing funds from the Cigarette Restitution Fund to be used for the Synar penalty.	
3.	Add budget bill language requesting a report on utilization of services and expenditures for the public behavioral health system by Medicaid eligibility.	
4.	Reduce general funds related to the Synar penalty.	$ 2,000,000
	Total Reductions	**$ 2,000,000**

Updates

Outpatient Services Programs Stakeholder Workgroup: Chapters 352 and 353 of 2014 required the Secretary of the Department of Health and Mental Hygiene to convene an Outpatient Services Programs Stakeholder Workgroup to (1) examine assisted outpatient programs, assertive community treatment programs, and other outpatient services programs with targeted outreach, engagement, and services; (2) develop a proposal for a program that, among other things, best serves individuals with mental illness who are at high risk for disruptions in the continuity of care; and (3) evaluate the dangerousness standard for involuntary admissions and emergency evaluations of individuals with mental disorders. A final report from the workgroup contained three proposals to address these issues.

Report on Mental Health Anti-stigma Education: A report was submitted in response to committee narrative from the 2014 JCR on the best practices and current programs available in the State concerning mental health anti-stigma education.

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 former Mental Hygiene Administration (MHA) and the Alcohol and Drug Abuse Administration (ADAA).

In fiscal 2015, funding for Medicaid-eligible services for the mentally ill was moved from MHA into the Medical Care Programs Administration (MCPA). Further, in fiscal 2016 funding for substance use disorder services are transferred from within MCPA from Program M00Q01.03 to M00Q01.10. However, for the purpose of reviewing the fiscal 2016 budget, the funding that is budgeted in M00Q01.10 is reflected in this analysis.

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 multicounty 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 (SAMHSA) evidence-based model. In fiscal 2014, a total of 257 recurring prevention programs were offered across the State, a drop of 61 from the prior year.

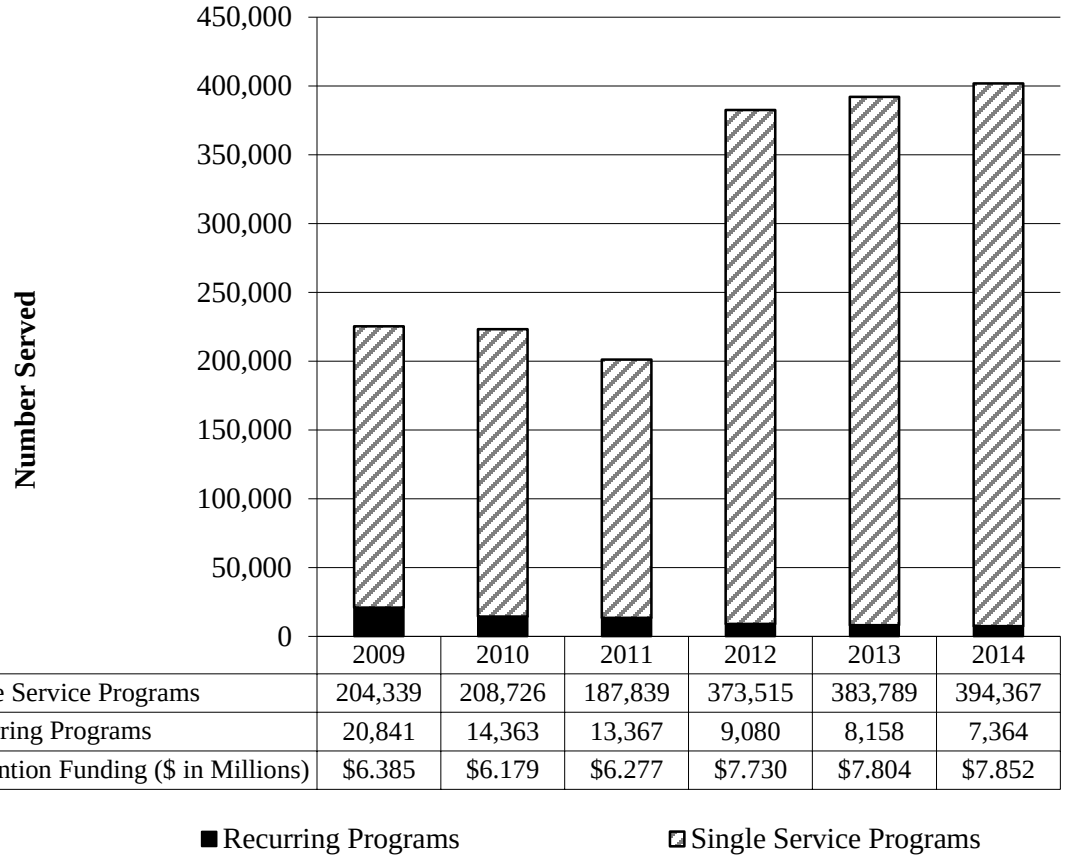
  Statewide, the successful completion rate for these types of programs is reported at 83%, a number that has varied little over the past decade. There is variation by county among programs in terms of successful completion. In fiscal 2014, for example, the successful completion rate varied from 91% in Cecil County to 80% in St. Mary's and Harford counties. 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 2014, 1,255 single service prevention activities were offered in Maryland, a decrease of 22 from the prior year.

As shown in **Exhibit 1**, prevention programming served almost 402,000 participants in fiscal 2014, 9,784 (2.5%) higher than served in fiscal 2013. Recurring programs continue to see a drop in people served, down 794 participants (9.7%) between fiscal 2013 and 2014, a decline that is similar to the prior year. Conversely, the number of participants served in single service programs grew by 10,578 between fiscal 2013 and 2014, 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.

Exhibit 1
BHA-funded Prevention Programs
Fiscal 2009-2014



	2009	2010	2011	2012	2013	2014
Single Service Programs	204,339	208,726	187,839	373,515	383,789	394,367
Recurring Programs	20,841	14,363	13,367	9,080	8,158	7,364
Prevention Funding ($ in Millions)	$6.385	$6.179	$6.277	$7.730	$7.804	$7.852

BHA: Behavioral Health Administration

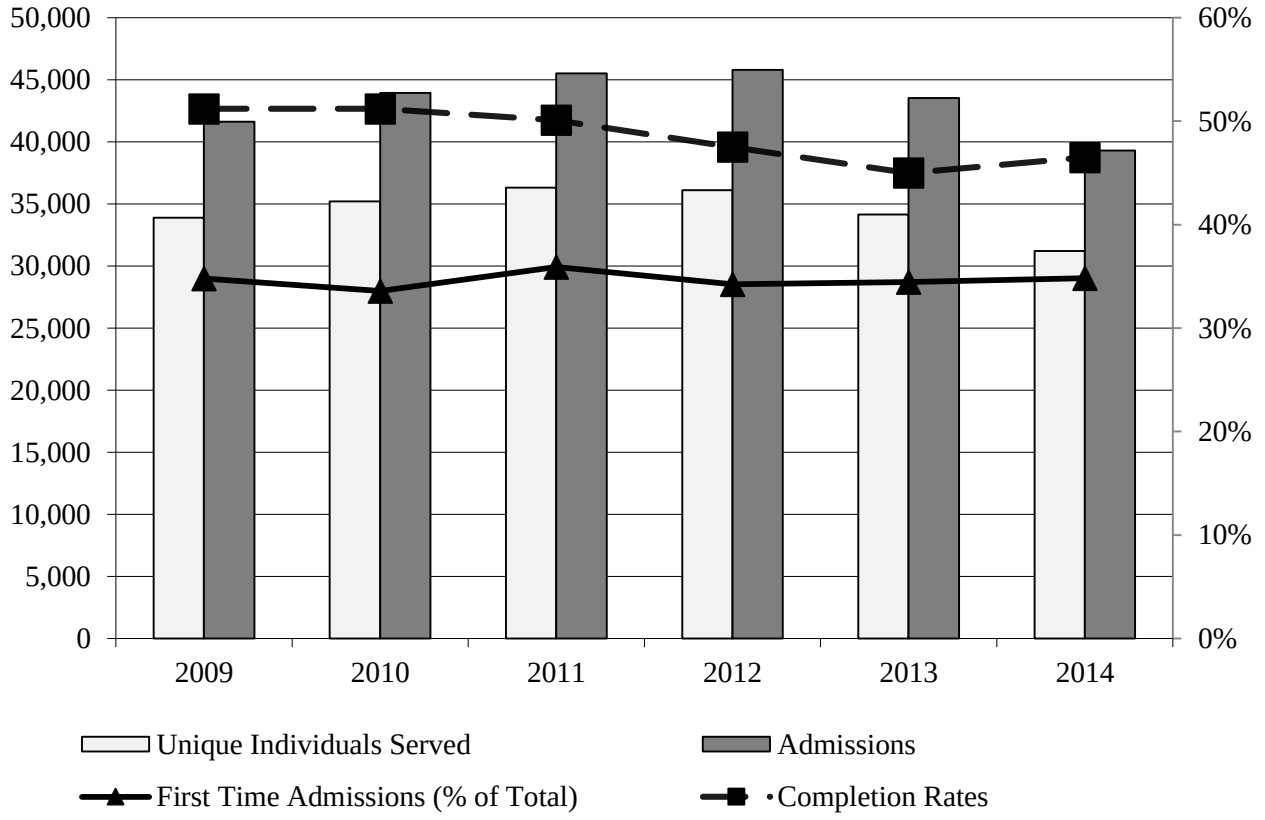
Source: Behavioral Health Administration

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 2015. However, BHA intends to apply for a five-year SAMSHA Partnership for Success grant that would allow them to continue and enhance the State prevention infrastructure and services provided through this program.

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, but fell more sharply between fiscal 2012 and 2013, has fallen drastically again between fiscal 2013 and 2014; the number of admissions fell from 43,524 to 39,318 (9.7%) and the number of unique individuals admitted fell from 34,161 to 31,202 (8.7%).

Exhibit 2
State-funded Treatment Programs – Various Data
Fiscal 2009-2014



Source: Behavioral Health Administration

While the decline in admissions has in the past been partially attributable to increases in length of stay within a treatment episode, which increased the average number of daily active patients but reduced the ability to accept admissions, the administration has noted in the past two years that data reporting compliance on the part of providers may not be as robust as in prior years, leading to what

appears to be drastic decreases in the number of admissions and the number of unique individuals served.

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. This reporting, however, should improve in future fiscal years now that the ASO has taken over for both the payment and reporting structures for substance abuse services.

