M00L
Behavioral Health Administration
Department of Health and Mental Hygiene

Operating Budget Data

($ in Thousands)

	FY 16 Actual	FY 17 Working	FY 18 Allowance	FY 17-18 Change	% Change Prior Year
General Fund	$871,336	$896,704	$967,643	$70,939	7.9%
Adjustments	0	15,841	-5,652	-21,493	
Adjusted General Fund	**$871,336**	**$912,546**	**$961,991**	**$49,446**	**5.4%**
Special Fund	57,913	52,114	47,630	-4,484	-8.6%
Adjustments	0	122	4,835	4,713	
Adjusted Special Fund	**$57,913**	**$52,236**	**$52,465**	**$229**	**0.4%**
Federal Fund	776,418	733,333	955,821	222,488	30.3%
Adjustments	0	155,600	-16	-155,616	
Adjusted Federal Fund	**$776,418**	**$888,933**	**$955,806**	**$66,872**	**7.5%**
Reimbursable Fund	10,514	7,796	7,713	-83	-1.1%
Adjusted Reimbursable Fund	**$10,514**	**$7,796**	**$7,713**	**-$83**	**-1.1%**
Adjusted Grand Total	**$1,716,180**	**$1,861,511**	**$1,977,975**	**$116,464**	**6.3%**

Note: Includes targeted reversions, deficiencies, and contingent reductions.

- After adjusting for fiscal 2017 targeted reversions and deficiencies and fiscal 2018 contingent reductions, the fiscal 2018 allowance for the Behavioral Health Administration (BHA) increases by $116.5 million (6.3%) over the fiscal 2017 working appropriation. The majority of this increase is in fee-for-service community behavioral health expenditures.

- There are three contingent reductions for BHA. Two would swap special funds with general funds with the third a reduction in retirement payments. All of these reductions are tied to provisions in the Budget Reconciliation and Financing Act of 2017.

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

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Personnel Data

	FY 16 Actual	FY 17 Working	FY 18 Allowance	FY 17-18 Change
Regular Positions	2,900.55	2,802.65	2,802.65	0.00
Contractual FTEs	189.85	224.94	214.55	-10.39
Total Personnel	**3,090.40**	**3,027.59**	**3,017.20**	**-10.39**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	215.17	7.68%
Positions and Percentage Vacant as of 12/31/16	272.85	9.74%

- The fiscal 2018 allowance contains no new regular positions for BHA.

- Budgeted turnover for BHA is increased in the fiscal 2018 allowance, from 6.86% to 7.68%. However, the overall vacancy rate within BHA has decreased from 10.26% to 9.74%. Even at this lower level of vacancy, BHA still has more than enough vacant positions currently to meet turnover.

Analysis in Brief

Major Trends

Substance Use Prevention: The number of people served by prevention programming grew by 10,970 (2.3%) compared to fiscal 2015. 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 Trends: Enrollment growth in the fee-for-service (FFS) community mental health system was 7.3% in fiscal 2016, which is slightly under the enrollment growth over a five-year period from fiscal 2012 through 2016. Individuals eligible for Medicaid under the traditional eligibility categories have increased by 3.8% between fiscal 2015 and 2016, while adults newly eligible under the ACA expansion have increased by 19.4% between fiscal 2015 and 2016.

Community Mental Health Fee-for-service System – Expenditure Trends: Expenditures grew at 4.0% in fiscal 2016, which is under the growth over the last five years at 7.2%. Growth over the five-year period from fiscal 2012 to 2016, has been driven by growth in inpatient expenses (8.3%) while growth in fiscal 2016 is primarily driven by growth in psychiatric rehabilitation services (7.1%). Most of the growth is also for the adult populations, which is a direct result of the ACA expansion.

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. Homelessness continues to be highest in clients with co-occurring mental health and SUD conditions. However, this population also experienced the highest net increase in functioning.

Issues

The Heroin and Opioid Epidemic – The Rise of Fentanyl: The use of heroin and opioids continues to be an epidemic in the State with opioid-related overdose deaths continuing to climb in fiscal 2016. Numerous actions have been taken by both the General Assembly as well as the Executive Branch to tackle this issue, including the addition of over $13.5 million to various programming across State government. There have also been changes at the federal level, including new federal legislation as well as a new Medicaid waiver for the State, which will allow the State to leverage federal funds for residential treatment services. **The department should comment on what strategies it is pursuing in order to take advantage of the new federal funding opportunities available due to the passage of the new federal legislation and on the extent to which public safety considerations are included in the Health – General Section 8-505 evaluation process. The Department of Legislative Services (DLS) is also recommending committee narrative on the adequacy of SUD treatment rates.**

Behavioral Health Integration – Furthering Financial and Oversight 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. SUD services for the uninsured and for Medicaid-ineligible services for the most part will be transferred to a FFS system by the beginning of fiscal 2018. However, some problems persist, including the inability of the Department of Health and Mental Hygiene (DHMH) to measure the performance metrics of the ASO utilizing appropriate Healthcare Effectiveness Data and Information Set (HEDIS) measures and the fact that the local oversight entities for mental health and SUD services are, for the most part, still separate entities. **The department should provide an update on what metrics they are considering and why the HEDIS metrics were included in the initial contract if measurement against these metrics was not going to be feasible. DLS is also recommending the adoption of committee narrative that requests BHA and DHMH to study the issue of combining local addictions authorities and core service agencies into integrated behavioral health authorities, and report back to the General Assembly with their recommendations.**

Forensic Services – Improving the Throughput of the System: In 2016, it became clear that DHMH lacked the adequate bed space or other additional capacity to receive people committed to DHMH under the Criminal Procedure Article. Numerous contempt hearings were held in Baltimore City and Prince George's County where officials from DHMH and the Office of Forensic Services, including the Secretary of Health and Mental Hygiene, were asked why State hospitals were too full to accept any new patients and why the hospitals were turning away patients and forcing them to remain incarcerated in violation of the law. In order to begin resolving the issue, and to address stakeholder concerns regarding significant delays associated with court-involved individuals navigating the State's forensic system of care, the Secretary of Health and Mental Hygiene convened a Forensic Services Workgroup. That workgroup issued a final report on August 31, 2016, which contained numerous recommendations. **The department should comment on the implementation of the Forensic Services Workgroup recommendations, the number of individuals currently waiting for placement at State hospitals, as well as how the department intends to improve security staffing levels without the addition of more positions for this purpose.**

Recommended Actions

1. Adopt narrative requesting a report on combining the core service agencies with the local addictions authorities.

2. Add language reducing the provider rate increase to 1% and dedicating the savings to offsetting the projected deficit.

3. Add language reducing the provider rate increase to 1% and dedicating the savings to offsetting the projected deficit.

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

5. Add language reducing the provider rate increase to 1% and dedicating the savings to offsetting the projected deficit.

6. Adopt narrative requesting a report on the adequacy of Medicaid substance use disorder treatment rates.

Updates

Psychiatric Utilization and Capacity in Acute Care Hospitals – Preliminary Results: During the 2016 interim, DLS began studying the impact that psychiatric patients were having on acute general hospitals throughout the State. This issue will discuss DLS's preliminary findings and where this study will focus going into the upcoming interim.

Report on Affordable Housing for Individuals with Severe Mental Illness: A report was submitted in response to a 2016 *Joint Chairmen's Report* request on the availability of affordable housing for individuals with severe mental illness. The report provides information on all of the affordable housing and homeless programming that BHA currently offers, as well as identifies potential barriers to housing for those individuals with severe mental illness.

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 disorders; and those with co-occurring mental illness, substance use, and/or gambling disorder.

In fiscal 2015, funding for Medicaid-eligible services for the mentally ill was moved into the Medical Care Programs Administration (MCPA). Further, in fiscal 2016 funding for substance use disorder (SUD) services was transferred from within MCPA from Program M00Q01.03 to M00Q01.10. However, for the purpose of reviewing the fiscal 2018 budget, the funding that is budgeted in M00Q01.10 is reflected in this analysis.

BHA's role includes:

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

- ***For Substance Use Disorder Services:*** Developing and operating unified programs for 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:*** These programs are 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 2016, a total of 249 recurring prevention programs were offered across the State, a decrease of 35 from the prior year.

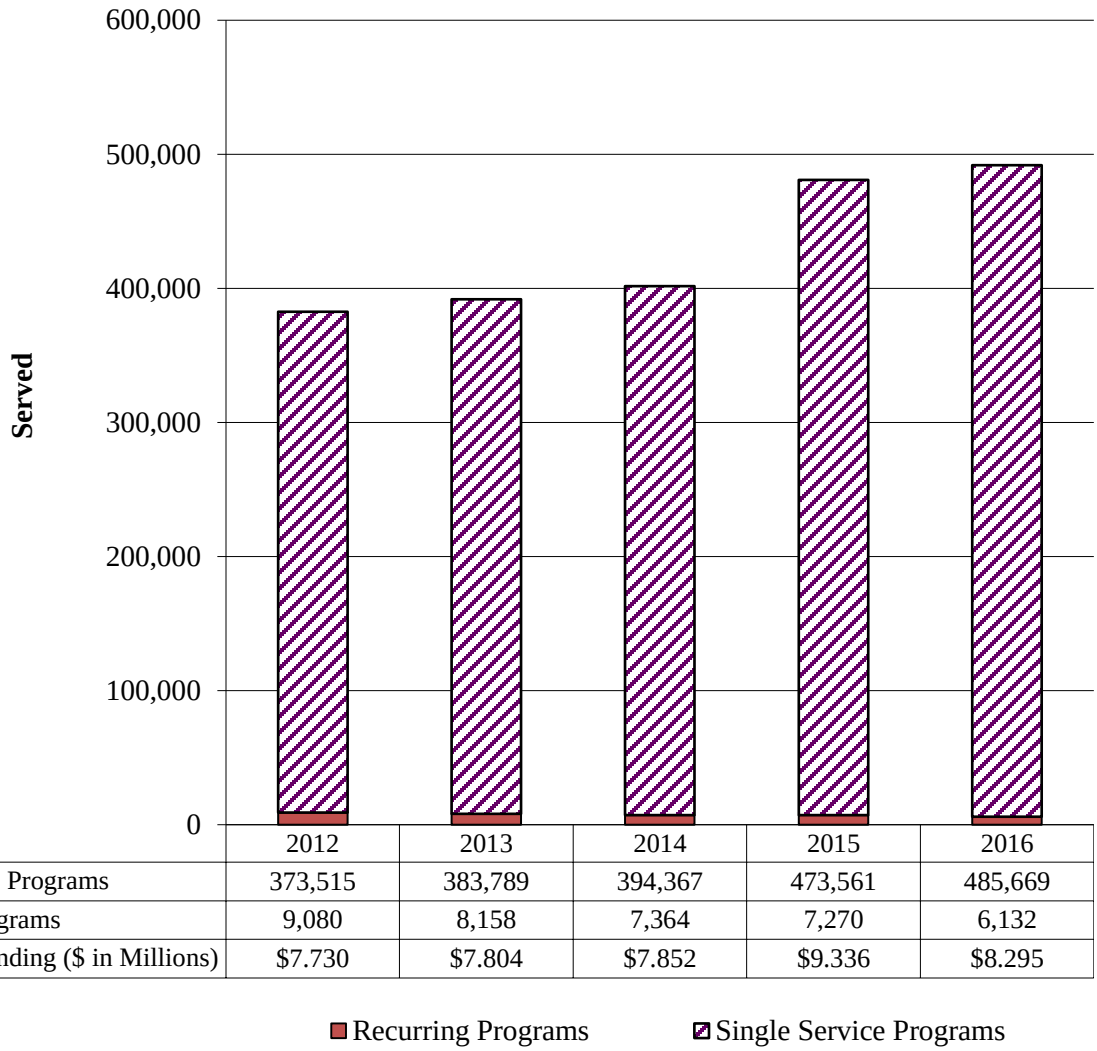
  Statewide, the successful completion rate for these types of programs is reported at 84%, a number that has varied little over the past decade. There is variation by county among programs in terms of successful completion. In fiscal 2016, for example, the successful completion rate varied from 91% in Howard County to 80% in Queen Anne's County. Beyond the counties, however, both Bowie State University and the University of Maryland Eastern Shore had a 100% completion rate for their recurring programs. 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:*** Single service programs include 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 2016, 1,337 single service prevention activities were offered in Maryland, an increase of 43 from the prior year.

