M00L
Behavioral Health Administration
Maryland Department of Health

Operating Budget Data

($ in Thousands)

	FY 17 Actual	FY 18 Working	FY 19 Allowance	FY 18-19 Change	% Change Prior Year
General Fund	$911,218	$972,705	$1,039,877	$67,172	6.9%
Adjustments	0	11,312	-7,028	-18,339	
Adjusted General Fund	**$911,218**	**$984,016**	**$1,032,849**	**$48,833**	**5.0%**
Special Fund	52,898	51,715	46,410	-5,305	-10.3%
Adjustments	0	0	2,003	2,003	
Adjusted Special Fund	**$52,898**	**$51,715**	**$48,413**	**-$3,302**	**-6.4%**
Federal Fund	860,798	965,842	1,046,732	80,890	8.4%
Adjustments	0	50,296	-8,345	-58,641	
Adjusted Federal Fund	**$860,798**	**$1,016,138**	**$1,038,387**	**$22,249**	**2.2%**
Reimbursable Fund	7,898	7,713	12,986	5,273	68.4%
Adjustments	0	0	3	3	
Adjusted Reimbursable Fund	**$7,898**	**$7,713**	**$12,990**	**$5,277**	**68.4%**
Adjusted Grand Total	**$1,832,813**	**$2,059,583**	**$2,132,639**	**$73,056**	**3.5%**

Note: FY 18 Working includes targeted reversions, deficiencies, and across-the-board reductions. FY 19 Allowance includes contingent reductions and cost-of-living adjustments.

- There are a total of 11 deficiency appropriations for the Behavioral Health Administration (BHA) in the budget. The two largest are for provider reimbursements, including $51.5 million ($17 million in general funds) for fiscal 2017 and $58.2 million ($7.8 million in general funds) for fiscal 2018.

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

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- Other general fund deficiencies include $3.3 million for fee-for-service (FFS) residential treatment services, $1.9 million for court-ordered placements in the community, $1.3 million for costs associated with expanding bed capacity at BHA's residential institutions, and $0.7 million for the operating costs associated with the Crownsville Hospital Center.

- After adjusting for fiscal 2018 deficiencies as well as fiscal 2018 and 2019 across-the-board actions, the allowance for BHA increases by $73.1 million, or 3.5%, over the fiscal 2018 working appropriation. The majority of this increase is in FFS community behavioral health provider reimbursements.

- There are two contingent reductions for BHA. One would swap special funds from the Maryland Community Health Resources Commission with general funds, while the second would reduce the mandated provider rate increase from 3.5% to 2%. Both of these actions are tied to provisions in the Budget Reconciliation and Financing Act of 2018.

Personnel Data

	FY 17 Actual	FY 18 Working	FY 19 Allowance	FY 18-19 Change
Regular Positions	2,810.65	2,857.90	2,891.90	34.00
Contractual FTEs	169.34	186.92	183.17	-3.75
Total Personnel	**2,979.99**	**3,044.82**	**3,075.07**	**30.25**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	230.35	8.06%
Positions and Percentage Vacant as of 12/31/17	322.50	11.28%

- The fiscal 2019 allowance includes 34 new regular positions for BHA. Of these positions, 33 are for new direct care workers at institutions that lost positions during the bed expansion, while 1 is for the Opioid Operational Command Center (OOCC).

- Further, during fiscal 2018, BHA gained 47.25 regular positions as part of the bed expansion effort. Of these, 20 came from outside of the Maryland Department of Health (MDH), while the rest were reassigned from other units of MDH.

- Budgeted turnover for BHA is increased in the fiscal 2019 allowance, from 7.68% to 8.06%. However, the overall vacancy rate within BHA has also increased from this time last year, from 9.74% to 11.28%. This is mainly due to the vacant positions being added to the department for the bed expansion initiatives.

Analysis in Brief

Major Trends

Substance Use Prevention: The number of people served by prevention programming grew by 2,333 (0.5%) compared to fiscal 2016. 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, with the number of consumers and expenditures for this population making up more than half of the total number of consumers and expenditures for all SUD treatment services in fiscal 2017.

Community Mental Health Fee-for-service System – Enrollment Trends: Enrollment growth in the FFS community mental health system was 2.5% in fiscal 2017, which is under the enrollment growth of 5.9% over the five-year period from fiscal 2013 through 2017. Individuals eligible for Medicaid under the traditional eligibility categories have increased by 2.4% between fiscal 2016 and 2017, while adults newly eligible under the ACA expansion have increased by 11.3% between fiscal 2016 and 2017.

Community Mental Health FFS System – Expenditure Trends: Expenditures grew at 2.8% in fiscal 2017, which is under the growth rate over the last five years at 5.3%. Growth over the five-year period from fiscal 2013 to 2017, as well as between fiscal 2016 and 2017, has been driven by growth in psychiatric rehabilitation expenses at 12.8% over the five-year period and at 14.7% for fiscal 2017. 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. While almost all metrics for individuals with mental illness improved in fiscal 2017, the reverse is seen for individuals with SUD and co-occurring conditions, making the outcome measurements worse overall compared to fiscal 2016.

Outcomes for State-run Psychiatric Facilities: Outcome measures for the State-run psychiatric facilities are based around readmissions as well as staff injuries. In fiscal 2017, all but one of the facilities kept the rate of readmission within 30 days below the goal of 5%, while all but one of the facilities failed to meet the goal of not having the rate of staff hours lost due to injury exceed 3 hours per 1,000 hours worked.

Issues

The Opioid Epidemic – Trying to Beat 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 2017. Numerous actions have been taken by both the General Assembly as well as the Executive Branch to tackle this issue, including the addition of almost $39 million to various programming across State government.

Some of the more significant actions include the passage of the Heroin and Opioid Prevention Effort and Treatment Act of 2017 as well as the formation of OOCC, which has been the lead agency distributing the majority of the funding targeted to address the epidemic. However, the department, as yet, has to turn in one of the reports requested in the *Joint Chairmen's Report* (JCR) regarding SUD treatment rates that was based on a recommendation of the Governor's Heroin and Opioid Emergency Task Force. **The department should comment on the status of the late JCR report. The department should also comment on when OOCC can be expected to make funding decisions for fiscal 2019 and when local jurisdictions and other providers can expect to receive their funds based on that timeline. Further, the Department of Legislative Services (DLS) recommends the adoption of committee narrative continuing to request quarterly reports from OOCC on spending from the Opioid Crisis Fund.**

State Psychiatric Institutions Expand, but Remain Full: In what has become a recurring issue, the department continues to have problems responding to the Judiciary's orders to commit people for mental health treatment. In response to contempt proceedings over the interim, the department moved ahead by adding 95 beds to the adult psychiatric system, which included 82 new beds within the State facilities. However, while the department has assigned new positions to this effort, it appears that it did not assign enough new positions, further exacerbating the understaffing that was determined by DLS over the interim. Further, while the department's staffing levels appear to have worsened, the staffing standards upon which this estimate is based are quite old and potentially out of date given the changing nature of the patients within the facilities. Also, over the interim, the Behavioral Health Advisory Council (BHAC) submitted a report on providing 24/7 access to crisis services throughout the State, which could potentially be a more cost-effective method of lowering the costs of inpatient treatment for forensic patients by preventing their entrance into the forensic system in the first place. However, there is no funding contained in the allowance for any expansion of crisis services. **The department should comment on which recommendations from the BHAC crisis report it plans to implement and provide a timeline for implementation. Further, DLS recommends adding budget bill language requesting a report containing a new staffing analysis.**

Private Psychiatric Capacity Fares No Better: During both the 2016 and 2017 interims, DLS studied the impact that psychiatric patients were having on acute general hospitals throughout the State based upon concerns that these patients were flooding both the inpatient capacity as well as emergency department (ED) capacity of these hospitals. What the study found was that while inpatient admissions and ED visits were down over the period fiscal 2013 to 2016, the length of stay and hours of observation were increasing, mainly in response to concerns surrounding readmission quality metrics included in the All-Payer Model Contract. Further, while hospitals were beginning to hold patients for longer, they did very little to increase either their inpatient or ED bed capacity, further exacerbating the problem for themselves. This is despite the State's efforts to create better relationships between hospitals and community providers in recognition that without better cooperation, the readmission test would cause problems. **The department should comment on what steps it has taken thus far to improve relationships between acute general hospitals and community-based behavioral health providers and what potential actions the department may be considering in the future.**

Behavioral Health Integration Continues to Improve: 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. As of January 1, 2018, almost all SUD services for the uninsured as well as State-funded services have been transitioned to FFS under ASO. In addition, the integration of local behavioral health authorities continues to make progress through the development of specific local plans. However, one of the main initiatives of integration was the insertion of performance metrics into the ASO contract in order to improve both health as well as financial outcomes of the carve-out. While these performance metrics were included in the contract that was signed by both parties, they have yet to be enforced or changed to new metrics that the department would actually be able to enforce. **The department should comment on the development process for the local plans. The department should comment on why the contract was initially signed without knowledge that the provisions were unenforceable, why the terms have yet to be modified, what new performance metrics the department is considering to include in the ASO contract, and when a modification to the contract will be done.**

JCR Submissions Remain Missing: As of the writing of this analysis, there are still two reports that remain to be submitted in response to the 2017 JCR. The first is a report on limiting the availability of tobacco products to minors, while the second has already been mentioned on SUD treatment provider rates. It is worth noting that MDH has not requested an extension for either report. **The department should comment on why the reports are late without any notification that the reports would be late.**

Operating Budget Recommended Actions

		Funds
1.	Add budget bill language requesting a report on the appropriate staffing levels required at the facilities operated by the Behavioral Health Administration.	
2.	Add budget bill language restricting surplus funds to only be spent on opioid crisis initiatives through the Opioid Operational Command Center.	
3.	Reduce funds for community behavioral health services.	$ 8,000,000
4.	Adopt committee narrative requesting quarterly reports on spending from the Opioid Crisis Fund.	
5.	Add budget bill language restricting Medicaid behavioral health provider reimbursements to that purpose.	

