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

## *Operating Budget Data*

**($ in Thousands)**

| | FY 15 Actual | FY 16 Working | FY 17 Allowance | FY 16-17 Change | % Change Prior Year |
|---|---|---|---|---|---|
| General Fund | $839,520 | $868,243 | $886,256 | $18,013 | 2.1% |
| Deficiencies and Reductions | 0 | -11,500 | -820 | 10,680 | |
| **Adjusted General Fund** | **$839,520** | **$856,743** | **$885,437** | **$28,693** | **3.3%** |
| Special Fund | 50,035 | 60,462 | 53,806 | -6,655 | -11.0% |
| Deficiencies and Reductions | 0 | 0 | -1 | -1 | |
| **Adjusted Special Fund** | **$50,035** | **$60,462** | **$53,805** | **-$6,657** | **-11.0%** |
| Federal Fund | 649,268 | 738,564 | 733,195 | -5,369 | -0.7% |
| Deficiencies and Reductions | 0 | 0 | -12 | -12 | |
| **Adjusted Federal Fund** | **$649,268** | **$738,564** | **$733,183** | **-$5,381** | **-0.7%** |
| Reimbursable Fund | 8,284 | 10,744 | 7,796 | -2,948 | -27.4% |
| **Adjusted Reimbursable Fund** | **$8,284** | **$10,744** | **$7,796** | **-$2,948** | **-27.4%** |
| **Adjusted Grand Total** | **$1,547,108** | **$1,666,513** | **$1,680,220** | **$13,708** | **0.8%** |

- After adjusting for fiscal 2016 reversions and a back of the bill reduction in health insurance, total funding for the Behavioral Health Administration (BHA) increases by $13.7 million (0.8%) over the fiscal 2016 working appropriation.

- There is a specified reversion of $11.5 million out of Medicaid reimbursements for behavioral health providers in fiscal 2016 due to lower than anticipated enrollment within the traditional Medicaid eligibility categories.

- A supplemental budget increases the fiscal 2017 allowance by $2.3 million to provide for a 2% community provider rate increase for substance use disorder treatment services to the uninsured to mirror the rate increase granted to other community behavioral health providers. That funding is not reflected in the data shown in the analysis.

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

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## *Personnel Data*

| | FY 15 Actual | FY 16 Working | FY 17 Allowance | FY 16-17 Change |
|---|---|---|---|---|
| Regular Positions | 2,900.85 | 2,900.55 | 2,800.85 | -99.70 |
| Contractual FTEs | 215.66 | 221.60 | 210.03 | -11.57 |
| **Total Personnel** | **3,116.51** | **3,122.15** | **3,010.88** | **-111.27** |

***Vacancy Data: Regular Positions***

| | | |
|---|---|---|
| Turnover and Necessary Vacancies, Excluding New Positions | 192.07 | 6.86% |
| Positions and Percentage Vacant as of 12/31/15 | 297.50 | 10.26% |

- The fiscal 2017 allowance contains a total reduction of 99.7 positions for BHA. One position is being added to Program Direction through a contractual conversion, while 100.7 positions are being abolished.

- The position abolitions are due to the privatization of the dietary and housekeeping functions at Springfield Hospital Center (56.0 and 21.0 positions, respectively), the privatization of the dietary function at the John L. Gildner Regional Institute for Children and Adolescents (RICA) (14.0 positions), a reduction from 38 to 34 beds at RICA – Baltimore (8.5 positions), and the transfer of 1.0 position to the Department of Information Technology. The remaining 0.2 position is a reduction of a partial position for dental services at Spring Grove Hospital Center. However, the privatization of the housekeeping function at Springfield is no longer moving forward, so these position reductions will be absorbed through vacancies throughout the rest of the department.

- Contractual employment decreases by 11.57 full-time equivalents (FTE) due to a number of changes. Student training food service positions and direct care aides each increase by 4.0 FTEs, while other food service staff decrease by 6.0 FTEs and security staff decrease by 4.5 FTEs. Other contractual reductions are for patient-based jobs and other employment.

- The overall vacancy rate for BHA increased between fiscal 2016 and 2017, mostly due to the hiring freeze instituted by the department for cost containment purposes in fiscal 2015. Budgeted turnover also increased by 0.94% in the allowance.

# *Analysis in Brief*

## Major Trends

***Substance Use Prevention:*** The number of people served by prevention programming grew by 79,100 (19.7%) compared to fiscal 2014. The growth was in single service programming.

***Substance Use Disorder Treatment Financing Driven by the Affordable Care Act Expansion:*** The expansion of eligibility for adults under the federal Affordable Care Act (ACA) has greatly increased the federal fund financing available for substance use disorder (SUD) treatment.

***Community Mental Health Fee-for-service System – Enrollment and Utilization Trends:*** Enrollment growth in the fee-for-service (FFS) community mental health system was 9.2% in fiscal 2015, which is slightly under the enrollment growth over a five-year period from fiscal 2011 through 2015. Individuals eligible for Medicaid under the traditional eligibility categories have declined between fiscal 2014 and 2015, while adults newly eligible under the ACA expansion continue to increase. However, the growth in total service units, while strong, was below enrollment growth in fiscal 2015.

***Community Mental Health Fee-for-service System – Expenditure Trends:*** Expenditures grew at 12.0% in fiscal 2015, outpacing growth over the last five years of 6.9%. This trend is due to an annualization of first-year costs associated with the ACA expansion population, the increasing number of individuals newly eligible for mental health services, as well as the fact that these individuals tend to be utilizing those services, such as inpatient psychiatric services, which are more expensive. However, the 100.0% federal funding rate for the ACA expansion population has limited the amount of State funds expended.

***Outcomes for Community Behavioral Health Services:*** Outcome measures derived from interviews with clients served in outpatient settings for both mental health and SUD treatment vary depending on the condition of the client. Those clients with a co-occurring mental health and SUD exhibit the highest levels of homelessness, while clients with a SUD are more likely to be arrested and clients with a mental health condition are more likely to be unemployed.

## Issues

***The Heroin Epidemic:*** The use of heroin and heroin-related substances continues to be an epidemic in the State with heroin-related overdose deaths continuing to climb in fiscal 2015. Numerous efforts have focused on this issue, including most recently the Governor's Heroin and Opioid Emergency Task Force which issued its final recommendations in December 2015. There is a total of $4.8 million in the State budget related to these recommendations, including $3.1 million within BHA. However, funding for SUD treatment continues to be relatively flat, even with the provider rate increases provided by the Administration, and there is an especially acute need for more funding for residential treatment for those individuals committed to the Department of Health and Mental Hygiene (DHMH) under Section 8-507 of the Health – General Article. **The Department of Legislative Services (DLS) thus**

**recommends that the funding appropriated for the Center of Excellence, as well as funding within the Department of Human Resources and the Department of Juvenile Services for a heroin screening tool, instead be utilized to fund residential treatment under Section 8-507. The department should also comment on the funding levels and bed availability that would be required under the Justice Reinvestment Coordinating Council bills.**

***Behavioral Health Integration – Furthering Financial Alignment:*** The integration of State mental health and SUD agencies and services is continuing, with FFS payments for SUD services being carved-out of HealthChoice under a single administrative service organization (ASO) since January 1, 2015. New information sharing arrangements have also been worked out between the ASO and the Medicaid Managed Care Organizations. However, SUD services for the uninsured continue to be financed on a grant-based system as opposed to FFS under the ASO, which is how mental health services for the uninsured are financed. The department has recently indicated that ambulatory SUD services will be transitioned within fiscal 2017, but other services will still remain in a grant-based system. **The department should comment on how it plans to ensure a smooth transition of ambulatory SUD treatment services to the ASO, and what plans it has for transferring the remaining grant-based funding to the ASO.**

***Funding for Institutions for Mental Disease:*** The Medicaid Institutions for Mental Disease exclusion prohibits the use of federal Medicaid financing for care provided to most adult patients between the ages of 21 and 65 in mental health and SUD residential treatment and inpatient facilities larger than 16 beds. The State in prior years has used numerous waivers to seek federal reimbursement for these services. However, all waivers and programs have expired since the end of fiscal 2015. Currently, the department is seeking individual waivers for SUD services and mental health services, but neither waiver currently has a timeline for approval. **The department should comment on the current status of these waiver applications, and how it plans to fund inpatient psychiatric services without federal funds in fiscal 2017.**

## Recommended Actions

1. Add language restricting Medicaid behavioral health provider reimbursements to that purpose.

2. Add budget bill language restricting funds for specified Heroin and Opioid Emergency Task Force Initiatives to only be spent on residential treatment services for Section 8-507 of the Health – General Article commitments.

## Updates

***Synar Compliance Improves Dramatically:*** A report was submitted in response to budget bill language from the 2015 *Joint Chairmen's Report* (JCR) on how the State would spend the Synar penalty funding in fiscal 2016 to ensure that no further penalty would be realized for the State. Based

on the most recent federal audit, the State's retailer violation rate has dropped so dramatically that the State will not incur a penalty within the fiscal 2017 budget.

***Reports on Behavioral Health Expenditures by Medicaid Eligibility Improve, but More Needs to Be Done:*** A report was submitted in response to budget bill language within the 2015 JCR providing information on the utilization and expenditures for behavioral health services based upon the user's eligibility group under Medicaid. While this report is useful, more work needs to be done to produce a comprehensive report that would allow DLS to prepare more robust and confident expenditure projections. **Thus, DLS and DHMH will continue to work together throughout the 2016 interim to come up with a more comprehensive and complete dataset and reporting structure.**

# 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 were transferred within MCPA from Program M00Q01.03 to M00Q01.10. However, for the purpose of reviewing the fiscal 2017 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 (CSAs) 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 Use Disorder Services –** developing and operating unified programs for substance use disorder (SUD) research, training, prevention, and rehabilitation in cooperation with federal, State, local, and private agencies.

## Performance Analysis: Managing for Results

### 1. Substance Use Prevention

State prevention services are provided through two types of programs:

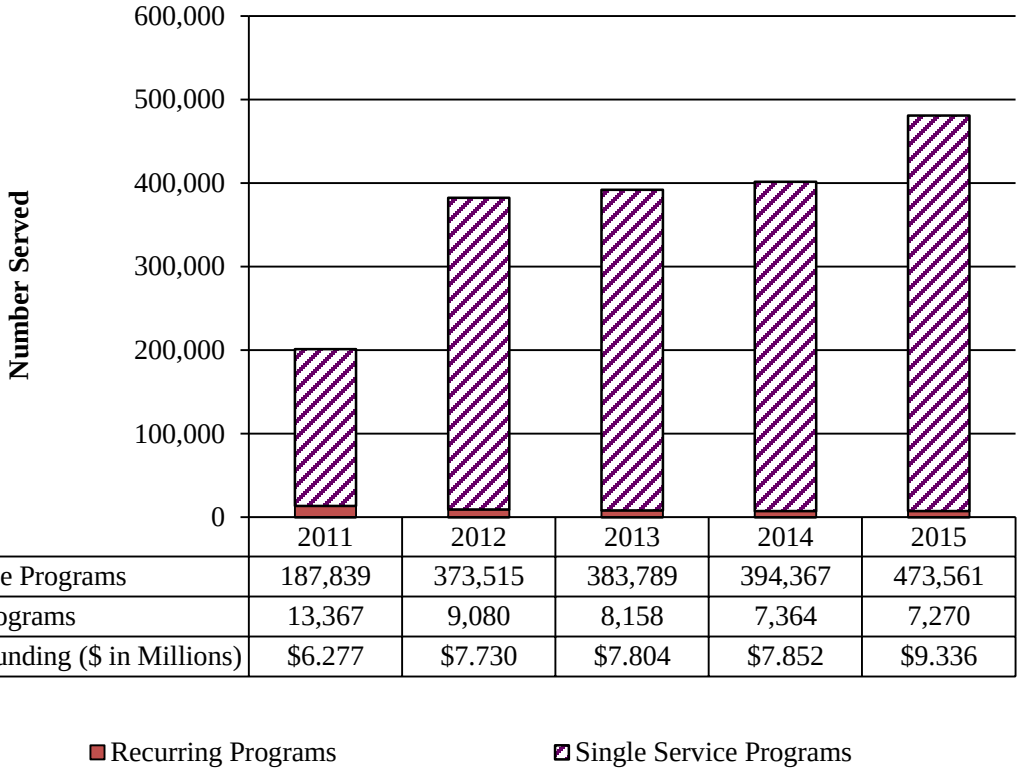
- **Recurring Prevention Programs –** *i.e.*, with the same group of individuals for a minimum of four separate occasions and with programming that is an approved Substance Abuse and Mental Health Services Administration (SAMHSA) evidence-based model. In fiscal 2015, a total of 284 recurring prevention programs were offered across the State, an increase of 27 from the prior year.