As shown in **Exhibit 1**, prevention programming served 491,801 participants in fiscal 2016, 10,970 (2.3%) higher than served in fiscal 2015. Recurring programs continue to see a drop in people served, down 1,138 participants (15.7%) between fiscal 2015 and 2016, continuing the declines experienced in recent years. Conversely, the number of participants served in single service programs grew by 12,108 between fiscal 2015 and 2016, or 2.6%.

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

Exhibit 1
Behavioral Health Administration-funded Prevention Programs
Fiscal 2012-2016



	2012	2013	2014	2015	2016
Single Service Programs	373,515	383,789	394,367	473,561	485,669
Recurring Programs	9,080	8,158	7,364	7,270	6,132
Prevention Funding ($ in Millions)	$7.730	$7.804	$7.852	$9.336	$8.295

Source: Behavioral Health Administration

Prevention funding decreased in fiscal 2016 for the first time since fiscal 2006, mainly due to the expiration of the federal Strategic Prevention Framework State Incentive Grant at the end of fiscal 2015. While BHA has been awarded new funding under the SAMSHA Partnership for Success grant that allows the State to continue and enhance the State's prevention infrastructure and services provided through this program, this new grant amount is only about half of the expired grant amount.

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 Medicaid program during fiscal 2015 and 2016. Fiscal 2015 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 Administrative Service Organization (ASO) as opposed to through the Medicaid Managed Care Organizations (MCO), while fiscal 2016 is the first full year of this arrangement. As seen in the exhibit, almost half of the individuals receiving SUD treatment in fiscal 2015, and more than half in fiscal 2016, 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 had a limited benefit and had a 50% federal fund matching rate. Under ACA, these services are entirely financed by the federal government during both fiscal 2015 and 2016, and individuals receive a full range of benefits. 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 2015-2016

	Fiscal 2015				Fiscal 2016			
Age	**Traditional**	**ACA Expansion**	**Total**	**% Expansion**	**Traditional**	**ACA Expansion**	**Total**	**% Expansion**
0-21	2,642	0	2,642	0.00%	3,829	0	3,829	0.00%
21 and Over	24,205	25,877	50,082	51.67%	32,975	40,121	73,096	54.89%
Total	**26,847**	**25,877**	**52,724**	**49.08%**	**36,804**	**40,121**	**76,925**	**52.16%**
% Adult	90.16%	100.00%	94.99%		89.60%	100.00%	95.02%	

ACA: Affordable Care Act
SUD: substance use disorder

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

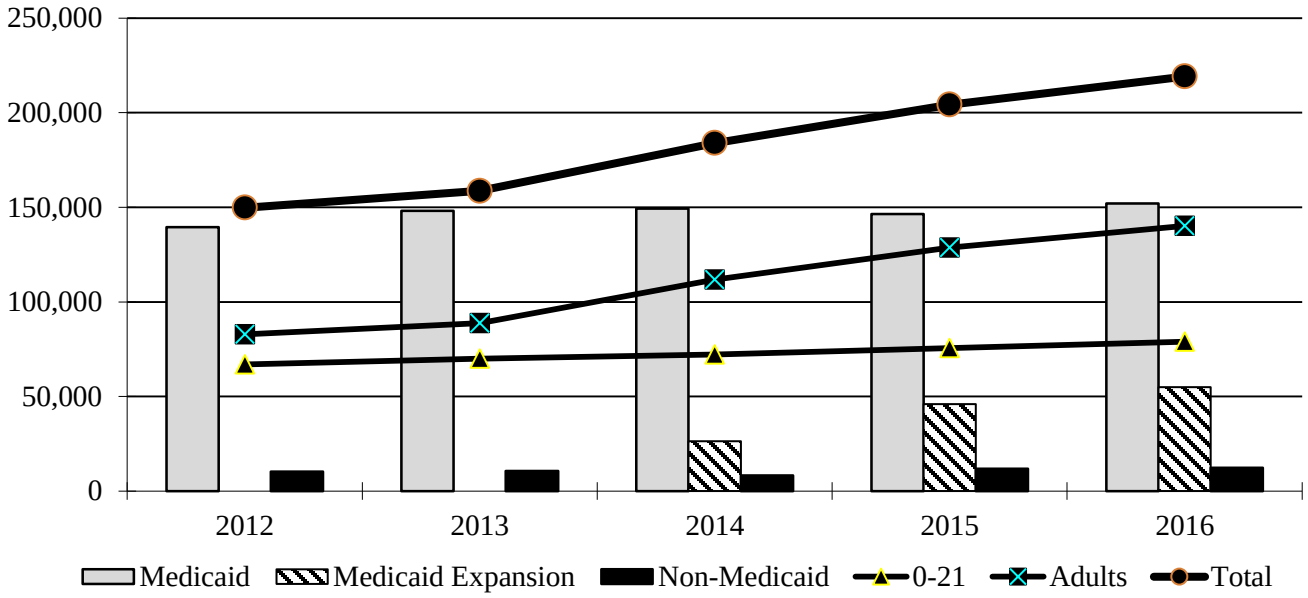
Note: ACA Expansion population includes individuals aged 19 up to 65.

Source: Behavioral Health Administration

3. Community Mental Health Fee-for-service System – Enrollment 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 10.0% between fiscal 2012 and 2016, which is higher than the 7.3% growth between fiscal 2015 and 2016. Interestingly, unlike the Medicaid program as a whole, Medicaid enrollment in Community Mental Health Services did not fall in 2016 indicating that redetermination problems did not appear to have as significant an impact on this population.

Exhibit 3
Community Mental Health Services Enrollment Trends
Fiscal 2012-2016



Note: 2016 data is incomplete.

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

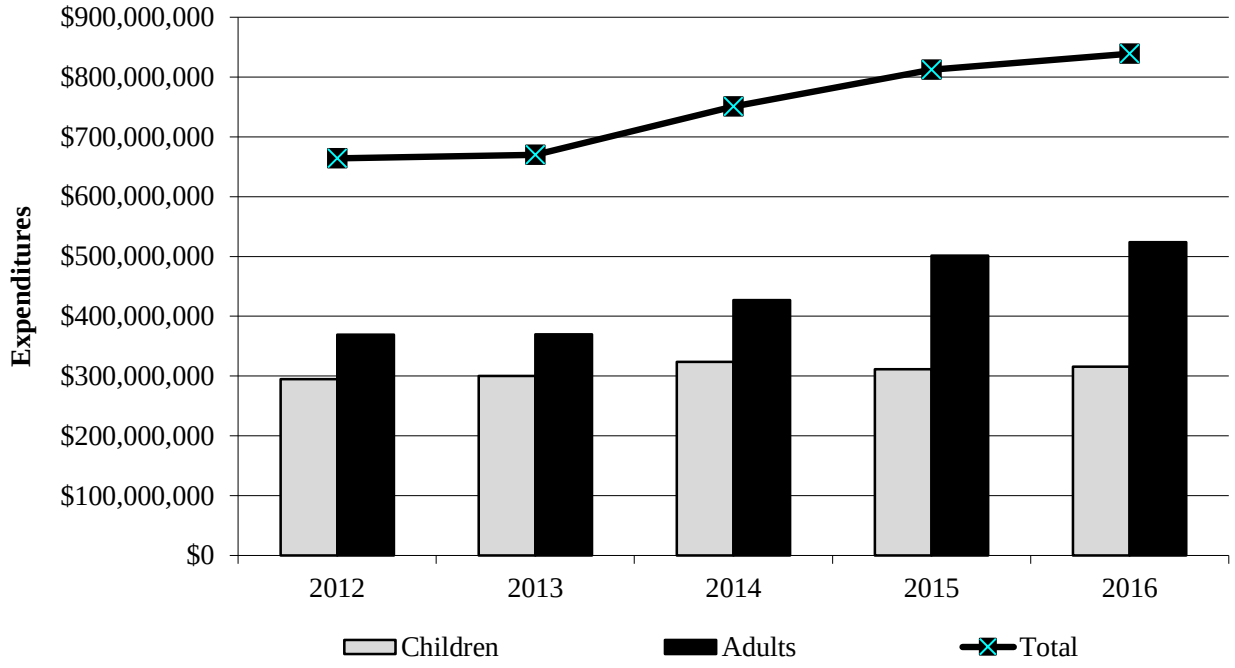
Increases in enrollment continue to be driven primarily by the new ACA expansion population. Enrollment just for this population grew by 19.4% between fiscal 2015 and 2016, compared to growth in the traditional Medicaid enrollment categories of only 3.8% during the same time period. When both populations are blended together, the number of consumers using mental health services with some form of Medicaid coverage increases by 7.5% between fiscal 2015 and 2016. The number of consumers receiving mental health services, who do not have Medicaid coverage, is also increasing by 4.4% over the time period shown, and by 3.9% between fiscal 2015 and 2016.

The exhibit also shows that enrollment growth over this time period has been driven by adults (14.1% between fiscal 2012 and 2016), 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 this time period shown, the number of adults in the program increases by 14.1% while the number of children increases by 4.2%. Adults make up 64.0% of total enrollment in fiscal 2016, compared to 55.3% in fiscal 2012.

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

Expenditure patterns historically mirror enrollment growth (**Exhibit 4**). Average annual expenditure growth over the fiscal 2012 to 2016 period is 7.2%, which is mainly driven by the increasing enrollment, especially for the ACA expansion population, as noted earlier. However, growth between fiscal 2015 and 2016, is 4.0%.

Exhibit 4
Community Mental Health Fee-for-service Expenditures
Fiscal 2012-2016

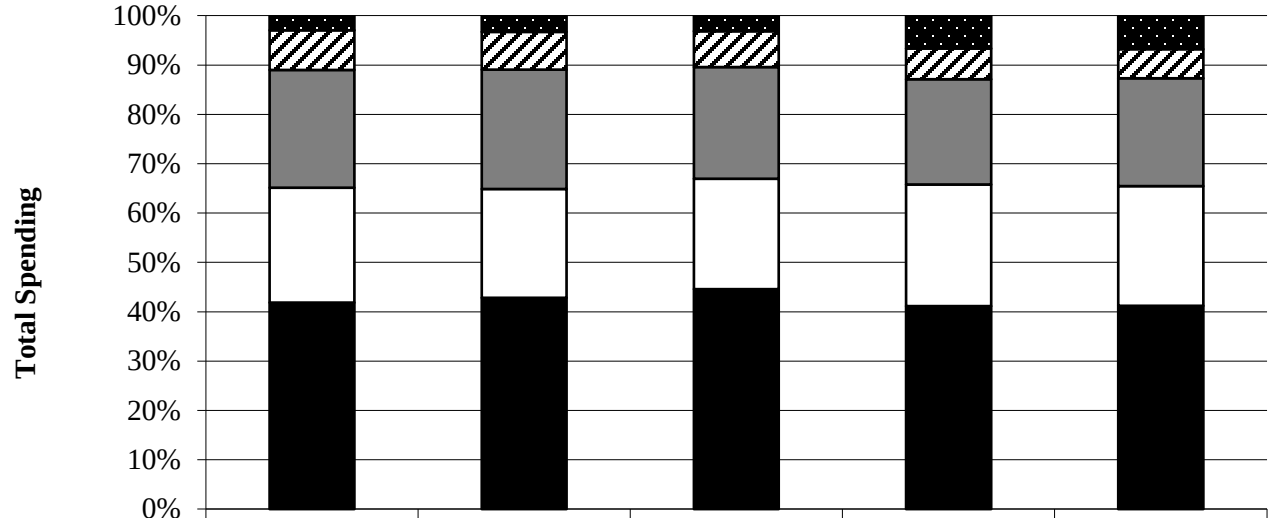


Note: 2016 data is incomplete.