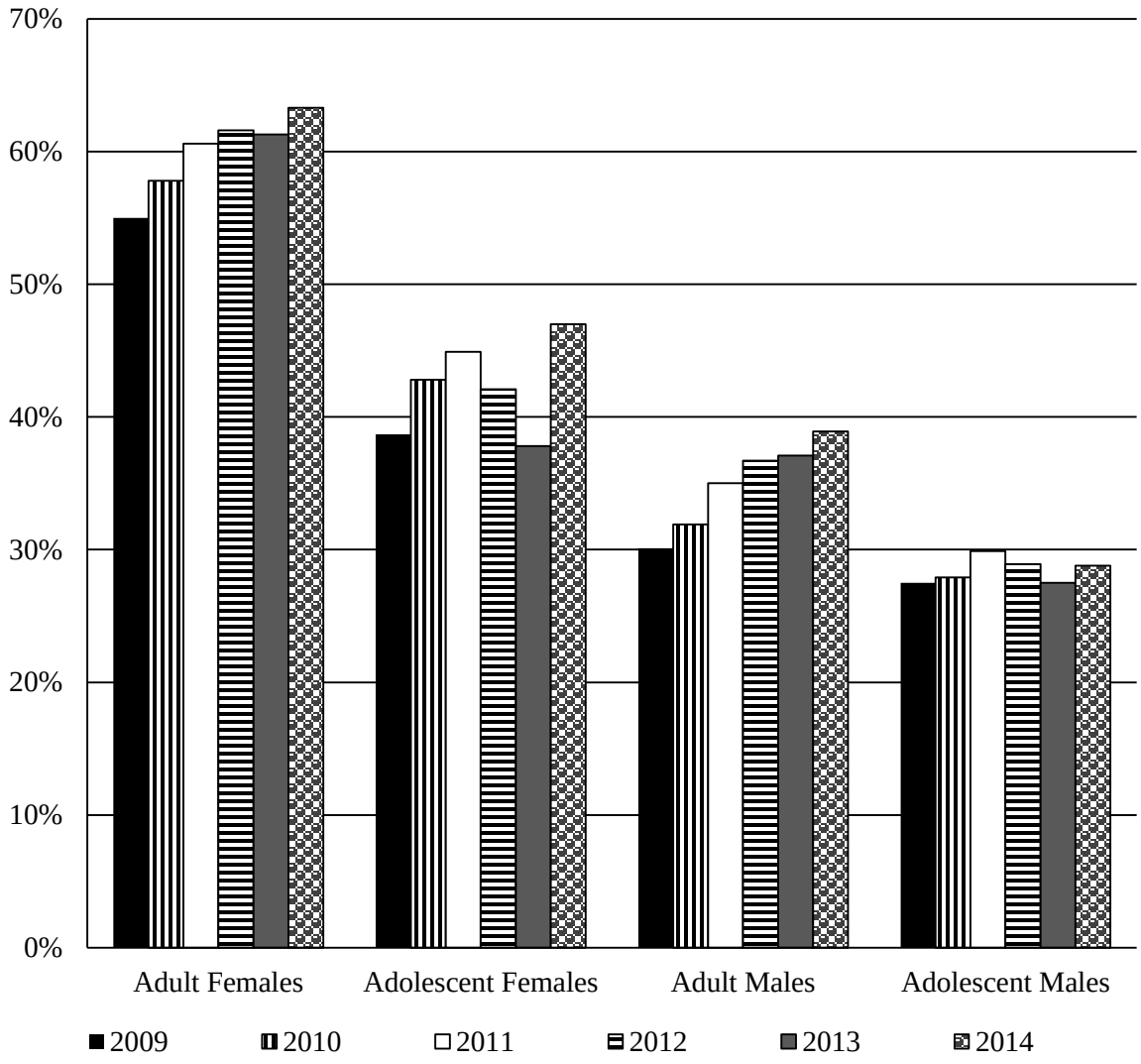
Completion rates (program completion and discharge without the need for further treatment or program completion with appropriate referral to the next level of treatment), which tended to vary little from year to year, rose from 45.0% to 46.5% between fiscal 2013 and 2014. However, this is still below the completion rates experienced before fiscal 2012, which were over 50.0%. In the past, the administration has noted the impact that an increase in heroin-related treatment cases can have upon completion rates. As further discussed in Issue 2, heroin is now the most reported primary substance for individuals seeking treatment through the State-supported system. In the past, completion rates associated with heroin-related treatment cases are generally 20.0% lower than those for nonheroin-related treatment cases.

One measure that is now worth tracking given the integration of mental health and substance abuse services is the number of users with co-occurring disorders in the system. **Exhibit 3** provides the co-occurrence rates by gender and age for users of the State-supported substance abuse system. As seen in the chart, there has been a gradual increase in the number of patients reporting co-occurrence symptoms over the last six years, especially among the adult populations.

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

- While there had 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, fiscal 2013 saw this percentage grow from 78.3% to 79.4%, and then grow further to 79.9% in fiscal 2014. 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 40.5%, and it jumped dramatically to 45.5% in fiscal 2013 and again to 46.0% in fiscal 2014. 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 3
Co-occurrence Rates for Mental Health and Substance Use Disorders By Age and Gender
Fiscal 2009-2014



Source: Behavioral Health Administration

Exhibit 4

State-funded Treatment Programs

Various Treatment Outcomes for Most Treatment Types

Fiscal 2009-2014

	Substance Abuse			Employed			Criminal Justice Involvement (Arrested in Prior 30 Days, % of Patients)		
	30 Days Prior to Admission	30 Days Prior to Discharge	Difference	At Admission	At Discharge	Difference	Prior to Admission	Prior to Discharge	Difference
2009	78.1%	39.9%	-38.2%	27.1%	35.1%	8.0%	6.9%	3.6%	-3.3%
2010	78.2%	38.7%	-39.5%	24.6%	32.2%	7.6%	7.0%	3.0%	-4.0%
2011	78.4%	37.5%	-40.9%	23.9%	31.1%	7.2%	7.0%	3.1%	-3.9%
2012	78.3%	40.5%	-37.8%	23.2%	30.5%	7.3%	7.2%	3.1%	-4.1%
2013	79.4%	45.5%	-33.9%	23.6%	30.7%	7.1%	7.3%	3.6%	-3.7%
2014	79.9%	46.0%	-33.9%	24.8%	31.8%	7.0%	7.1%	4.8%	-2.3%

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 51.2% in Caroline County to 91.2% in Baltimore City. Substance abuse within 30 days prior to discharge ranges from a low of 13.1% in Frederick County (also the jurisdiction with the lowest level in fiscal 2013) to 69.2% in Baltimore City (also the jurisdiction with the highest level in fiscal 2013). 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 2014 the percentage of people who were employed both at admission to treatment and at discharge were higher than in fiscal 2013, both data points are still a long way from pre-recession levels.

  The jurisdictional data makes for even grimmer reading. 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 (51.0%), it has the lowest level of persons employed at admission, 11.6%, which rises only to 17.5% at discharge. The variation in terms of employment at admission and discharge is quite marked across the State. Queen Anne's County, for example, has 46.5% employed at admission to treatment and 59.0% 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 2014 relates to the surge in heroin cases. These individuals tend to have much lower levels of employment at admission (half that of nonheroin cases).

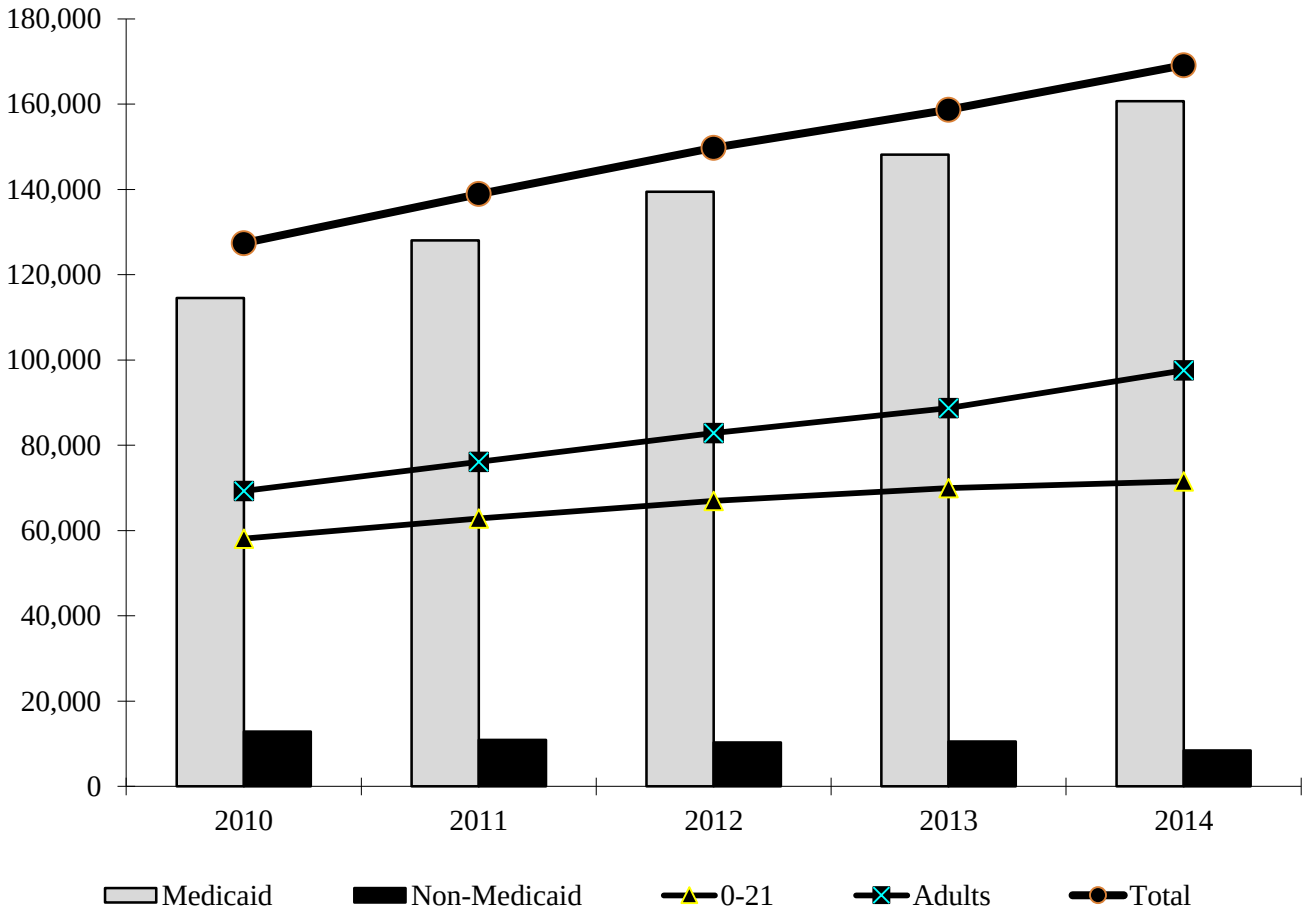
- The relative change in the level of criminal justice involvement 30 days prior to treatment compared to 30 days prior to discharge showed a marked change between fiscal 2013 and 2014 compared to prior years. Criminal justice involvement at admission was lower but the level of involvement at discharge much 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 (19.4%) had the highest percentage of individuals who were arrested 30 days prior to admission, compared to St. Mary's County with only 2.5%. In terms of persons arrested 30 days prior to discharge, Frederick County had only 1.8% of clients arrested, compared to 9.7% in Carroll and Wicomico counties. A total of 9 jurisdictions, (Baltimore, Caroline, Carroll, Harford, Kent, Queen Anne's, St. Mary's, and Somerset counties and Baltimore City) saw more people arrested within 30 days prior to discharge than prior to admission.

3. Community Mental Health Fee-for-service 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 7.3% between fiscal 2010 and 2014, which is similar to the 6.6% growth between fiscal 2013 and 2014.

Exhibit 5
Community Mental Health Services Enrollment Trends
Fiscal 2010-2014



Note: Data for fiscal 2014 is incomplete. Enrollment counts may be duplicated across coverage types. Enrollment in the Baltimore City capitation project is included.

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

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 (8.8% between fiscal 2010 and 2014 and 8.5% between fiscal 2013 and 2014), with the non-Medicaid population falling by 10.0% over the period shown, and falling even more sharply, by 20.0%, between fiscal 2013 and 2014.

The exhibit also shows that enrollment growth over the period has been driven by adults (8.9% between fiscal 2010 and 2014), reflecting both prior strong growth in the Primary Adult Care program, the State's fiscal 2009 expansion to parents of children in Medicaid, as well as the fiscal 2014 Affordable Care Act (ACA) expansion. In particular, enrollment growth for adults grew by 10.0% between fiscal 2013 and 2014. This compares to 5.3% for children and adolescents between fiscal 2010 and 2014, and 2.2% between fiscal 2013 and 2014. Adults make up 57.7% of total enrollment in fiscal 2014, compared to 54.4% in fiscal 2010.