  Statewide, the successful completion rate for these types of programs is reported at 86%, a number that has varied little over the past decade. There is variation by county among programs in terms of successful completion. In fiscal 2015, for example, the successful completion rate varied from 100% in Caroline and Cecil counties to 83% in Washington County. It should be noted that since programming varies from one jurisdiction to the next, there is no universal definition of what is considered a "successful completion."

- **Single Service Programs –** such as presentations, speaking engagements, training, *etc*., that are provided to the same group on less than four separate occasions. Participant numbers are either known or estimated. In fiscal 2015, 1,294 single service prevention activities were offered in Maryland, an increase of 39 from the prior year.

As shown in **Exhibit 1**, prevention programming served almost 481,000 participants in fiscal 2015, 79,100 (19.7%) higher than served in fiscal 2014. Recurring programs continue to see a drop in people served, down 94 participants (1.3%) between fiscal 2014 and 2015, a decline that somewhat eased off from the prior year. Conversely, the number of participants served in single service programs grew by 79,194 between fiscal 2014 and 2015, or 20.1%.

**Exhibit 1**
**Behavioral Health Administration-funded Prevention Programs**
**Fiscal 2011-2015**




| | 2011 | 2012 | 2013 | 2014 | 2015 |
|---|---|---|---|---|---|
| Single Service Programs | 187,839 | 373,515 | 383,789 | 394,367 | 473,561 |
| Recurring Programs | 13,367 | 9,080 | 8,158 | 7,364 | 7,270 |
| Prevention Funding ($ in Millions) | $6.277 | $7.730 | $7.804 | $7.852 | $9.336 |

Source: Behavioral Health Administration

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

Prevention funding continues to increase because of the availability of federal Strategic Prevention Framework State Incentive Grant funds. This grant expired at the end of fiscal 2015.

However, BHA has been awarded new funding under the SAMSHA Partnership for Success grant that will allow them to continue and enhance the State prevention infrastructure and services provided through this program.

## 2. Substance Use Disorder Treatment Financing Driven by the Affordable Care Act Expansion

**Exhibit 2** provides the number of adults who were recorded as receiving treatment through the Administrative Service Organization (ASO) during fiscal 2015, which was the first fiscal year within which reimbursement for services provided to individuals receiving care for a SUD condition through the Medicaid program was provided by the ASO as opposed to through the Medicaid Managed Care Organizations (MCO). As seen in the exhibit, almost half of the individuals receiving SUD treatment in fiscal 2015 were eligible for Medicaid under the Affordable Care Act (ACA) expansion, which increased the federal poverty level under which adults are eligible for Medicaid to 138%. While these individuals did receive SUD treatment prior to the ACA expansion, they did so under the Primary Adult Care (PAC) program, which was entirely financed by the State. Under ACA, these services are entirely financed by the federal government. This is especially significant since, as also seen in Exhibit 2, adults make up the vast majority of the population receiving SUD treatment.

**Exhibit 2**
**SUD Treatment Data by Medicaid Eligibility and Age**
**Fiscal 2015**

| | Medicaid Eligibility | | | |
|---|---|---|---|---|
| **Age** | **Traditional*** | **ACA Expansion** | **Total** | **% Expansion** |
| 0-17 | 2,070 | 1 | 2,071 | 0.05% |
| 18-64 | 23,486 | 25,425 | 48,911 | 51.98% |
| 65 and Over | 212 | 2 | 214 | 0.93% |
| **Totals** | **25,768** | **25,428** | **51,196** | **49.67%** |
| % Adult | 91.14% | 99.99% | 95.54% | |

ACA: Affordable Care Act
SUD: substance use disorder

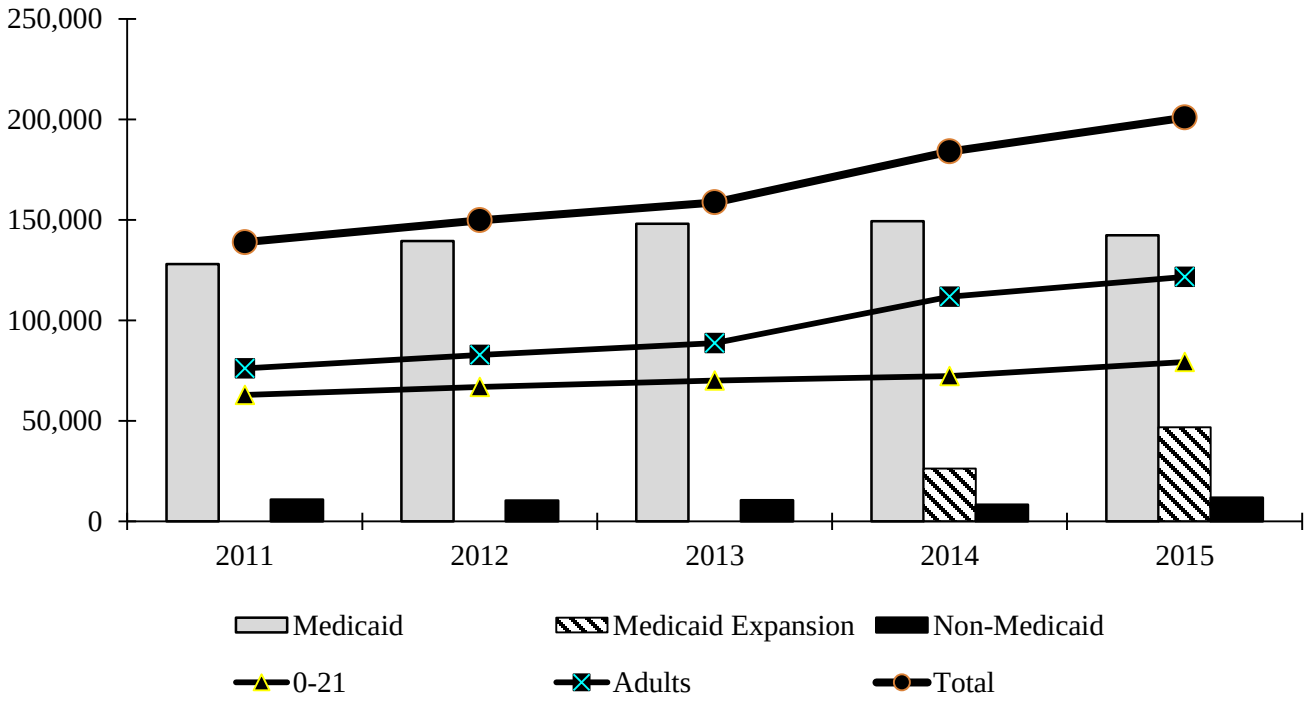
*Traditional includes all Medicaid coverage groups from before the ACA expansion.

Source: Behavioral Health Administration

## 3. Community Mental Health Fee-for-service System – Enrollment and Utilization Trends

As shown in **Exhibit 3**, total enrollment in the fee-for-service (FFS) community mental health system (Medicaid and non-Medicaid) has increased at an average annual rate of 9.7% between fiscal 2011 and 2015, which is similar to the 9.2% growth between fiscal 2014 and 2015.

**Exhibit 3**
**Community Mental Health Services**
**Enrollment Trends**
**Fiscal 2011-2015**




Note: Data for fiscal 2015 is incomplete. Enrollment counts may be duplicated across coverage types. Baltimore City capitation project is included.

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

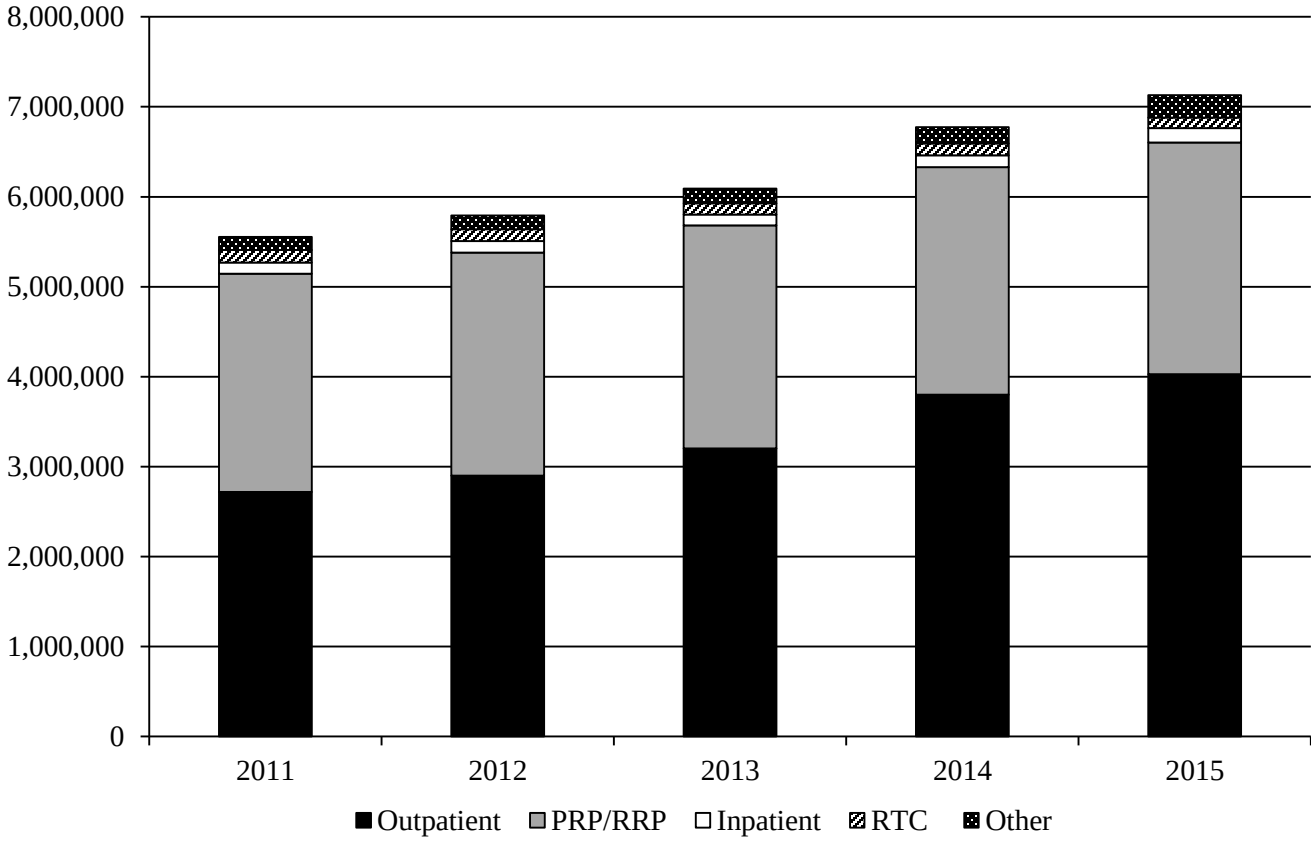
One major change in fiscal 2015 is the drop in the traditional Medicaid population. This eligibility category decreased by 4.7% between fiscal 2014 and 2015. This is most likely attributable to the Medicaid redeterminations which have resulted in fewer people renewing their Medicaid eligibility. However, this decrease was more than made up for in increases for the new ACA expansion population. This difference is particularly interesting because in the overall Medicaid program,

redetermination impacted the traditional and expansion populations alike. When both populations are blended together, the number of consumers using mental health services with some form of Medicaid coverage increases by 7.6% between fiscal 2014 and 2015. More potentially concerning, the non-Medicaid population rises by 1.9% over the period shown, with a sharp increase between fiscal 2014 and 2015 of 42.2%. Most of this increase is from children using services.