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

Beyond overall expenditure growth, there have also been some changes in expenditure patterns between different services (**Exhibit 5**). All services, with the exception of residential treatment, have expenditure growth between fiscal 2012 and 2016, with the largest increases being in other services, as well as inpatient spending (31.8% and 8.3%, respectively). However, most of the growth in other services is due to changes in the way that Medicaid and BHA are reporting these expenditures, with mobile treatment services now being separated out from traditional outpatient services. The inpatient increase, however, is mostly attributable to the ACA expansion population which, under the old PAC program, did not have access to these services.

Exhibit 5
Community Mental Health Service Expenditures by Service Type
Fiscal 2012-2016



	2012	2013	2014	2015	2016
Other	$19,699,732	$21,588,505	$23,761,643	$56,038,608	$59,478,400
RTC	53,243,697	50,740,960	54,304,385	52,823,755	51,887,521
PRP and RRP	158,366,382	159,771,844	170,161,634	179,882,167	191,997,633
Inpatient	154,515,302	145,656,749	167,598,555	207,982,106	212,500,876
Outpatient	277,934,562	283,015,346	334,820,189	347,611,925	361,808,223

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

Note: 2016 data 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. The data presented in **Exhibit 6** is restricted to clients with at least two data points (generally six months, but up to several years apart) and with the same questionnaire type (*i.e.*, the same age group) for those responses. The data compares the initial interview with the most recent interview and compares results from fiscal 2012, 2013, 2014, 2015, and 2016 cohorts. What is most notable about these trends is that the net improvement in functioning for adults dramatically fell in fiscal 2015. While fiscal 2016 saw an improvement for adults, this is still below the historical levels. This trend was not seen as dramatically in children, but net improvement did decline in fiscal 2016. Data on employment continues to be mixed, for while neither fiscal 2015 nor 2016 saw increases in employment between observations, unemployment overall – within the group – has seen a steady decline.

Exhibit 6
Outcome Measurement System Data
Fiscal 2012-2016

	Reported in 2012	Reported in 2013	Reported in 2014	Reported in 2015	Reported in 2016
Adult Mental Health Outcomes					
Net Improvement in Functioning (Percent of Total Observations)	14.7%	14.3%	14.4%	4.5%	8.1%
Increase in Employment Between Observations	-1.7%	-0.1%	0.4%	-1.5%	-0.6%
Persons Unemployed in Both Observations	63.5%	63.1%	61.5%	59.9%	59.5%
Homelessness in Both Observations	5.5%	5.0%	4.7%	4.6%	3.7%
Children and Adolescents Mental Health Outcomes					
Net Improvement in Functioning (Percent of Total Observations)	15.2%	14.1%	14.6%	14.6%	13.7%

Source: Behavioral Health Administration; Department of Legislative Services

Beyond just data on the mental health population, the ASO has now begun to collect information on those receiving outpatient services with both mental health and SUD conditions. The data presented in **Exhibit 7** is based on the same measurements as the data in Exhibit 6, but instead now shows the metrics for fiscal 2016 for each consumer type by treatment. As seen in the exhibit, the greatest problems are split amongst various populations. Net improvement in functioning is greatest within the co-occurring population at 16.9%, while it is lowest amongst those with only a SUD disorder at 3.7%.

In contrast, homelessness continues to be especially acute for those with a co-occurring disorder at 9.5%. Further, those with a mental health diagnosis are the most likely to be unemployed at 59.5%.

Exhibit 7
Outcome Measurement System Data
Fiscal 2016

Adult Behavioral Health Outcomes	All	MH	SUD	Co-occurring
Net Improvement in Functioning (Percent of Total Observations)	7.7%	8.1%	3.7%	16.9%
Increase in Employment Between Observations	-0.2%	-0.6%	7.3%	3.2%
Persons Unemployed in Both Observations	58.3%	59.5%	42.2%	53.5%
Homelessness in Both Observations	3.8%	3.7%	5.0%	9.5%

MH: mental health
SUD: substance use disorder

Source: Behavioral Health Administration; Department of Legislative Services

Fiscal 2017 Actions

Proposed Deficiency

There are five different deficiencies for BHA, totaling $17,971,397 in general funds and $173,693,400 in total funds. The first two deficiencies are for community services within BHA, beginning with $2.0 million in general funds to augment the State's effort to address the heroin and opioid epidemic. These funds are going to be used to cover the cost of Health – General Article 8-507 treatment placements ($1.5 million) as well as the Opioid Operational Command Center ($0.5 million). The second community services deficiency is $7.0 million to cover the cost of inpatient psychiatric services for the Medicaid-eligible population.

Two additional deficiencies concern BHA institutions. The first is $500,000 to provide funds needed to establish a new 20-bed unit at the Clifton T. Perkins Hospital Center. The second deficiency is $471,397 in general funds and $122,003 in special funds, for a total of $593,400, to provide for operational expenses at the Crownsville Hospital Center. These funds were not provided for last year, because the Department of Health and Mental Hygiene (DHMH) believed that it would be able to dispose of the property during fiscal 2017.

Finally, there is a deficiency of $163.6 million, including $8.0 million in general funds for behavioral health provider reimbursements and contractual services. This is mainly due to increasing enrollment trends that were not predicted last session, especially for the ACA expansion population.

Targeted Reversions

The Governor's budget plan includes one targeted reversion for BHA. This is $2,130,000 in general funds restricted within the Medicaid behavioral health provider reimbursements to be used in order to restore positions that were abolished in the fiscal 2017 allowance due to privatization efforts at the Springfield Hospital Center and the Gildner Regional Institute for Children and Adolescents (RICA). While these functions were subsequently not privatized, positions and funding were taken from other programs within BHA to backfill the positions abolished instead of recreating the positions through the Board of Public Works (BPW). With that action, the Governor has indicated that he will not need to transfer these restricted funds, which will revert to the General Fund at the close of fiscal 2017.

Section 20 Position Abolitions

The fiscal 2017 budget bill contained a section that directed the Executive Branch to abolish 657.0 positions and achieve a savings of $25.0 million, including $20.0 million in general funds and $5.0 million in special funds. This agency's share of the reduction is 0.7 positions and approximately $2.3 million in general funds and $1,000 in special funds.

Proposed Budget

As shown in **Exhibit 8**, after adjusting for fiscal 2017 deficiencies and targeted reversions, as well as fiscal 2018 contingent reductions, the fiscal 2018 allowance for BHA increases by $116.5 million (6.3%) over the fiscal 2017 working appropriation. The majority of this increase ($111.6 million) is tied to increases in FFS community behavioral health services.

Exhibit 8
Proposed Budget
DHMH – Behavioral Health Administration
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2016 Actual	$871,336	$57,913	$776,418	$10,514	$1,716,180
Fiscal 2017 Working Appropriation	912,546	52,236	888,933	7,796	1,861,511
Fiscal 2018 Allowance	961,991	52,465	955,806	7,713	1,977,975
Fiscal 2017-2018 Amount Change	$49,446	$229	$66,872	-$83	$116,464
Fiscal 2017-2018 Percent Change	5.4%	0.4%	7.5%	-1.1%	6.3%

Where It Goes:

Personnel Expenses	
Overtime	$4,439
Miscellaneous salary adjustments	1,231
Eastern Shore psychiatry salaries	896
Clifton T. Perkins Hospital Center reclassification funds	268
Social Security contributions	151
Workers' compensation premium assessment	-364
Employee and retiree health insurance	-832
Pension payments	-1,367
Turnover adjustments	-1,613
Fee-for-service Community Behavioral Health Services	
Enrollment for Medicaid-eligible services	49,641
Applied Behavioral Analysis services transfer from M00Q01.03	31,102
Rate adjustment for community providers (2% increase)	16,233
Regulated rate assumptions	11,374
Cost settlements	4,198
Enrollment for Medicaid State-funded and uninsured mental health services	1,258
Money follows the person	-220
Institutions for Mental Disease funding	-1,949
Community Mental Health Grants and Contracts	
Rate increase for core service agencies	1,143
Decrease in mental health federal grant funds	-1,191

Where It Goes:	
Core Service Agency program reductions	-1,397
Community Substance Use Disorder Services	
Community provider rate increase for uninsured services (2%)	2,853
Problem Gambling Fund	1,732
Fee-for-service expenditures and grants	-388
Federal fund grant changes	-1,106
Program Direction	
PDMP (new special and federal funds)	1,738
Institutions	
Medical care contracts (various)	916
Crownsville deficiency	-593
Eastern Shore psychiatry contract	-1,670
Privatization contract back out	-2,655
Other	2,636
Total	**$116,464**

DHMH: Department of Health and Mental Hygiene
PDMP: Prescription Drug Monitoring Program

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

Across-the-board Reductions

The fiscal 2018 budget bill includes a $54.5 million (all funds) across-the-board contingent reduction for a supplemental pension payment. Annual payments are mandated for fiscal 2017 through 2020 if the Unassigned General Fund balance exceeds a certain amount at the close of the fiscal year. This agency's share of these reductions is $815,660 in general funds, $675 in special funds, and $15,674 in federal funds. This action is tied to a provision in the Budget Reconciliation and Financing Act (BRFA) of 2017.

Personnel

Personnel expenditures for BHA increase the allowance by approximately $2.8 million. The largest increase is $4.4 million in increased overtime expenditures in the allowance. However, this level of anticipated expenditure is still $1.3 million less than the fiscal 2016 actual expenditure level, which totaled $15.3 million. Fiscal 2016 overtime payments were higher than recent historical trends, with the most recent three-year average being $12.9 million. With overall vacancies declining in the current fiscal year as well, this amount of overtime should be adequate to cover the agency's expected need.

The other large increases in personnel costs concern various salary adjustments throughout the administration. Of note, there is an increase of almost $900,000 in salaries for psychiatry positions at the Eastern Shore Hospital Center. These positions have been historically difficult to fill, and the hospital had to contract for psychiatry services. However, at this increased salary level, 3 of the 5 positions have now been filled, with the last 2 positions in active recruitment. There is also an increase of $268,000 for reclassifications at the Clifton T. Perkins Hospital Center in order to staff a new 20-bed unit at the center. This increase is net of the deficiency appropriation provided for this purpose. Further, there is an additional $1.2 million in salary increases due to a combination of hiring various positions above base, as well as the annualization of increment payments from fiscal 2017.

Some large personnel decreases help offset increases in salaries and overtime, in particular an increase in the turnover expectancy from 6.86% to 7.68%, resulting in a decrease of $1.6 million. As stated previously, however, BHA currently has more than enough vacancies to meet this turnover target presently. There are also large decreases for pension payments ($1.4 million), inclusive of the contingent reduction noted above, as well as health insurance payments ($0.8 million).