6.	Reduce funds for the deficiency for substance use disorder residential treatment.	3,264,681
	Total Reductions to Fiscal 2018 Deficiency Appropriation	**$ 3,264,681**
	Total Reductions to Allowance	**$ 8,000,000**

Updates

Behavioral Health Accreditation Process Moves Forward: A report was submitted in response to the 2017 JCR on the department's efforts to help ensure that all behavioral health providers were scheduled to obtain accreditation by an approved organization no later than January 1, 2018, in order to be licensed by April 1, 2018, to provide community-based behavioral health services. The report focused on the SUD provider network, which had the most issues with the accreditation process, and noted that within this network, 354 out of 427 (83%) providers are either accredited or actively engaged in the process. Of the remaining providers, 26 (6%) are actively seeking BHA assistance while 47 (11%) providers have taken no discernible action.

Placement Determinations for Children with Complex Medical Needs: A report was submitted in response to fiscal 2018 budget bill language from the Department of Human Services (DHS), MDH, and the Maryland State Department of Education (MSDE) on the processes in place to ensure coordination between DHS, MDH, MSDE, and any hospital serving children and adolescents with mental illness, developmental disabilities, or complex medical needs in order to find appropriate community placements or in order to find out-of-home placements for youth. As detailed in the report, BHA has a critical role in these processes, which includes providing both DHS and MSDE a weekly report of all hospital admissions and discharges and any other relevant updates from the prior week.

M00L
Behavioral Health Administration
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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 2019 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 SUD Services:*** Developing and operating unified programs for SUD research, training, prevention, and rehabilitation in cooperation with federal, State, local, and private agencies, as well as working closely with the local addictions authorities (LAA) to coordinate and deliver these services.

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 evidence-based model. In fiscal 2017, a total of 206 recurring prevention programs were offered across the State, a decrease of 43 from the prior year.

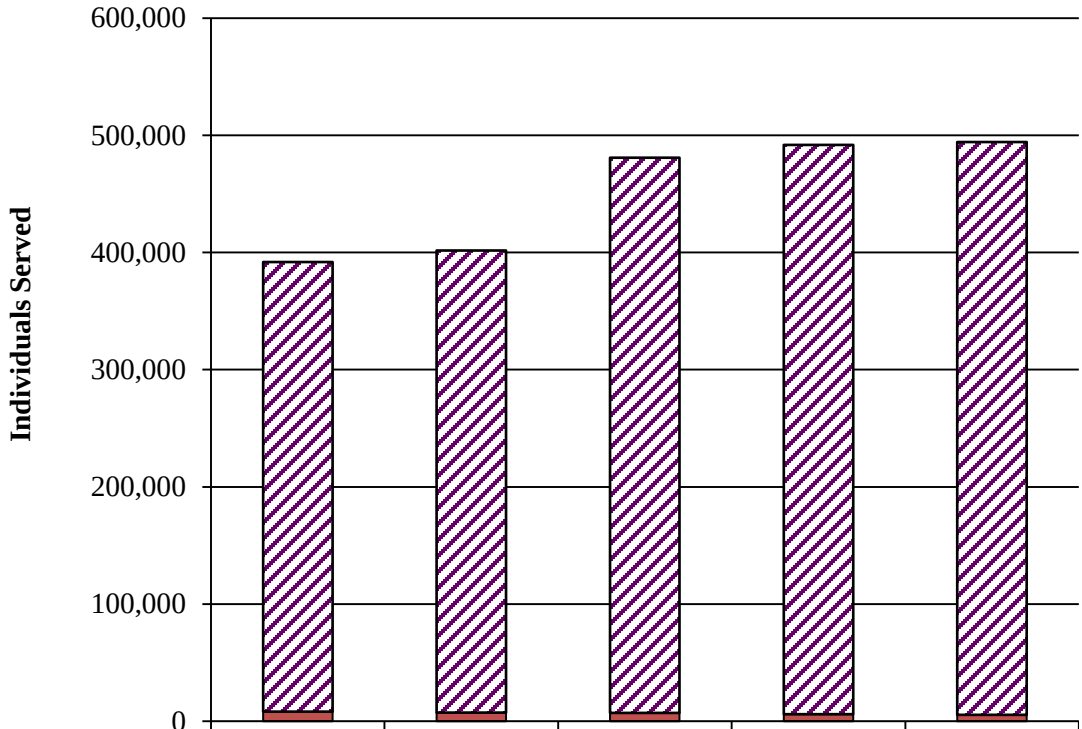
  Statewide, the successful completion rate for these types of programs is reported at 85%, a number that has varied little over the past decade. There is variation by county among programs in terms of successful completion. In fiscal 2017, for example, the successful completion rate varied from 100% in Caroline County to 82% in Dorchester, Garrett, and Queen Anne's counties. Beyond the counties, the University of Maryland Eastern Shore also 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 2017, 1,304 single service prevention activities were offered in Maryland, a decrease of 33 from the prior year.

As shown in **Exhibit 1**, prevention programming served 494,134 participants in fiscal 2017, 2,333 (0.5%) higher than served in fiscal 2016. Recurring programs continue to see a drop in people served, down 735 participants (12.0%) between fiscal 2016 and 2017. Conversely, the number of participants served in single service programs grew by 3,068 between fiscal 2016 and 2017, or 0.6%. These trends continue to reflect the change in program focus from individual-based programming to population-based programming/activities established in fiscal 2012, which 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 misuse of alcohol, tobacco, and other drugs. Environmental strategies tend to be primarily single service activities, limiting the funding available for recurring programs. The broader reach of environmental programming, including mass media campaigns, boosts exposure to single service activities.

Prevention funding increased slightly in fiscal 2017. Most of this change has to do with the expiration of one federal grant and the initiation of a different federal grant. Further, all prevention funding in fiscal 2017 remained federally funded.

Exhibit 1
Behavioral Health Administration-funded Prevention Programs
Fiscal 2013-2017



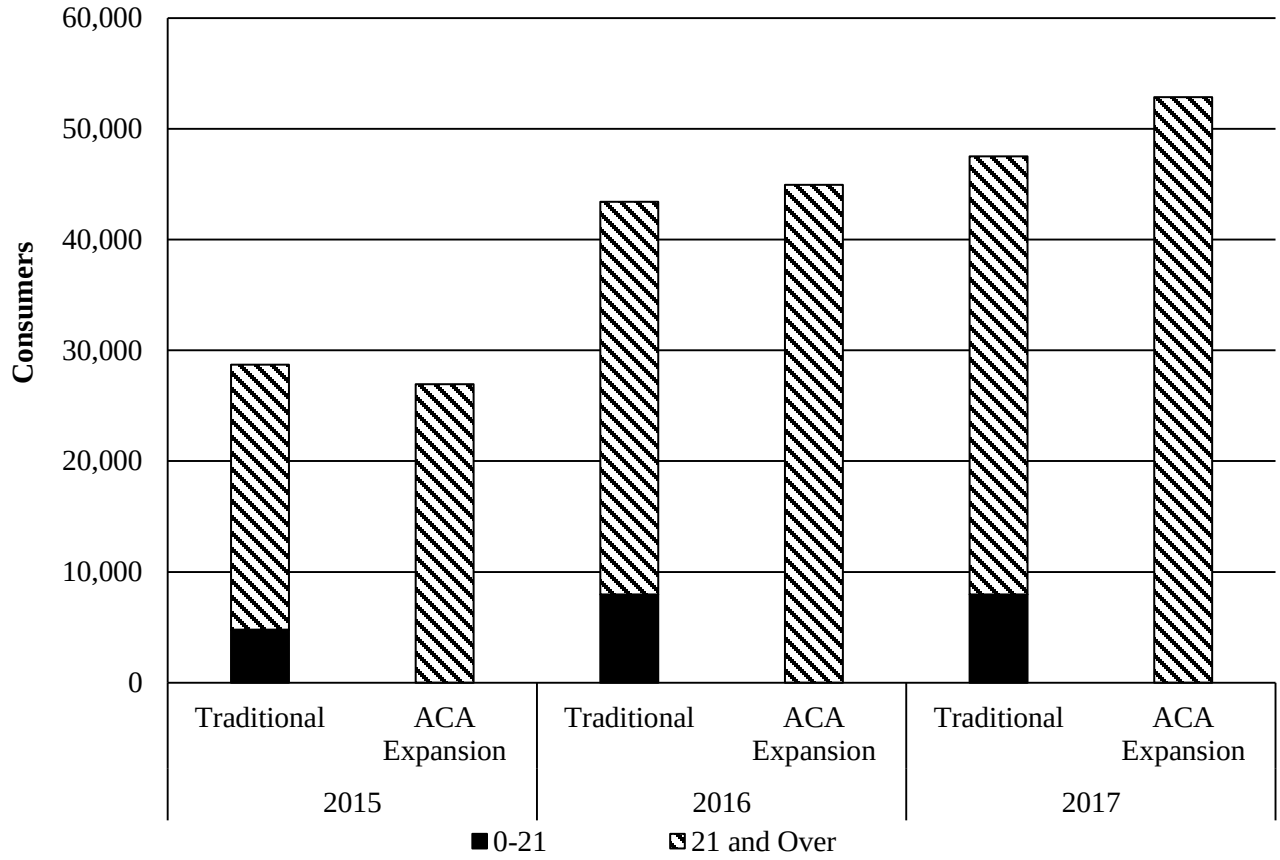
	2013	2014	2015	2016	2017
Single Service Programs	383,789	394,367	473,561	485,669	488,737
Recurring Programs	8,158	7,364	7,270	6,132	5,397
Prevention Funding ($ in Millions)	$7.804	$7.852	$9.336	$8.295	$8.658

Source: Maryland Department of Health

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

Exhibit 2 provides the number of consumers who were recorded as receiving treatment through the Medicaid program during fiscal 2015 through 2017. 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.