The exhibit also shows that enrollment growth over the period has been driven by adults (12.4% between fiscal 2011 and 2015), reflecting both prior strong growth in the PAC program, the State's fiscal 2009 expansion to parents of children in Medicaid, as well as the fiscal 2014 ACA expansion. Over the period shown, the number of adults in the program increases by 12.4% while the number of children increases by 6.0%. Adults make up 60.5% of total enrollment in fiscal 2015, compared to 54.8% in fiscal 2011. However, enrollment growth for children outpaces enrollment growth for adults between fiscal 2014 and 2015 at 9.7% compared to 8.8%, mostly due to the increase in uninsured children. **BHA should comment on the reasons why the number of uninsured children rose so dramatically in fiscal 2015.**

In terms of utilization of services, trends are shown in **Exhibit 4**. The exhibit shows that over the five-year period, total service units are up at an average annual rate of 6.4%. In fact, fiscal 2015 had the largest number of total service units in over 10 years, and the growth between fiscal 2014 and 2015 was 5.2%. This increase has been driven by increases in both outpatient services (up 10.3% over the period and 6.0% over the prior year) as well as other services including crisis, supported employment, and respite care (up 13.8% over the period and 35.7% over the prior year). In fact, all service types had increases in the total number of services over the prior year in fiscal 2015, with the exception of residential treatment, 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.

**Exhibit 4**
**Community Mental Health Fee-for-service**
**Service Utilization Trends**
**Fiscal 2011-2015**
**(Units of Service)**




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

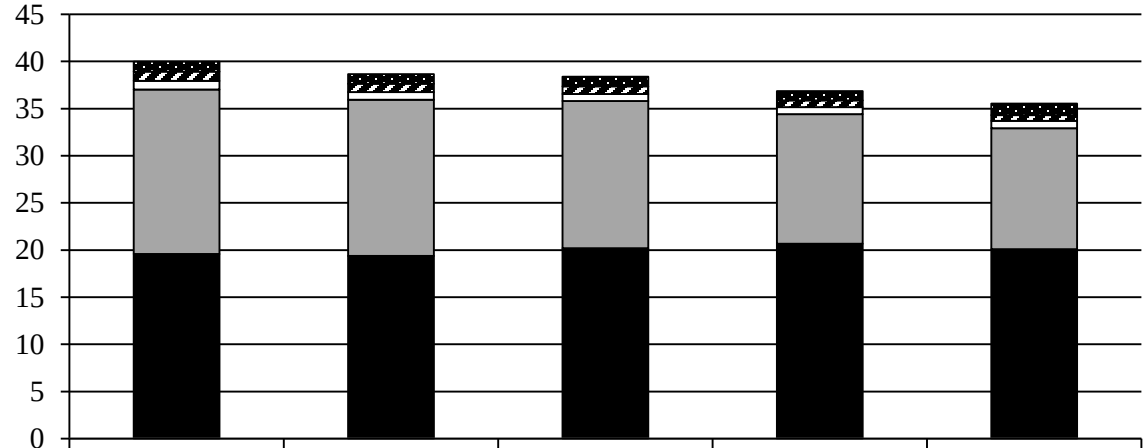
Note: Data for fiscal 2015 is incomplete. Total service unit data includes service units for the Baltimore City capitation project.

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

It is worth noting the difference between the enrollment growth in the system between fiscal 2011 and 2015 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 most of the more intensive services, such as inpatient, psychiatric and residential rehabilitation, and residential treatment, as seen in **Exhibit 5**. Traditional outpatient services increase over the time period by 0.7%, however, they decrease in fiscal 2015 by 2.9%. The largest increases in services per capita over the

time period by far are for the other services category at 3.8%, with a jump in fiscal 2015 of 24.2%. This includes mainly wraparound services such as crisis and respite care as well as supported employment. One notable trend in fiscal 2015, however, is the increase in inpatient services provided. While inpatient services declined over the period shown by 3.2%, they increased in fiscal 2015 by 10.0%, reversing a decline which had been occurring since fiscal 2009. This is concerning since inpatient services are the most expensive services on a per service basis and potentially are not eligible for federal match depending on the facility where the services are provided.

**Exhibit 5**
**Community Mental Health Fee-for-service**
**Service Utilization Trends**
**Fiscal 2011-2015**
**(Services Per Capita)**




| | 2011 | 2012 | 2013 | 2014 | 2015 |
|---|---|---|---|---|---|
| Other | 1.06 | 1.02 | 1.03 | 0.99 | 1.23 |
| RTC | 0.98 | 0.88 | 0.79 | 0.71 | 0.59 |
| Inpatient | 0.90 | 0.84 | 0.75 | 0.72 | 0.79 |
| PRP/RRP | 17.46 | 16.55 | 15.63 | 13.75 | 12.82 |
| Outpatient | 19.57 | 19.38 | 20.18 | 20.68 | 20.09 |

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

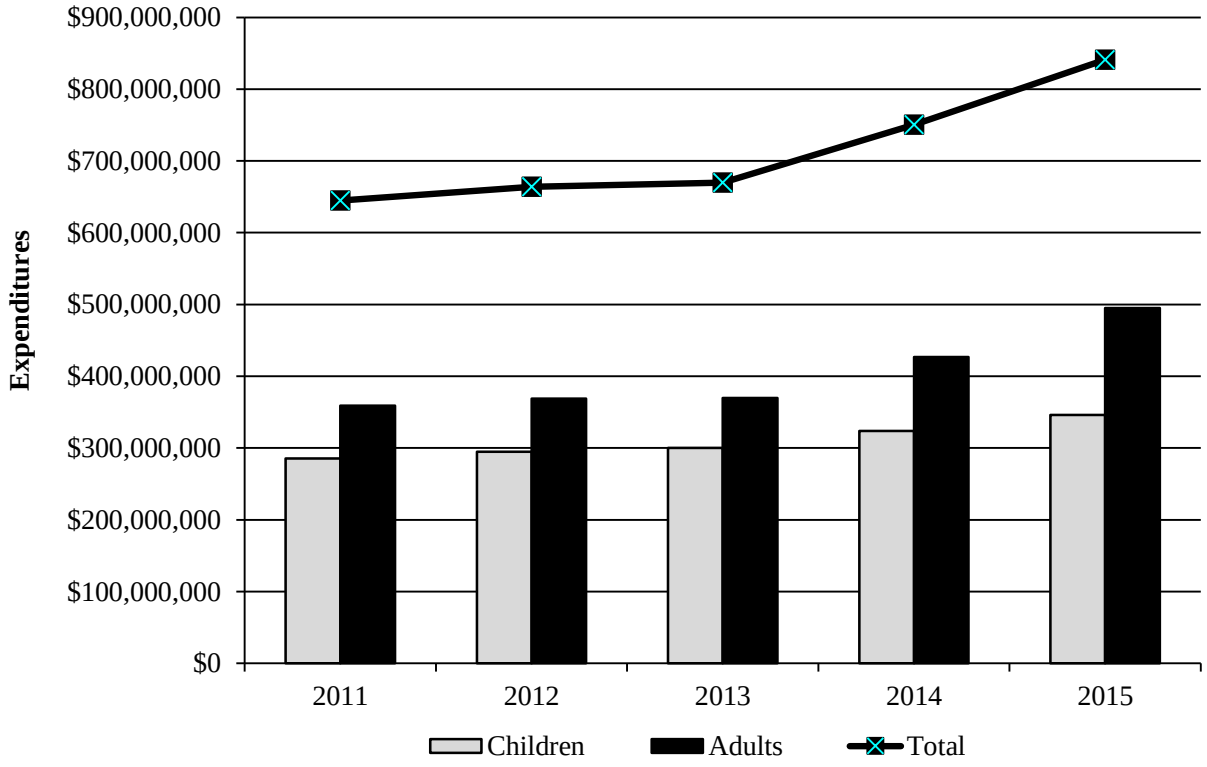
Note: Data for fiscal 2015 is incomplete. Total service unit data includes service units for the Baltimore City capitation project.

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

## 4. Community Mental Health Fee-for-service System – Expenditure Trends

Expenditure patterns historically mirror enrollment growth (**Exhibit 6**). Average annual expenditure growth over the fiscal 2011 to 2015 period is 6.9%. However, growth between fiscal 2014 and 2015 is 12.0%, which is mainly driven by the first full year of costs for the ACA expansion population and the increase in demand for services noted in the previous section.

**Exhibit 6**
**Community Mental Health Fee-for-service Expenditures**
**Fiscal 2011-2015**



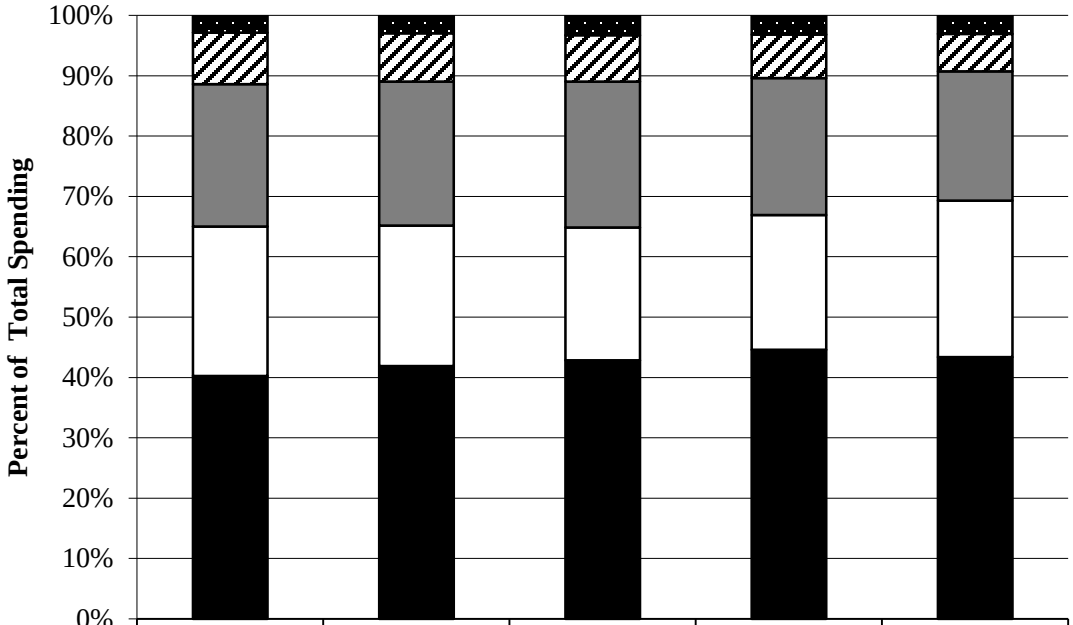

Note: Data for fiscal 2015 is incomplete. Total expenditure data includes expenditures for the Baltimore City capitation project.

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 7**). All services, with the exception of residential treatment, had expenditure growth between fiscal 2014 and 2015, with the largest growth

being in inpatient services expenditures at 30.3%. This is mostly attributable to the ACA expansion population which, under the old PAC program, did not have access to these services. This growth is particularly troubling since, as explained in more detail in Issue 3, the State does not receive federal matching funds for inpatient services if they are provided within a specialty psychiatric hospital.

**Exhibit 7**
**Community Mental Health Service Expenditures by Service Type**
**Fiscal 2011-2015**




| | 2011 | 2012 | 2013 | 2014 | 2015 |
|---|---|---|---|---|---|
| Other | $18,329,753 | $19,699,732 | $21,588,505 | $23,761,643 | $25,886,279 |
| RTC | $55,193,989 | $53,243,697 | $50,740,960 | $54,304,385 | $52,303,651 |
| PRP and RRP | $152,065,731 | $158,366,382 | $159,771,844 | $170,161,634 | $179,756,021 |
| Inpatient | $159,818,003 | $154,515,302 | $145,656,749 | $167,598,555 | $218,298,269 |
| Outpatient | $259,343,588 | $277,934,562 | $283,015,346 | $334,820,189 | $364,517,517 |

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

Note: Data for fiscal 2015 is incomplete.

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

## 5. Outcomes for Community Behavioral Health Services

Outcome data from BHA's Outcomes Measurement System continues to be limited to outpatient clinics. However, they have now begun to collect information on those receiving outpatient services with both mental health and SUD conditions. The data presented in **Exhibit 8** is based on the most recent interview of clients, and in each situation asks whether or not the individual has either been homeless, arrested, or unemployed within the last six months. The percentages are the number of individuals who answered yes to these questions. As seen in the exhibit, the greatest problems are split amongst various populations. Homelessness and criminal justice involvement are highest amongst those with a SUD condition, with homelessness being especially acute for those with a co-occurring disorder. However, those with a mental health diagnosis are the most likely to be unemployed.