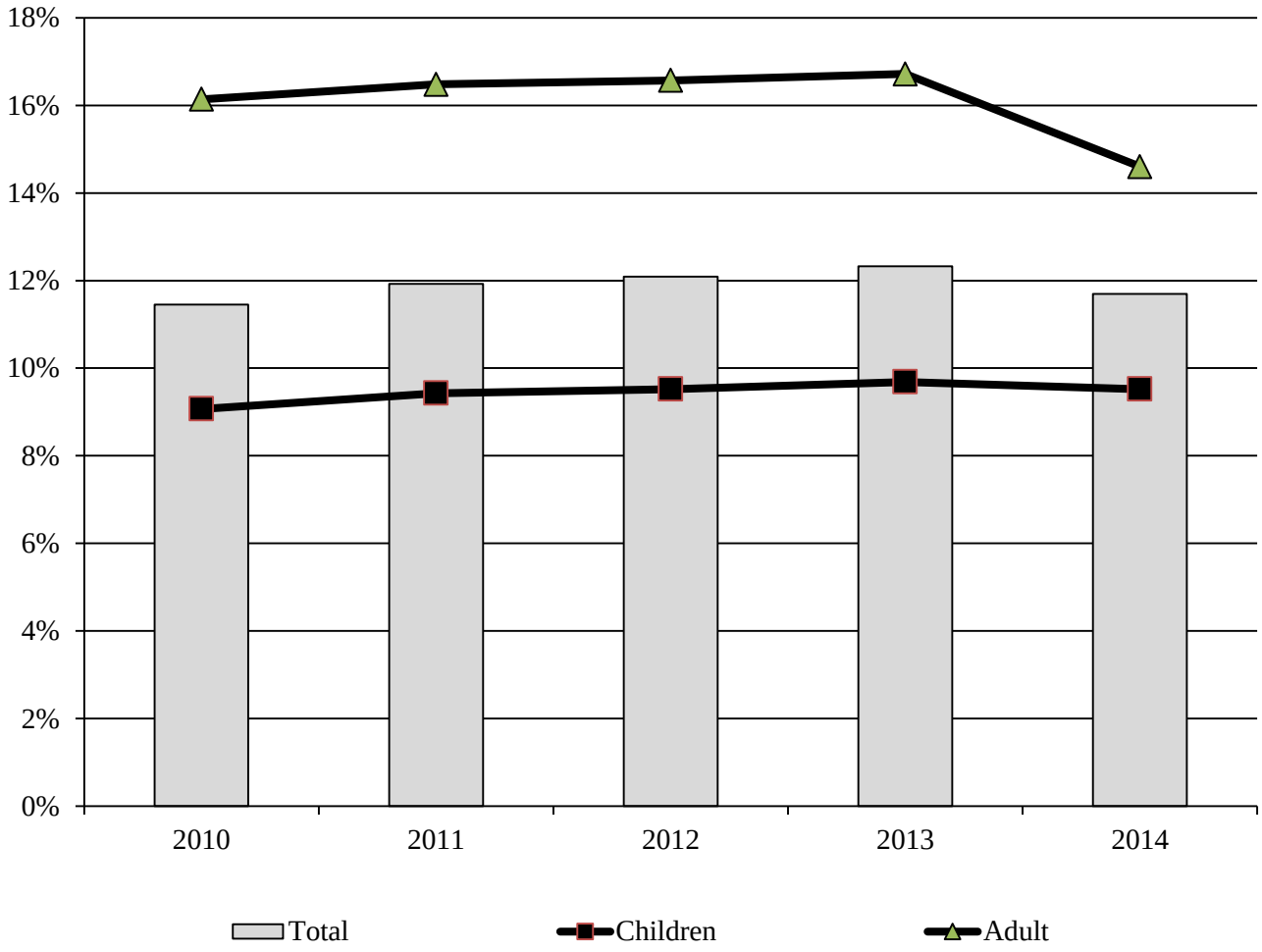
The percentage of Medicaid enrollees utilizing FFS community mental health services, the penetration rate, dropped between fiscal 2013 and 2014. The rate shrank from 9.7% to 9.5% among children enrolled in Medicaid/Maryland Children's Health Program and from 16.7% to 14.6% among adults. As shown in **Exhibit 6**, prior to fiscal 2014, the penetration rate in both children and adults had grown steadily between fiscal 2012 and 2013. The decline in the adult penetration rate would be due to the fact that the ACA expansion population overall does not appear to have as great a need for mental health services as the traditional Medicaid-eligible population.

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 up 3.9%. In fact, fiscal 2014 had the largest number of total service units in over 10 years, and the growth between fiscal 2013 and 2014 was 11.1%. This increase has been driven by increases in both outpatient services (up 5.5% over the period and 18.6% over the prior year) as well as other services including crisis, supported employment, and respite care (up 10.5% over the period and 10.9% over the prior year). In fact, all service types had increases in the total number of services over the prior year in fiscal 2014, mainly reflecting the fact that the ACA expansion increased the number of services available to a population that previously had largely been unable to obtain them.

It is worth noting the difference between the enrollment growth in the system between fiscal 2010 and 2014 and contrasting that with the total service units provided in the same period. Over the time period, there has been a decline in the average number of services per capita for each service type excluding the other services, as seen in **Exhibit 8**. While this is not the case between fiscal 2013 and 2014, there was still a decline of 5.6% in Psychiatric Rehabilitation and Residential Rehabilitation Programs as well as a decline of 9.2% for Residential Treatment Centers (RTC). These declines, as well as the general decline in the average number of services per capita over the time period, are 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);

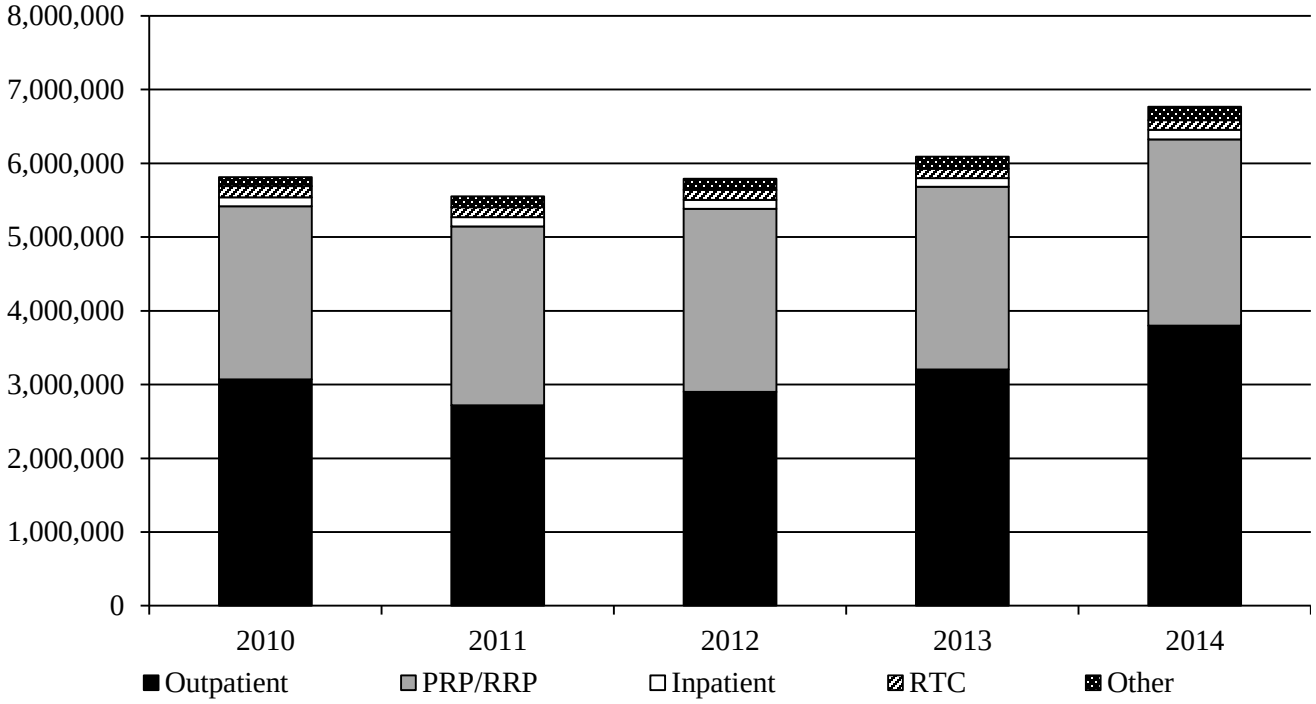
Exhibit 6
Community Mental Health Services Penetration Rate
Fiscal 2010-2014



Note: Data for fiscal 2014 is incomplete.

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

Exhibit 7
Community Mental Health Fee-for-services Service Utilization Trends
(Units of Service)
Fiscal 2010-2014

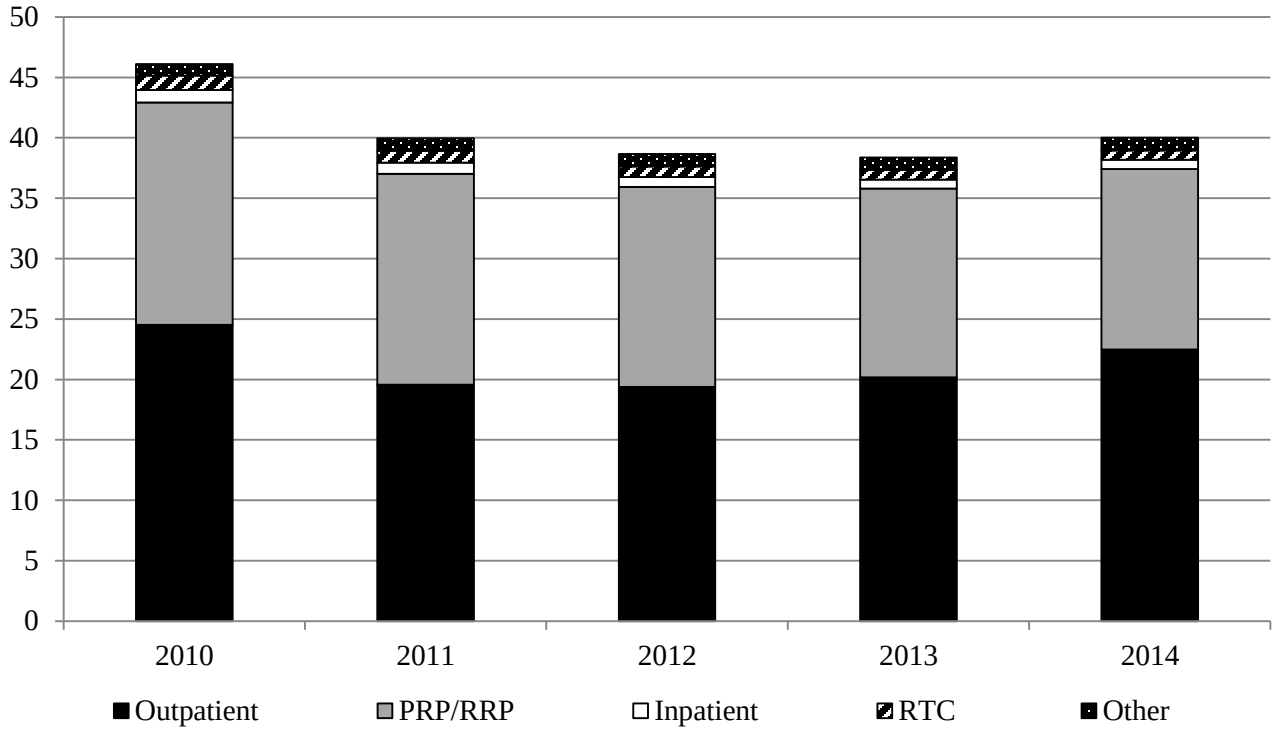


PRP: Psychiatric Rehabilitation Program
RRP: Residential Rehabilitation Program
RTC: Residential Treatment Center

Note: Data for fiscal 2014 is incomplete. Total service unit data includes service units for the Baltimore City capitation project.

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

Exhibit 8
Community Mental Health Fee-for-services Service Utilization Trends
(Services per capita)
Fiscal 2010-2014



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

Note: Data for fiscal 2014 is incomplete. Total service unit data includes service units for the Baltimore City capitation project.