Exhibit 2
SUD Treatment Data by Medicaid Eligibility and Age
Fiscal 2015-2017



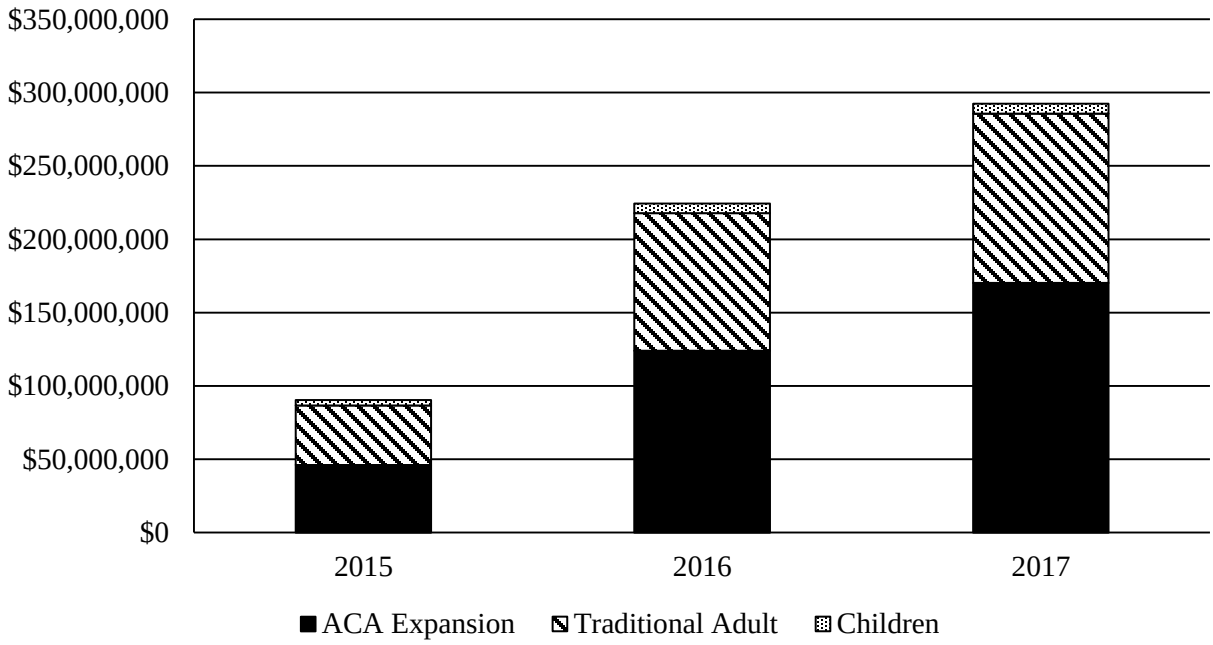
ACA: Affordable Care Act
SUD: substance use disorder

Source: Maryland Department of Health; Department of Legislative Services

As seen in the exhibit, individuals eligible for Medicaid through the Affordable Care Act (ACA) expansion, which increased the federal poverty level under which adults are eligible for Medicaid to 138%, make up almost half of the individuals receiving SUD treatment in fiscal 2015 and more than half in fiscal 2016 and 2017. 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 the ACA, not only do these individuals receive a full range of benefits, but the services are heavily federally financed at a rate of 100% in both fiscal 2015 and 2016 and an average rate of 97.5% in fiscal 2017. This federal financing is especially important when looking at **Exhibit 3**, which shows that expenditures on the ACA expansion population

also make up a large proportion of expenditures though the Medicaid program for SUD services. While overall expenditures increase by 30.3%, expenditures for the ACA expansion population increase by 37.4% and further make up for 58.3% of all expenditures in fiscal 2017, compared to 55.2% of expenditures in fiscal 2016.

Exhibit 3
Substance Use Disorder Services – Expenditure Trends
Fiscal 2015-2017



ACA: Affordable Care Act

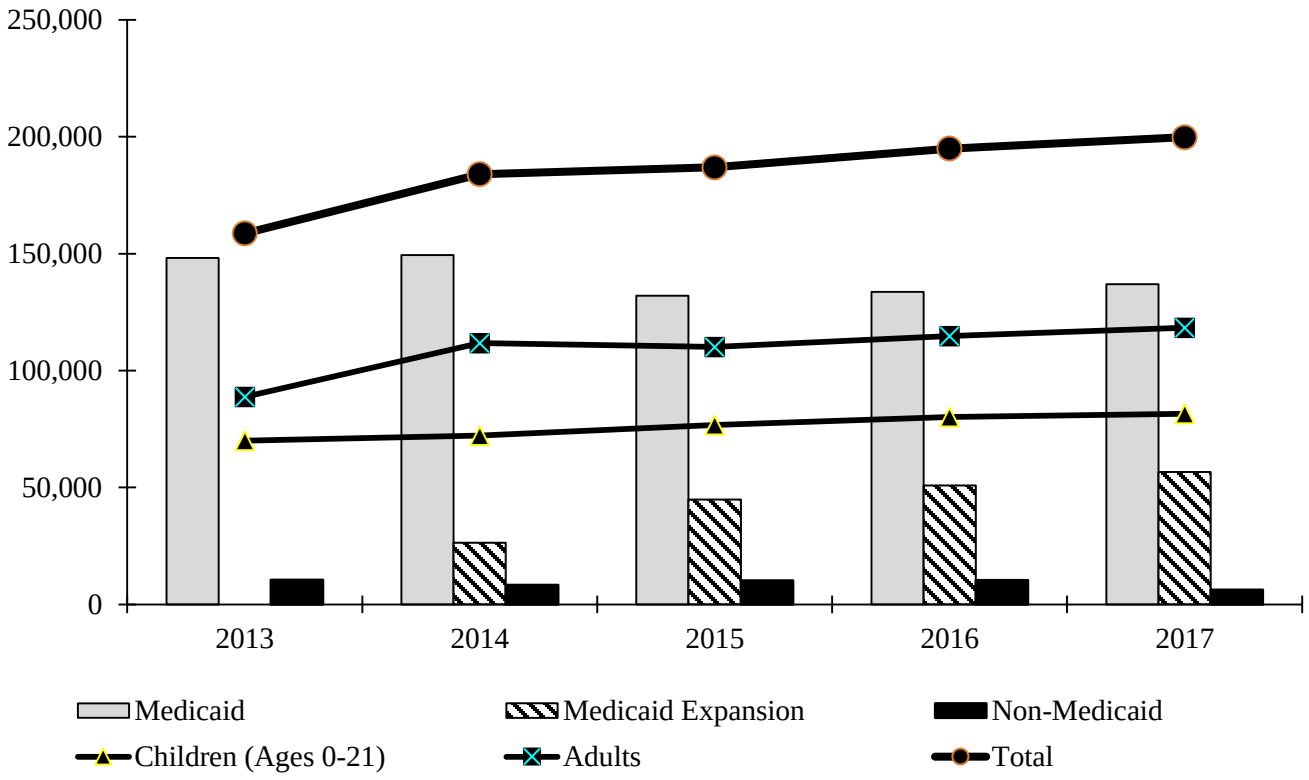
Source: Maryland Department of Health; Department of Legislative Services

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

As shown in **Exhibit 4**, total enrollment in the fee-for-service (FFS) community mental health system (Medicaid and non-Medicaid) has increased at an average annual rate of 5.9% between fiscal 2013 and 2017, which is higher than the 2.5% growth between fiscal 2016 and 2017. Increases in enrollment continue to be driven primarily by the ACA expansion population. Enrollment just for this population grew by 11.3% between fiscal 2016 and 2017, compared to 2.4% growth in the traditional Medicaid enrollment categories 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 4.9% between fiscal 2016 and 2017. The number of consumers receiving mental health services who do not have Medicaid coverage, however, is declining by 12.2% over the time period shown and by 39.9% between fiscal 2016 and 2017.

Exhibit 4
Community Mental Health Services Enrollment Trends
Fiscal 2013-2017



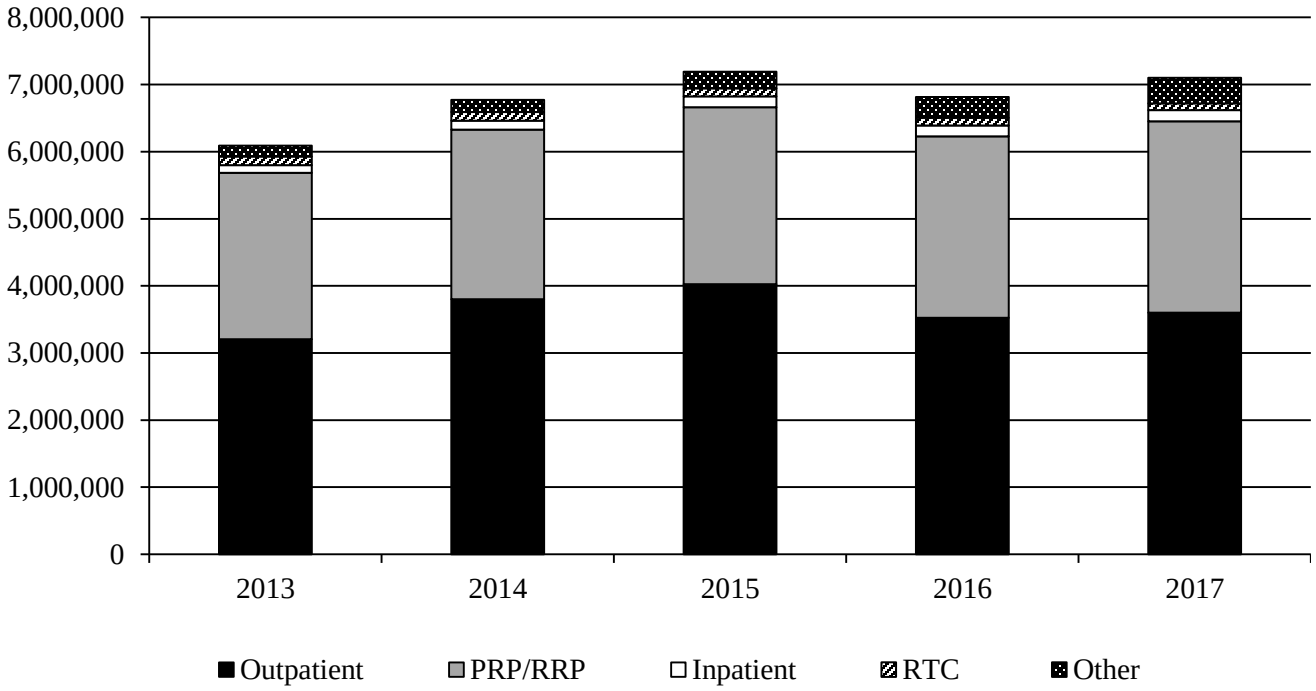
Source: Maryland Department of Health; Department of Legislative Services

The exhibit also shows that enrollment growth over this time period has been driven by adults (7.5% between fiscal 2013 and 2017), reflecting both prior strong growth in the PAC program, the State's fiscal 2009 expansion to parents of children in Medicaid, as well as the fiscal 2014 ACA expansion. Over the time period shown, the number of adults in the program increases by 7.5% while the number of children increases by 3.9%. Adults make up 59.2% of total enrollment in fiscal 2017, compared to 55.9% in fiscal 2013.