**Exhibit 8**
**Outcome Measurement System Data**
**Fiscal 2015**

| | Homeless | Criminal Justice Involvement | Unemployment |
|---|---|---|---|
| ***Adult*** | | | |
| All | 12.4% | 6.7% | 66.4% |
| MH | 2.3% | 3.5% | 87.0% |
| SUD | 12.9% | 20.2% | 54.3% |
| Co-occuring | 18.2% | 16.0% | 64.5% |
| ***Children*** | | | |
| All | 2.3% | 4.1% | 87.0% |
| MH | 2.3% | 3.5% | 87.0% |
| SUD | 4.2% | 35.4% | 85.8% |
| Co-occuring | 3.1% | 27.8% | 89.2% |

MH: mental health
SUD: substance use disorder

Source: Behavioral Health Administration

## Fiscal 2016 Actions

### Cost Containment

The fiscal 2016 budget contained an across-the-board reduction for all State agencies, which resulted in a 0.6% across-the-board general fund reduction for the Department of Health and Mental Hygiene (DHMH) totaling $27,215,000. Of this total amount, BHA was assigned a cost containment decrease of $2,639,890 in general funds. Actions undertaken to make up this cut include utilizing additional federal fund attainment in lieu of general funds ($1,375,000), decreasing funds for services for the uninsured ($450,000), and a 2% operating expenses reduction at all of the State psychiatric institutions ($814,890).

Further, there is a specified reversion in the Governor's fiscal 2017 budget plan of $11,500,000 from Medicaid behavioral health in fiscal 2016. These funds are available due to lower than anticipated spending on the traditional Medicaid population, due to declining enrollment within that population.

## Proposed Budget

As shown in **Exhibit 9**, after adjusting for the fiscal 2016 specified reversion as well as fiscal 2017 back of the bill reductions, the fiscal 2017 allowance for BHA grows by $13.7 million (0.8%) over the fiscal 2016 working appropriation. Not included in these numbers is $2.3 million from Supplemental Budget No. 2. Including this amount, expenditures increase by $16.0 million, or 1.0%.

**Exhibit 9**
**Proposed Budget**
**Department of Health and Mental Hygiene**
**Behavioral Health Administration**
**($ in Thousands)**

| How Much It Grows: | General Fund | Special Fund | Federal Fund | Reimb. Fund | Total |
|---|---|---|---|---|---|
| Fiscal 2015 Actual | $839,520 | $50,035 | $649,268 | $8,284 | $1,547,108 |
| Fiscal 2016 Working Appropriation | 856,743 | 60,462 | 738,564 | 10,744 | 1,666,513 |
| Fiscal 2017 Allowance | 885,437 | 53,805 | 733,183 | 7,796 | 1,680,220 |
| Fiscal 2016-2017 Amount Change | $28,693 | -$6,657 | -$5,381 | -$2,948 | $13,708 |
| Fiscal 2016-2017 Percent Change | 3.3% | -11.0% | -0.7% | -27.4% | 0.8% |

**Where It Goes:**

| | |
|---|---|
| **Personnel Expenses** | |
| Employee and retiree health insurance | $4,299 |
| Retirement contributions | 3,899 |
| Overtime | 731 |
| Workers' compensation premium assessment | 433 |
| Turnover adjustments | 188 |
| New position (1.0 full-time equivalent (FTE)) | 77 |
| Other compensation | 48 |
| Other fringe benefit adjustments | -275 |
| Abolished positions (100.7 FTEs) | -5,844 |
| **Community Behavioral Health Services** | |
| ***Fee-for-Service Expenditures*** | |
| Regulated rate increase assumptions | 14,787 |
| Community provider rate increase (2%) | 12,248 |
| Enrollment and utilization: uninsured and State-funded | -5,551 |
| Enrollment and utilization: Medicaid | -21,853 |
| ***Grants and Contracts – Mental Health*** | |
| Care Management Entity funding | 1,610 |
| Maryland Collaboration for Homeless Enhancement Services Grant | 1,427 |
| Core Service Agency rate increase (2%) | 1,260 |
| Increase in Community Mental Health Service Block Grant (federal funds) | 1,064 |
| Administrative Service Organization contract | 247 |
| Expiring federal grants | -1,013 |
| Core Service Agency various programming | -1,471 |
| ***Grants and Contracts – Substance Use Disorders*** | |
| New federal grant funding | 2,187 |
| Increased federal grant funding | 1,112 |
| Synar penalty | -2,612 |
| **Program Direction** | |
| Heroin Task Force initiatives | 3,059 |
| Prescription Drug Monitoring Program | 441 |
| Maryland Institute for Policy Analysis and Research | 204 |
| **Facilities** | |
| Privatization contracts | 4,492 |
| Purchase of care contracts at Spring Grove Hospital Center | 701 |
| Crownsville Hospital Center facility maintenance | -690 |
| Non-personnel operating costs from privatized functions | -1,726 |
| Other Changes | 228 |
| **Total** | **$13,708** |

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

## Across-the-board Reductions

The fiscal 2017 budget bill includes an across-the-board reduction for employee health insurance, based on a revised estimate of the amount of funding needed. For DHMH, the amount of these reductions is $1,424,451 in general funds, $132,440 in special funds, and $251,138 in federal funds across the entire department, of which $832,865 is in the BHA budget ($819,526 general funds, $1,266 special funds, $12,073 federal funds). There is an additional across-the-board reduction to abolish positions statewide, but the amounts have not been allocated by agency.

## Personnel

Personnel expenditures net of back of the bill reductions increase by $3.6 million. The largest increases, consistent with other State agencies, are for employee and retiree health insurance contributions as well as retirement contributions at $4.3 million and $3.9 million, respectively. One new position within Program Direction also adds $76,936. This position is a contractual conversion of a program administrator position which assists homeless and mentally ill individuals with accessing entitlements and other supportive programs.

There is also an increase of $730,986 in overtime expenses. However, it should be noted that the current allowance for overtime is still below the most recent actual from fiscal 2015. During that year, overtime expenses across the agency totaled $13.7 million, which is in line with other recent historical trends. However, the current allowance only allots $9.6 million. This is problematic, both because the State hospital centers continue to be over capacity and because vacancy rates within the hospitals continue to be quite high. According to the most recent vacancy data, vacancy rates at the two largest hospital centers, Springfield and Spring Grove, are 13.8% and 11.9%, respectively.

The largest change in personnel expenditures is the decrease of $5.8 million for abolished positions. There are 100.7 positions abolished within BHA for a variety of reasons. A total of 77.0 positions are being abolished at Springfield Hospital Center due to the privatization of the dietary and housekeeping functions at the hospital. The position abolitions due to these privatizations are 56.0 and 21.0, respectively, with the majority of these positions being currently filled. However, due to an error in the calculations for the cost of the outsourced housekeeping contract, DHMH is no longer pursuing this specific privatization. The 21.0 position reduction, however, will still be made up with vacancies from throughout the department. More information on this is provided under the discussion of changes within the facilities.

There is also a decrease of 14.0 positions at the John L. Gildner Regional Institute for Children and Adolescents (RICA) due to the privatization of the dietary function at that facility as well. Personnel savings from all of the privatizations totals $5.5 million. A further 8.5 positions are being reduced at RICA – Baltimore due to a residential bed reduction from 38 to 34 beds, and 1.0 position is being transferred to the Department of Information Technology as part of the centralization of information technology functions across the State. The remaining 0.2 position is a reduction of a partial position for dental services at Spring Grove Hospital Center.

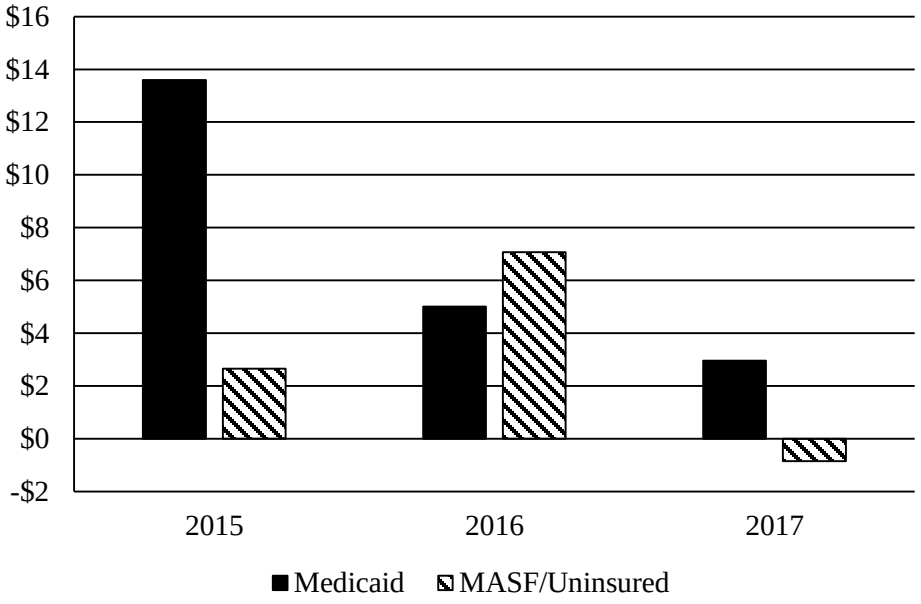
## Community Behavioral Health Services

### Fee-for-service Expenditures

Overall spending on FFS expenditures for behavioral health treatment, including services for those within the Medicaid program as well as the uninsured and State-funded services for the Medicaid-eligible, decreases by approximately $369,000. Most of this is due to reduced expenditures related to enrollment and utilization trends, falling $21.9 million, with a particularly sharp decrease in federal funds. There is also an assumed decrease of $5.6 million for the uninsured and State-funded services budget, which declines due to the fact that an extra $10.0 million added to the budget via budget amendment from the Maryland Health Insurance Plan (MHIP) fund is not continued into fiscal 2017. Beyond these reductions, there are rate increases for behavioral health providers. Regulated rate increase assumptions add $14.8 million to the budget, while a 2% community provider rate increase adds $12.2 million.

The Department of Legislative Services (DLS) estimate of the adequacy of State-supported funds to meet demand for FFS community behavioral health services is provided in **Exhibit 10**. Overall, the budget for Medicaid-eligible spending looks to be in balance when it comes to State-supported funding. Based on the most recent spending projections for fiscal 2015 and using projected enrollment growth, current utilization trends, and provider rate increases, it appears that the fiscal 2016 budget for behavioral health Medicaid services is slightly overfunded by $5.0 million in terms of State funding after taking into consideration the $11.5 million targeted reversion. The current fiscal 2015 accrual levels appear to be well above the level needed to closeout fiscal 2015, with a $13.6 million surplus projected. The fiscal 2017 budget also has a projected surplus of State funding at $3.0 million. However, for both fiscal 2016 and 2017, given the overall level of State funding, the surplus represents a variance of only 1.4% and 0.8%, respectively.

**Exhibit 10**
**Projected General Fund Balances**
**Fiscal 2015-2017**
**($ in Millions)**




MASF: Medical Assistance State Funded

Note: Excludes the Baltimore Capitation Project.

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

Funding for the uninsured as well as State-funded services for Medicaid-eligible individuals looks to be adequate as well. While there is a projected deficit within fiscal 2017, this represents only a 1.1% variance from the amount contained within the allowance. **Over the three years, there is a surplus of $30.4 million including Medicaid, Medicaid State-funded, and uninsured services.** However, there are two trends that happened within fiscal 2015 that could affect funding adequacy in both fiscal 2016 and 2017. First, as noted previously, the number of individuals receiving services for the uninsured increased dramatically in fiscal 2015, particularly for children. At this time, it is unclear why this increase occurred since there was not a corresponding decrease of children enrolled in Medicaid utilizing behavioral health services.

Second, within fiscal 2015 there was an unusually high utilization of inpatient mental health services within specialty psychiatric hospitals. Due to the federal exclusion of reimbursement for mental health or SUD services within an institution for mental disease (IMD), these inpatient services

must be entirely funded by the State. In fiscal 2015, inpatient utilization within an IMD was especially acute for the former PAC population, which prior to the ACA expansion did not have access to inpatient psychiatric services. Once that access was granted, these patients began presenting at much greater numbers at both acute care hospitals as well as psychiatric hospitals throughout the State. For those presenting at acute care, since they are within the ACA expansion population, the State was reimbursed at 100%. However, for those presenting at a specialty psychiatric hospital, the only federal reimbursement available was through a federal demonstration project, which only reimbursed at 50% and ended at the conclusion of fiscal 2015. In order to prevent spending from inflating at this rate again, BHA is currently monitoring the number of patients which can be admitted to a private psychiatric facility and encouraging those facilities to seek placement for patients within an acute care hospital prior to admission to the IMD facility. Without BHA utilizing this procedure, or obtaining additional federal funding through one of the waivers discussed in Issue 3, it is possible that the deficit in fiscal 2017 presented in Exhibit 10 could become much larger.