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

- RTC (limiting use for short-term diagnostic and evaluation services rather than longer treatment stays, plus developing community alternatives to RTC placement); and

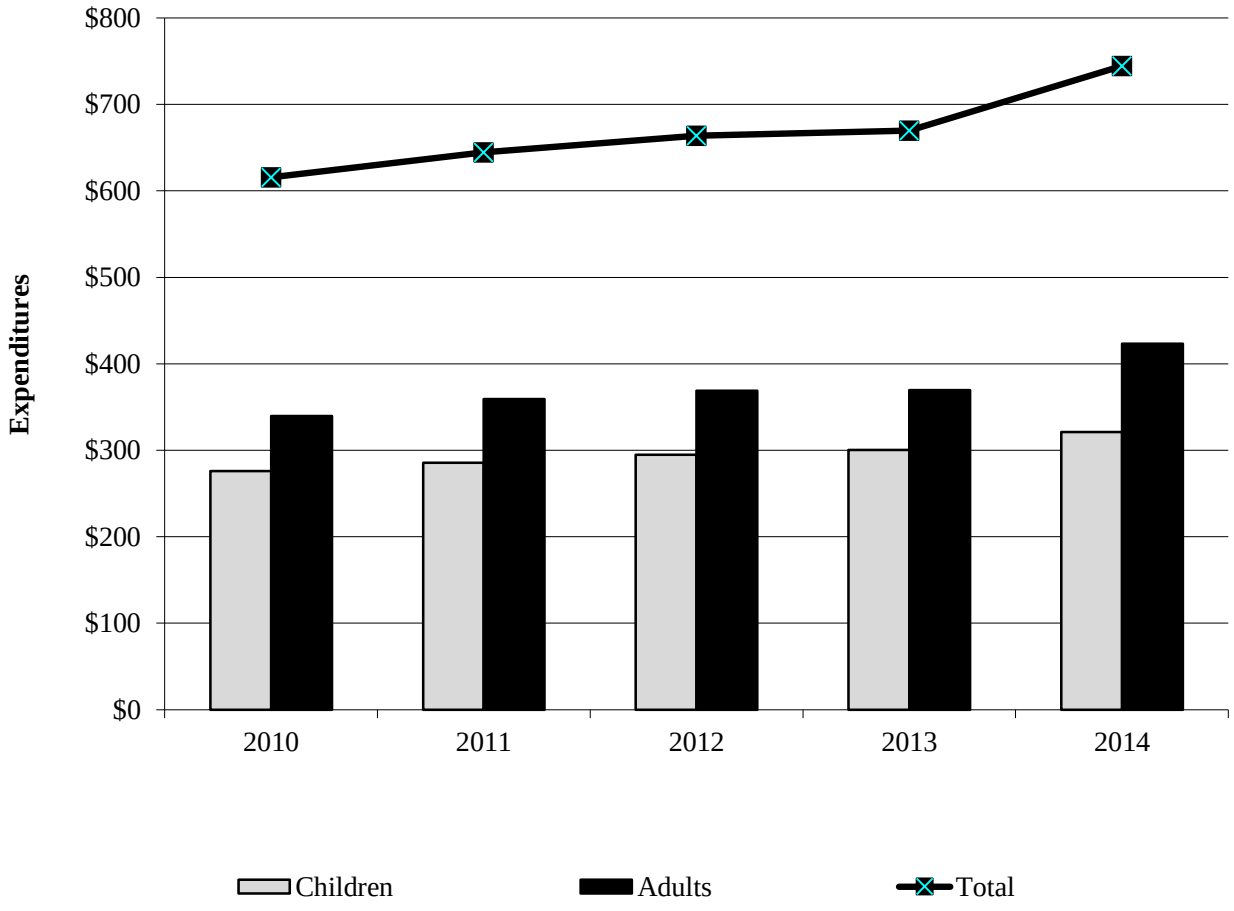
- intensive outpatient (prompted by perceived inappropriate overutilization of this service); and

- the fact that new enrollees, prior to the ACA expansion, appeared to require fewer services generally.

4. Community Mental Health FFS System: Expenditure Trends

Expenditure patterns historically mirror enrollment growth (**Exhibit 9**). Expenditure growth over the fiscal 2010 to 2014 period is 4.9%. However, growth between fiscal 2013 and 2014 is 12.8%, which is mainly driven by the increase in demand for services noted in the previous section.

Exhibit 9
Community Mental Health Fee-for-services Expenditures
Fiscal 2010-2014
($ in Millions)

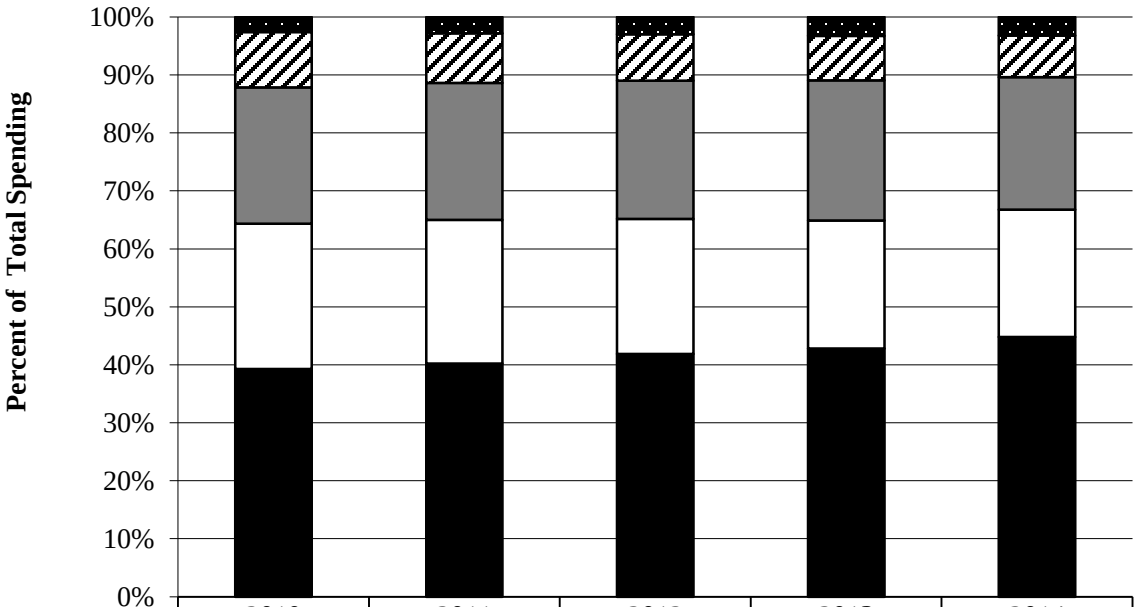


Note: Data for fiscal 2014 is projected from the most recent expenditure data. Total expenditures exclude funding for the Baltimore City capitation project.

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

Reflecting the changes in service utilization noted above, there has been a corresponding change in expenditure patterns between different services (**Exhibit 10)**. All services had expenditure growth between fiscal 2013 and 2014, with the largest growth being in outpatient services expenditures at 18.0%. More surprisingly, inpatient expenditures also had a major increase of 12.4%, again attributable to the ACA expansion population.

Exhibit 10
Community Mental Health Service Expenditures by Service Type
Fiscal 2010-2014



	2010	2011	2012	2013	2014
Other	$16,175,298	$18,329,753	$19,699,732	$21,588,505	$23,746,759
RTC	58,561,029	55,193,989	53,243,697	50,740,960	53,866,673
PRP and RRP	144,952,130	152,065,731	158,366,382	159,771,844	170,093,386
Inpatient	154,038,002	159,818,003	154,515,302	145,656,749	163,709,230
Outpatient	241,974,085	259,343,588	277,934,562	283,015,346	333,915,931

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

Note: Data for fiscal 2014 is incomplete.

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

5. Outcomes for Community Mental Health Services

Outcome data from BHA'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 2010, 2011, 2012, 2013, and 2014 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, but rose in fiscal 2014.

Data on adult employment in fiscal 2014, while improved over fiscal 2013, remains a concern. The percent of unemployed adults with serious mental illness receiving treatment in outpatient settings in both observations is 61.5%. This level of unemployment is slighter better than unemployment levels for persons discharged from substance abuse treatment, but lack of employment is clearly a major barrier to recovery in both treatment settings.

Exhibit 11
Community Mental Health Services Outpatient Fee-for-service
Selected Outcomes
Fiscal 2010-2014

	Reported in 2010	Reported in 2011	Reported in 2012	Reported in 2013	Reported in 2014
Adult Outcomes					
Net Improvement in Functioning (Percent of Total Observations)	12.0%	13.8%	21.8%	24.6%	27.2%
Increase in Employment between Observations	-5.5%	-2.2%	-1.7%	-0.1%	0.4%
Persons Unemployed in Both Observations	61.4%	74.0%	63.5%	63.1%	61.5%
Homelessness in Both Observations	6.6%	5.5%	5.5%	5.0%	4.7%
Children and Adolescents Outcomes					
Net Improvement in Functioning (Percent of Total Observations)	14.3%	16.0%	15.3%	14.2%	14.6%

Source: Behavioral Health Administration; Department of Legislative Services

Fiscal 2015 Actions

Cost Containment

On July 7, 2014, the Board of Public Works (BPW) withdrew a total of $77.1 million in appropriations as fiscal 2015 cost containment. This included two reductions for BHA, including $680,017 in funding for inpatient hospital services not needed due to the federal ACA, as well as $2.2 million to be swapped with federal funds available from a prior year award under the Emergency Psychiatric Demonstration Waiver.

On January 7, 2015, BPW further withdrew an additional $205.3 million in appropriations as fiscal 2015 cost containment. Specific reductions to BHA included $3.3 million in provider rate decreases, resulting in the rate increase for fiscal 2015 falling from 4% to 2%, as well as $685,000 by reducing the psychiatrist evaluation and management (E&M) reimbursement rate from 100% to 87% of Medicare effective April 2015. There is also a fund swap of $3.0 million where special funds from the Maryland Community Health Resources Commission were used in place of general funds to cover behavioral health services for the uninsured.

The BPW reductions of January 2015 also included a 0.6% across-the-board general fund reduction to the Department of Health and Mental Hygiene (DHMH) totaling $25,448,100. If allocated proportionally, it would equal $5,041,378 in this program. A summary of all of these actions is displayed in **Exhibit 12**.

Exhibit 12
Fiscal 2015 Reconciliation
($ in Thousands)

Action	Description	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Legislative Appropriation with Budget Amendments		**$813,418**	**$47,553**	**$529,024**	**$8,332**	**$1,398,328**
July BPW	Remove funding for inpatient hospital services as well as funding to be replaced with federal funds from Emergency Psychiatric Demonstration Waiver.	-2,880	0	0	0	-2,880
Working Appropriation		**$810,538**	**$47,553**	**$529,024**	**$8,332**	**$1,395,448**

Action	Description	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
January BPW	Reduce rate increase for community providers from 4% to 2%; reduce psychiatrist evaluation and management reimbursement rate from 100% to 87% of Medicare; swap general funds for uninsured services with special funds from the Maryland Community Health Resources Commission.	-6,955	3,000	0	0	-3,955
January BPW Across the board	This unit is part of Department of Health and Mental Hygiene, which received a 0.6% across-the-board general fund reduction totaling $25,448,100. If allocated proportionally, it would equal $5,041,378 in this program.					
Total Actions Since January 2015		***-$6,955***	***$3,000***	***$0***	***$0***	***-$3,955***
Adjusted Working Appropriation		**$803,583**	**$50,553**	**$529,024**	**$8,332**	**$1,391,493**

BPW: Board of Public Works

Source: Department of Legislative Services

Proposed Budget

As shown in **Exhibit 13**, after adjusting for fiscal 2015 and 2016 cost containment and back of the bill reductions, the fiscal 2016 allowance for BHA grows by $266 million (19.1%) over the fiscal 2015 working appropriation. The majority of this increase is due to $211 million being transferred from program M00Q01.03 to program M00Q01.10 for substance abuse treatment under the new integrated behavioral health carve-out.

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

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2014 Actual	$785,711	$50,596	$445,517	$9,323	$1,291,148
Fiscal 2015 Working Appropriation	803,583	50,553	529,024	8,332	1,391,493
Fiscal 2016 Allowance	862,580	48,448	738,552	7,944	1,657,525
Fiscal 2015-2016 Amt. Change	$58,998	-$2,105	$209,528	-$388	$266,032
Fiscal 2015-2016 Percent Change	7.3%	-4.2%	39.6%	-4.7%	19.1%

Where It Goes:

Personnel Expenses	
Employee and retiree health insurance	$6,131
Increments and other compensation (prior to cost containment)	5,204
Retirement contributions	2,766
Other salary adjustments	1,016
Social Security contributions	598
Overtime	334
Other fringe benefit adjustments	114
Workers' compensation premium assessment	-652
Turnover adjustments	-861
Section 20: 2% salary adjustment reduction	-3,605
Section 21: Elimination of employee increment	-4,267
Community Mental Health Services	
Fee-for-Service Expenditures	
Affordable Care Act enrollment (100% Federal Funds)	64,924
Other enrollment and utilization	4,851
ACA Emergency Psychiatric Grant expiration	-2,200
Reduce psychiatrist rate for evaluation and management to 87% of Medicare	-5,480
Rate adjustment for community providers, returning to fiscal 2014 rates (-2%)	-15,043

Where It Goes:

Grants and Contracts	
ASO contract	4,454
Various federal mental health grants	-221
Expiration of Alternatives Grant	-7,187
Substance Abuse Services	
Substance use disorder Medicaid transfer	211,430
Substance Abuse Treatment Funding (SAPT block grant related)	1,195
Various other federal substance abuse grants	-1,133
Program Direction	
Synar Penalty	2,612
State-run Psychiatric Facilities (nonpersonnel expenses)	1,687
Other	-635
Total	**$266,032**

ASO: administrative service organization
SAPT: Substance Abuse Prevention and Treatment

Note: Numbers may not sum to total due to rounding. The fiscal 2015 working appropriation reflects deficiencies and the Board of Public Works reductions to the extent that they can be identified by program. The fiscal 2016 allowance reflects back of the bill and contingent reductions to the extent that they can be identified by program.