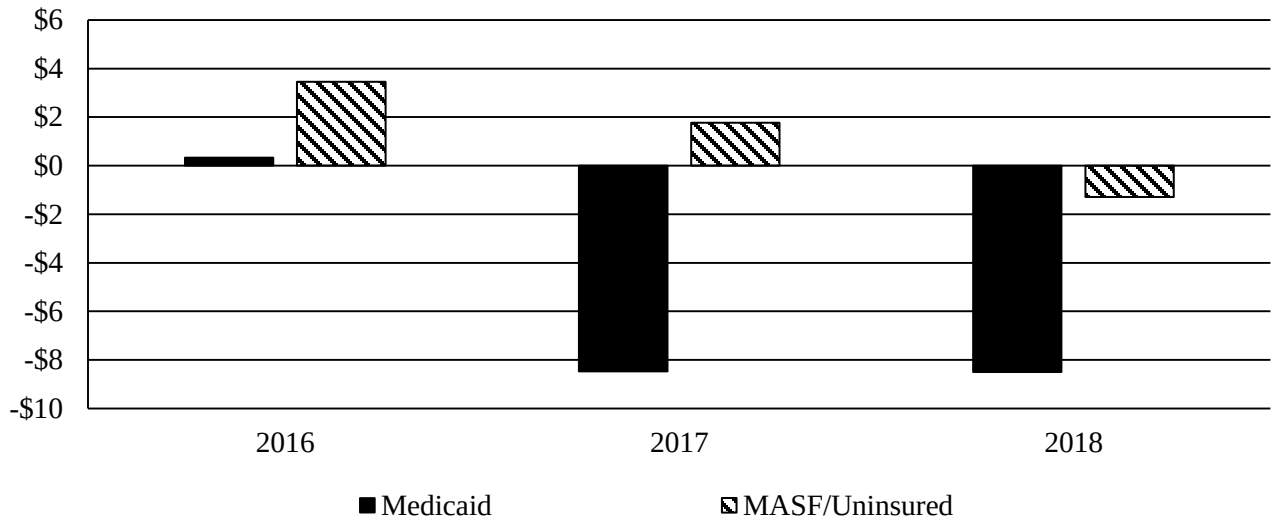
Community Behavioral Health Services

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, increases the fiscal 2018 allowance above the current working appropriation by approximately $111.6 million, accounting for the majority of the change within the overall BHA allowance. The largest change is $49.6 million to account for enrollment and utilization trends, which follows the trends previously discussed. There is also an increase of $31.1 million due to the transfer and annualization of reimbursement for Applied Behavioral Analysis services to ensure compliance with recent federal guidance on the provision of services for children with Autism Spectrum Disorder. Other large increases include $16.2 million for a 2% community provider rate increase, as well as $11.4 million for regulated rate assumptions.

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 9**. Overall, State funding for Medicaid-eligible spending looks to be inadequate in both 2017 and 2018, even after including the fiscal 2017 deficiency of $8.0 million in general funds for Medicaid behavioral health provider reimbursements. Based on recent spending projections for fiscal 2016 and 2017 and using projected enrollment growth, current utilization trends and projected provider rate increases, it appears that the fiscal 2016 budget for behavioral health Medicaid services is slightly overfunded, while both the fiscal 2017 and 2018 budgets appear to be underfunded by $8.5 million in terms of State-support in each fiscal year. This deficit represents a variance from the total amount of State support of 2.2% and 2.1%, respectively.

Exhibit 9
Projected General Fund Balances
Fiscal 2016-2018
($ in Millions)



MASF: Medical Assistance State Funded

Note: Excludes the Baltimore Capitation Project.

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

In contrast, funding for the uninsured as well as State-funded services for Medicaid-eligible individuals looks to be in better shape. Both fiscal 2016 and 2017, after accounting for the $7.0 million general fund deficiency for services rendered at an institution for mental disease (IMD), have projected surpluses of $3.5 million and $1.8 million, respectively, while fiscal 2018 has a projected deficit of $1.3 million. However, the variances for these budgets in fiscal 2017 and 2018, are even smaller than for the Medicaid-eligible spending at 2.0% and 1.4%, respectively. Further, while past spending on IMDs has been capped in recent years, including fiscal 2016, in fiscal 2017 to date, there has not been a cap. Consequently, spending on IMD services has continued to rise in fiscal 2017 above what was experienced in fiscal 2016. To the extent that IMD spending growth continues to climb at the rate currently seen in fiscal 2017, these surpluses could turn into deficits as well.

It is also worth noting that there are two contingent general fund reductions included in the fiscal 2018 budget related to FFS expenditures for the uninsured. In both cases the reduction would be back-filled with special funds: $3.75 million from the Community Health Resources Commission Fund and $1.086 million from the Senior Prescription Drug Assistance Fund. Both transfers are tied to provisions in the BRFA of 2017.

Grants and Contracts – Mental Health

Various grants and contracts for mental health providers decrease by $1.4 million below the current working appropriation, mainly due to the reduction of federal funds. CSA budgets decrease by $1.4 million, mainly in federal funds. This decrease, however, is partially offset by an increase for CSAs of $1.1 million in general funds tied to the 2% community provider rate increase. There is also a reduction of $1.1 million due to the expiration of federal grant funds for various projects, as well as an overall decrease in funds from the Community Mental Health Services Block Grant.

Grants and Contracts – Substance Use Disorders

Overall, grant funding for SUD services increases by $3.1 million, which is mostly due to an increase of $2.8 million tied to the 2% community provider rate increase. There is also an increase of $1.7 million in special funds for the Problem Gambling Fund due to the opening of the new casino in Prince George's County, as well as the assumption that funds reserved for treatment will be rolled over to fiscal 2018. These funds, however, could be used for SUD treatment services in fiscal 2017, if desired. **The department should comment on the rationale for rolling the funds over as opposed to spending them on other authorized treatment services.**

These increases are offset by some decreases, including the loss of $1.1 million in federal funds under the Substance Abuse Prevention and Treatment Block Grant. While funding remains mostly flat absent the provider rate increase, it should be noted that all of these increases are net of the deficiency, all increases undertaken based on the recommendations of the Heroin and Opioid Emergency Task Force, as well as transfers for treatment restricted by the General Assembly. More information on these funding enhancements can be found in Issue 1.

There is also one major increase in the Program Direction section of the budget, which is tied directly to the State's efforts to combat heroin and opioid use disorders, which is $1.7 million for the Prescription Drug Monitoring Program (PDMP). This enhancement is entirely due to new special and federal funds that are available to increase the services offered by the PDMP.

Institutions

Funding for the State-operated hospital centers and facilities, beyond changes in personnel expenditures, decreases by $4.0 million below the current working appropriation. Most of this decrease is due to the difference in the operating costs of the dietary and housekeeping functions at the Springfield Hospital Center and the dietary function at RICA – Gildner being staffed by State employees as opposed to being contracted out to private companies. Since the personnel funds were transferred from other programs, those costs were mainly flat. The difference, however, between

the privatization contracts and the general operating costs for these functions decreases the allowance by $2.7 million.

Other major changes include a decrease of $1.7 million for contractual psychiatric services at the Eastern Shore Hospital Center, which was previously discussed, as well as an increase of $0.9 million for offsite medical care contract costs across the various State hospitals.

One other change worth noting is that, despite the deficiency, there is no funding for security or utilities at the now closed Crownsville Hospital Center. If the State is unable to dispose of this property in fiscal 2018, there will have to be an additional deficiency appropriation, similar to this year, to cover the cost of securing and maintaining this property. **The department should comment on its future plans for the Crownsville Hospital Center and if it is actually feasible that the State would not have to maintain this property from the beginning of fiscal 2018.**

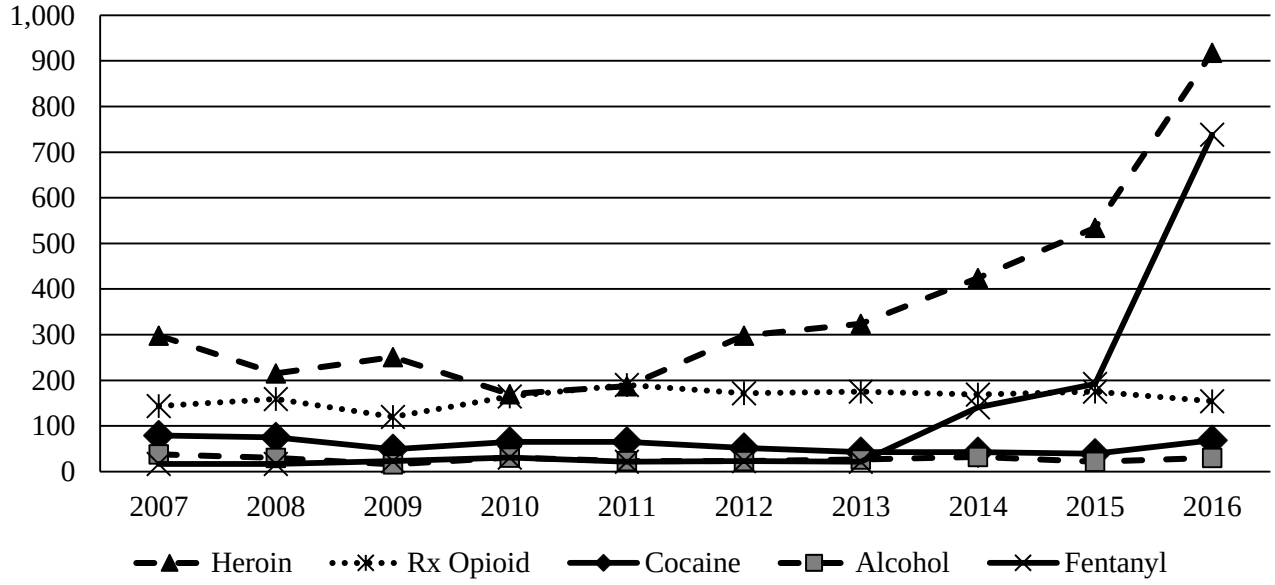
Issues

1. The Heroin and Opioid Epidemic – The Rise of Fentanyl

Opioid use and overdose continues to be a serious and urgent public health issue. As seen in **Exhibit 10**, since 2007, opioids, including heroin, prescription opioids, and fentanyl have been involved in the majority of the State's overdose deaths, with deaths related to fentanyl drastically increasing from 2014 through 2016. In fact, 2016, on a January through September year-to-date basis, is the highest year for overdose deaths in the time period shown, mainly due to the dramatic rise in fentanyl-related deaths, as fentanyl has become more prevalent.

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 10
Overdose Death by Related Substance
January to September 2007-2016*



Rx: medical prescriptions

* 2016 counts are preliminary.

Note: Cocaine, Rx opioid, and alcohol deaths are only those that were not in combination with heroin and/or fentanyl.

Source: Department of Health and Mental Hygiene

Inter-Agency Heroin and Opioid Coordinating Council

In February 2015, the Governor issued two executive orders establishing the Governor's Inter-Agency Heroin and Opioid Coordinating Council and the Heroin and Opioid Emergency Task Force to establish a coordinated statewide and multi-jurisdictional effort to prevent, treat, and significantly reduce heroin and opioid abuse.

In December 2015, the task force submitted a final report that contained 33 final recommendations, 10 interim recommendations, and 10 resource allocations. Of the final 33 recommendations, 8 related to expanding access to treatment; 5 related to enhancing quality of care; 2 related to boosting overdose prevention efforts; 6 related to escalating law enforcement options; 6 related to reentry and alternatives to incarceration; 4 related to promoting education tools for youth, parents, and school officials; and 2 related to improving State support services. In August 2016, the council submitted a mid-year report to the Governor that focused on the recommendations contained in the task force's final and interim reports. As for expanding access to treatment, among other initiatives, BHA has implemented a statewide buprenorphine access expansion plan, and the Governor's Office of Crime Control and Prevention (GOCCP) funded 11 reentry medication assisted treatment Vivitrol programs.