It is also worth noting that the Administration has utilized special funds from the surplus within the Senior Prescription Drug Assistance Program fund to offset general funds within the FFS programs for the uninsured. Currently, the appropriation is $8.3 million. However, DLS estimates that there is only $6.0 million available for this purpose (see the Medical Care Programs Administration analysis for additional detail). BHA will have to find additional sources of revenue in order to make up for this difference in fiscal 2017.

**Grants and Contracts – Mental Health**

Various grants and contracts for mental health providers increase by $3.1 million above the current working appropriation. The largest increase is $1.6 million for the Care Management Entity (CME) function. Previously, the Governor's Office for Children (GOC) ran a program that provided wraparound services for children with severe emotional disturbance in order to keep these children out of residential treatment facilities and in their homes and communities. During fiscal 2016, a budget amendment was processed which transferred $2.8 million for this program from GOC to BHA. For fiscal 2016, BHA will continue funding the contract that is currently in use by the State. However, in fiscal 2017, $4.4 million has been provided to the CSAs in order to switch from the current CME to a Targeted Case Management (TCM) system.

In particular, this switch seeks to take advantage of the State Plan Amendments that redefined TCM for children and adolescents and created the 1915(i) service array. The current TCM system already provides care coordination to youth with intensive needs who are eligible for Medicaid, and in particular the 1915(i) service array is available to support home and community-based plans of care for youth in the highest level of intensity who also meet financial eligibility requirements. By eliminating the CME and redirecting funds to the TCM system, the State intends to establish a more efficient system that also draws down the federal Medicaid match for TCM services for Medicaid-eligible children. The funding included in the fiscal 2017 allowance is to support the continuation of services at varying intensity levels for youth that are both eligible and ineligible for Medicaid, similar to those services provided by the CME, and is based on the historical costs of youth served by the CME.

### Grants and Contracts – Substance Use Disorders

The major increases in grants and contracts for SUD services are for federal funding that is either new or enhanced in fiscal 2017. New grants total $2.2 million and include the Maryland Collaboration for Homeless Enhancement Services grant at $1.4 million (with an additional $1.4 million for the mental health component of this grant as well) and a grant of $794,300 for medication assisted treatment for heroin and prescription opioid addiction. Also, not included in these numbers, is an additional $2.3 million from Supplemental Budget No. 2. This supplemental added funds due to the fact that SUD services for the uninsured, which are currently provided through grants and contracts and not on a FFS basis, were not calculated into the rate increase for community providers in the allowance as originally submitted. These increases are partially offset by the decrease of $2.6 million for the Synar penalty. However, the State intends to continue funding the Synar program within the Prevention and Health Promotion Administration (PHPA) of DHMH. More on the Synar program and penalty can be found in Update 1.

## Program Direction

The largest increase for Program Direction is $3.1 million for initiatives related to the Governor's Heroin and Opioid Emergency Task Force recommendations. The largest part of this funding at $1.0 million is to establish the Maryland Center of Excellence for Prevention and Treatment under the Behavioral Health Advisory Council in order to further study issues surrounding SUD and especially heroin and opioid addiction. Other major uses of these funds include a Good Samaritan Law Public Awareness Campaign ($700,000), providing recovery support specialists to assist pregnant women with substance use disorders ($622,000), and requiring mandatory registration and querying of the Prescription Drug Monitoring Program (PDMP) ($522,000). More on these items, including other items funded as part of the task force recommendations, can be found in Issue 1.

## Facilities

The largest increase in the budgets for the State-operated hospital centers and facilities is $4.5 million for the privatization contracts for Springfield Hospital Center and RICA – Gildner. Overall, the cost of the contracts minus the savings from the abolished positions as well as the operating costs of those functions lowers the fiscal 2017 allowance by $2.7 million. However, some issues have been noticed with the privatization process for these contracts, in particular with the housekeeping contract at Springfield.

According to DHMH, both of the dietary contracts at Springfield and RICA – Gildner have been reviewed and certified by the Department of Budget and Management that they will save the amounts mandated by statute. However, at this time the amounts included in the budget are projections based on the costs of privatized food services at other State hospital centers. Since a Request for Proposals (RFP) cannot be issued until 60 days after employees have been notified, the actual costs of the contracts are unknown at this time.

One privatization has already been pulled back, which is the contract for housekeeping services at Springfield Hospital Center. This privatization is no longer moving forward due to an error in the

calculation of the costs of the contract based on the square footage of the facility. The State did not include in its estimate the correct size of the facility that would need to be maintained, and based on a revised cost estimate it is no longer feasible to privatize this service. However, while the Administration does not intend to move forward with the privatization of housekeeping services at this time, the reduction of 21 positions, as well as the cost differential, will now be absorbed through other vacancies throughout the department. **BHA should comment on the status of these contracts, when the RFP will be released by the State, and how the department intends to absorb the position reductions and other costs now that the housekeeping privatization is no longer moving forward.**

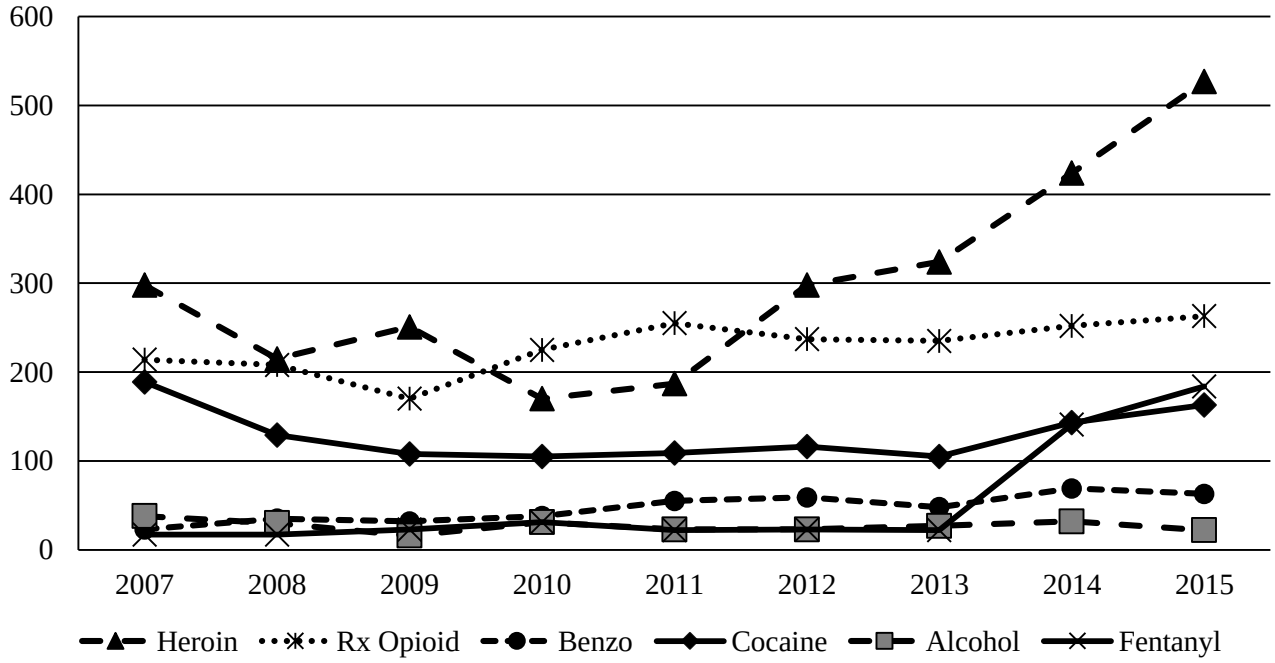
There is also a decrease of $690,000 in operating costs for the closed Crownsville Hospital Center. After a task force in the interim did not determine a reasonable use of the property, it is unclear how BHA and DHMH intend to dispose of the property to such an extent that no more upkeep will be necessary in fiscal 2017. **The department should comment on its future plans for the Crownsville Hospital Center.**

# *Issues*

## 1. The Heroin Epidemic

Opioid use and overdose continues to be a serious and urgent public health issue. As seen in **Exhibit 11**, since 2007 heroin and/or prescription opioid drugs have been involved in the majority of the State's overdose deaths, with deaths related to fentanyl also increasing in 2014 and 2015. In fact, 2015, on a January through September year-to-date basis, is the highest year for overdose deaths in the time period shown. Various actions have been taken in an attempt to combat overdose deaths as well as heroin and opioid use throughout the State in recent years.

**Exhibit 11**
**Overdose Deaths by Related Substance**
**January-September 2007-2015***




Rx: medical prescriptions

*2015 counts are preliminary.

Source: Department of Health and Mental Hygiene

## Prescription Drug Monitoring Program

The PDMP, established by Chapter 166 of 2011, 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. PDMP can make data on prescription opioids available to health care providers, pharmacists, patients, health occupations licensing boards, specific DHMH administrations, law enforcement, and PDMPs in other states. PDMP is integrated with Chesapeake Regional Information System for our Patients, the State-designated health information exchange.

According to DHMH, as of November 1, 2015, PDMP has 14,258 registered users and is averaging 20,000 patient queries per week. PDMP is interoperable with PDMPs in Virginia and West Virginia. In October 2015, PDMP began analyzing data to identify patients getting controlled substances from multiple providers and alerting providers. In December 2015, the PDMP Advisory Board made recommendations in its annual report regarding mandatory registration and use of PDMP by health care providers. The recommendations call for phasing in mandatory registration and use after taking steps to streamline user registration, educate providers, support provider workflow integration, and improve system capacity and data quality. A similar recommendation was provided by the Governor's Heroin and Opioid Emergency Task Force and would be implemented by HB 456 or SB 382.

## Overdose Response Program

Chapter 299 of 2013 established the Overdose Response Program in DHMH to authorize certain individuals, through the issuance of a certificate, to administer naloxone to an individual experiencing opioid overdose when medical services are not immediately available. DHMH authorizes private and public entities to train and certify individuals to administer naloxone. As of June 2015, over 8,700 individuals were trained (34% of whom are law enforcement). In addition, over 8,000 doses of naloxone were dispensed and 145 administrations were reported. Chapter 356 of 2015 expanded the program to authorize standing orders for naloxone and provided additional legal protections for prescribers and administrators of naloxone.

## Joint Committee on Behavioral Health and Opioid Use Disorders

Chapter 464 of 2015 established the Joint Committee on Behavioral Health and Opioid Use Disorders, comprising five senators and five delegates, to oversee the State's PDMP and State and local programs to treat and reduce opioid use disorders. The joint committee must review the final report of the Heroin and Opioid Emergency Task Force and review and monitor the activities of the Governor's Inter-Agency Heroin and Opioid Coordinating Council. The joint committee must also monitor the effectiveness of the State Overdose Prevention Plan; local overdose prevention plans and fatality review teams; strategic planning practices to reduce prescription drug abuse; and efforts to enhance overdose response laws, regulations, and training.

The joint committee has received briefings on the DHMH overdose prevention strategy; the Screening, Brief Intervention and Referral to Treatment Program; the funding of behavioral health

services; opioid use disorders and treatments; the activities of the Justice Reinvestment Coordinating Council (JRCC); the Baltimore Mayor's Heroin and Treatment Task Force; and the Heroin and Opioid Emergency Task Force.

## Inter-Agency Heroin and Opioid Coordinating Council

In response to the State's heroin and opioid epidemic, the Governor issued an executive order in February 2015 establishing the Governor's Inter-Agency Heroin and Opioid Coordinating Council. The council, which is chaired by the Secretary of Health and Mental Hygiene, consists of representatives of the departments of State Police, Public Safety and Correctional Services, Juvenile Services, Education, and the Maryland Institute for Emergency Medical Services Systems. The council's duties include developing recommendations for policy, regulations, or legislation to facilitate improved sharing of public health and public safety information among State agencies. The council must update the Governor biannually on each agency's efforts to address heroin and opioid education, treatment, interdiction, overdose, and recovery. On behalf of the council, DHMH must submit an annual report to the Governor and the public in the form of the Inter-Agency Heroin and Opioid Coordination Plan. The council met on four occasions in 2015.