In terms of utilization of services, trends are shown in **Exhibit 5**. The exhibit shows that over the five-year period, total service units are up by an average annual rate of 3.9%. In fact, each of the fiscal years shown in the exhibit represent the highest service unit years since fiscal 2004, with fiscal 2015 having the largest number of total service units in over 10 years. Further, while there was

a decline in fiscal 2016, the growth between fiscal 2016 and 2017 was 4.2%, higher than the average annual rate over the last five years. This increase has been driven by increases in various other services including crisis, supported employment, respite care, and in particular targeted case management (TCM) services. Most of the reason for this increase is a change in the way that TCM services for children are now financed. Whereas previously, TCM services were provided by a care management entity under the Governor's Office for Children, within fiscal 2016, these services were transferred to BHA and are now provided through the Public Behavioral Health System under ASO, which increased the number of TCM services captured in this data. However, all service types had increases in the total number of services over the prior year in fiscal 2017, with the exception of residential treatment, continuing to reflect the fact that the ACA expansion increased access to services for a population that previously had largely been unable to obtain them.

Exhibit 5
Community Mental Health Fee-for-service
Service Utilization Trends
Fiscal 2013-2017
(Units of Service)

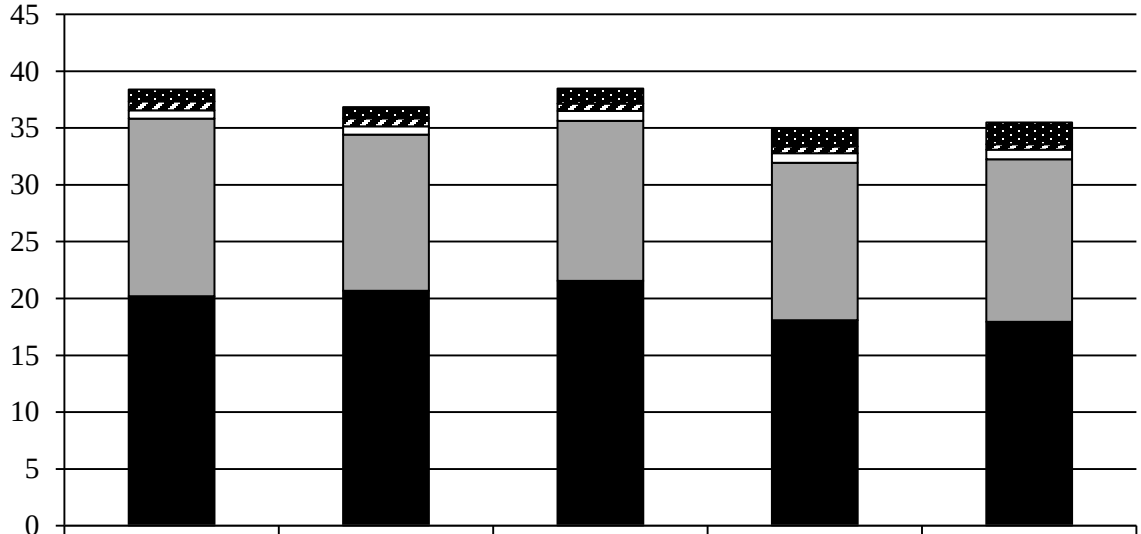


PRP: Psychiatric Rehabilitation Program
RRP: Residential Rehabilitation Program
RTC: Residential Treatment Center

Source: Maryland Department of Health; Department of Legislative Services

It is worth noting the difference between the enrollment growth in the system between fiscal 2013 and 2017 and contrasting that with the total service units provided in the same period. Over the time period, there has been a decline in the average number of services per capita for most of the traditional services, such as outpatient, psychiatric and residential rehabilitation, and residential treatment, as seen in **Exhibit 6**. The largest increase in services per capita over the time period by far are for the other services category at 16.8%, with a jump in fiscal 2017 of 19.3%. This includes mainly wraparound services such as TCM, crisis, respite care, and supported employment.

Exhibit 6
Community Mental Health Fee-for-service
Service Utilization Trends
Fiscal 2013-2017
(Services Per Capita)



	2013	2014	2015	2016	2017
Other	1.03	0.99	1.32	1.61	1.92
RTC	0.79	0.71	0.64	0.59	0.48
Inpatient	0.75	0.72	0.87	0.84	0.84
PRP/RRP	15.63	13.75	14.10	13.86	14.28
Outpatient	20.18	20.68	21.53	18.08	17.95

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

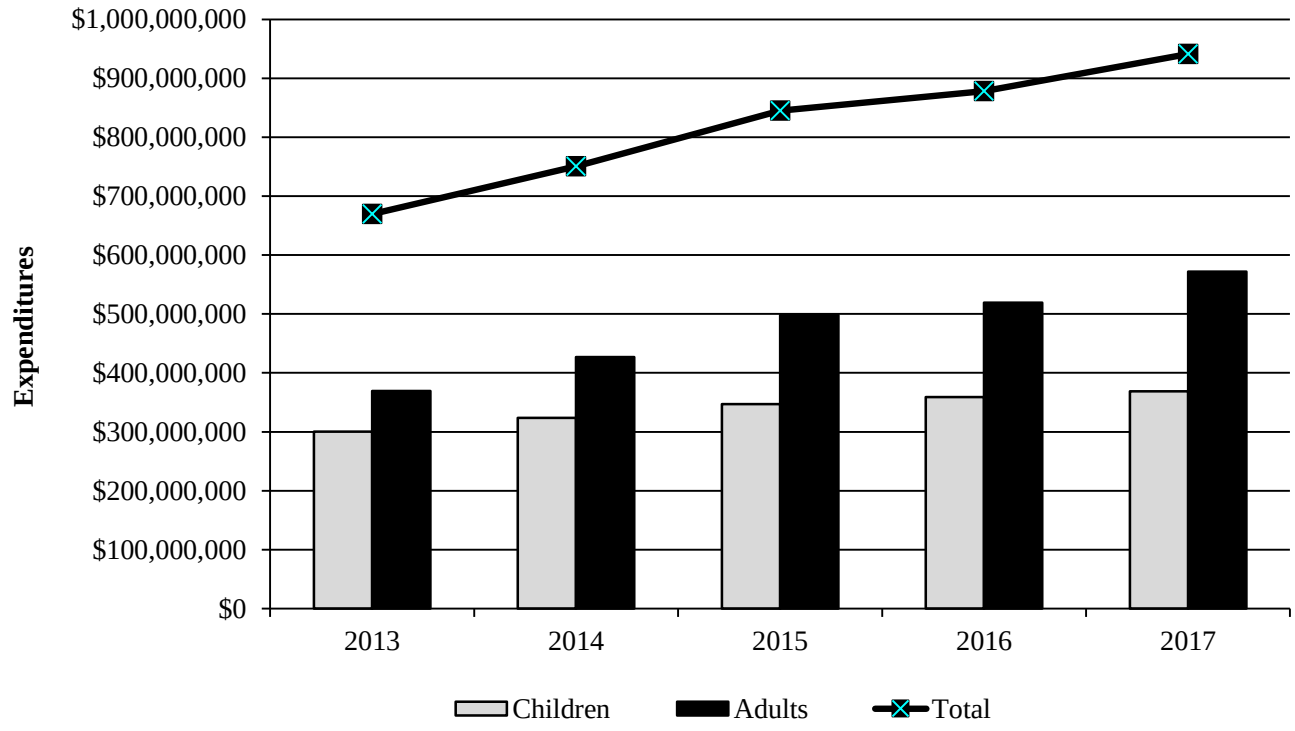
Source: Maryland Department of Health; Department of Legislative Services

One other notable trend is the slowing rate of growth in services per capita for inpatient services that began in fiscal 2016 and continues into fiscal 2017. While inpatient services increased over the period shown by 3.1%, it only increased in fiscal 2017 by 0.5%, signaling the continuing leveling off trend from the large initial growth due to the ACA expansion. This is potentially positive since inpatient services are the most expensive services on a per service basis and potentially are not eligible for federal match depending on the facility where the services are provided.

4. Community Mental Health FFS System – Expenditure Trends

Expenditure patterns historically mirror enrollment growth (**Exhibit 7**). Average annual expenditure growth over the fiscal 2013 to 2017 period is 9.2%, which is mainly driven by the increasing enrollment, especially for the ACA expansion population, as noted earlier. However, growth between fiscal 2016 and 2017, is 7.0%.

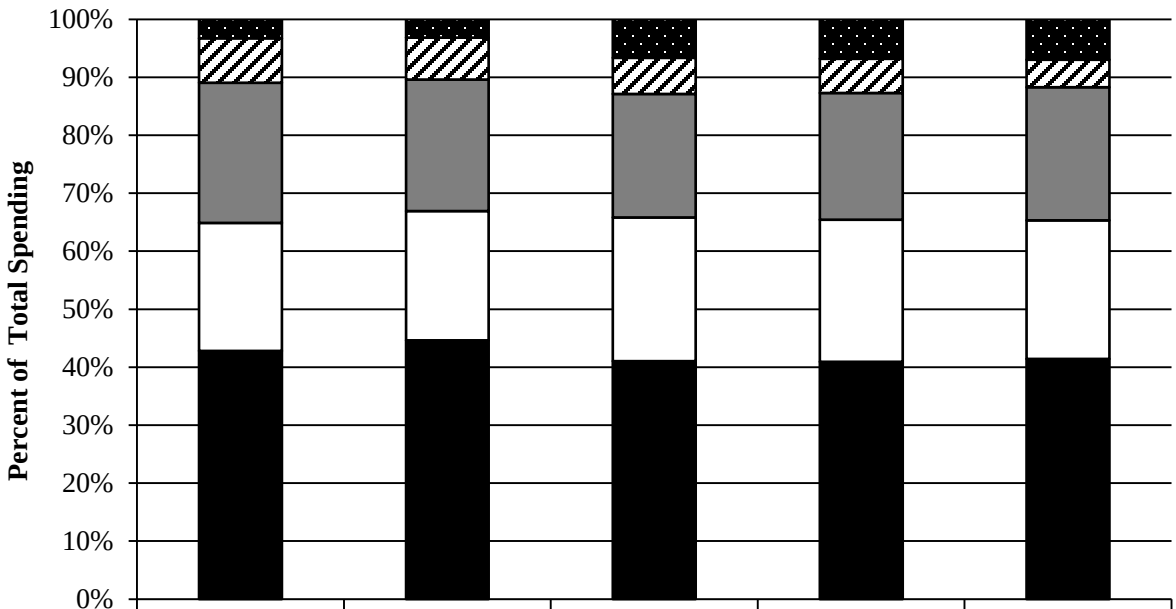
Exhibit 7
Community Mental Health Fee-for-service Expenditures
Fiscal 2013-2017



Source: Maryland Department of Health; Department of Legislative Services

Beyond overall expenditure growth, there have also been some changes in expenditure patterns between different services (**Exhibit 8**). All services, with the exception of residential treatment, have expenditure growth between fiscal 2013 and 2017, with the largest increase in other services, as well as inpatient spending (32.0% and 11.5%, respectively). However, most of the growth in other services is due to the change in the TCM reimbursement model from the care management entity to ASO previously discussed, while the growth in inpatient services over the timeframe is mostly attributable to the ACA expansion population which, under the old PAC program, did not have access to these services.