Joint Committee on Behavioral Health and Opioid Use Disorders

Chapter 464 of 2015 established the Joint Committee on Behavioral Health and Opioid Use Disorders, comprised of five senators and five delegates, to oversee the State's PDMP and State and local programs to treat and reduce opioid use. The joint committee is required to monitor the activities of the Governor's Inter-Agency Heroin and Opioid Coordinating Council and 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.

During the 2016 interim, the joint committee received briefings from the Department of Public Safety and Correctional Services (DPSCS) and DHMH on the removal of Suboxone film from the Medicaid pharmacy preferred drug list. The action was controversial among providers who argued that such removal disrupts the clinical care of patients. A reason stated for the removal was because of the smuggling of the product into prisons. The joint committee also received briefings from the Governor's Inter-Agency Heroin and Opioid Coordinating Council on DHMH's Opioid Treatment Workgroup work plan and on the feasibility and desirability of analyzing prescription drug monitoring data.

DHMH Overdose Prevention Strategy

DHMH established an overdose prevention strategy with the goals of improving epidemiology and strategic planning, providing naloxone training and distribution, reducing prescription opioid misuse and inappropriate prescribing, and targeting outreach to high-risk individuals for treatment and recovery support services through programs such as:

- ***Overdose Response Program:*** In December 2015, a statewide standing order was issued that allows all Maryland pharmacists to dispense naloxone without a prescription to anyone trained and certified under the Overdose Response Program. The program has authorized 58 organizations to conduct naloxone trainings and issue certificates, including local health departments, SUD programs, community organizations, and law enforcement agencies. Since March 2014, over 34,000 individuals have been trained, over 38,000 doses of naloxone were dispensed, and 1,181 administrations were reported.

- ***Prescription Drug Monitoring Program:*** Chapter 147 of 2016 requires all Maryland-licensed prescribers and pharmacists to register with the PDMP by July 1, 2017. The PDMP helps providers identify patients who may be misusing opioids and other prescription drugs by providing real-time, online access to their patients' controlled substance prescription history. Beginning in 2018, providers will be required to use the PDMP before prescribing opioids or benzodiazepines, a group of sedative medications that present significant overdose risks particularly when prescribed and used in combination with opioids.

- ***Local Overdose Fatality Review Teams:*** Local overdose fatality review teams are multi-agency/multi-disciplinary teams assembled at the jurisdictional level to conduct confidential reviews of overdose deaths. The goals of the teams are to prevent future deaths by identifying missed opportunities for prevention; build working relationships with local stakeholders; and recommend policies, programs, and laws to prevent overdose. DHMH provides data and technical assistance to the 18 teams. Teams have found that decedents have had significant contact with government systems, alcohol is often involved, older drug users are at high risk due to co-occurring chronic health issues, care coordination needs improvement, and there is often an occurrence of trauma just before death.

- ***Opioid Misuse Prevention Programs in Local Jurisdictions:*** Funds are provided to 22 jurisdictions to strengthen and enhance their local overdose prevention plans through data, analysis, strategic planning, and implementation of evidence-based opioid misuse prevention strategies.

- ***Overdose Survivors Outreach Program:*** The Overdose Survivors Outreach Program is an initiative to improve health outcomes for overdose survivors or those at risk for overdose by collaborating with hospitals and local health departments to facilitate interventions by peer recovery specialists in the emergency department. As of August 2016, four hospitals in Baltimore City and two hospitals in Anne Arundel County are participating in the program;

130 individuals have been referred to treatment through peers and 40% of survivors have been engaged in treatment.

- ***Screening, Brief Intervention, and Referral to Treatment:*** DHMH is expanding access to Screening, Brief Intervention, and Referral to Treatment (SBIRT), an evidence-based tool used to identify individuals with the potential for substance abuse and provide medical and behavioral intervention. Funded through a five-year federal grant, SBIRT will be implemented in 53 community primary care centers and two hospital emergency departments in 15 jurisdictions with the expectation of screening at least 90,000 primary care patients to identify and intervene with at-risk behaviors. Additional private funding has positioned the State to expand SBIRT to adolescent primary care patients in selected clinics and several college and university health care settings.

- ***Fentanyl Awareness:*** DHMH has filmed a public service announcement in partnership with Maryland Public Television that is being broadcast on stations throughout the State. Pocket-size cards, describing the dangers of fentanyl and recognizing the signs of an overdose have been sent to all local health departments.

- ***Family Support Navigation System:*** In partnership with the Maryland Coalition of Families, BHA is implementing a Family Support Navigation System to empower and inform families caring for youth, adolescents, and young adults facing challenges related to substance use. The goal is to connect families to peers who have experience coping with substance-related behaviors and are trained to connect families to recovery support services in their communities that promote improving quality of life, preventing relapse, and sustaining recovery.

Federal Comprehensive Addiction and Recovery Act of 2016

In July 2016, President Barack H. Obama signed the Comprehensive Addiction and Recovery Act (CARA), which authorizes over $181 million each year in new funding and is the first major federal substance use legislation in 40 years. Specifically, the CARA:

- expands office-based treatment by allowing nurse practitioners and physician assistants to prescribe buprenorphine for opioid use disorders;

- requires that office-based treatment practitioners have the capacity (including necessary training) to either provide directly, or by referral, all drugs approved by the Food and Drug Administration for the treatment of opioid use disorder;

- authorizes grants to opioid treatment programs and practitioners who offer office-based medication assisted treatment to expand access to naloxone through co-prescribing;

- reauthorizes funding for the National All Schedules Prescription Electronic Reporting Act for states to improve or maintain a prescription drug monitoring program;

- directs the U.S. Secretary of Health and Human Services to develop recommendations regarding education programs for opioid prescribers;

- authorizes grants to states to expand evidence-based medication assisted treatment in areas with high rates of opioid and heroin use;

- authorizes grants to state SUD agencies to carry out pilot programs for nonresidential treatment of pregnant and postpartum women; and

- authorizes grants to states to implement integrated opioid abuse response initiatives, including expanding availability of medication assisted treatment and behavioral therapy for opioid use disorder.

While this legislation has increased the funding opportunities available to states for SUD treatment, the overall amount of federal funding is declining in the State budget for this purpose. At this time, there appears to be no new federal grants added to the fiscal 2018 allowance tied to the CARA. **The department should comment on what strategies it is pursuing in order to take advantage of the new federal funding opportunities available due to the passage of this legislation.**

Justice Reinvestment and Residential Treatment Options

Chapter 515 of 2016, the Justice Reinvestment Act, generally implemented the various recommendations of the Justice Reinvestment Coordinating Council by altering provisions relating to sentencing, corrections, parole, and offender supervision. One of the provisions of this Act related to the court-ordered treatment provisions of the Health – General Article and, in particular, the time it takes to place someone into treatment under Section 8-507. The law changed the placement provision from "prompt placement" to 21 days. In recognition of the fact that this provision would necessitate an increase in the number of beds provided and funded by the State, the Governor included $3 million in a supplemental budget for these treatment services in fiscal 2017.

In response to the supplemental appropriation, the 2016 *Joint Chairmen's Report* (JCR) requested that DHMH, in conjunction with the Judiciary, submit a report on the alternatives to residential treatment that could be provided under the Section 8-507 order, including the appropriateness of utilizing recovery support housing in conjunction with outpatient services to meet the needs of those individuals committed to DHMH. The reports were submitted by DHMH on January 20, 2017, and by the Judiciary on January 23, 2017.

In the reports, both DHMH and the Judiciary note that the level of appropriate treatment for the placements are determined by the Health – General Section 8-505 evaluation that must take place prior to the commitment. Both agencies agree that the least restrictive alternative should govern the level of placement for SUD treatment commitment. However, it should be noted that the Judiciary in its commentary noted that the definition of least restrictive alternative should be fully consistent with clinical appropriateness as well as public safety considerations, and that an overreliance on a supportive housing or recovery housing model might damage sentencing confidence and undermine the

overarching goal of encouraging viable treatment alternatives to incarceration. This was not mentioned in the DHMH report as being a factor, as DHMH noted that their evaluations are based on the appropriate level of care as directed by the American Society of Addiction Medicine criteria. **The department should comment on the extent to which public safety considerations are included in the Health – General Section 8-505 evaluation process.**

Targeted Funding to the Opioid Crisis

In addition to all of the programs and changes that have already been mentioned, there have also been specific appropriations provided that directly address the heroin and opioid crisis. **Exhibit 11** provides detail on the various funding enhancements that have been undertaken in direct relation to the heroin and opioid epidemic since fiscal 2016. Starting with the fiscal 2016 budget, the General Assembly, through Section 48 of the budget bill, restricted $2 million to be used to expand SUD treatment targeted at individuals with a heroin use disorder. This funding was subsequently transferred in accordance with the restriction by the Governor and allocated based on the recommendations of the Heroin and Opioid Emergency Task Force in the first interim report.

Exhibit 11
Funding Targeted to the Heroin and Opioid Crisis
Fiscal 2016-2018

	2016	2017	2018
Department of Health and Mental Hygiene			
General Assembly Withheld Allotment for Treatment (Section 48)	$2,000,000	$2,000,000	$2,000,000
General Assembly Withheld Allotment for Treatment (Center of Excellence and Screening)	0	1,100,000	1,100,000
Supplemental Budget Funding for Court-ordered Treatment (Section 8-507)	0	3,000,000	3,000,000
Opioid Deficiency (for Court-ordered Treatment and Opioid Operational Command Center)	0	2,000,000	2,000,000
Implementing a Good Samaritan Law Public Awareness Campaign	0	697,653	697,653
Providing Recovery Support Specialists to Assist Pregnant Women with Substance Use Disorders	0	622,622	622,622
Requiring Mandatory Registration and Querying of the Prescription Drug Monitoring Program	0	522,245	522,245
Implementing a Statewide Buprenorphine Access Expansion Plan	0	206,480	206,480

	2016	2017	2018
Expanding Online Overdose Education and Naloxone Distribution	0	10,000	10,000
New Funding for Prescription Drug Monitoring Program (Special and Federal Funds)	0		1,974,592
Subtotal	***$2,000,000***	***$10,159,000***	***$12,133,592***
Governor's Office of Crime Control and Prevention			
Day Reporting Center	$0	$540,000	$270,000
Safe Streets	0	180,000	180,000
Subtotal	***$0***	***$720,000***	***$450,000***
Department of Public Safety and Correctional Services			
Outpatient Addictions Aftercare at the Metropolitan Transition Center	$0	$358,000	$358,000
Expand the Segregated Addictions Program at the Maryland Correctional Training Center	0	138,000	138,000
Subtotal	***$0***	***$496,000***	***$496,000***
State Police			
Multi-jurisdictional State Police Heroin Investigation Unit	$0	$200,000	$200,000
Designating HIDTA the Central Repository for Maryland Drug Intelligence	0	75,000	75,000
Subtotal	***$0***	***$275,000***	***$275,000***
Maryland State Department of Education			
Local School Websites to Promote Drug and Heroin Awareness	$0	$100,000	$100,000
Department of Juvenile Services			
Screenings	$0	$0	$50,000
Grand Total	**$2,000,000**	**$11,750,000**	**$13,504,592**

HIDTA: High Intensity Drug Trafficking Area

Source: Behavior Health Administration

In fiscal 2017, the Governor included $4.75 million for items recommended by the Heroin and Opioid Emergency Task Force, including $3.06 million in BHA for various initiatives. This funding was approved by the General Assembly as requested, with the exception of $1.1 million for a Center of Excellence on Heroin and Opioid Issues that was to be used to set up a research arm that would support the Behavioral Health Advisory Council. This funding was restricted by the legislature to instead be used for the purpose of funding an expansion of the current level of SUD treatment services. The Governor subsequently agreed to this transfer as well. This was all in addition to the $3.0 million for residential treatment services for court-ordered commitments, which was previously mentioned.