Cost Containment

The largest cost containment action for BHA is the rate reduction for community providers in the fiscal 2016 allowance. The 2% midyear rate increase in fiscal 2015 is being taken out of the fiscal 2016 allowance. This reduction, combined with the annualization of the psychiatrist E&M reduction mentioned under fiscal 2015 cost containment, removes over $23 million in funding from the allowance.

The fiscal 2016 allowance also contains back of the bill reductions for the 2015 cost-of-living adjustment (COLA) as well as removing increment/merit payments from agency allowances. These reductions equal $7.8 million for BHA.

Further, there is a 2.0% across-the-board reduction in the fiscal 2016 allowance, which includes a 0.6% across-the-board general fund reduction to DHMH totaling $27,215,000. If allocated proportionally, it would equal $5,581,825 in this program.

Personnel

Personnel expenditures prior to cost containment increase the allowance by $14.7 million. The largest increase is $6.1 million for employee and retiree health insurance payments. Other large increases include $5.2 million for increments and other compensation prior to cost containment, $2.8 million for retirement contributions, and over $1.0 million in other salary adjustments. While overtime costs only increase by $334,000, the total amount could be underfunded since funding in the allowance is $4.2 million below the most recent actual.

Program Direction

There is one major operating increase in BHA Program Direction of $2.6 million. This is due to a penalty assessed by the federal government relating to the Synar amendment provision. As part of the agreement for accepting the Substance Abuse Prevention and Treatment (SAPT) block grant, the State has agreed to have federal regulators audit the State to the extent that tobacco retailers are selling tobacco to minors in the State. The limit for compliance with this provision is 20.0%. If a state exceeds this percentage, they must either pay a penalty amount based on the percentage of retailers found out of compliance over the limit, or surrender SAPT funding. In Maryland's most recent audit, 31.8% of audited retailers has sold tobacco to minors. Thus, Maryland had to pay the equivalent of 11.8% of its SAPT block grant amount for tobacco compliance. While some funds in the Prevention and Health Promotion Administration counted toward the total, an additional $2.6 million had to be funded in order to meet the requirements of the Synar penalty.

Synar penalty compliance has been a problem in Maryland. While this funding may help establish programs to fill in the gaps in training and enforcement, there is still concern about how effective these programs may be. In recent years, recruitment concerns, not resource availability, has been identified as the prevailing problem since the State is only allowed to hire 16- and 17-year olds, and further has had issues with some area schools in terms of encouraging recruitment. **The Department of Legislative Services (DLS) recommends that language be added to the budget bill requesting a report on how the Synar penalty funds will be spent and how the compliance and training programs will operate. Further, DLS recommends that available funds from the Cigarette Restitution Fund (CRF) balance be used to pay for a portion of the Synar penalty in lieu of general funds. The administration is currently projecting a $2.5 million fund balance for CRF at the end of the fiscal 2016.**

Community Mental Health Services

FFS System

Total spending in the FFS system for mental health services increases by $47.1 million, after accounting for the previously mentioned cost containment, which reduced provider rates to the fiscal 2014 level. Most of this growth is due to enrollment under the ACA expansion, which increases in the allowance by $64.9 million. This increase in fiscal 2016 is entirely federally funded. However,

beginning in fiscal 2017, the State will be required to provide a small amount of general funds for this population. Other enrollment and utilization trends resulted in an additional increase of $4.9 million.

The adequacy of general funds for the mental health FFS system is currently a matter of speculation. The mix of State-matched versus 100% Federal Medical Assistance Percentage (FMAP) services was such that in fiscal 2014, an anticipated $11 million general fund surplus is anticipated. DHMH has indicated that it intends to use this surplus to partially cover the fiscal 2015 across-the-board reduction to the department, although this has not yet been confirmed by the Department of Budget and Management.

This same mix of State-matched versus 100% FMAP services continues into fiscal 2015 according to BHA. This has resulted in an estimated overfunding of $21 million in general funds in that year. As a result, DHMH has made the decision not to transfer a like amount of general funds to support substance abuse carve-out from Medicaid into the Behavioral Health Program in fiscal 2015 in order to cover a projected shortfall in regular Medicaid payments.

In terms of the fiscal 2016 allowance, DLS is projecting a slight deficit in general funds for the program. However, due to ongoing issues related to the reimbursement mix, the extent of the deficit is unknown at this time. While the overall mix of general versus federal funds overstated general fund need in fiscal 2014 and 2015, the fiscal 2016 budget has a higher of ratio of federal to general funds than what the program is currently experiencing.

Community Mental Health Grants and Contracts

Grants and contracts decrease by $3.0 million, mainly due to the expiration of the Alternatives to Psychiatric Residential Treatment Facilities for Children grant, which results in a decrease of $7.2 million, all of which is federal funds. This is offset by large increases in other contracts, including a $4.5 million increase in the cost of the new ASO contract.

Substance Abuse Services

As previously mentioned, there is a $211 million increase in substance abuse services funding. However, this is not an increase as much as a fund transfer between programs within DHMH. This entire amount is based on the estimated cost for substance abuse services provided under the managed care organizations (MCO) in prior years as well as the expectation of what they would have spent in the second half of fiscal 2015. This, however, could prove to be problematic since the MCOs paid for services under a different structure than the new FFS system. MCOs have the ability to actively manage the care of the patients, and in some instances ordered the discharge of a patient from treatment prior to when the treatment provider would have considered optimal for the successful completion of that treatment. To the extent that substance abuse patients could remain in treatment longer under a FFS system, this amount of funding could prove to be inadequate to cover all of fiscal 2016.

Beyond the increase in FFS Medicaid expenditures for substance abuse, funding for other substance abuse services is relatively flat to the prior year. There are some increases in programs receiving general funds for substance abuse, including recovery support services and the buprenorphine

initiative. However, the increase is only about $887,000, or 1.2%, and is further offset by decreases in federally funded programs totaling $824,000. As further explained in Issue 2, this level funding could be an issue to the State's efforts to treat individuals addicted to heroin and other opioid-related substances.

Issues

1. Behavioral Health Integration – Implementation and Issues

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 previous 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 an expanded carve-out of behavioral health services from the managed care system with added performance risk. Specifically, all substance abuse would be carved out from MCOs and delivered as FFS through an ASO, joining specialty mental health services, which were already carved-out from managed care. The ASO contract includes incentives/penalties for performance against set targets.

Some of the most visible signs of the integration include the merger of the former MHA and ADAA into the newly created BHA, as codified in Chapter 460 of 2014, as well as the reconfiguration of funding streams so that in the fiscal 2016 budget funding for Medicaid-eligible specialty mental health and substance abuse services for Medicaid-eligible individuals are located in the Medicaid program, with funding for the uninsured/underinsured and for Medicaid-ineligible services located in BHA. Further, BHA finalized, and BPW approved, a contract for the new ASO, which took effect January 1, 2015.

Changes in Care

For the most part, the change to a FFS system under an ASO does not require any change to the specialty mental health services since this model is the same as the previous delivery model. However, it does create a significant change in the way in which substance abuse services are delivered throughout the State, including the fact that Medicaid-reimbursable substance abuse services for the uninsured will now be provided FFS through an ASO. This effectively creates treatment on demand for eligible individuals for those services which change to a FFS model, which is much different from the previous grant-based managed care system.

Another major change is that under the proposed system, income eligibility for uninsured services will be set at 250% of the federal poverty level (FPL), with certain additional criteria including having applied for Medicaid or insurance through the Maryland Health Benefit Exchange, having a valid Social Security number, and being a Maryland resident. Certain temporary exceptions will apply, but this revised eligibility criteria has a higher income limit than previously in place for specialty mental health services (200% FPL) and eliminates the sliding-fee scale previously used for substance abuse services, which imposed a $5 fee for most services for individuals with incomes below 100% of the FPL and a percentage charge for service to individuals above 100% of the FPL.

The ASO will be responsible for coordination with both local agencies and the MCOs in order to ensure appropriate referrals from MCOs and coordination between MCOs and behavioral health providers. The ASO will also be responsible for providing additional training to providers in terms of developing and enhancing provider competency in the areas of mental health and substance abuse services and how to seek authorizations and payments though the ASO.

The ASO contract contains various outcome-based standards, which the ASO will be held responsible for upholding. Beginning in year three of the contract, BHA will employ appropriate Healthcare Effectiveness Data and Information Set (HEDIS) measures in order to track the performance of the ASO against other states. There will be seven measures, six of which will be HEDIS-based, and a seventh that is State specific. For each measure, the State must be at or above the fiftieth percentile (or 70.0% for the State specific measure). For each outcome standard not met, the ASO will repay to the State 0.0714% of the invoice amounts for the preceding 12 months. Thus, if all seven measures are missed, the total amount of damages is capped at 0.5% of the total contract. The measures to be used include:

- adherence to antipsychotic medications for individuals with schizophrenia;
- follow-up care for children prescribed attention deficit and hyperactive disorder medication;
- antidepressant medication management;
- plan all-cause readmission;
- mental health utilization – inpatient;
- initiation and engagement of alcohol and other drug dependence treatment; and
- the percentage of people in the specialty behavioral health system who have a primary care physician visit within a year (State specific).

Reporting on these standards is set to begin in July 2016 with the average for each outcome standard determined at the end of 2016 and similar averages established each year thereafter. Further, it should be noted that while there are penalties for not performing to the outcome-based standards, there are no bonuses or inducement payments for exceeding them. It should be worth monitoring how these outcome-based standards change the way in which the care is delivered to individuals in the public behavioral health system.

Further, Chapter 460 also required that the Secretary of DHMH convene a stakeholder workgroup over the interim to make recommendations on issues related to behavioral health, including statutory and regulatory changes to (1) fully integrate mental health and substance use disorder treatment and recovery support, and (2) promote health services. DHMH submitted the report on December 26, 2014. The report noted that DHMH will continue to review the statute and regulations

to make the necessary changes required to continue the integration of BHA, including the delineation of the responsibilities of the Secretary of DHMH and the Director of BHA, removing antiquated language and references to programming no longer used, and providing language to prevent discrimination in both treatment and housing for individuals with a behavioral health disorder. DHMH and BHA are also going to create a Behavioral Health Advisory Council to expand opportunities for stakeholder involvement and help improve the integration of the behavioral health carve-out. Legislation is expected to be introduced to provide for the necessary statutory changes.

Issues Going Forward

One of the first issues to arise out of the integration process has been with the payment for residential substance abuse detoxification treatment. Previously, providers throughout the State had reported being paid for this service under the MCOs. However, once the ASO took over the payment system in January, Medicaid began denying payments to these providers saying that under federal Medicaid guidelines these facilities count as institutions for mental diseases (IMD), and are thus not eligible for Medicaid reimbursement. An IMD is characterized as a facility of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including substance abuse. This has caused numerous providers to lose their ability to claim reimbursement for these services. At this point, the State needs to decide if it is going to continue funding these services on a FFS basis as a State-funded service, or if it is going to drop that coverage that previously existed for Medicaid-eligible recipients in the State.

Another issue is the arrangement for non-Medicaid reimbursable substance abuse services (such as residential services) where funding will stay with the local jurisdiction. A major policy goal of the integration process is to streamline funding sources and management of services for both mental health and substance abuse care. This would mean switching the majority of services for uninsured substance abuse patients from the current grant-based system to a FFS system. This would mirror how most community mental health services for the uninsured are delivered. While some services were slated to begin this transition at the beginning of fiscal 2016, only residential services will transition at this time. There had been plans to migrate ambulatory services as well, but those have been put on hold indefinitely due to concerns from local health officials. Further, there is still no plan for the majority of the rest of the grant-based programs to transition to a FFS under the ASO. While such a migration could be destabilizing to the current system, not migrating this funding to the ASO would undermine the policy rational for integration.