Exhibit 8
Community Mental Health Services Expenditures by Service Type
Fiscal 2013-2017



	2013	2014	2015	2016	2017
Other	$21,588,505	$23,761,643	$56,057,440	$59,534,766	$65,554,999
RTC	50,740,960	54,304,385	52,827,035	52,011,824	44,413,538
PRP and RRP	159,771,844	170,161,634	179,854,706	192,150,986	216,134,404
Inpatient	145,656,749	167,598,555	209,774,441	214,844,699	224,765,038
Outpatient	283,015,346	334,820,189	346,706,531	359,683,751	389,217,277

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

Source: Maryland Department of Health; 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 9** 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 2013, 2014, 2015, 2016, and 2017 cohorts. Most of the data for the adult mental health population remains positive with a notable improvement in the net improvement of functioning, which fell dramatically in fiscal 2015 to 4.5%, but has since recovered to 11% in fiscal 2017. Net improvement for children, however, is in its second straight year of decline, down to 13.2%. The other data is also rather positive, with steady declines in the number of persons unemployed and homeless in both observations, as well as a small improvement in the increase in employment between observations.

Exhibit 9
Outcome Measurement System Data
Fiscal 2013-2017

	Reported in 2013	Reported in 2014	Reported in 2015	Reported in 2016	Reported in 2017
Adult Mental Health Outcomes					
Net Improvement in Functioning (Percent of Total Observations)	14.3%	14.4%	4.5%	8.1%	11.0%
Increase in Employment Between Observations	-0.1%	0.4%	-1.5%	-0.6%	0.3%
Persons Unemployed in Both Observations	63.1%	61.5%	59.9%	59.5%	57.8%
Homelessness in Both Observations	5.0%	4.7%	4.6%	3.7%	3.5%
Children and Adolescents Mental Health Outcomes					
Net Improvement in Functioning (Percent of Total Observations)	14.1%	14.6%	14.6%	13.7%	13.2%

Source: Maryland Department of Health

Beyond just data on the mental health population, ASO has now begun to collect information on those receiving outpatient services with both mental health and SUD conditions. The data presented in **Exhibit 10** is based on the same measurements as the data in Exhibit 9, but instead now shows the metrics for fiscal 2016 and 2017 for each consumer type by treatment. As seen in the exhibit, while

there has been improvement for the mental health populations, overall the metrics for fiscal 2017 are worse than in fiscal 2016. This is because both those individuals with SUD conditions as well as co-occurring conditions experienced a dramatic decline in both the net improvement of functioning and increase in employment along with increases in the number of individuals unemployed.

Exhibit 10
Outcome Measurement System Data
Fiscal 2016-2017

Adult Behavioral Health Outcomes	2016				2017			
	All	MH	SUD	Co-occuring	All	MH	SUD	Co-occuring
Net Improvement in Functioning (Percent of Total Observations)	10.9%	8.1%	3.7%	16.9%	8.3%	11.0%	1.2%	11.9%
Increase in Employment Between Observations	-0.2%	-0.6%	7.3%	3.2%	0.5%	0.3%	1.2%	1.9%
Persons Unemployed in Both Observations	58.3%	59.5%	42.2%	53.5%	56.1%	57.8%	51.6%	62.8%
Homelessness in Both Observations	3.8%	3.7%	5.0%	9.5%	3.9%	3.5%	5.3%	7.3%

MH: mental health
SUD: substance abuse disorder

Source: Maryland Department of Health

6. Outcomes for State-run Psychiatric Facilities

Beyond the large community-based system that is financed and managed by the department, BHA also oversees the State's large residential psychiatric facilities, including four regional adult psychiatric hospitals (Thomas B. Finan, Eastern Shore, Springfield, and Spring Grove hospital centers), one maximum forensic psychiatric facility (Clifton T. Perkins Hospital Center), and two Regional Institutes for Children and Adolescents (RICA), which are residential treatment facilities for children (RICA – Baltimore and the John L. Gildner RICA in Montgomery County).

Exhibit 11 provides performance metrics for the facilities regarding the readmission rate, for which every facility the goal is to have a 30-day readmission rate below 5%. As shown in the exhibit, all but one of the facilities met this goal in fiscal 2017, which is worse than fiscal 2016 when all of the facilities were in compliance. Further, three of the facilities had higher readmission rates in fiscal 2017 than 2016.

Exhibit 11
State-run Facilities: Readmissions within 30 Days of Discharge
Fiscal 2013-2017
(Percent of Total Admissions)

Readmission	2013	2014	2015	2016	2017
Thomas B. Finan	6.4%	1.2%	11.1%	3.8%	8.1%
RICA – Baltimore	0.0%	0.0%	0.0%	2.5%	0.0%
Eastern Shore	2.2%	5.2%	2.1%	2.4%	3.0%
Springfield	4.1%	2.3%	2.6%	2.0%	2.8%
Spring Grove	2.5%	1.4%	1.6%	1.2%	1.1%
Clifton T. Perkins	2.2%	3.2%	3.7%	1.4%	0.0%
RICA – Gildner	0.0%	0.0%	0.0%	0.0%	0.0%

RICA: Regional Institutes for Children and Adolescents

Source: Governor's Budget Books

Exhibit 12 provides data on the rate of staff time lost due to injury sustained in the performance of an employee's job duties. The goal is to not have this rate exceed 3 hours per 1,000 hours worked. As seen in the exhibit, all but one of the facilities failed to meet this goal. However, four facilities did see improvement from fiscal 2016.

Exhibit 12
State-run Facilities: Rate of Staff Time Lost Due to Injury
Fiscal 2013-2017
(Number of Hours per 1,000 Hours Worked)

Staff Injury	2013	2014	2015	2016	2017
Thomas B. Finan	2.2	10.5	14.1	11.0	9.9
RICA – Baltimore	2.6	0.4	0.5	0.7	3.8
Eastern Shore	0.2	3.1	0.7	17.3	0.4
Springfield	5.8	3.2	3.2	5.8	4.1
Spring Grove	2.0	1.6	1.2	3.8	5.0
Clifton T. Perkins	8.3	9.2	12.6	19.5	15.6
RICA – Gildner	2.3	1.3	1.4	1.0	4.7

RICA: Regional Institutes for Children and Adolescents

Source: Governor's Budget Books

Fiscal 2018 Actions

Proposed Deficiency

There are a total of 11 deficiency appropriations for BHA in the budget. The two largest are for Medicaid provider reimbursements, including $17,000,000 in general funds and $34,460,000 in federal funds (for services provided in fiscal 2017 for which there is currently insufficient accrual available) and $7,800,000 in general funds and $50,360,000 in federal funds for reimbursement for fiscal 2018 based on recent trends. Additionally, there are further deficiencies to increase capacity in the community to accommodate court-ordered placements ($1,975,335 in general funds) and additional funds for FFS residential treatment services ($3,264,681 in general funds).

The rest of the deficiencies are for the various residential institutions under the jurisdiction of BHA. In total, $1,277,998 in general funds are being added to various institutions to cover operational costs as well as some salary differentials in order to support the department's expansion of both its inpatient adult psychiatric beds as well as beds at the RICAs to reduce the number of children in out-of-state placement. This is in addition to $492,513 in general funds within the Developmental Disabilities Administration to support the expansion of beds at Potomac Center as part of the BHA adult psychiatric expansion. Further, there is an additional deficiency to cover the costs of maintaining the Crownsville Hospital Center, including $733,593 in general funds and $6,273 in special funds.

Cost Containment

On September 6, 2017, the Board of Public Works (BPW) reduced appropriations across State government, which included within the Maryland Department of Health (MDH) an across-the-board 25% reduction in travel expenses. The share of this reduction within BHA is $34,281.

Across-the-board Employee and Retiree Health Insurance Reduction

The budget bill includes an across-the-board reduction for employee and retiree health insurance in fiscal 2018 to reflect a surplus balance in the fund. This agency's share of this reduction is $3,739,973 in general funds, $6,314 in special funds, and $64,340 in federal funds.

Proposed Budget

As shown in **Exhibit 13**, the fiscal 2019 allowance for BHA increases by $73.1 million net of fiscal 2018 and 2019 across-the-board actions. The majority of this increase ($69.9 million) is tied to increases in FFS community behavioral health services.