For the 2017 session, the Governor has included a $2.0 million deficiency appropriation for heroin and opioid treatment for fiscal 2017. This funding will be split to fund additional Section 8-507 beds ($1.5 million), as well as the Opioid Operational Command Center ($0.5 million), which will be discussed in more detail later. For the Section 8-507 beds, this level of funding will increase bed capacity in fiscal 2017 from 180 to 240. All of these aforementioned funding enhancements have been maintained in the fiscal 2018 allowance for BHA. Further, in December 2016, the State received a new federal waiver through the Medicaid program to receive federal reimbursement for up to two 30-day stays in residential treatment services per year per eligible enrollee. While no new funding has been included to date for this program, DHMH anticipates that it can leverage an additional federal dollar for every State dollar that it spends on this service, which is currently budgeted for $32.9 million in fiscal 2018. Further, the number of residential treatment beds available for Section 8-507 commitments and other individuals will be 720 in fiscal 2018.

Beyond treatment, the State has also expanded the PDMP, some of which was done in response to the Heroin and Opioid Emergency Task Force recommendations. Beyond those enhancements, for fiscal 2018, there is an additional $250,000 in new special funds and $1.7 million in new federal funds for the PDMP and related programming. All told, there is at least $12.1 million that is directly attributable to the heroin and opioid crisis within the fiscal 2018 DHMH allowance that is either new or enhancements that have been carried over from the prior years, beginning in fiscal 2016, as displayed in Exhibit 11.

Beyond DHMH, there are some enhancements in other programs and agencies. In the fiscal 2018 allowance the Department of Juvenile Services (DJS) is allocated $50,000 for heroin and opioid screening. DJS's overall SUD funding for fiscal 2018 is $1.63 million. In fiscal 2016, DJS identified 35 youth as opioid-dependent out of the entire DJS population, while all drug offenses combined (including distribution), accounted for only 5% of total intake cases. DJS has established diversion programs that utilize Medicaid funds to connect kids to services without formalizing the cases. This has the added benefit of leveraging more funds beyond just general funds.

There is also funding within the GOCCP fiscal 2018 allowance. The Day Reporting Centers are budgeted for $270,000, which is a pilot program recommended by the Heroin and Opioid Emergency Task Force. In fiscal 2017, the appropriation was $540,000. The Maryland Safe Streets program also funds heroin coordinators in 17 counties and one at the Maryland State Police. The appropriation for fiscal 2018 is the same as fiscal 2017 at $4.6 million. This program is also open for applicants to apply for any heroin and opioid-related programs.

The DPSCS fiscal 2018 allowance includes $138,000 for a segregation addictions program and $358,000 for transitioning inmates to outpatient addictions aftercare. This is consistent with what was added by the Administration in fiscal 2017. Finally, some funding has also been included in the Maryland State Police as well as the Maryland Department of Education for programming that was also recommended by the task force.

Altogether, funding specifically targeted to the opioid crisis is $13.5 million in the fiscal 2018 allowance. However, this would represent only about 2.5% of the amount of spending that BHA spends on the treatment of SUD patients as a whole. This fiscal 2018 allowance includes $377.2 million in Medicaid provider reimbursements for all SUD treatments, as well as an additional $160.9 million in either FFS payments or grants for treatment to the uninsured or for treatment that is not reimbursable by Medicaid. While all of this treatment funding is not for those with a heroin or opioid use disorder specifically, the most recent data provided by BHA indicates that consumers with heroin or opioids as their primary SUD condition make up the majority of those individuals receiving State-supported treatment.

Moving Forward – New Legislation and Other Issues

In January 2017, the Governor announced the 2017 Heroin and Opioid Prevention, Treatment, and Enforcement Initiative, which includes the formation of the statewide Opioid Operational Command Center. This center is designed to allow for better coordination between the various State and local agencies that are all affected by the epidemic. In addition to the center, the Governor also announced three new pieces of legislation that he would propose to the General Assembly this session. The first, and to date, the only one to be introduced in both houses, is the Distribution of Opioids Resulting in Death Act (SB 539/HB 687), which seeks to create a new felony, punishable by up to 30 years, for individuals who distribute an opioid or opioid analog, the use of which causes the death of another.

At the time of writing, the other pieces of legislation have only been introduced in the House. This includes the Prescriber Limits Act (HB 1432), which would seek to limit the duration of prescription opioids prescribed upon the initial consultation or treatment to a seven-day supply, with certain exceptions. The other bill is the Overdose Prevention Act (HB 1549), which will seek to authorize local fatality review teams to review nonfatal overdose data in addition to the fatal overdose data that they currently review, and allow the Office of Controlled Dangerous Substances Administration within DHMH to take action on the controlled dangerous substance registration of a prescriber or dispenser of these substances based on investigations of the federal Drug Enforcement Administration or a State professional licensing board.

In addition to these Administration proposals, there have been multiple bills introduced by various legislators surrounding a number of issues concerning heroin and opioid use disorders. The topics of these bills range from recovery housing regulations, to new treatment programs in hospitals, to further changes in the naloxone program that will increase the availability of this important overdose reversal drug even more so than it is today, to increasing rates for behavioral health providers.

One of the recommendations from the Heroin and Opioid Emergency Task Force that is currently underway is a review of Medicaid and other rates provided to SUD treatment providers. This recommendation was based on the fact that the State budget, at the time, had not included a substantial rate increase for these providers in over 10 years. The report stated that making sure that these rates are adequate is considered very important for the treatment community since they need to attract more physicians to the field of SUD treatment at a time when practitioners are in high demand. Without attracting a more thriving workforce and expanded capacity, it was unclear how the availability of the treatment options provided would be able to adequately expand to meet the current demand. However, as of this writing, the review underway is only a comparison of rates with surrounding states, not a review of rate adequacy. **DLS is recommending committee narrative on the adequacy of SUD treatment rates.**

2. Behavioral Health Integration – Furthering Financial and Oversight 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 Mental Hygiene Administration and the Alcohol and Drug Abuse Administration 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, 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 with year three of the contract, DHMH is supposed to employ appropriate Healthcare Effectiveness Data and Information Set (HEDIS) measures in order to track the performance of the ASO against other states. There are seven measures, six of which are 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 was 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. However, DHMH has reported that the ASO was unable to meet the required HEDIS deliverables, as the ASO did not have access to the necessary somatic data. While the ASO indicated that it would require access to all Medicaid claims data, DHMH only provided a more limited data set. The ASO indicated it was not comfortable working with the limited data set. At this time, the ASO has recommended that DHMH waive the liquidated damages associated with the performance measures and is awaiting further guidance from DHMH on this request. DHMH has indicated that they are also considering the possibility of utilizing alternative metrics that the ASO would have access to in order to further evaluate the ASO's performance. **The department should provide an update on what metrics they are considering and why the HEDIS metrics were included in the initial contract if measurement against these metrics was not going to be feasible.**

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 created a significant change in the way in which SUD services for the uninsured

are delivered throughout the State. Previously, these services were provided on a grant-based system through the Local Addictions Authorities (LAAs), who then either provided the services themselves or contracted with other providers. With the transition of Medicaid-reimbursable SUD services from the MCOs to the ASO, the SUD grants for the uninsured were the only treatment funds which were 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 is now going through a transitional process whereby most services are being transferred to FFS over a span of a couple of years. After a year of working with each LAA to prepare them for the process, BHA began moving SUD ambulatory services to FFS, with all services transferred by January 1, 2017. 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 $21.4 million, and will be funded utilizing the Cigarette Restitution funds that BHA receives. Furthermore, in anticipation of the new federal waiver previously mentioned for SUD residential treatment, these services will be transitioned to FFS under the ASO on July 1, 2017. This will now mean that a majority of the treatment dollars in the system for both State-funded and uninsured services will now be financed on a FFS basis. Even after these transfers, about $50.5 million will remain for grants to the LAAs to fund treatment services that are not currently reimbursable by Medicaid or are not included under the State-funded treatment regime for Medicaid-eligible individuals, such as some recovery services as well as peer and family supports. This is in comparison to the almost $67.0 million that the CSAs receive for similar services and programming for individuals with a severe mental illness.

Oversight Entities Still Separate

Now that the specific treatment dollars have been split out from the other grant funding, the last vestige of a separate system remains the local entities that help oversee the Public Behavioral Health System: the CSAs and LAAs and the State funding streams for these entities. While some CSAs and LAAs have combined into a single entity, with the notable example of Baltimore City, the vast majority of these entities are still separate throughout the State. To the extent that these entities still provide some services, they are receiving separate streams of funding to support separate programming for separate individuals. Some coordination has been taking place among the entities, most notably the fact that they have formed a unified association where representatives from each CSA and LAA meet to discuss issues and coordinate efforts. However, as long as there remain separate entities with separate funding streams, this can create a situation where an individual with a co-occurring disorder may have to switch treatment providers or go to separate providers in order to maintain their access to the treatment services that are funded through the grant based system. **DLS is recommending the adoption of committee narrative that requests BHA and DHMH to study the issue of combining LAAs and CSAs into integrated Behavioral Health Authorities and report back to the General Assembly with their recommendations.**

3. Forensic Services – Improving the Throughput of the System

BHA operates an Office of Forensic Services (OFS) that interacts with criminal courts in the State to respond to certain forensic issues set forth in various sections of Title 3 of the Criminal Procedure Article and Title 8 of the Health – General Article.

Subject to Sections 3-105 and 3-111 of the Criminal Procedure Article, OFS is responsible for evaluating defendants' competency to stand trial and their criminal responsibility for the crimes with which they are charged. OFS contracts with forensic evaluators in every jurisdiction to conduct these evaluations. While a majority of the cases require no further evaluation, some cases require further assessment, in which the defendant is referred to a State facility, or result in a commitment to a State facility for treatment pursuant to Sections 3-106(b) or 3-112 of the Criminal Procedure Article. In addition, Sections 8-505, 8-506, and 8-507 of the Health – General Article require DHMH to conduct certain court-ordered evaluations to determine whether a defendant is in need of and may benefit from certain substance use treatments and authorize a court to commit a defendant to DHMH for inpatient evaluation or treatment for substance use under certain circumstances.

In 2016, it became clear that DHMH lacked the adequate bed space or other additional capacity to receive people committed to DHMH under the Criminal Procedure Article. Numerous contempt hearings were held in Baltimore City and Prince George's County where officials from DHMH and OFS, including the Secretary of Health and Mental Hygiene, were asked why State hospitals were too full to accept any new patients and why the hospitals were turning away patients and forcing them to remain incarcerated in violation of the law. In a letter to the Judiciary in April 2016, the Secretary of Health and Mental Hygiene identified the bed shortage and inability of DHMH to admit patients in a timely manner as a crisis for DHMH, and the Secretary committed to resolve the issue as quickly as possible.

Forensic Services Workgroup

In order to begin resolving the issue, and to address stakeholder concerns regarding significant delays associated with court-involved individuals navigating the State's forensic system of care, the Secretary of Health and Mental Hygiene convened a Forensic Services Workgroup. The workgroup, composed of community stakeholders (including representatives from the Judiciary, prosecutors, public defenders, community providers, consumers, and advocates for individuals with mental illness), was asked to address various longstanding issues with the forensic system of care, including (1) the lack of availability of State hospital beds to complete court-ordered forensic evaluations as well as to honor court commitments within statutory time requirements; (2) the length of time that it takes for individuals assessed as ready for release following their commitment by the courts to return to court for disposition; (3) appropriate placement of incarcerated individuals ordered for evaluation and assessed, but not yet adjudicated as incompetent; and (4) the impact on State facility staff from State hospitals' census consistently being at or above maximum capacity, managing a predominately forensic patient population, and not being staffed or compensated based on a "forensic" classification.