The State will also be 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. While this should not be a problem for most large-scale providers, certain smaller providers could face mounting costs since the accreditation process would be more expensive than the process previously in place. DHMH is currently reviewing the regulations to determine which programs need to be licensed, licensed and accredited, or exempt from both.

The agency should comment on what substance abuse services for the uninsured it plans to migrate to a FFS system and what services it plans to leave on a grant-based structure, when it plans to do so, and why some services, if any, will remain grant-based while others are migrated

to FFS. The agency should also comment on its plans for reimbursing for residential detoxification services conducted in an IMD, and when it expects regulations concerning accreditation and licensing to be implemented.

2. The Heroin Epidemic: What to Do?

Opioid use and overdose has become an urgent public health threat. As seen in **Exhibit 14,** since 2007 heroin and/or prescription opioid drugs have been involved in the majority of the State's overdose deaths. From January through September 2014, there were 428 heroin-related overdoses, 104 more than the same period in 2013. During the same time period, there were 252 deaths from prescription opioids, 17 more deaths than the same period in 2013. There was also a large spike in fentanyl-related overdoses, with 141 in the same time period for 2014, which is an increase of 119 over 2013. Further, as seen in **Exhibit 15**, heroin and prescription opioids are the two substances which have seen increases as a percentage of admissions to substance abuse treatment in the State since fiscal 2009. Prescription opioid use as a primary substance abuse problem for admission to a State-supported treatment program increased 92% from fiscal 2009 through 2012 before decreasing by 22% through 2014. However, heroin use as a primary reason for treatment admission has increased 44% from fiscal 2011 to 2014, becoming the first substance since reporting began in the mid-1970s to surpass alcohol as the leading primary problem used for treatment admission. Various actions have been taken in an attempt to combat other overdose deaths as well as heroin and opioid use throughout the State in recent years.

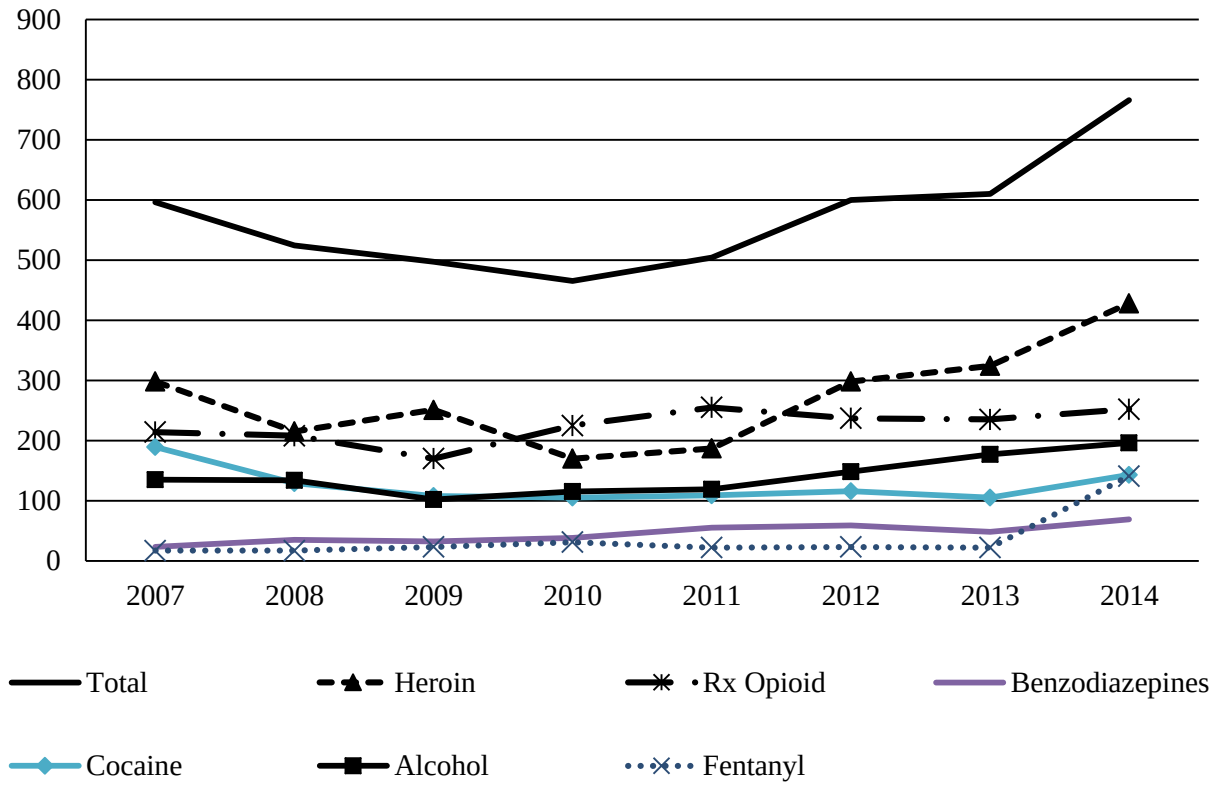
Administration of Naloxone

Naloxone, also known as Narcan, is an opioid antagonist that reverses opioid-related sedation and respiratory depression. Chapter 299 of 2013 established an Overdose Response Program in DHMH to authorize certain individuals, through the issuance of a certificate, to administer naloxone to an individual experiencing opioid overdose to help prevent a fatality when medical services are not immediately available. To qualify for a certificate, an individual must (1) be age 18 or older; (2) have, or reasonably expect to have, the ability to assist an individual who is experiencing an opioid overdose; and (3) successfully complete an educational training program. A physician or nurse practitioner may prescribe and dispense naloxone to a certificate holder.

Good Samaritan Laws

Good Samaritan laws are intended to prevent incidences where medical attention is required for an overdose but not sought because of the threat of arrest or incarceration. Chapter 401 of 2014 establishes that a person who, in good faith, assists someone experiencing a drug- or alcohol-related medical emergency may be immune from criminal prosecution if evidence was obtained solely through the person seeking to help the person experiencing the emergency. The law also protects the individual experiencing the medical emergency. DHMH will be providing information on the Good Samaritan law as part of a public education campaign to increase understanding and awareness.

Exhibit 14
Overdose Deaths by Related Substance
January – September 2007-2014*

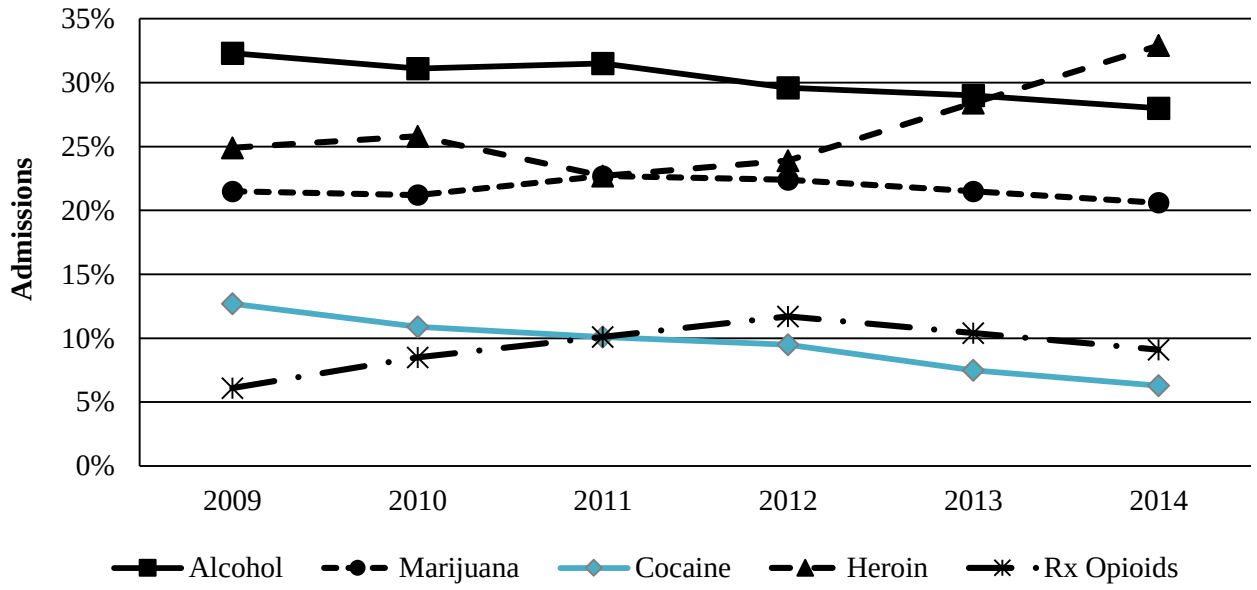


Rx: medical prescriptions

*2014 counts are preliminary.

Source: Department of Health and Mental Hygiene

Exhibit 15
Admissions with Selected Primary Substance Problems in State-supported Treatment Programs
Fiscal 2009-2014



Rx: medical prescriptions

Source: Department of Health and Mental Hygiene

Prescription Drug Monitoring Program

Established by Chapter 166 of 2011, the Prescription Drug Monitoring Program (PDMP) aims to reduce prescription drug misuse and diversion by creating a secure database of all Schedule II through V controlled dangerous substances prescribed and dispensed in the State. The PDMP can make data on prescription opioids available to health care providers, pharmacists, patients, researchers, health occupations licensing boards, and public health and safety agencies.

Chapter 651 of 2014 authorized the PDMP to review prescription drug monitoring data for indications of possible misuse or abuse of a monitored prescription drug and, if indicated, report the possible misuse or abuse to the prescriber or dispenser. Before reporting possible misuse or abuse, the PDMP must obtain clinical guidance from its technical advisory committee regarding indications of possible misuse or abuse and interpretation of the prescription monitoring data that indicated possible misuse or abuse. According to DHMH, 5,000 health care providers in the State are using the PDMP, and the system is receiving 12,000 queries per week. By early 2015, DHMH hopes to have the PDMP interoperable with other states.

Overdose Prevention Council

In response to the rise in opioid overdose deaths in the State, Governor Martin J. O'Malley issued an executive order in June 2014 establishing the Overdose Prevention Council as a subcabinet within the Office of the Governor. The council consists of the leaders of DHMH, the Department of State Police, the Department of Public Safety and Correctional Services, the Department of Juvenile Services, and the Maryland Institute for Emergency Medical Services Systems. The council is charged with advising the Governor on establishing a coordinated statewide effort to reduce the number of fatal and nonfatal unintentional overdoses in the State. In addition, the council is responsible for developing recommendations for policy, regulations, and legislation to address the opioid overdose epidemic and facilitate improved sharing of public health and public safety information among State agencies. Among other things, the council is required to develop a statewide plan to reduce overdoses that includes sharing information and data by State agencies, and analyzing the data for trends to target prevention efforts. At that time, the Governor's strategic goal is to reduce overdose deaths by 20% by the end of 2015.

Treatment Options for Youth with Heroin-related Substance Use Disorders

The 2014 *Joint Chairmen's Report* (JCR) requested a report on the treatment options available for youth with heroin-related substance use disorders, focusing mainly on residential treatment services and the number of youth seeking such services. The report was submitted on November 17, 2014, and noted that there are three major residential treatment facilities which serve youth with heroin-related addictions: Catoctin Summit in Washington County; Jackson Unit in Allegany County; and Mountain Manor in Baltimore City. The report noted that a fourth provider, Pathways of Anne Arundel County, has the capacity to treat youth with heroin-related addictions but is currently not serving any due to lack of demand.

The report also noted that the length of stay ranged from as long as four to six months at Catoctin Summit to as short as 10 days at Mountain Manor in fiscal 2014. Mountain Manor, however, reported that the average length of stay in 2014 was down from a traditional 30-day average due to the early discharge of patients by MCOs. Further, the report indicated that none of the three facilities were reporting any wait times for placement into treatment, and further, none of the facilities as of the report date were full. The report also noted that nonresidential services are available in all 24 local jurisdictions of the State.

Issues Moving Forward

Despite all of these efforts, addiction to opioids, and especially heroin remains a vexing problem for the State. At this point, the fiscal 2016 allowance contains no new funding to specifically address the problem. Indeed funding for substance abuse services is essentially flat between fiscal 2015 and 2016. Further, as noted in Exhibit 2, while the number of admissions to treatment has been declining, treatment for heroin requires a much more intensive form of treatment than other substances, especially residential treatment options. Thus, flat funding of substance abuse services while the underlying mix in the demand for substance use treatment points to higher heroin use could strain the existing budget.