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

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2017 Actual	$911,218	$52,898	$860,798	$7,898	$1,832,813
Fiscal 2018 Working Appropriation	984,016	51,715	1,016,138	7,713	2,059,583
Fiscal 2019 Allowance	1,032,849	48,413	1,038,387	12,990	2,132,639
Fiscal 2018-2019 Amount Change	$48,833	-$3,302	$22,249	$5,277	$73,056
Fiscal 2018-2019 Percent Change	5.0%	-6.4%	2.2%	68.4%	3.5%

Where It Goes:

Personnel Expenses	
Employee and retiree health insurance, primarily the impact of the fiscal 2018 health insurance deduction holidays	$3,395
General salary increase	2,947
Overtime costs	2,104
New positions (34 full-time equivalents)	1,870
Workers' and unemployment compensation	519
Retirement contributions	-86
Turnover adjustments	-527
Salary adjustments	-1,121
Social Security contributions	-1,316
Fee-for-service Community Behavioral Health Services	
Enrollment and utilization for Medicaid-eligible services	84,319
Rate adjustment for community providers (2% increase)	17,868
Regulated rate changes	12,761
Cost settlements	4,355
Administrative Service Organization contract	4,322
Psychiatric inpatient spending	2,068

Where It Goes:

Money Follows the Person	21
Enrollment and utilization for Medicaid State-funded and uninsured services	-349
Data match savings	-10,150
Applied Behavioral Health Analysis	-19,645
Drug screening savings	-25,598
Community Mental Health Grants and Contracts	
Rate increase for Core Service Agencies (2%)	1,143
Decrease in mental health federal grant funds	-4,599
Community Substance Use Disorder Services	
Rate increase for uninsured (2%)	2,755
Problem Gambling fund	-923
Fee-for-service and uninsured enhancements	-947
Federal fund grant changes	-3,332
Institutions	
Crownsville deficiency	-740
Program Direction	
Opioid Crisis Fund	3,200
Prescription Drug Monitoring Program (federal funds)	-993
Other	-265
Total	**$73,056**

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

Personnel

Personnel expenses for BHA increase by $7.8 million in fiscal 2019. The largest increases have to do with statewide adjustments, including $3.4 million tied to the reduction of health insurance expenses in fiscal 2018, as well as the fiscal 2019 general salary increase. The fiscal 2019 allowance includes funds for a 2% general salary increase for all State employees, effective January 1, 2019. These funds are budgeted in the Department of Budget and Management's statewide program and will be distributed to agencies during the fiscal year. This agency's share of the general salary increase is $2,915,042 in general funds, $3,283 in special funds, $25,728 in federal funds, and $3,351 in reimbursable funds.

Beyond the statewide adjustments, the two most notable changes are increases for overtime as well as for new positions. Overtime costs are increased by $2.1 million in the fiscal 2019 allowance to a total of $16.2 million. Further, it should be noted that while the most recent actual overtime expenses

totaled $16.6 million, BHA's total overtime expenses only averaged $15.2 million from fiscal 2015 to 2017. The allowance appears to have not only adequately budgeted for overtime but even possibly overbudgeted given the department's focus on filling vacancies, which hopefully would cause overtime costs to decline.

Also, there is $1.9 million added to the budget for new regular positions, totaling 34 full-time equivalent positions. This includes 1 additional position for the Opioid Operational Command Center (OOCC), 1 position for the Thomas B. Finan Hospital Center, 8 new positions for Springfield Hospital Center, 11 new positions for Spring Grove Hospital Center, and 13 new positions for Clifton T. Perkins Hospital Center. The additional positions within the facilities are to further support the department's efforts at expanding its residential bed capacity in fiscal 2018 as there were many positions reallocated to various hospitals internally to more quickly staff up the expansions.

It should be mentioned that during the interim, the Department of Legislative Services (DLS) conducted a staffing analysis of the BHA hospitals to determine if they were adequately staffed. Due to the timing of the analysis, the staffing analysis did not take into consideration the additional beds added to the system for BHA since DLS did not have the appropriate staffing detail to conduct a robust analysis. With the submission of the fiscal 2019 allowance, DLS has updated its prior numbers, and now can conclude that BHA is understaffed by approximately 104 positions, compared to the 49-position deficit presented in the interim report. More information on this topic is presented in Issue 4.

Community Behavioral Health Services

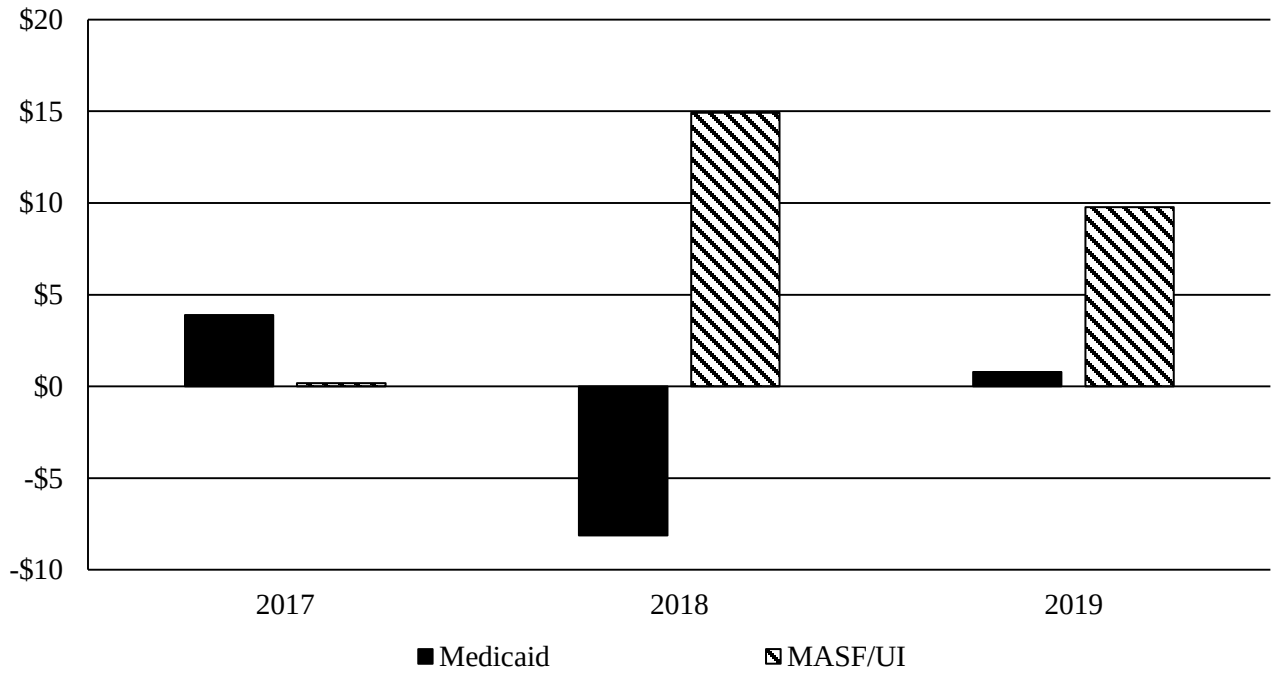
FFS Expenditures

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 2019 allowance by $69.9 million, accounting for the majority of the change within the overall BHA allowance. The largest change is $84.3 million to account for enrollment and utilization trends, which follows the trends previously discussed. The next largest increases include the proposed 2% community provider rate increase ($17.9 million) as well as regulated rate increases ($12.8 million).

The FFS budget increases adjustments for various cost containment actions, including $25.6 million from drug screening savings as well as $10.1 million in assumed savings from a data matching initiative. The drug screening savings are a result of Medicaid no longer reimbursing for more expensive drug screening services that have not been proven to be more effective than other screening services that can be offered at a much cheaper rate, while the data matching initiative involves searching databases to ensure that enrollees in Maryland Medicaid are actually eligible. More information on the data matching can be found in the MCPA analysis. Further, while there is a large decrease of $19.6 million in Applied Behavioral Analysis services, this is mainly a function of those services being overbudgeted in the current fiscal 2018 appropriation due to the very slow start to the program.

The DLS estimate of the adequacy of State-supported funds to meet demand for FFS community behavioral health services is provided in **Exhibit 14**. Overall, funding across fiscal 2017 through 2019 appears to be more than adequate. In fact, in both fiscal 2018 and 2019, it appears as though there is more than enough to support expected spending, especially for State-funded and uninsured services, with an overall surplus of $6.8 million for fiscal 2018 and $10.5 in fiscal 2019. This projected surplus of general funds is mainly due to a transition to FFS financing for SUD residential treatment services as well as the increased federal match for these services though the HealthChoice waiver. **DLS recommends deleting the deficiency appropriation for SUD residential treatment services and reducing general funds by $8 million in fiscal 2019. DLS also recommends withholding an additional $2.5 million for the Opioid Crisis Fund to backfill funds used for rates from that program.**

Exhibit 14
Projected General Fund Balance
Fiscal 2017-2019
($ in Millions)



MASF: Medical Assistance State Funded
UI: uninsured

Source: Maryland Department of Health; Department of Legislative Services

Grants and Contracts – Mental Health

Various grants and contracts for mental health providers decrease by $3.5 million, mainly as a result of decreases in two federal fund grants, the Community Mental Health Services Block (CMHSB) grant ($2.6 million) and the Maryland Collaboration for Homeless Enhancement Services (MD CHES) grant ($1.1 million). The CMHSB decline represents both a change in the way the grant is funded as well as a decline in the total amount of the grant, while MD CHES is ending in fiscal 2019. These decreases are partially offset by additional general funds ($1.1 million) due to the proposed 2% rate increase for the CSAs.

Grants and Contracts – SUD

Overall, grants and contracts for SUD services, outside of the funding contained in the Opioid Crisis Fund (OCF), decrease by $2.4 million. Again, the majority of the decrease is attributable to declining federal revenues, this time both for the SUD portion of MD CHES ($1.4 million) as well as a decline in funding for the Maryland Opioid Rapid Response (MORR) funding ($1.7 million), which was granted to the State under the federal 21st Century Cures (CURES) Act. Again, these decreases are partially offset by the proposed 2.0% rate increase for community providers which is also applied to these grants.

Other Changes

The only other large change in the BHA allowance is an increase of $3.2 million in the OCF. This brings total funding up to $13.7 million, including grants as well as the operating expenses of OOCC. This funding is further discussed in Issue 1. There are also some notable decreases, including $1 million in special and federal funds for the Prescription Drug Monitoring Program that were provided last year for one-time startup costs as well as a decrease of $0.7 million due to the fact that once again the department has failed to budget for the costs of operating the Crownsville Hospital Center.