The workgroup met on four occasions and issued a final report on August 31, 2016, which contained numerous recommendations, including:

- increasing bed capacity within DHMH, including the immediate opening of 24 inpatient hospital beds to address the current backlog of court-committed individuals, the rapid creation of 24 "step-down" beds within the existing DHMH infrastructure, expedited contracting with community-based hospitals to use private-sector psychiatric beds, and an expedited reassessment of actual bed needs;

- increasing availability of community crisis services, including an immediate statewide assessment of currently available crisis services, a rapid determination of which active crisis services programs are most effective in responding to crises in a way that minimizes entry and reentry into the criminal justice system, and expedited funding support through budget reallocation as well as additional budget allocations to the most effective programs;

- expanding the capacity of OFS, including an immediate increase in the number and efficiency of forensic services staff, a rapid restructuring of DHMH chain of command to fully integrate the management, delivery of services, and reporting of findings to the court under OFS, and an expedited review of newly generated data to determine where to place existing resources and evaluate the need for additional resources;

- increasing outpatient provider capacity to meet the needs of forensic patients, including an immediate increase in support to existing providers who already accept forensically involved patients, the rapid assessment of outpatient provider reimbursement structure, and the expedited increase of rates of reimbursement and the types of services that are reimbursable;

- centralizing DHMH's forensic processes, including the immediate centralization of all processes related to the delivery of forensic services, the rapid reassessment and reclassification of staff at all State hospitals to a forensic classification, and the expedited implementation of salary and staffing changes; and

- increasing education to reduce stigma in both the general public and the mental health treatment community, including the immediate inclusion of anti-stigma education for providers who receive training to treat forensically involved patients, the rapid development and expansion of public anti-stigma educational programs, including the use of crisis intervention training for police and first responders, and the expedited inclusion of anti-stigma educational funding in the next budget cycle.

DHMH, BHA, and OFS have taken numerous steps to address some of the recommendations, which were presented to several legislative committees at a hearing on September 13, 2016. Specifically, DHMH will contract with the Bon Secours Hospital to operate a pretrial diversion program, which will divert patients to the Bon Secours Hospital prior to their entry into the formal forensic system of care. The State has also partnered with a community provider at the Springfield Hospital Center to run a program, known as Segue, which will provide 16 transitional beds onsite at

the Springfield Hospital Center. Finally, the Secretary of Health and Mental Hygiene has begun the process of appointing a new advisory council, which will track DHMH's progress on the recommendations on an ongoing basis.

During the workgroup process, DHMH identified numerous patients who were still residing within State hospitals but who no longer met the medical criteria for inpatient care. After identifying these patients, BHA and OFS were able to secure sufficient wraparound services and other treatment options to enable the release of these patients from the hospital. This has allowed the State hospitals to not only reduce census numbers to below 100%, but as of the September 13 legislative hearing, to reduce the number of individuals waiting in jails throughout the State for a State hospital placement from 84 to 12.

Following these efforts, the average populations of each State hospital has been brought down below the staffed and budgeted level, with the exception of the Clifton T. Perkins Hospital Center. However, as previously mentioned, there is a deficiency appropriation to open an additional 20-bed unit at the Clifton T. Perkins Hospital Center. This should partially alleviate the pressure at this institution, but at this time, it is unclear how BHA intends to focus on getting people out of this hospital.

Security Concerns Remain at the Institutions

Beyond the work of the workgroup, language included in the 2016 JCR requested a report on security recommendations at BHA facilities in response to concerns about staff security and the ability of the current employees to deal with an ever increasing forensic population. This report identified a number of recommendations, mainly by surveying the various facilities on what their own respective security needs are. While almost all of the surveyed recommendations were included as final recommendations in the report, the one response that is not addressed is the need for more staff. Six of the seven institutions surveyed requested additional staff for their hospitals, but the final report submitted by DHMH, other than noting this request, is silent on the issue. **The department should comment on the implementation of the Forensic Services Workgroup recommendations, the number of individuals currently waiting for placement at State hospitals, as well as how the department intends to improve security staffing levels without the addition of more positions for this purpose.**

Recommended Actions

1. Adopt the following narrative:

   Combining the Various Behavioral Health Authorities: Given the policy imperative to fully integrate behavioral health services in the State, the Department of Health and Mental Hygiene (DHMH) should provide a report on the feasibility, costs, and benefits of merging the core service agencies (CSA) with the local addictions authorities (LAA). This report should include information on the grants that each recipient entity receives, including how grants are divided up amongst administrative and treatment costs, and how the experience of those counties with merged behavioral health authorities differ from the counties where these authorities remain separate. Finally, the report should include recommendations on whether or not it would be beneficial to the oversight and efficiency of the public behavioral health system to combine CSA and LAA in each jurisdiction where it is not already so. This report should be submitted by November 1, 2017.

Information Request	**Author**	**Due Date**
Report on combing CSAs with LAAs in various jurisdictions	DHMH	November 1, 2017

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

   Further provided that $2,103,478 of this appropriation made for the purpose of providing a community provider rate increase may not be expended for the purpose, but instead may only be transferred to Program M00Q01.10 Medicaid Behavioral Health Provider Reimbursements to cover shortfalls in base spending for that program. Funds not expended for this restricted purpose may not be transferred by budget amendment or otherwise to any other purpose and shall revert to the General Fund.

   Explanation: This language restricts funding included in the fiscal 2018 budget for 1% of a proposed 2% community provider rate increase and instead directs that the additional funds may only be transferred to Program M00Q01.10 in order to cover shortfalls in spending based on estimates of significant deficiencies in the budget for that program. This restriction allows for only a 1% rate increase for community providers. Any funds not transferred for this purpose shall revert to the General Fund.

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

   , provided that $365,024 of this appropriation made for the purpose of providing a community provider rate increase may not be expended for that purpose, but instead may only be transferred to Program M00Q01.10 Medicaid Behavioral Health Provider Reimbursements to cover shortfalls in base spending for that program. Funds not expended for this restricted

purpose may not be transferred by budget amendment or otherwise to any other purpose and shall revert to the General Fund.

Explanation: This language restricts funding included in the fiscal 2018 budget for 1% of a proposed 2% provider rate increase and instead directs that those funds may only be transferred to Program M00Q01.10 to cover shortfalls in spending based on estimates of significant deficiencies in the budget for that program. This restriction allows for only a 1% rate increase for community providers. Any funds not transferred for this purpose shall revert to the General Fund.

4. 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: This language restricts Medicaid behavioral health provider reimbursements to that purpose.

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

, provided that $2,518,010 of this appropriation made for the purpose of providing a community provider rate increase may not be expended for that purpose, but instead may only be expended to cover shortfalls in base spending for this program. Funds not expended for this purpose may not be transferred by budget amendment or otherwise to any other purpose and shall revert to the General Fund.

Explanation: This language restricts funding included in the fiscal 2018 budget for 1% of a proposed 2% community provider rate increase and instead restricts the funds provided for that purpose to only be spent on shortfalls in base spending based on estimates of significant deficiencies in the budget for the program. This restriction allows for only a 1% rate increase for community providers. Any funds not spent for this purpose shall revert to the General Fund.

6. Adopt the following narrative:

Review of the Substance Use Disorder Treatment Rates: The Governor's Heroin and Opioid Emergency Task Force recommended that the Department of Health and Mental Hygiene (DHMH) review all of the Medicaid rates for substance use disorder services and then continue to review those rates every three years. The budget committees are concerned about the follow through on this recommendation and request a report from DHMH on the adequacy of the rates for substance use disorder treatment services within the Medicaid program. This report is due on November 1, 2017.

Information Request	Author	Due Date
Report on the adequacy of substance use disorder Medicaid treatment rates	DHMH	November 1, 2017

Updates

1. Psychiatric Utilization and Capacity in Acute Care Hospitals – Preliminary Results

In response to concerns that behavioral health patients were flooding acute care hospital emergency rooms and services, DLS began studying the utilization and capacity of acute general hospitals for psychiatric treatment over the 2016 interim. DLS requested information from the Health Services Cost Review Commission on the number and dispositions of psychiatric patients at all acute care hospitals, as well as information from the Maryland Health Care Commission on the bed capacity of these facilities, for the time period fiscal 2013 through 2015. **Exhibit 12** provides information on the number of dispositions, average length of stay, and average number of patient days for each year.

Exhibit 12
Psychiatric Utilization of Acute Care Hospitals
Fiscal 2013-2015

	Dispositions			Avg. Length of Stay (Days)			Avg. Patient Days		
Hospital	**2013**	**2014**	**2015**	**2013**	**2014**	**2015**	**2013**	**2014**	**2015**
Total	**23,342**	**22,542**	**22,250**	**5**	**6**	**6**	**124,532**	**124,926**	**125,634**
Percent Increase		-3.43%	-1.30%		20.00%	0.00%		0.32%	0.57%

Source: Health Services Cost Review Commission

As shown in Exhibit 12, the number of psychiatric patients has decreased, but the average length of stay has increased by a full day between fiscal 2013 and 2015. This has resulted in a small increase in the total number of patient days experienced by acute care hospitals. However, while the number of patient days has increased, the acute general bed capacity has declined over this time period, as shown in **Exhibit 13**. Many hospitals have relatively little utilization. Hospitals that represent higher than 4% of the total number of dispositions, are shown in **Exhibit 14**. Among these hospitals, there is also a large discrepancy between the number of staffed beds at each facility, which results in different impacts for each of the high utilization hospitals in terms of the number of patient days per bed.

Exhibit 13
Bed Capacity Changes
Fiscal 2013 and 2015

	2013	2015	Change
MedStar Franklin Square Hospital Center	24	40	16
Union Memorial Hospital of Cecil County	6	11	5
Peninsula Regional Medical Center	10	12	2
Bon Secours Hospital	25	24	-1
University of Maryland Shore Medical Center at Dorchester	16	15	-1
University of Maryland Medical Center	56	54	-2
Calvert Memorial Hospital	12	9	-3
MedStar Southern Maryland Hospital Center	28	25	-3
MedStar Montgomery Medical Center	25	19	-6
MedStar St. Mary's Hospital	12	6	-6
University of Maryland Harford Memorial Hospital	27	20	-7
Laurel Regional Hospital	18	9	-9
Total	**696**	**681**	**-15**

Note: Total includes all acute care hospitals throughout the State.

Source: Maryland Health Care Commission

Exhibit 14
Selected Hospital Psychiatric Utilization Data
Fiscal 2013-2015

Hospital	Dispositions			Avg. Patient Days			Staffed Beds			Patient Days Per Bed		
	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015
Johns Hopkins Hospital	1,568	1,461	1,603	8,750	9,066	9,606	100	100	100	87.50	90.66	96.06
MedStar Union Memorial	1,381	1,397	1,216	7,231	7,608	6,766	26	26	26	278.12	292.62	260.22
MedStar Franklin Square	881	1,292	1,186	4,645	7,003	6,480	24	40	40	193.53	175.09	162.01
Prince George's Hospital Center	1,114	1,119	1,128	5,781	6,016	6,209	28	28	28	206.46	214.85	221.75
UMMC Midtown Campus	1,010	1,015	1,085	5,700	6,034	6,288	28	28	28	203.57	215.51	224.57
MedStar Montgomery	1,189	1,134	1,041	6,221	6,015	5,738	25	19	19	248.82	316.59	302.02
Suburban	1,035	1,096	1,014	5,335	6,069	5,769	24	24	24	222.30	252.87	240.35
Western Maryland Regional Medical Center	1,041	945	956	5,492	5,161	5,407	17	17	17	323.08	303.60	318.08
MedStar Southern Maryland	780	751	943	4,037	3,998	5,263	28	25	25	144.17	159.91	210.53
Meritus Medical Center	901	338	921	4,902	1,861	5,291	18	18	18	272.33	103.39	293.94
Sinai Hospital of Baltimore	1,010	961	917	5,420	5,354	5,568	24	24	24	225.83	223.07	232.00
Frederick Memorial Hospital	972	981	890	5,089	5,530	4,941	21	21	21	242.31	263.35	235.29

UMMC: University of Maryland Medical Center

Source: Health Services Cost Review Commission; Maryland Health Care Commission

DLS will be continuing to study this issue into the next interim to try and determine why the average length of stay has increased and what impact the disparate experiences with psychiatric patients is having on the various hospitals in the State.