## Heroin and Opioid Emergency Task Force

In February 2015, the Governor also established, by executive order, the Heroin and Opioid Emergency Task Force, which consists of the Lieutenant Governor; an appointee of the President of the Senate, the Speaker of the House, and the Attorney General; and seven members of the public. The task force must assist the Governor in establishing a coordinated statewide and multijurisdictional effort to prevent, treat, and significantly reduce heroin and opioid abuse and advise the Governor and the Director of Homeland Security on immediate steps to improve coordination between federal, State, and local law enforcement regarding the trafficking and distribution of heroin and opioids in the State. The task force held six regional summits throughout the State to hear input from concerned Marylanders who have been impacted by the heroin epidemic. Based on information provided at the summits, the task force established five workgroups: Access to Treatment and Overdose Prevention; Quality of Care and Workforce Development; Intergovernmental Law Enforcement Coordination; Drug Courts and Reentry; and Education, Public Awareness, and Prevention.

In August 2015, the task force submitted an interim report, which contained 10 recommendations for immediate implementation including earlier and broader incorporation of heroin and opioid prevention into the health curriculum, implementation of emergency department opioid prescribing guidelines, training for the Maryland State Police on the Good Samaritan Law, and establishing a faith-based addiction treatment database. The report also detailed how $2 million in additional treatment and prevention funding, earmarked by the legislature and released by the Governor for fiscal 2016, will be spent, including naloxone training and distribution to local health departments and local detention centers; overdose survivor outreach programs in hospital emergency departments; prescriber education; recovery housing and detoxification services for women with children; and increased bed capacity at the A.F. Whitsitt Center, a partially State-financed residential treatment facility on the Eastern Shore. Most of this funding is continued in the fiscal 2017 allowance.

On December 1, 2015, the task force submitted its final report to the Governor which included 33 recommendations in response to 7 key goals of the task force. Those recommendations are provided in **Exhibit 12**. Furthermore, approximately $4.8 million in general funds has been added to various agencies throughout the State to support some of the recommendations of the task force, including almost $3.1 million within BHA, as shown in **Exhibit 13**. Beyond this funding, the one recommendation that could greatly affect funding for SUD treatment is to review Medicaid rates for SUD treatment services every three years. DHMH indicates that they are currently working towards beginning this review. However, what is most troubling about the recommendations and the funding provided for the task force initiatives is how little of the funding is directed towards basic SUD treatment services, especially in areas where the State is aware that there are funding shortfalls. Outside of the rate increase for providers, State-supported funding for SUD treatment is entirely flat in fiscal 2017. Meanwhile, the recommendations would instead fund a new research entity with the Center of Excellence as well as screening tools at the Department of Human Resources (DHR) and the Department of Juvenile Services (DJS), all of which are either duplicative of State services already offered or should not be necessary given the resources that the State has already committed to these functions within the fiscal 2017 allowance.

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**Exhibit 12**

## Heroin and Opioid Emergency Task Force Recommendations

**Expanding Access to Treatment**

Implementing a Statewide Buprenorphine Access Expansion Plan

Reviewing the Substance Use Disorder Reimbursement Rates Every Three Years

Expanding Access to Treatment through Payments to Noncontracting Specialists and to Noncontracting Nonphysician Specialists

Improving Provider Panel Lists

Expanding Access to Training for Certified Peer Recovery Specialists

Providing Recovery Support Specialists to Assist Pregnant Women with Substance Use Disorders

Transitioning Inmates to Outpatient Addictions Aftercare and Community Providers

Incentivizing Colleges and Universities to Start or Expand Collegiate Recovery Programs

**Enhancing Quality of Care**

Requiring Mandatory Registration and Querying of the Prescription Drug Monitoring Program

Authorizing the Opioid-associated Disease Prevention and Outreach Program

Requiring and Publishing Performance Measures on Addiction Treatment Providers

Requiring Continuing Professional Education on Opioid Prescribing for the Board of Podiatric Medical Examiners and Board of Nursing and on Opioid Dispensing for the Board of Pharmacy

Requiring Drug Monitoring for Medicaid Enrollees Prescribed Certain Opioids Over an Extended Time

**Boosting Overdose Prevention Efforts**

Expanding Online Overdose Education and Naloxone Distribution

Implementing a Good Samaritan Law Public Awareness Campaign

**Escalating Law Enforcement Options**

Enacting a Maryland Racketeer Influenced and Corrupt Organization Statute

Creating a Criminal Penalty for Distribution of Heroin or Fentanyl Resulting in Fatal or Nonfatal Overdose

Creating a Multijurisdictional Maryland State Police Heroin Investigation Unit

Designating the High Intensity Drug Trafficking Area's Case Explorer the Central Repository for Maryland Drug Intelligence

Enhancing Interdiction of Drug-Laden Parcels

Strengthening Counter-Smuggling Efforts in Correctional Facilities

**Reentry and Alternatives to Incarceration**

Establishing a Day Reporting Center Pilot Program to Integrate Treatment into Offender Supervision

Expanding the Segregation Addictions Program in Correctional Facilities

Implementing a Swift and Certain Sanctions Grid for Probation and Parole

Institutionalizing a Substance Use Goal into the Maryland Safe Streets Initiative

Establishing a Recovery Unit at Correctional Facilities

Studying the Collateral Consequences of Maryland Laws and Regulations on Employment of Ex-offenders

**Promoting Educational Tools for Youth, Parents, and School Officials**

Creating a User-friendly Educational Campaign on School Websites

Training for School Faculty and Staff on Signs of Student Addiction

Promoting Evidence-based Prevention Strategies that Develop Refusal Skills

Support Student-based Film Festivals on Heroin and Opioid Abuse

**Improving State Support Services**

Implementing Comprehensive Heroin and Opioid Abuse Screening at the Department of Juvenile Services and the Department of Human Resources

Establishing the Maryland Center of Excellence for Prevention and Treatment under the Behavioral Health Advisory Council

Source: *Final Report of the Governor's Heroin and Opioid Emergency Task Force*

## Exhibit 13
## Funded Recommendations of the Heroin and Opioid Emergency Task Force
### Fiscal 2017

| | |
|---|---|
| **Department of Health and Mental Hygiene** | |
| Establishing the Maryland Center of Excellence for Prevention and Treatment under the Behavioral Health Advisory Council | $1,000,000 |
| Implementing a Good Samaritan Law Public Awareness Campaign | 697,653 |
| Providing recovery support specialists to assist pregnant women with substance use disorders | 622,622 |
| Requiring mandatory registration and querying of the prescription drug monitoring program | 522,245 |
| Implementing a Statewide Buprenorphine Access Expansion Plan | 206,480 |
| Expanding online overdose education and naloxone distribution | 10,000 |
| ***Subtotal*** | ***$3,059,000*** |
| **Department of Public Safety and Correctional Services** | |
| Day reporting center through the Division of Parole and Probation – Central Region | 540,000 |
| Outpatient addictions aftercare at the Metropolitan Transition Center | 358,000 |
| Expand the segregated addictions program at the Maryland Correctional Training Center | 138,000 |
| ***Subtotal*** | ***$1,036,000*** |
| **State Police (included within Supplemental Budget No. 2)** | |
| Multi-jurisdictional State Police Heroin Investigation Unit | 200,000 |
| Designating HIDTA the Central Repository for Maryland drug intelligence | 75,000 |
| ***Subtotal*** | ***$275,000*** |
| **Governor's Office of Crime Control and Prevention** | |
| Safe Streets | 180,000 |
| **Maryland State Department of Education** | |
| Local school websites to promote drug and heroin awareness | 100,000 |
| **Department of Juvenile Services and Department of Human Resources** | |
| Screenings | 100,000 |
| **Grand Total** | **$4,750,000** |

HIDTA: High Intensity Drug Trafficking Area

Source: State Budget

## Justice Reinvestment Coordinating Council

Chapter 42 of 2015 established JRCC in the Governor's Office of Crime Control and Prevention (GOCCP). JRCC was tasked with convening a stakeholder workgroup and, using a data-driven approach, to develop a statewide framework of sentencing and corrections policies to further reduce the State's incarcerated population, reduce spending on corrections, and reinvest in strategies to increase public safety and reduce recidivism. JRCC's final report in December 2015 contained numerous recommendations and reinvestment strategies, and one of the major reinvestment priorities includes SUD and mental health treatment. SB 1005 and HB 1312 seek to codify many of these recommendations and reinvestment strategies.

One area in particular that these bills address is the process by which drug offenders can be committed to SUD treatment within DHMH under Section 8-507 of the Health – General Article. In particular, the legislation would change the timing by which defendants would be placed into treatment from "prompt placement" to 30 days. Based on a report requested through the 2014 *Joint Chairmen's Report* (JCR), it currently takes on average approximately 120 days to place a defendant into a residential treatment facility. Thus, if either of these bills were to be enacted into law as written, DHMH would need to place defendants about four times as quickly as they currently do. Further, it should be noted that the providers delivering the residential treatment have indicated that they could increase their intake of patients if appropriate funding were provided within the State budget. Currently, only $6 million is allocated for forensic placements into residential treatment under Section 8-507, which serves approximately 360 people. Even without a change in statute, it is apparent that there is not adequate funding within the current allowance to meet the demand for residential SUD treatment under this procedure. **DLS thus recommends that the funding appropriated for the Center of Excellence, as well as funding within DHR and DJS for a heroin screening tool, instead be utilized to fund residential treatment under Section 8-507. The department should also comment on the funding levels and bed availability that would be required under the JRCC bills.**

## 2. Behavioral Health Integration – Furthering Financial Alignment

For the past several years, DHMH has been working on the issue of integrating mental health and SUD care. The need to do this was prompted by observations that the previous service delivery system for mental health and SUD 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 part of the integration process, the State chose to move forward with an expanded carve-out of behavioral health services from the managed care system with added (though limited) performance risk. Specifically, all SUD services would be carved out from the 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 limited risk 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 beginning with the fiscal 2016 budget funds for Medicaid-eligible specialty mental health and SUD 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 the Board of Public Works (BPW) approved, a contract for the new ASO, which took effect January 1, 2015.

The ASO is responsible for coordination with both local agencies and the MCOs in order to ensure appropriate referrals from the MCOs and coordination between the MCOs and behavioral health providers. The ASO is responsible for providing additional training to providers in terms of developing and enhancing provider competency in the areas of mental health and SUD 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 for the beginning of fiscal 2017, 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.

Two pieces of legislation enacted last session also further advanced the process of behavioral health integration in Maryland. The first, Chapter 328 of 2015, merged the Maryland Advisory Council on Mental Hygiene and the State Drug and Alcohol Abuse Council into the Behavioral Health Advisory Council in October 2015. The second, Chapter 469 of 2015, included numerous technical and clarifying changes to statute which were recommended by the BHA Integration Stakeholder Workgroup. These changes included a series of technical, clarifying, and updated changes related to the powers, duties, and responsibilities of BHA, as well as removing obsolete references to programming that is no longer administered by BHA and language that is no longer commonly used in the behavioral health community. Other changes included technical changes to eliminate inconsistencies between mental health and SUD services.

## Information Sharing

One of the early issues with the integration process concerned the sharing of specialty behavioral health information between the MCOs and the ASO. The use and disclosure of protected health information (PHI) is governed, generally, by the Health Insurance Portability and Accountability Act (HIPAA). Under HIPAA, PHI may be disclosed for purposes of treatment, payment, and health care operations without patient consent. However, in nearly all cases, the disclosure of SUD treatment and prevention records is subject to the more restrictive and stringent standard of 42 Code of Federal Regulations (CFR) Part 2, which prohibits the disclosure of PHI absent specific authorization from the patient. With the transfer of SUD services from the MCOs to the ASO, HIPAA and 42 CFR Part 2 prevented the sharing of SUD treatment information without specified authorization between the MCOs and the ASO. In response to concerns about how this would impact care coordination activities for Medicaid members, the 2015 JCR required DHMH to describe the efforts conducted by the ASO and the MCOs to improve the exchange of information and coordination of care for Medicaid-eligible individuals who use specialty behavioral health services in the context of federal regulations governing data-sharing. This report was submitted to the budget committees on November 9, 2015.