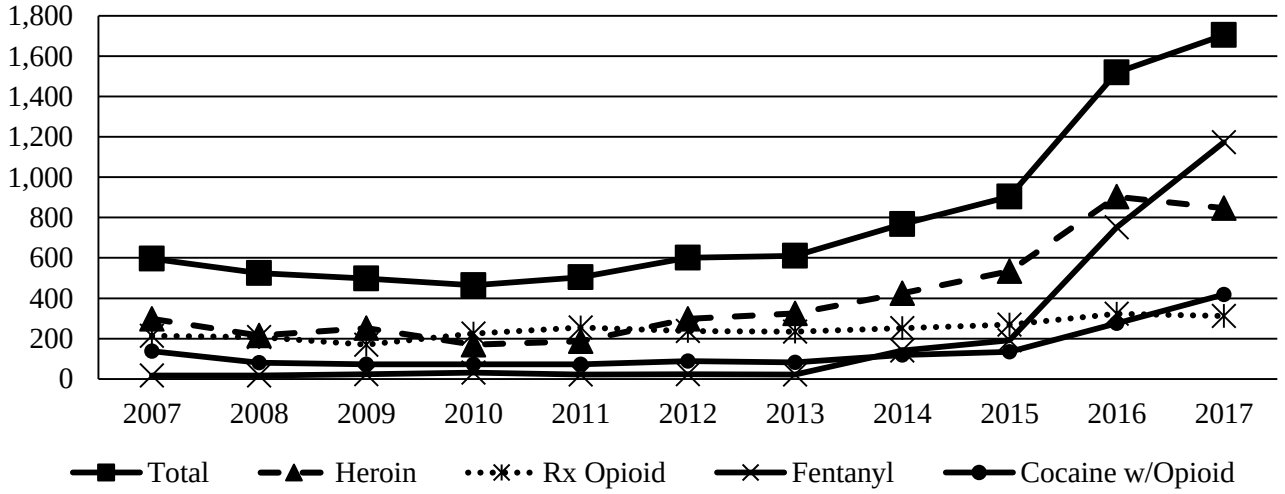
The Crownsville oversight is rather striking in that since the previous session, MDH seems to have completely changed their mind as to what to do with the property. The department had previously indicated that they were looking to finally dispose of the closed hospital property, which has been vacated, with some minimal exceptions, since 2004. However, in June 2017, the department set up an arrangement with the Maryland Stadium Authority (MSA) to provide new ideas about how the property could be used in a beneficial way by the department. The department is to provide MSA with $400,000, but there is no funding within the MDH budget that has been identified to pay for the study. **The department should comment on the project being undertaken by MSA, how the department intends to pay for their portion of the study, and further comment on why operating funds were not placed in the allowance if the department no longer seeks to dispose of the property.**

Issues

1. The Opioid Epidemic – Trying to Beat Fentanyl

Opioid use, and in particular overdoses and overdose deaths continue to be a serious and urgent public health issue. As seen in **Exhibit 15**, the dramatic rise in overdose deaths in recent years, and in particular, in the first three quarters of 2016 and 2017, has been primarily driven by fentanyl, which is a powerful synthetic opioid that is estimated to be up to 50 times more powerful than heroin. Fentanyl is now heavily present within the illicit opioid supply within the State, and, in part, also explains the rise in both heroin as well as prescription opioid deaths also shown in the exhibit. In addition, beginning in 2016, the State has been testing overdose victims for another synthetic opioid known as carfentanil, which is an even more powerful opiate normally used as an elephant tranquilizer. While there were no positive tests in 2016, to date in 2017, 57 individuals have tested positive for this new substance. Further, there has also been a notable increase in the number of overdose deaths where cocaine and opioids were both present, potentially signaling that fentanyl is not only in the illicit heroin and prescription opioid supply but in the illicit cocaine supply as well. The presence of these substances and their impact on the overdose deaths in the State show the urgent need to not only treat individuals with opioid use and other SUDs but to prevent the occurrence of new users as well.

Exhibit 15
Overdose Deaths by Related Substance
January to September 2007-2017*



Rx: medical prescriptions

*2017 counts are preliminary.

Source: Maryland Department of Health

Federal Actions to Address the Opioid Crisis

Several federal actions in the past 18 months have expanded funding for substance use and taken other measures to address the opioid crisis. In 2016, the Comprehensive Addiction and Recovery Act authorized over $181 million annually, and the CURES Act authorized up to $970 million to be distributed through the State Targeted Response to the Opioid Crisis grants. The grants are to be used by states to increase access to treatment and reduce unmet treatment needs and opioid-related overdose deaths. In 2017, Maryland received a two-year, $20 million grant for the prevention and treatment of opioid abuse, which is funding the MORR program in both fiscal 2018 and 2019. In March 2017, President Donald J. Trump signed an executive order establishing the President's Commission on Combating Drug Addiction and the Opioid Crisis. The commission issued an interim report with recommendations in July 2017 and a final report in November 2017. On October 26, 2017, President Trump declared the opioid crisis a public health emergency, to be effective for 90 days. The declaration authorizes the U.S. Department of Health and Human Services to expand access to telemedicine in rural areas, waive certain regulations that may be hampering the response to the opioid epidemic, and shift grant funding to address the opioid crisis – further, the most recent budget proposal by the Trump Administration proposes to increase federal spending on the opioid crisis by $13 billion in federal fiscal years 2018 and 2019.

Maryland Actions to Address the Opioid Crisis

Legislative Response

The General Assembly of Maryland passed several comprehensive acts during the 2017 session to address the State's opioid crisis that addressed prevention, treatment, overdose response, and prescribing guidelines.

Chapters 571 and 572 of 2017, the Heroin and Opioid Prevention Effort (HOPE) and Treatment Act, among other things, requires (1) BHA to establish crisis treatment centers that provide individuals in a SUD crisis with access to clinical staff, requiring at least one center to be established by June 1, 2018; (2) MDH to establish and operate a toll-free health crisis hotline; (3) certain health care facilities and systems to make available to patients the services of health care providers who are trained and authorized under federal law to prescribe opioid addiction treatment medications, including buprenorphine; (4) each hospital, by January 1, 2018, to have a protocol for discharging a patient who was treated for a drug overdose or identified as having a SUD; (5) the Governor's proposed budget for fiscal 2019 through 2021 to include specified rate adjustments for community behavioral health providers; (6) the Department of Public Safety and Correctional Services (DPSCS) and MDH to develop a plan to increase the provision of SUD treatment, including medication assisted treatment (MAT), in prisons and jails; (7) the authorization of the provision of naloxone through a standing order and requires that MDH establish guidelines to coprescribe naloxone to high-risk individuals; and (8) the expansion of private insurance coverage for opioid use disorders by prohibiting certain carriers from applying a pre-authorization requirement for a prescription drug when used for treatment of an opioid use disorder and that contains methadone, buprenorphine, or naltrexone.

Chapter 573 of 2017, the Heroin and Opioid Education and Community Action Act (Start Talking Maryland Act) requires (1) the State Board of Education to expand an existing program in public schools to encompass drug addiction and prevention education that specifically includes instruction related to heroin and opioid addiction and prevention and information relating to the lethal effect of fentanyl; (2) each local board of education to establish a policy requiring each public school to obtain and store naloxone and other overdose-reversing medication to be used in an emergency situation; (3) each local board of education or local health department to hire a sufficient number of community action officials or develop and implement a program that provides community relations and education functions that coordinate forums and conduct public relations efforts; and (4) specified institutions of higher education in Maryland to establish a policy that addresses heroin and opioid addiction and prevention, including awareness training for incoming students, obtaining and storing naloxone, and campus police training.

Chapter 570 of 2017 requires a health care provider, on treatment for pain and based on the clinical judgment of the provider, to prescribe the lowest effective dose of an opioid and a quantity that is no greater than that needed for the expected duration of pain severe enough to require an opioid that is a controlled dangerous substance (CDS). The Act provides that the quantity limitations do not apply to opioids prescribed to treat a substance-related disorder; pain associated with a cancer diagnosis; pain experienced while the patient is receiving end-of-life, hospice, or palliative care services; or chronic pain. A violation of the Act is grounds for disciplinary action by the appropriate health occupations board.

Executive Branch Initiatives

The Administration has taken several initiatives to address the opioid epidemic, including implementing Medicaid payment reforms, establishing OOCC, declaring a state of emergency for the opioid crisis, and providing additional funding targeted to the crisis.

Medicaid Reforms: Maryland transitioned its Medicaid billing for SUD services to a FFS system on January 1, 2015, as part of the behavioral health integration initiative. Rates were established based on prevailing Medicare rates for those services at that time. Since then, the State has implemented changes to the rates and rate structure, in particular, for the provision of the weekly bundled rate for MAT and methadone services. Effective March 1, 2017, the State rebundled the weekly MAT reimbursement rate to allow opioid treatment programs to bill for outpatient counseling separately. The rebundled rates are intended to encourage the provision of more counseling sessions by allowing for enhanced billing.

While these rates at the time were based on the prevailing Medicare rate, one of the recommendations of the Governor's Heroin and Opioid Emergency Task Force was for MDH to conduct a comprehensive review of the Medicaid and other rates provided to SUD providers. While MDH had indicated that the review was currently underway and further indicated at last year's budget hearing that the review was nearly complete, no review has been produced. Further, in response to concerns that the review would be forgotten, the budget committees requested through the *Joint Chairmen's Report* (JCR) a formal report on the adequacy of SUD treatment rates and set a due date of November 1, 2017. However, no report has yet been submitted, almost a year after the

department indicated that they were done with the report. **The department should comment on the status of the late JCR report.**

In addition, as part of its recently approved HealthChoice waiver, Maryland was granted a limited exception to the federal Institutes for Mental Disease exclusion, which will allow the State to receive federal Medicaid reimbursement for the provision of residential treatment for individuals between the ages of 21 and 65 for up to two 30-day stays per year. This new provision has changed SUD residential treatment from an entirely State-funded, limited benefit to a widely available benefit for all Medicaid-eligible beneficiaries. Maryland is only the third state to receive this type of waiver.

Opioid Operational Command Center: In January 2017, Governor Lawrence J. Hogan, Jr., issued an executive order establishing OOCC to facilitate collaboration between State and local public health, human services, education, and public safety entities to combat the heroin and opioid crisis. OOCC will (1) develop operational strategies to continue implementing the recommendations of the Governor's Heroin and Opioid Emergency Task Force; (2) collect, analyze, and facilitate the sharing of data relevant to the epidemic from State and local sources while maintaining the privacy and security of sensitive personal information; (3) develop a Memorandum of Understanding among State and local agencies that provides for the sharing and collection of health and public safety information and data relating to the heroin and opioid epidemic; (4) assist and support local agencies in the creation of opioid intervention teams (OIT); and (5) coordinate the training of and provide resources for State and local agencies addressing the threat to the public health, security, and economic well-being of the State.