2. Report on Affordable Housing for Individuals with Severe Mental Illness

The 2016 JCR requested a report from BHA and DHMH on their efforts to promote the development of affordable housing for individuals with severe mental illness in the community. In particular, the report should include discussion of the issues surrounding affordable housing for these individuals, an explanation of what projects DHMH is promoting to address this issue, and what barriers DHMH sees in the future. This report was submitted on November 16, 2016.

In the report, DHMH highlights housing and supportive services programs that are maintained by the State in three areas: current service-connected housing resources, services providing support to individuals to obtain and maintain independent or supportive housing, and efforts to increase and support affordable housing. The current service-connected housing resources include BHA's Residential Rehabilitation Program as well as the federal Continuum of Care grant program. Services that provide support to individuals to obtain and maintain independence or supportive housing include the Psychiatric Rehabilitation Program, targeted case management, and the Assertive Community Treatment Program. Finally, efforts to increase and support affordable housing include the Maryland Partnership for Affordable Housing, which is a joint venture between DHMH, the Maryland Department of Disabilities, the Department of Housing and Community Development, the Housing First Pilot Project, the Permanent Supportive Housing program, and the federal Maryland Collaboration for Homeless Enhancement Services pilot grant program.

At this time, the barriers that DHMH foresees in the future for housing include a lack of affordable housing stock, the previous tenant histories of some individuals with severe mental illness, the lack of transportation options located near available affordable housing, and certain individuals' lack of documentation needed to secure the housing. Further, while all of these issues are present in Maryland, DHMH notes that they are not unique to the State but rather are experienced across the country.

Appendix 1
Current and Prior Year Budgets
DHMH – Behavioral Health Administration
($ in Thousands)

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2016					
Legislative Appropriation	$847,497	$48,452	$738,513	$7,944	$1,642,406
Deficiency Appropriation	0	275	4,258	0	4,533
Budget Amendments	24,711	12,115	50,242	3,055	90,123
Reversions and Cancellations	-873	-2,929	-16,595	-485	-20,882
Actual Expenditures	**$871,336**	**$57,913**	**$776,418**	**$10,514**	**$1,716,180**
Fiscal 2017					
Legislative Appropriation	$892,593	$52,112	$733,265	$7,796	$1,685,766
Cost Containment	0	0	0	0	0
Budget Amendments	4,111	2	69	0	4,182
Working Appropriation	**$896,704**	**$52,114**	**$733,333**	**$7,796**	**$1,689,948**

DHMH: Department of Health and Mental Hygiene

Note: Does not include targeted reversions, deficiencies, and contingent reductions. Numbers may not sum to total due to rounding.

Fiscal 2016

The Behavioral Health Administration's (BHA)'s fiscal 2016 budget ended $73,774,672 above the legislative appropriation. General funds increased by $23,838,516, mostly through budget amendments. General fund budget amendment increases included the following:

- $7,603,810 to realign funding taken for the 2% across-the-board reduction;
- $7,600,000 in provider reimbursements to restore provider rates, per Section 48 of the budget bill;
- $7,132,911 in provider reimbursements due to increased utilization;
- $3,592,630 to restore a 2% salary reduction;
- $2,000,000 to expand services for individuals with a heroin use disorder, per Section 48 of the budget bill;
- $436,477 to realign funds for closeout purposes; and
- $21,298 in pension payments due to contact negations for State Law Enforcement Officers Labor Alliance (SLEOLA) members.

Budget amendments also removed general funds, including $3,625,857 due to lower than expected costs for off grounds hospitalizations and overtime at certain facilities as well as $50,252 due to a position transfer. A further $872,501 in general funds were reverted in fiscal 2016, mostly due to vacancies as well as lower than expected savings on outpatient care off grounds.

Special funds increased by $9,460,957 above the legislative appropriation. This is mostly due to increases through budget amendments, including $10,000,000 to increase reimbursements for services rendered within an institution for mental disease for Medicaid recipients, $2,000,000 to restore funding for the Synar penalty, $105,435 for underbudgeted expenses within the institutions, and $9,619 to restore the 2% salary reduction. There was also a deficiency appropriation for $275,000 to realize revenues from the Marijuana Citation Fund. These increases were partially offset by $2,929,097 in cancellations at the end of the year mainly due to lower than expected realization of special fund revenue.

Federal funds increased by $37,905,352 above the legislative appropriation. The largest increase was $45,000,000 in provider reimbursements due to increased utilization. Other increases included $5,190,536 through budget amendments and $4,258,389 through deficiency appropriations for various federal grants that were originally underbudgeted and $51,268 to restore the 2% salary reduction. Of this amount, $16,594,841 was canceled at the end of the fiscal year mainly due to slower than expected spending on federal grants, the majority of which will be rolled over into fiscal 2017.

Reimbursable funds increased by $2,569,847 from the legislative appropriation. The majority of this increase was due to the transfer of the Care Management Entity from the Children's Cabinet to BHA, increasing the budget by $2,800,000. Other budget amendments increased spending by $254,917 mainly for emergency preparedness operations and care coordination services. Cancellations totaled $485,070, which were all tied to lower than expected expenditures on special populations.

Fiscal 2017

To date, the budget for BHA has increased by $4,181,635 above the legislative appropriation for fiscal 2017. General funds have increased by $4,111,441, of which the largest increase is $3,533,343 for the transfer of increment payments for fiscal 2017. Other increases include $333,299 to realign salary reductions as a result of Section 20 of the budget bill, $111,735 to implement recommendations from the fiscal 2017 annual salary review, $100,000 for transfers related to restrictive language in the budget bill, and $33,064 to implement the provisions of the collective bargaining agreement with SLEOLA.

Special funds were increased by $1,679, including $1,026 related to Section 20 and $653 for increments. Federal funds were increased by $68,515 for the increment payments as well.

Appendix 2
Object/Fund Difference Report
DHMH – Behavioral Health Administration

Object/Fund	FY 16 Actual	FY 17 Working Appropriation	FY 18 Allowance	FY 17 - FY 18 Amount Change	Percent Change
Positions					
01 Regular	2,900.55	2,802.65	2,802.65	0.00	0%
02 Contractual	189.85	224.94	214.55	-10.39	-4.6%
Total Positions	**3,090.40**	**3,027.59**	**3,017.20**	**-10.39**	**-0.3%**
Objects					
01 Salaries and Wages	$ 242,701,367	$ 247,720,215	$ 251,670,682	$ 3,950,467	1.6%
02 Technical and Spec. Fees	11,836,754	13,638,467	10,834,165	-2,804,302	-20.6%
03 Communication	568,813	465,471	557,363	91,892	19.7%
04 Travel	209,259	247,860	229,045	-18,815	-7.6%
06 Fuel and Utilities	9,413,608	9,292,114	9,083,368	-208,746	-2.2%
07 Motor Vehicles	662,373	722,727	744,646	21,919	3.0%
08 Contractual Services	1,435,413,718	1,405,451,786	1,690,923,722	285,471,936	20.3%
09 Supplies and Materials	13,636,996	11,343,762	13,658,852	2,315,090	20.4%
10 Equipment – Replacement	869,946	184,396	249,051	64,655	35.1%
11 Equipment – Additional	145,013	9,630	48,349	38,719	402.1%
12 Grants, Subsidies, and Contributions	202,604	348,481	310,617	-37,864	-10.9%
13 Fixed Charges	519,882	522,814	497,296	-25,518	-4.9%
Total Objects	**$ 1,716,180,333**	**$ 1,689,947,723**	**$ 1,978,807,156**	**$ 288,859,433**	**17.1%**
Funds					
01 General Fund	$ 871,335,701	$ 896,704,435	$ 967,643,119	$ 70,938,684	7.9%
03 Special Fund	57,913,156	52,114,172	47,629,696	-4,484,476	-8.6%
05 Federal Fund	776,417,856	733,333,247	955,821,291	222,488,044	30.3%
09 Reimbursable Fund	10,513,620	7,795,869	7,713,050	-82,819	-1.1%
Total Funds	**$ 1,716,180,333**	**$ 1,689,947,723**	**$ 1,978,807,156**	**$ 288,859,433**	**17.1%**

DHMH: Department of Health and Mental Hygiene

Note: Does not include targeted reversions, deficiencies, and contingent reductions.

Appendix 3
Fiscal Summary
DHMH – Behavioral Health Administration

Program/Unit	FY 16 Actual	FY 17 Wrk Approp	FY 18 Allowance	Change	FY 17 - FY 18 % Change
01 Deputy Secretary for Behavioral Health	$ 1,948,620	$ 2,116,324	$ 2,091,475	-$ 24,849	-1.2%
01 Program Direction	18,121,871	21,924,980	22,433,626	508,646	2.3%
02 Community Services	259,684,521	262,450,985	268,093,468	5,642,483	2.1%
03 Community Services for Medicaid Recipients	70,887,323	66,562,437	73,652,748	7,090,311	10.7%
04 Thomas B. Finan Hospital Center	19,892,434	21,137,076	20,958,779	-178,297	-0.8%
05 Regional Institute for Children and Adolescents – Baltimore City	14,173,523	13,744,364	14,575,955	831,591	6.1%
07 Eastern Shore Hospital Center	20,299,308	20,035,133	20,113,778	78,645	0.4%
08 Springfield Hospital Center	73,931,557	74,872,347	74,938,116	65,769	0.1%
09 Spring Grove Hospital Center	83,836,523	86,127,020	85,928,262	-198,758	-0.2%
10 Clifton T. Perkins Hospital Center	64,137,299	65,468,799	67,322,111	1,853,312	2.8%
11 John L. Gildner Regional Institute for Children and Adolescents	11,851,945	11,767,836	12,091,868	324,032	2.8%
15 Services and Institutional Operations	1,727,231	1,289,831	1,383,909	94,078	7.3%
10 Medicaid Behavioral Health Provider Reimbursements	1,075,688,178	1,042,450,591	1,315,223,061	272,772,470	26.2%
Total Expenditures	**$ 1,716,180,333**	**$ 1,689,947,723**	**$ 1,978,807,156**	**$ 288,859,433**	**17.1%**
General Fund	$ 871,335,701	$ 896,704,435	$ 967,643,119	$ 70,938,684	7.9%
Special Fund	57,913,156	52,114,172	47,629,696	-4,484,476	-8.6%
Federal Fund	776,417,856	733,333,247	955,821,291	222,488,044	30.3%
Total Appropriations	**$ 1,705,666,713**	**$ 1,682,151,854**	**$ 1,971,094,106**	**$ 288,942,252**	**17.2%**
Reimbursable Fund	$ 10,513,620	$ 7,795,869	$ 7,713,050	-$ 82,819	-1.1%
Total Funds	**$ 1,716,180,333**	**$ 1,689,947,723**	**$ 1,978,807,156**	**$ 288,859,433**	**17.1%**

DHMH: Department of Health and Mental Hygiene

Note: Does not include targeted reversions, deficiencies, and contingent reductions.