In the report, DHMH notes that given the federal requirement on health information sharing, and in particular SUD treatment information, the department made the decision to obtain individual Release of Information (ROI) forms from Medicaid beneficiaries accessing SUD services. The ASO and the MCOs have worked collaboratively with SUD providers toward a goal of obtaining a signed consent form from every SUD services recipient willing to provide consent. All SUD programs and providers – as well as mental health providers delivering SUD services to Maryland Medicaid members – have been instructed to request an ROI form prior to the provision of SUD services. Completed forms allow the ASO to release authorization and claims data to the enrollee's MCO – along with providers specified by the patient – and thereby coordinate care across the continuum of care. The consent form is required to be updated by the patient annually. As of mid-September 2015, 78% of patients accessing SUD services had completed an ROI form, and only 1% of patients had elected not to consent and declined to complete the ROI.

## Financing for SUD Services to the Uninsured

For the most part, the change to a FFS system under an ASO did not require any change to the specialty mental health services for the uninsured since this model is the same as the previous delivery model. However, it will create a significant change in the way in which SUD services for the uninsured are delivered throughout the State. Currently, these services are provided on a grant-based system through the Local Addictions Authorities (LAAs), who then either provide the services themselves or contract with other providers. With the transition of Medicaid-reimbursable SUD services from the MCOs to the ASO, the SUD services grants for the uninsured are the only treatment funds which are not reimbursed by the ASO on a FFS basis. Alignment of financing is a major goal of behavioral health integration, as this change will effectively create treatment on demand for eligible individuals for those services within the FFS model, which is much different from the previous grant-based and managed care system.

The transfer from the grant-based system to FFS for SUD services has been repeatedly pushed back. Currently, BHA has developed a plan to transfer the financing of some of these services from grants to FFS within fiscal 2017. The first half of fiscal 2017 will provide for a transition period where LAAs and other providers will have the opportunity to either switch to FFS or develop plans to help them prepare for the switch. Then, beginning on January 1, 2017, SUD ambulatory services will be moved to the ASO and a FFS model. These services include ambulatory withdrawal management, assessment, Level I Outpatient, Level II.1 Intensive Outpatient, and opioid treatment services. The estimated dollar amount of the transfer is approximately $25.2 million, which is approximately 30% of the amount of the grants. However, at this time there is currently no plan for the transfer of the other services and funding to the ASO, meaning that financing for these services will remain on a grant-based structure for the near future. **The department should comment on how it plans to ensure a smooth transition of ambulatory SUD treatment services to the ASO, and what plans it has for transferring the remaining grant-based funding to the ASO.**

## 3. Funding for Institutions for Mental Disease

The Medicaid IMD exclusion prohibits the use of federal Medicaid financing for care provided to most adult patients between the ages of 21 and 65 in mental health and SUD residential treatment and inpatient facilities larger than 16 beds. In the past, Maryland has used numerous waivers to allow for some federal funding to be used to reimburse IMD facilities for serving Medicaid eligible patients. The State has also used State-only funds to purchase bed capacity. However, recently some issues with IMD funding have emerged.

Last year, one of the first issues to arise was with the payment for residential SUD 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 2015, Medicaid began denying payments to these providers saying that under federal guidelines these facilities count as IMDs and are thus not eligible for Medicaid reimbursement. This caused numerous providers to lose their ability to claim reimbursement for these services. Last year, BHA and DHMH in a letter to the budget and policy committees noted that they would take numerous steps to help these providers, including

implementing another level of payment for partial hospitalization, which is a federally reimbursable service, as well as providing technical assistance to these providers and encouraging them to decrease their size to fit under the IMD exclusion. Since that time, the State has also been actively working to secure a waiver for residential SUD treatment within an IMD. DHMH and Medicaid have also been meeting biweekly with the federal Centers for Medicare and Medicaid Services (CMS) and their outside technical assistance consultants about the breadth and depth of services provided by Medicaid, and they note that the discussions have been productive and encouraging. Further discussions on the IMD waiver for SUD residential treatment services will also be a part of the renewal of the larger Medicaid HealthChoice waiver.

Beyond SUD services, the IMD exclusion also affects the ability of psychiatric inpatient and residential programs from claiming federal reimbursement for their services. The State recently sought a waiver from CMS for reimbursement for services rendered within an IMD for both mental health and SUD services, but was informed that CMS would only consider such a waiver for SUD services at this time. The State also participated in a program which provided federal reimbursement for inpatient mental health services, which was known as the ACA Emergency Psychiatric Demonstration (EPD). However, this program, as originally designed, expired at the end of fiscal 2015, resulting in funding shortfalls for private hospitals specializing in behavioral health treatment within the fiscal 2016 budget. In order to address this shortfall in fiscal 2016, DHMH authorized a transfer of $10 million from the MHIP fund balance to BHA to cover costs for this purpose. However, as mentioned earlier, BHA is still actively managing the number of patients who are admitted to a private psychiatric facility in order to keep spending contained.

CMS also recently promulgated new regulations where the federal government would provide reimbursement for services rendered within an IMD for the first 15 days of service for a particular individual for both SUD and mental health services. However, the regulations stipulated that this would only be for services financed through an MCO. While Maryland does have an MCO structure, the FFS behavioral health carve-out prevents Maryland from taking advantage of this new regulation.

Separately, the State is actively seeking to be involved with – and participate once again in – the EPD program now that it has been extended by Congress. One difficulty, however, is that CMS is currently working on how they will determine the cost neutrality of the EPD program, which is a new requirement within the extension of the EPD program. Without guidance from CMS on how cost neutrality is going to be determined, it is still unclear how the State would participate in the program and begin once again to draw down on EPD federal funds.

If the State is not able to participate in the EPD program within fiscal 2017 and no further IMD waiver is granted by CMS, it is unclear how the State will be able to continue to support inpatient and residential treatment for the Medicaid-eligible population without rationing these services. **The department should comment on the current status of these waiver applications and how it plans to fund inpatient psychiatric services without federal funds in fiscal 2017.**

# *Recommended Actions*

1. Add the following language:

   All appropriations provided for program M00Q01.10 Medicaid Behavioral Health Provider Reimbursements are to be used for the purposes herein appropriated, and there shall be no budgetary transfer to any other program or purpose.

   **Explanation:** The language restricts Medicaid behavioral health provider reimbursements to that purpose.

2. Add the following section:

   SECTION XX: AND BE IT FURTHER ENACTED, That $1,000,000 of the general fund appropriation in Program M00L01.02 Community Services made for the purpose of establishing a Center of Excellence for Prevention and Treatment, $50,000 of the general fund appropriation in Program N00B00.04 General Administration – State made for the purpose of implementing a heroin screening tool, and $50,000 of the general fund appropriation in Program V00D02.01 Departmental Support made for the purpose of establishing a heroin screening tool may not be expended for those purposes and instead may only be transferred to, and expended in, Program M00L01.02 Community Services for the purpose of funding residential treatment services for defendants committed to the Department of Health and Mental Hygiene under Section 8-507 of the Health – General Article.

   **Explanation:** This section fences off appropriations made to implement recommendations from the Governor's Heroin and Opioid Emergency Task Force for the purpose of establishing the Center of Excellence for Prevention and Treatment as well as implementing heroin screening tools within the Department of Human Resources (DHR) and the Department of Juvenile Services (DJS), and restricts those funds to be expended only on residential treatment services for defendants committed to the Department of Health and Mental Hygiene under Section 8-507 of the Health – General Article. Both DHR and DJS already have screening tools for heroin, and the Center of Excellence is not necessary. Funding for commitments under Section 8-507 is currently not enough to meet the demands from the State courts for those placements.

# *Updates*

## 1. Synar Compliance Improves Dramatically

As part of the agreement for accepting the federal Substance Abuse Prevention and Treatment (SAPT) block grant, the State has agreed to have federal regulators audit the State on the extent to which tobacco retailers are selling tobacco to minors in the State. This program is known as the Synar program. The limit on the retailer violation rate (RVR) is 20.0%. If a state exceeds this percentage, it must either pay an alternate penalty amount based on the RVR above the 20.0% limit or surrender SAPT funding. In the past two federal fiscal years, the State had an RVR of 24.1% and 31.4%, which resulted in alternative penalty payments in State fiscal 2015 and 2016, essentially requiring higher State expenditures on retail tobacco enforcement.

In response to these penalties, the fiscal 2016 budget bill included language which withheld $100,000 in general funds within BHA pending a report from DHMH containing information on the funding and outcome measures for Synar compliance programs. In particular, the report needed to include information on how funds related to the penalty were expended, the structure and nature of tobacco retailer compliance programs that utilize the penalty funds, how programs ensured future compliance with the federal Synar inspections of tobacco retailers, and whether additional regulatory or statutory changes are needed to ensure compliance. The report was submitted on December 16, 2015.

In the report, DHMH and BHA detailed how BHA jointly implemented compliance activities with PHPA, and developed a program through which local health departments (LHD) received grant funding based on the RVR, number of tobacco sales outlets, and population size of each jurisdiction. Through these grants, LHDs further partnered with local nongovernmental organizations to conduct education campaigns, increase awareness, and promote store-level staff training and compliance with the State youth access law. Minority Outreach and Technical Assistance organizations from the Office of Minority Health and Health Disparities were also funded to support LHD activities. Further partnerships were developed with the Legal Resource Center for Public Health Policy and the University of Maryland Carey School of Law, as well as with the Maryland Office of the Comptroller to further coordinate and facilitate better enforcement and educational outreach efforts. One full-time equivalent contractual position was also hired within PHPA to oversee Synar-related activities.

Compliance activities are expected to continue into the future to ensure that the State remains in compliance with the federal Synar statute. Funding has been placed within the PHPA budget utilizing funds from the Cigarette Restitution Fund to continue the program in fiscal 2017. DHMH also recently completed the required federal fiscal 2016 audit and the non-compliance rate was 13.8%, which is down from the previous year mark of 31.4%, demonstrating that the efforts of DHMH are having a positive effect.

## 2. Reports on Behavioral Health Expenditures by Medicaid Eligibility Improve, but More Needs to Be Done

With the numerous changes that have occurred within the Medicaid program, with different federal matching rates for different eligibility populations, it has become more difficult and complex to project spending, and especially the general/federal funding splits, for the behavioral health carve-out services, particularly with the reports that BHA previously provided for this purpose. Due to these concerns, the fiscal 2016 budget bill included language which withheld $100,000 in general funds within BHA pending a report from DHMH containing information on the utilization and expenditures for behavioral health services based upon the user's eligibility group under Medicaid. The language further stipulated that, beginning with the period ending June 30, 2015, the quarterly report that is produced by the ASO which oversees the public behavioral health system include a breakdown of data based on the user's eligibility group under Medicaid.

On September 1, 2015, DHMH submitted the report, which contained a new quarterly report that provided a breakdown of claims data based on some broad eligibility categories, including a breakout of adults who qualify for Medicaid under the federal ACA expansion. However, due to data limitations and timing, no data on SUD claims was included in the report. Since the initial report, DLS has received two other reports which seek to provide more detailed information on the behavioral health services. Medicaid has provided a report that contains both mental health and SUD treatment data on a monthly basis by eligibility category. Further, a quarterly report containing SUD services data was recently submitted separately to DLS. Both of these reports will continue to help DLS analysts prepare more robust and confident expenditure projections. However, more work needs to be done to produce a more comprehensive report and data set that serves the interests of all parties involved. **Thus, DLS and DHMH will continue to work together throughout the 2016 interim to come up with a more comprehensive and complete dataset and reporting structure.**

Appendix 1

# *Current and Prior Year Budgets*

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

| | General Fund | Special Fund | Federal Fund | Reimb. Fund | Total |
|---|---|---|---|---|---|
| **Fiscal 2015** | | | | | |
| Legislative Appropriation | $812,166 | $46,020 | $513,232 | $8,467 | $1,379,885 |
| Deficiency Appropriation | 0 | 0 | 0 | 0 | 0 |
| Cost Containment | -21,963 | 0 | 0 | 0 | -21,963 |
| Budget Amendments | 49,974 | 4,823 | 142,705 | 600 | 198,102 |
| Reversions and Cancellations | -656 | -808 | -6,669 | -782 | -8,915 |
| **Actual Expenditures** | **$839,520** | **$50,035** | **$649,268** | **$8,284** | **$1,547,108** |
| **Fiscal 2016** | | | | | |
| Legislative Appropriation | $847,497 | $48,452 | $738,513 | $7,944 | $1,642,406 |
| Budget Amendments | 20,746 | 12,009 | 51 | 2,800 | 35,607 |
| **Working Appropriation** | **$868,243** | **$60,462** | **$738,564** | **$10,744** | **$1,678,013** |

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

## Fiscal 2015

BHA's fiscal 2015 budget ended $167,223,158 above the legislative appropriation. General funds increased by $27,354,111, mostly through budget amendments. Large general fund budget amendments included the following:

- $33,098,243 in provider reimbursements tied to the migration of SUD services from the MCOs to the behavioral health carve-out;
- $7,742,155 for increased costs at State hospital centers, including costs for off grounds outpatient services, increased overtime, and other expenses;
- $5,220,516 for increased Medicaid State-funded services;
- $3,296,006 related to the fiscal 2015 cost-of-living adjustment (COLA) and annual salary review;
- $1,378,382 for centrally budgeted employee health insurance adjustments; and
- $729,351 for increases in the ASO contract.