The agency should comment on how it plans to combat heroin use and overdose deaths going forward, and what further options may be necessary for treatment and prevention of heroin use in both the near and long-term future.

3. Treatment and Service Options for Court-involved Individuals

BHA operates an Office of Forensic Services (OFS), which is the entity within DHMH that interacts with the criminal courts of Maryland to respond to certain statutorily defined forensic questions. These specific questions are defined in the Criminal Procedure Article, Title 3, Sections 3-105, 106, 108, 111, 112, and 114-120, as well as in the Health-General Article, Sections 8-505 and 507. These questions break down into two major categories.

Subject to Criminal Procedure Article, Sections 3-105 and 3-111, OFS is responsible for evaluating a defendant's competency to stand trial and/or their criminal responsibility for the crimes with which they are charged. OFS contracts with forensic evaluators in every jurisdiction to conduct these evaluations. While a majority of the cases require no further evaluation, a minority may either require further assessment, in which case the defendant is referred to one of the State facilities, or result in a commitment to a State facility for treatment pursuant to Criminal Procedure Article, Section 3 106(b) or 3-112.

Under Health-General Article, Section 8-505, OFS is responsible for the evaluation of a criminal defendant's need for and amenability to substance abuse treatment. If the court then orders services pursuant to Section 8-507, OFS has the responsibility to facilitate the defendant's prompt placement into services.

Based upon concerns that there were unacceptable wait times for both the evaluation and treatment for individuals in both of these court-involved categories, the 2014 budget bill included language withholding funds and requesting that a workgroup be convened by the department that included various stakeholders in order to review the average wait times for residential placement in State-run psychiatric facilities as well as for treatment under the 8-507 orders, to review and report on the availability of staff and services for court-involved individuals, and to report on any recommendations based on an analysis of this data. This report was submitted to the relevant committees on December 12, 2014.

Data on Forensic Populations

The workgroup examined the average and median wait times for the various populations for fiscal 2012 through 2014. This data is presented in **Exhibit 16**. According to the workgroup's report, while average wait times were above the standards that would be required, the median wait times were within the expected limits. Thus, they felt that the data demonstrated that there were not systemic issues with the forensic treatment system, but rather that there were various outlier cases that needed to be examined in order to make smaller improvements. However, it should be noted that for the initial evaluations, including § 3-105 and § 3-111, the statute provides a date by which these evaluations

Exhibit 16
Treatment and Service Options for Court-involved Individuals
Wait Times for Treatment (in Days)
Fiscal 2012-2014

Statutory Orders	Statutory Wait Time	Mean 2012	Mean 2013	Mean 2014	Median 2012	Median 2013	Median 2014
3-105	7	9.10	10.59	12.98	7	7	10
3-106(b)	n/a	3.11	6.00	5.88	1	3	3
3-111	60	31.00	24.68	16.94	22	18	12
3-112	n/a	3.14	6.77	3.05	1	3	1
8-507 Placement	"Prompt"	165	161	174	126	133	145

Source: Department of Health and Mental Hygiene

should be done, which is 7 and 60 days, respectively. While § 3-111 evaluations are in line with statutory guidance, the fact that the median measure for § 3-105 evaluations is 7 days means that half of all of these evaluations are taking place beyond the statutory guidelines.

Further, it was noted that for § 8-507 placement, the statute calls for prompt placement of a defendant into treatment by the department. While the issue as to whether or not these wait times are prompt is debatable, what came up in the workgroup discussion was the fact that these times are not conducive to the timeframes in which the Maryland District Court normally operates. According to the members of the Judiciary who served on the workgroup, this has led to many judges at the District Court level not utilizing this treatment option for individuals for whom it may be more beneficial than incarceration.

Recommendations

The final report from the workgroup contained seven recommendations, summarized as follows:

- add 100 beds to the State-supported psychiatric system;
- conduct an additional assessment of § 8-505 and § 8-507 order wait times;
- update the most recent study on the demand for substance abuse treatment services since the implementation of the federal ACA;

- expedite the building of the forensics database to better capture the information provided in this report;

- develop Managing for Results outcomes to measure the performance of OFS;

- develop a joint behavioral health and criminal justice system for the identification of high utilizers of services of both systems; and

- increase staffing for psychiatric evaluations, especially at Spring Grove Hospital Center, by approximately 10 FTEs.

One thing that BHA did not comment on during various early presentations to the budget committees on this subject is what it would cost to implement these recommendations. While they have said that they do not intend to pursue the addition of 100 beds at this time due the fiscal condition of the State, other recommendations, including the increase in staffing for forensic evaluations, could also have a large fiscal impact.

The agency should comment on what the potential fiscal impact of the workgroup's recommendations could be in the future. DLS also recommends that the withheld allotment in the fiscal 2015 budget be released.

Recommended Actions

1. Add the following language to the general fund appropriation:

, provided that $100,000 of this appropriation made for the purpose of administration may not be expended until the Department of Health and Mental Hygiene submits a report to the Senate Budget and Taxation Committee and House Appropriations Committee concerning how funds related to the Synar penalty are to be expended, on the structure and nature of the tobacco retailer compliance programs that will utilize these funds, how these programs will ensure future compliance with the federal Synar inspections of tobacco retailers, and whether additional regulatory or statutory changes are needed to ensure compliance. The report shall be submitted by November 15, 2015, and the budget committees shall have 45 days to review and comment. Funds restricted pending the receipt of the report may not be transferred by budget amendment or otherwise to any other purpose and shall revert to the General Fund if the report is not submitted to the committees.

Explanation: The language requests the Department of Health and Mental Hygiene (DHMH) to report on the compliance programs it intends to fund with the Synar penalty funds located in the Behavioral Health Administration budget.

Information Request	**Author**	**Due Date**
Information on funding and outcome measures for Synar compliance programs	DHMH	November 15, 2015

2. Add the following language to the general fund appropriation:

Further provided that authorization is hereby provided to process a Special Fund amendment up to $2,000,000 from the Cigarette Restitution Fund to support the Synar Program.

Explanation: This language authorizes the administration to process a special fund budget amendment in the amount of $2,000,000 from the Cigarette Restitution Fund to support the Synar program.

3. Add the following language to the general fund appropriation:

Further provided that $100,000 of this appropriation made for the purpose of administration may not be spent until the Department of Health and Mental Hygiene submits a report to the budget committees containing information on the utilization and expenditure for behavioral health services based upon the user's eligibility group under Medicaid. The report shall be submitted by August 1, 2015, and the budget committees shall have 45 days to review and

comment. Funds restricted pending the receipt of the report may not be transferred by budget amendment or otherwise to any other purpose and shall revert to the General Fund if the report is not submitted to the committees. Further provided that, beginning with the period ending June 30, 2015, the quarterly report that is produced by the administrative service organization which oversees the public behavioral health system is requested to break down data based on the user's eligibility group under Medicaid.

Explanation: This language requests that the Department of Health and Mental Hygiene (DHMH) report on the breakdown of users within the public behavioral health system based on how those users qualify for Medicaid. Specifically, the report should break down whether the individuals qualify under the federal Affordable Care Act expansion, or under traditional Medicaid eligibility. This data should be incorporated into the quarterly reports that the administrative service organization submits to the department.

Information Request	**Author**	**Due Date**
Utilization and expenditures on behavioral health services by Medicaid eligibility	DHMH	August 1, 2015

		Amount Reduction	
4.	Reduce general funds related to the Synar penalty. The agency is authorized to process a budget amendment to provide for these costs with special funds from the Cigarette Restitution Fund.	$ 2,000,000	GF
	Total General Fund Reductions	**$ 2,000,000**	

Updates

1. Outpatient Services Programs Stakeholder Workgroup

Prompted by concerns that individuals with serious mental illness are not receiving treatment due to failures of the State's mental health system, Chapters 352 and 353 of 2014 required the Secretary of Health and Mental Hygiene to convene an Outpatient Services Programs Stakeholder Workgroup to (1) examine assisted outpatient programs, assertive community treatment programs, and other outpatient services programs with targeted outreach, engagement, and services; (2) develop a proposal for a program that, among other things, best serves individuals with mental illness who are at high risk for disruptions in the continuity of care; and (3) evaluate the dangerousness standard for involuntary admissions and emergency evaluations of individuals with mental disorders.

A final report of DHMH's findings and recommendations was submitted to the Senate Finance Committee and the House Health and Government Operations Committee on December 10, 2014. The report from DHMH included three main recommendations based on discussions of the workgroup that focus on (1) outpatient civil commitment; (2) the dangerousness standard for involuntary admissions and emergency evaluations; and (3) access to voluntary outpatient mental health services. The recommendations are discussed below.

Outpatient Civil Commitment

Outpatient civil commitment (OCC) provides court-ordered community-based services, including medication, to adults with severe mental illness who are nonadherent to treatment. While DHMH is not planning on requesting legislation in the 2015 session to establish OCC in the State, they did outline in the report a detailed proposal for such a program. Under this proposal, specified individuals would be authorized to request the Secretary to conduct an investigation to determine whether a petition for OCC should be filed for a specific adult. The Secretary, or the Secretary's designee, may file an OCC petition only if the Secretary, or the Secretary's designee, believes that it is likely that it can be proven by clear and convincing evidence that the individual meets the statutory OCC criteria.

To be placed under an OCC order, the Office of Administrative Hearings will have to find that, among other things, (1) the individual is an adult; (2) the individual has a mental disorder as defined by Health-General Section 10-101; (3) the individual, based on a clinical determination, is not providing for or meeting the needs of daily living in the community without supervision; (4) the individual has been involuntarily admitted at least twice within the past 48 months; (5) the individual has been offered an opportunity to participate voluntarily in recommended treatment but either declines to do so or fails to adhere to treatment recommendations; (6) in view of the individual's treatment history and current behavior, the individual is in need of mandatory outpatient treatment in order to prevent deterioration that would likely result in the individual meeting the criteria for involuntary admission under Health-General Section 10-617; (7) the individual is likely to benefit from outpatient treatment that will help protect the individual; and (8) there is no appropriate and feasible less restrictive alternative.

Additionally, the proposal includes services that should be mandated services under OCC, reporting requirements related to OCC, and the rights of individuals who are under an OCC order, such as the right to not be involuntarily committed solely for a failure to comply with an order. The department estimates that such a program would cost $3.0 million per 100 individuals.

The Dangerousness Standard for Involuntary Admissions and Emergency Evaluations

Under current law, an individual must present a danger to the life or safety of the individual or of others to be ordered to undergo an emergency evaluation and be involuntarily admitted to a hospital or psychiatric facility. Concerns have been raised that the dangerousness standard is interpreted and applied in an inconsistent manner that sometimes results in the denial of necessary involuntary evaluation, hospitalization, and treatment for individuals who are seriously ill but do not present an imminent danger to themselves or others. DHMH is proposing to address the inconsistency by adopting, in regulations, a definition for the dangerousness standard so that it means, in consideration of the individual's current condition and, if available, personal and medical history that (1) there is a substantial risk that the individual will cause harm to self or others if admission is not ordered or (2) the individual so lacks the ability to care for himself or herself that there is a substantial risk of death or serious bodily injury if admission is not ordered. The department rejected, as overbroad, feedback calling for dangerousness to include a risk of psychiatric deterioration. The department also is proposing to implement case-based training that will be made available to a variety of individuals, including first responders, emergency department clinicians, inpatient psychiatric staff, and administrative law judges.

Access to Voluntary Outpatient Mental Health Services

DHMH is also proposing to improve access to several types of voluntary outpatient mental health services already provided in the State. First, the department is proposing that funding for assertive community treatment services should be increased if OCC is established in the State. Through assertive community treatment, mental health services are provided by a multi-disciplinary team who delivers the services in any community setting where the services are needed to individuals whose needs have not been met through traditional outpatient services. Second, while peer support services have been integrated into assertive community treatment, the department believes that these services should be further integrated into other voluntary outpatient mental health services, and additional funding should be appropriated to expand these services in every jurisdiction. Third, the department is proposing a funding increase for rental subsidies since housing is essential to ensure that individuals with mental illnesses can remain stable. Finally, DHMH believes additional funding should be appropriated to enhance the crisis services available in each jurisdiction. Crisis services are a continuum of services that include walk-in crisis services, mobile crisis teams, police-based crisis intervention teams, and case management. Some type of crisis services are offered in all jurisdictions; however, the exact services and the funding available vary.