These increases were offset by some decreases in general funds, including $21,963,184 for 2015 cost containment. Cost containment actions included:

- $11,381,536 in 2014 accrual that was no longer necessary either due to greater federal fund attainment or underspent general funds, which were credited towards the 2015 2% general reduction amount;
- $7,009,531 due to the January 2015 BPW action which lowered provider reimbursement rates increases from 4% to 2%, lowered the psychiatrist evaluation and management rates from 100% to 87% of Medicare, and swapped general funds for special funds from the Maryland Community Health Resources Commission;
- $2,880,017 removed by BPW in July 2014 to remove funding for inpatient hospital services no longer needed and to swap general funds with federal funds under the EPD waiver;
- $685,822 for a hiring freeze conducted across DHMH to obtain the amount necessary under the 2% general reduction; and
- $6,278 in lower operations costs for the office of the Deputy Secretary for Behavioral Health.

Budget amendments also removed general funds totaling $1,491,001 for contractual expenses, legal service costs and other adjustments in the central office and grant-based programs. A further

$656,357 in general funds were reverted in fiscal 2015, mostly due to increased federal fund revenue obtained through Medicaid-related administrative work.

Special funds increased by $4,014,923 above the legislative appropriation. This is mostly due to increases through budget amendments, including $3,000,000 to backfill cost containment actions, $1,529,071 in additional funding for the Supplemental Security Income/Social Security Disability Insurance, Outreach, Access, and Recovery housing initiative, and $294,115 for both the COLA and other miscellaneous expenses. These increases were partially offset by $808,263 in cancellations at the end of the year mainly due to lower than expected special fund revenue within the institutions.

Federal funds increased by $136,036,469 above the legislative appropriation. The largest increase was $114,308,443 in relation to the transfer of SUD services to the behavioral health carve-out. Other increases included $11,365,605 in additional SAPT block grant funding, $10,030,000 in additional funding under the EPD waiver, $6,974,283 in increased Medicaid provider reimbursements and federal matching activities, and $26,695 for the COLA. Of this amount, $6,668,557 was canceled at the end of the fiscal year mainly due to the end of the Alternatives to Psychiatric Residential Treatment Facilities for Children federal grant.

Reimbursable funds decreased by $182,345 from the legislative appropriation. Cancellations totaled $782,014 which were all tied to lower than expected expenditures on special populations. One reimbursable budget amendment added $599,669 to cover the cost of emergency preparedness enhancements for DHMH institutions.

## Fiscal 2016

To date, the budget for BHA has increased by $35,606,944 above the legislative appropriation for fiscal 2016. General funds have increased by $20,746,188, of which the largest increase is for funds authorized through Section 48 of the fiscal 2016 budget bill. This includes $7,600,000 to maintain provider rates for community-based mental health providers as well as $2,000,000 for heroin treatment. Other general fund increases include $7,603,810 to realign funds with the cost containment strategy which was previously discussed, and $3,592,630 to restore the 2% salary reduction. There is one general fund decrease of $50,252 due to the transfer of funds for an assigned subobject.

Special funds increase by $12,009,488 above the legislative appropriation. This is due to an increase of $10,000,000 from the MHIP fund to pay for inpatient services which were previously covered under the EPD waiver, as well as $2,000,000 for the Synar penalty, which is consistent with the 2015 JCR. The remainder of the increase at $9,488 is for the 2% salary restoration. Federal funds also increase by $51,268 for the same reason. Reimbursable funds increase by $2,800,000 to cover costs related to the CME.

Appendix 2

# *Audit Findings*

**Thomas B. Finan Hospital Center**

| | |
|---|---|
| Audit Period for Last Audit: | July 1, 2011 – September 21, 2014 |
| Issue Date: | February 5, 2015 |
| Number of Findings: | 0 |
| Number of Repeat Findings: | 0 |
| % of Repeat Findings: | 0% |
| Rating: (if applicable) | n/a |

The audit did not disclose any findings.

**Clifton T. Perkins Hospital Center**

| | |
|---|---|
| Audit Period for Last Audit: | February 17, 2012 – April 28, 2015 |
| Issue Date: | September 18, 2015 |
| Number of Findings: | 1 |
| Number of Repeat Findings: | 1 |
| % of Repeat Findings: | 100% |
| Rating: (if applicable) | n/a |

***Finding 1:*** **Internal controls were not sufficient to ensure that all collections were deposited.**

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

**Springfield Hospital Center**

| | |
|---|---|
| Audit Period for Last Audit: | July 29, 2011 – January 27, 2015 |
| Issue Date: | October 6, 2015 |
| Number of Findings: | 1 |
| Number of Repeat Findings: | 0 |
| % of Repeat Findings: | 0% |
| Rating: (if applicable) | n/a |

***Finding 1:*** A management employee exercised virtually complete control over all aspects of the procurement and related invoice approvals for maintenance contracts, resulting in questionable activity with one contractor.

## Spring Grove Hospital Center

| | |
|---|---|
| Audit Period for Last Audit: | January 18, 2012 – February 16, 2015 |
| Issue Date: | October 15, 2015 |
| Number of Findings: | 2 |
| Number of Repeat Findings: | 1 |
| % of Repeat Findings: | 50% |
| Rating: (if applicable) | n/a |

***Finding 1:*** **Controls were not established to ensure collections were properly accounted for and deposited.**

***Finding 2:*** Spring Grove recordkeeping procedures for equipment were not in compliance with certain requirements.

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

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

| Object/Fund | FY 15 Actual | FY 16 Working Appropriation | FY 17 Allowance | FY 16 - FY 17 Amount Change | Percent Change |
|---|---|---|---|---|---|
| **Positions** | | | | | |
| 01 Regular | 2,900.85 | 2,900.55 | 2,800.85 | -99.70 | -3.4% |
| 02 Contractual | 215.66 | 221.60 | 210.03 | -11.57 | -5.2% |
| **Total Positions** | **3,116.51** | **3,122.15** | **3,010.88** | **-111.27** | **-3.6%** |
| **Objects** | | | | | |
| 01 Salaries and Wages | $ 241,095,287 | $ 242,819,891 | $ 247,208,258 | $ 4,388,367 | 1.8% |
| 02 Technical and Spec. Fees | 12,582,054 | 10,600,242 | 14,797,978 | 4,197,736 | 39.6% |
| 03 Communication | 533,070 | 463,869 | 453,759 | -10,110 | -2.2% |
| 04 Travel | 214,653 | 311,956 | 247,860 | -64,096 | -20.5% |
| 06 Fuel and Utilities | 10,327,257 | 10,702,122 | 9,292,114 | -1,410,008 | -13.2% |
| 07 Motor Vehicles | 733,464 | 793,962 | 722,727 | -71,235 | -9.0% |
| 08 Contractual Services | 1,267,226,605 | 1,398,423,628 | 1,395,921,448 | -2,502,180 | -0.2% |
| 09 Supplies and Materials | 13,063,358 | 12,551,416 | 11,343,762 | -1,207,654 | -9.6% |
| 10 Equipment – Replacement | 372,167 | 277,599 | 184,396 | -93,203 | -33.6% |
| 11 Equipment – Additional | 129,792 | 5,543 | 9,630 | 4,087 | 73.7% |
| 12 Grants, Subsidies, and Contributions | 264,524 | 438,620 | 348,481 | -90,139 | -20.6% |
| 13 Fixed Charges | 565,713 | 623,888 | 522,814 | -101,074 | -16.2% |
| **Total Objects** | **$ 1,547,107,944** | **$ 1,678,012,736** | **$ 1,681,053,227** | **$ 3,040,491** | **0.2%** |
| **Funds** | | | | | |
| 01 General Fund | $ 839,520,284 | $ 868,243,374 | $ 886,256,297 | $ 18,012,923 | 2.1% |
| 03 Special Fund | 50,034,908 | 60,461,818 | 53,806,432 | -6,655,386 | -11.0% |
| 05 Federal Fund | 649,268,397 | 738,563,772 | 733,194,629 | -5,369,143 | -0.7% |
| 09 Reimbursable Fund | 8,284,355 | 10,743,772 | 7,795,869 | -2,947,903 | -27.4% |
| **Total Funds** | **$ 1,547,107,944** | **$ 1,678,012,736** | **$ 1,681,053,227** | **$ 3,040,491** | **0.2%** |

DHMH: Department of Health and Mental Hygiene

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. The fiscal 2017 allowance does not include contingent reductions.

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

| Program/Unit | FY 15 Actual | FY 16 Wrk Approp | FY 17 Allowance | Change | FY 16 - FY 17 % Change |
|---|---|---|---|---|---|
| 01 Deputy Secretary for Behavioral Health | $ 2,102,472 | $ 1,929,618 | $ 2,093,256 | $ 163,638 | 8.5% |
| 01 Behavioral Health Administration | 327,924,246 | 338,600,797 | 342,440,306 | 3,839,509 | 1.1% |
| 04 Thomas B. Finan Hospital Center | 19,636,238 | 20,291,057 | 21,024,601 | 733,544 | 3.6% |
| 05 Regional Institute For Children and Adolescents – Baltimore City | 13,605,962 | 14,149,882 | 13,627,337 | -522,545 | -3.7% |
| 07 Eastern Shore Hospital Center | 19,524,451 | 19,532,938 | 20,142,104 | 609,166 | 3.1% |
| 08 Springfield Hospital Center | 74,806,549 | 75,247,099 | 74,760,356 | -486,743 | -0.6% |
| 09 Spring Grove Hospital Center | 84,667,087 | 81,793,842 | 86,142,716 | 4,348,874 | 5.3% |
| 10 Clifton T. Perkins Hospital Center | 63,284,983 | 62,900,708 | 65,423,977 | 2,523,269 | 4.0% |
| 11 John L. Gildner Regional Institute for Children and Adolescents | 11,721,627 | 12,104,730 | 11,661,246 | -443,484 | -3.7% |
| 15 Services and Institutional Operations | 2,260,384 | 1,931,769 | 1,286,737 | -645,032 | -33.4% |
| 01 Medical Care Programs Administration | 927,573,945 | 1,049,530,296 | 1,042,450,591 | -7,079,705 | -0.7% |
| **Total Expenditures** | **$ 1,547,107,944** | **$ 1,678,012,736** | **$ 1,681,053,227** | **$ 3,040,491** | **0.2%** |
| General Fund | $ 839,520,284 | $ 868,243,374 | $ 886,256,297 | $ 18,012,923 | 2.1% |
| Special Fund | 50,034,908 | 60,461,818 | 53,806,432 | -6,655,386 | -11.0% |
| Federal Fund | 649,268,397 | 738,563,772 | 733,194,629 | -5,369,143 | -0.7% |
| **Total Appropriations** | **$ 1,538,823,589** | **$ 1,667,268,964** | **$ 1,673,257,358** | **$ 5,988,394** | **0.4%** |
| Reimbursable Fund | $ 8,284,355 | $ 10,743,772 | $ 7,795,869 | -$ 2,947,903 | -27.4% |
| **Total Funds** | **$ 1,547,107,944** | **$ 1,678,012,736** | **$ 1,681,053,227** | **$ 3,040,491** | **0.2%** |

DHMH: Department of Health and Mental Hygiene

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. The fiscal 2017 allowance does not include contingent reductions.