2. Report on Mental Health Anti-stigma Education

Based on concerns that the persistence of stigma concerning mental health treatment continues to discourage individuals from seeking appropriate care, the budget committees inserted narrative in the 2014 JCR requesting a report on anti-stigma education best practices, the current application of those best practices in each jurisdiction of the State, and the cost of developing a statewide model anti-stigma education program. The department submitted this report on November 17, 2014.

In the report, the department noted that there are currently no nationally recognized evidence-based practices for mental health anti-stigma education programs according to the SAMHSA National Registry of Evidence-based Programs and Practices. However, SAMHSA has developed a toolkit containing strategies for developing these types of anti-stigma initiatives, and many of the strategies are already used in Maryland's existing programs.

Maryland has three main anti-stigma education programs: the Anti-Stigma Project, Mental Health First Aid, and the Children's Mental Health Matters Campaign. All three of these projects use some of the identified strategies, including: involving mental health consumers; using existing commemorative events such as Mental Health Awareness Month; using train-the-trainer and peer-to-peer opportunities; and working closely with key partners to promote buy-in. Further, the department estimates that a statewide anti-stigma education program would cost approximately $200,000.

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 2014					
Legislative Appropriation	$793,710	$48,910	$443,420	$10,431	$1,296,471
Deficiency Appropriation	-11,473	636	27,699	0	16,862
Budget Amendments	3,475	1,757	233	170	5,636
Reversions and Cancellations	0	-706	-25,835	-1,278	-27,820
Actual Expenditures	**$785,711**	**$50,596**	**$445,517**	**$9,323**	**$1,291,148**
Fiscal 2015					
Legislative Appropriation	$810,003	$46,020	$513,232	$8,332	$1,377,587
Cost Containment	-2,880	0	0	0	-2,880
Budget Amendments	3,415	1,533	15,792	0	20,740
Working Appropriation	**$810,538**	**$47,553**	**$529,024**	**$8,332**	**$1,395,448**

Note: Numbers may not sum to total due to rounding. The fiscal 2015 working appropriation does not include January 2015 Board of Public Works reductions and deficiencies.

Fiscal 2014

BHA completed fiscal 2014 $5,322,804 below the legislative appropriation.

Deficiency appropriations added $16,861,661 to the original legislative appropriation, which included the addition of $27,699,066 in federal funds and $636,066 in special funds as well as the removal of $11,473,471 in general funds. For the Community FFS Medicaid program, $27,812,291 in federal funds were added and $8,330,075 in general funds were removed due to expected enrollment changes related to the ACA. Further, $642,410 in special funds were swapped in place of general funds due to available funds from the Strategic Energy Investment Fund. Other additions also include $4,956,510 in general funds for overtime costs at the Clifton T. Perkins Hospital Center, and $563,190 in general funds for interpreters for the deaf at the Springfield Hospital Center. These additions were offset by BHA's share of the across-the-board cuts for health insurance and retirement contributions, which totaled $8,020,686 in general funds, $6,344 in special funds, and $113,225 in federal funds.

Budget amendments added $5,635,677, including $3,475,301 in general funds, $1,756,686 in special funds, $233,312 in federal funds, and $170,378 in reimbursable funds. Budget amendments related to the fiscal 2014 COLA, salary increments, and annual salary review adjustments added $3,484,541 in general funds, $4,165 in special funds, and $74,246 in federal funds. Other increases through budget amendments include an increase of $1,600,000 in special funds from the Dedicated Purpose Account to offset decreases for the SAPT block grant; $623,434 in general funds as a result of the transfer of 7.0 positions and funding from the Developmental Disabilities Administration's Secure Evaluation and Therapeutic Treatment Center unit to OFS; $170,378 in reimbursable funds from various agencies for costs associated with court-involved individuals, utilities, and emergency snow storm expenses; and $4,841 in federal funds to realign payments to the State Retirement Agency and Department of Information Technology. There were also decreases through budget amendments, including $48,965 in general funds due to the transfer of 1.0 position from BHA to the Deputy Secretary for Public Health Services office, as well as $287,000 in general funds to realign health insurance expenditures. Closeout amendments reduced general funds by $296,709 while increasing special funds by $152,521 and federal funds by $154,225.

Reversions and cancellations totaled $27,820,142, including $295 in general funds, $706,458 in special funds, $25,835,470 in federal funds, and $1,277,919 in reimbursable funds. The vast majority of the federal fund cancellations were due to lower than expected expenditures on the ACA expansion population.

Fiscal 2015

To date, BHA's fiscal 2015 working appropriation has been increased by $17,860,169, including $534,556 in general funds, $1,533,313 in special funds, and $15,792,300 in federal funds. The July BPW action removed $2,880,017 in general funds, while the 2015 COLA added $1,815,049 in general funds, $4,242 in special funds, and $26,695 in federal funds. General funds were also increased by $1,466,836 as part of the annual salary review budget amendment, as well as by $132,688 due to a personal identification number transfer from the office of the Deputy Secretary

for Behavioral Health into BHA. Special funds were increased by $1,529,071 to cover the cost of the CSA contracts for the Supplemental Security Income/Social Security Disability Insurance, Outreach, Access, and Recovery Housing First Program, which provides rental assistance, housing assistance, advocacy, and linkages to resources for individuals with severe behavioral health conditions, experiencing homelessness, and have accessed federal disability benefits.

Federal fund increases beyond the COLA included $7,203,539 from the federal SAPT block grant to support additional training and awareness programs concerning the SAPT block grant ($358,122) as well as cover the increased cost of substance abuse prevention and treatment activities ($6,845,417) as well as $4,162,066 from the federal Substance Abuse and Mental Health Services – Projects of Regional and National Significance grant to support various community-based services including transition activities, suicide prevention and early intervention, referral to treatment, and adolescent and youth substance abuse prevention and treatment. An additional $4,400,000 in federal funds are part of the ACA Medicaid Emergency Psychiatric Demonstration program and will be used to cover the increased cost of inpatient hospital services connected to this program.

Appendix 2

Audit Findings

Mental Hygiene Administration

Audit Period for Last Audit:	July 1, 2010 – October 7, 2013
Issue Date:	September 2014
Number of Findings:	5
Number of Repeat Findings:	2
% of Repeat Findings:	40%
Rating: (if applicable)	n/a

Finding 1: **MHA lacked adequate procedures to ensure that documentation of eligibility was obtained and reviewed for uninsured patients.**

Finding 2: Certain contract deliverables were not received from an independent firm hired to monitor critical ASO activities.

Finding 3: The ASO's internal network, which hosted MHA information, was not adequately secured.

Finding 4: The ASO stored sensitive information, relating to MHA consumers, and did not adequately restrict access to the sensitive information.

Finding 5: **Internal controls were not sufficient to ensure all receipts were deposited.**

*Bold denotes item repeated in full or part from preceding audit report.

Appendix 3

Audit Findings

Alcohol and Drug Abuse Administration

Audit Period for Last Audit:	July 15, 2011 – June 30, 2014
Issue Date:	October 2014
Number of Findings:	0
Number of Repeat Findings:	n/a
% of Repeat Findings:	n/a
Rating: (if applicable)	n/a

The most recent audit of ADAA did not disclose any findings.

Object/Fund Difference Report
DHMH – Behavioral Health Administration

Object/Fund	FY 14 Actual	FY 15 Working Appropriation	FY 16 Allowance	FY 15 - FY 16 Amount Change	Percent Change
Positions					
01 Regular	2,919.45	2,911.85	2,912.35	0.50	0%
02 Contractual	216.13	207.98	214.47	6.49	3.1%
Total Positions	**3,135.58**	**3,119.83**	**3,126.82**	**6.99**	**0.2%**
Objects					
01 Salaries and Wages	$ 224,024,469	$ 236,110,323	$ 250,759,388	$ 14,649,065	6.2%
02 Technical and Spec. Fees	12,672,846	10,105,536	10,577,686	472,150	4.7%
03 Communication	436,463	456,565	449,691	-6,874	-1.5%
04 Travel	199,787	292,890	304,034	11,144	3.8%
06 Fuel and Utilities	11,251,117	10,468,511	10,752,122	283,611	2.7%
07 Motor Vehicles	821,619	763,735	810,123	46,388	6.1%
08 Contractual Services	1,027,707,761	1,122,996,185	1,377,727,431	254,731,246	22.7%
09 Supplies and Materials	12,349,887	12,966,076	12,655,059	-311,017	-2.4%
10 Equipment – Replacement	626,894	253,922	285,399	31,477	12.4%
11 Equipment – Additional	107,392	47,178	5,543	-41,635	-88.3%
12 Grants, Subsidies, and Contributions	387,394	428,209	438,620	10,411	2.4%
13 Fixed Charges	562,102	558,436	630,880	72,444	13.0%
Total Objects	**$ 1,291,147,731**	**$ 1,395,447,566**	**$ 1,665,395,976**	**$ 269,948,410**	**19.3%**
Funds					
01 General Fund	$ 785,711,066	$ 810,537,840	$ 870,342,303	$ 59,804,463	7.4%
03 Special Fund	50,596,208	47,553,297	48,464,860	911,563	1.9%
05 Federal Fund	445,517,176	529,024,229	738,645,041	209,620,812	39.6%
09 Reimbursable Fund	9,323,281	8,332,200	7,943,772	-388,428	-4.7%
Total Funds	**$ 1,291,147,731**	**$ 1,395,447,566**	**$ 1,665,395,976**	**$ 269,948,410**	**19.3%**

Note: The fiscal 2015 working appropriation does not include January 2015 Board of Public Works reductions and deficiencies. The fiscal 2016 allowance does not reflect contingent or across-the-board reductions.

Fiscal Summary
DHMH – Behavioral Health Administration

Program/Unit	FY 14 Actual	FY 15 Wrk Approp	FY 16 Allowance	Change	FY 15 - FY 16 % Change
01 Mental Hygiene Administration	$ 1,016,309,502	$ 331,151,704	$ 326,369,184	-$ 4,782,520	-1.4%
04 Thomas B. Finan Hospital Center	18,737,040	19,444,008	20,763,370	1,319,362	6.8%
05 Regional Institute For Children and Adolescents – Baltimore City	13,462,415	13,566,379	14,444,419	878,040	6.5%
07 Eastern Shore Hospital Center	18,620,197	19,000,221	20,071,793	1,071,572	5.6%
08 Springfield Hospital Center	71,249,706	74,208,911	78,173,379	3,964,468	5.3%
09 Spring Grove Hospital Center	78,836,233	80,405,165	84,577,811	4,172,646	5.2%
10 Clifton T. Perkins Hospital Center	60,953,952	61,501,346	64,692,346	3,191,000	5.2%
11 John L. Gildner Reg. Institute for Children and Adolescents	11,087,803	11,603,992	12,439,214	835,222	7.2%
15 Services and Institutional Operations	1,890,883	2,317,065	1,934,164	-382,901	-16.5%
01 Medical Care Programs Administration	0	782,248,775	1,041,930,296	259,681,521	33.2%
Total Expenditures	**$ 1,291,147,731**	**$ 1,395,447,566**	**$ 1,665,395,976**	**$ 269,948,410**	**19.3%**
General Fund	$ 785,711,066	$ 810,537,840	$ 870,342,303	$ 59,804,463	7.4%
Special Fund	50,596,208	47,553,297	48,464,860	911,563	1.9%
Federal Fund	445,517,176	529,024,229	738,645,041	209,620,812	39.6%
Total Appropriations	**$ 1,281,824,450**	**$ 1,387,115,366**	**$ 1,657,452,204**	**$ 270,336,838**	**19.5%**
Reimbursable Fund	$ 9,323,281	$ 8,332,200	$ 7,943,772	-$ 388,428	-4.7%
Total Funds	**$ 1,291,147,731**	**$ 1,395,447,566**	**$ 1,665,395,976**	**$ 269,948,410**	**19.3%**

Note: The fiscal 2015 working appropriation does not include January 2015 Board of Public Works reductions and deficiencies. The fiscal 2016 allowance does not reflect contingent or across-the-board reductions.