Governor's State Of Emergency Declaration And Funding: In March 2017, Maryland became the first state to declare a state of emergency for the opioid crisis, activating the Governor's emergency management authority and enabling increased and more rapid coordination between the State and local jurisdictions. In conjunction with the declaration, Governor Hogan included a supplemental budget appropriation of $10 million, part of a $50 million, five-year commitment to address the State's heroin and opioid epidemic. In July 2017, the Governor along with OOCC, MDH, and the Governor's Office of Crime Control and Prevention (GOCCP) announced that they had made new funding decisions for $22 million within the fiscal 2018 budget, which included the $10 million in the OCF, $10 million in CURES Act funding through MORR, and $2.1 million from GOCCP. **Exhibit 16** provides an overview of what will be funded through this initiative. Prevention efforts include a public awareness campaign, funding to train community teams on overdose response and linking to treatment, a pilot program to create school-based teams for early identification of the problems related to SUDs, and distribution of opioid information to health care facilities and providers that offer treatment. Enforcement initiatives include funding to disrupt drug trafficking organizations for the heroin coordinator program and to increase MDH's regulatory oversight of CDS. Treatment funding will be used for funding for OITs within each jurisdiction, expand treatment beds and implement a tracking system to identify available beds; improve access to naloxone; establish a 24-hour crisis center in Baltimore City; expand use of peer recovery support specialists; expand Screening, Brief Intervention, and Referral to Treatment to hospitals and parole, probation, and correctional facilities; increase access to MAT; expand law enforcement diversion programs; and improve the State's crisis hotline.

Exhibit 16
Opioid Operational Command Center Funding
Fiscal 2018

Prevention	
Public Awareness Campaigns	$1,400,000
Training for Community Teams	700,000
Pilot Program for School-based teams for early identification of substance use disorder (SUD)	200,000
Distribute information on opioids	200,000
Support for education initiatives with a focus on recovery schools and school recovery programs	200,000
Total Prevention	**$2,700,000**
Enforcement	
Add to existing efforts to disrupt and dismantle drug trafficking organizations	$1,250,000
Continue heroin coordinator program	850,000
Increase the Maryland Department of Health's oversight of controlled dangerous substances	450,000
Technology to support law enforcement	100,000
Total Enforcement	**$2,650,000**
Treatment	
Opioid Intervention Teams	$4,000,000
Expand treatment beds statewide and institute tracking system	3,200,000
Improve access to naloxone	2,700,000
Establish 24-hour crisis center in Baltimore City	2,000,000
Expand the use of peer recovery specialists	1,600,000
Expand the Screening, Brief Intervention, and Referral to Treatment program	1,000,000
Increase access to medications that support recovery from SUD	780,000
Support the expansion of existing law enforcement diversion programs	183,000
Improve the statewide crisis hotline	143,000
Rate setting study	80,000
Total Treatment	**$15,686,000**
Grand Total	**$21,036,000**

Source: Maryland Department of Health

This new funding in fiscal 2018 was in addition to other funding that has been provided both within the MDH budget as well as other State agencies, either due to recommendation of the Governor's Heroin and Opioid Emergency Task Force or through actions taken by the General Assembly. **Exhibit 17** provides an overview of all of the funding specifically dedicated to the opioid crisis since fiscal 2016 and includes funding that has been included in the fiscal 2019 allowance.

Exhibit 17
Funding Targeted to the Opioid Crisis
Fiscal 2016-2019

	2016	2017	2018	2019
Maryland Department of Health				
Opioid Crisis Fund	$0	$0	$10,000,000	$13,000,000
Maryland Opioid Rapid Response (CURES Act federal funds)	0	0	10,036,843	8,364,036
Additional Funding for Treatment	2,000,000	3,100,000	3,100,000	3,100,000
Opioid Operational Command Center	0	500,000	500,000	700,000
Supplemental Budget funding for Court-ordered Treatment (Section 8-507)	0	3,000,000	3,000,000	3,000,000
Opioid Deficiency (for court-ordered treatment)	0	1,500,000	1,500,000	1,500,000
Implementing a Good Samaritan Law Public Awareness Campaign	0	697,653	697,653	697,653
Providing Recovery Support Specialists to Assist Pregnant Women with Substance Use Disorders	0	622,622	622,622	622,622
Requiring Mandatory Registration and Querying of the Prescription Drug Monitoring Program	0	522,245	522,245	522,245
Implementing a Statewide Buprenorphine Access Expansion Plan	0	206,480	206,480	206,480
Expanding Online Overdose Education and Naloxone Distribution	0	10,000	10,000	10,000
New funding for Prescription Drug Monitoring Program (special and federal funds)	0	0	1,974,592	0
Subtotal	***$2,000,000***	***$10,159,000***	***$32,170,435***	***$31,723,036***

	2016	2017	2018	2019
Department of Public Safety and Correctional Services				
Conversion of Baltimore City Detention Center into a residential substance abuse disorder treatment facility	$0	$0	$0	$1,200,000
Outpatient addictions aftercare at the Metropolitan Transition Center	0	358,000	358,000	0
Expand the segregated addictions program at the Maryland Correctional Training Center	0	138,000	138,000	138,000
Subtotal	***$0***	***$496,000***	***$496,000***	***$1,338,000***
State Police				
Multi-jurisdictional State Police Heroin Investigation Unit	$0	$200,000	$200,000	$200,000
Designating HIDTA the Central Repository for Maryland Drug Intelligence	0	75,000	75,000	75,000
Subtotal	***$0***	***$275,000***	***$275,000***	***$275,000***
Governor's Office of Crime Control and Prevention				
Day reporting center (previously in the Department of Public Safety and Correctional Services)	$0	$540,000	$270,000	$270,000
Opioid Response Funding (determined by OOCC)	0	0	2,100,000	2,100,000
Safe Streets	0	180,000	180,000	180,000
Subtotal	***$0***	***$720,000***	***$2,550,000***	***$2,550,000***
Maryland State Department of Education				
Start Talking Maryland Act	$0	$0	$0	$3,000,000
Local school websites to promote drug and heroin awareness	0	100,000	100,000	100,000
Subtotal	***$0***	***$100,000***	***$100,000***	***$3,100,000***
Grand Total	**$2,000,000**	**$11,750,000**	**$35,591,435**	**$38,986,036**

CURES: 21st Century Cures
HIDTA: High Intensity Drug Trafficking Area
OOCC: Opioid Operational Command Center

Source: State Budget

At this time, the most notable increases in fiscal 2019 funding are for the OCF ($3.0 million), the Maryland State Department of Education (MSDE) ($3.0 million) to begin funding initiatives under the Start Talking Now Act, and DPSCS ($1.2 million) for a new residential SUD treatment facility on the grounds of the Baltimore City Detention Center. However, with the OCF, one of the issues for fiscal 2019 is that despite the general fund increase, a large portion of these general funds ($5.3 million) have already been designated to support the 2% rate increase for providers, which is not one of the uses that the fund supported in fiscal 2018. The Administration has indicated that this was done in response to both the HOPE and Treatment Act as well as budget language that prioritized new initiatives within the HOPE Act when it came to making decisions on OCF funding. However, this language only applied to the fiscal 2018 allotment. Further, at this time, OOCC has yet to make any funding decisions regarding either the OCF or the federal MORR funding.

The pace of the OOCC funding decisions is worth noting as well. While the funds were all appropriated in April, there were no funding decisions until July as to what the money could be used for. Further, after funding announcements were made, many of the OITs had to wait until mid-September to receive their funds as OOCC required that each of the local jurisdictions submit their OIT funding proposals to OOCC for approval at the State level, even though the point of the OIT funding was to give local jurisdictions control over their own responses. In effect, by having so many decision levels and staggered funding decisions that must be revisited and changed every year, the Administration has made the provision of opioid funding during a state of emergency more bureaucratic. **The department should comment on when OOCC can be expected to make funding decisions for fiscal 2019 and when local jurisdictions and other providers can expect to receive their funds based on that timeline. Further, DLS recommends the adoption of committee narrative continuing to request quarterly reports from OOCC on spending from the OCF.**

2. State Psychiatric Institutions Expand, but Remain Full

Patient flow through the State's adult inpatient psychiatric facilities has continued to remain a concern. This concern is not new, as **Appendix 2** identifies up to 72 recommendations that have been presented to the department since 1999 dealing with this issue, of which only 51 recommendations (71%) have been either fully or partially implemented by the department. However, even with this heighted focus, the issue reached a boiling point this summer as numerous contempt hearings were held in response to the number of people waiting, and the average wait time, to be admitted to a State psychiatric hospital continued to climb, with some of the highest totals ever recorded happening in the last year. The most pressing case resulted in numerous officials within MDH being held in contempt by the Baltimore City Circuit Court in July. While the order was subsequently stayed pending appeal, the department began taking action in order to address the Judiciary's concerns.

Bed Expansion and Other Actions

The main response to the contempt proceedings, other than the new rates begun during fiscal 2018, has been to expand the State's residential bed capacity as well as purchase admissions beds within private hospitals. Altogether, the expansion totals 95 beds, and as shown in **Exhibit 18**, the expansion should be completed within the current fiscal year. Further, the department has also changed

the organizational structure and the admissions process for the State hospital system. Previously, each of the hospitals in many ways operated independently from one another, with their own directors and waitlists for the patients provided from their assigned jurisdictions. Now, as of November 1, 2017, BHA has reorganized and created both a State Director of Hospitals as well as a Centralized Admissions Office for the adult psychiatric institutions. This was done in order to build a more efficient admissions process for the system as a whole and to give BHA greater control over the court-ordered waitlist.

Exhibit 18
State Psychiatric Hospitals Bed Expansion and Purchase Schedule

Hospital	Beds	Completion
Clifton T. Perkins	20	April 2017
Clifton T. Perkins	20	December 2017
Potomac Center	12	October 2017
Potomac Center	6	January 2018
Eastern Shore Hospital	24	March 2018
Bon Secours (private)	5	November 2017
Adventist (private)	8	November 2017

Source: Maryland Department of Health

Beyond these actions, there are also some legislative initiatives that are being formulated. These include HB 111 and SB 233, which would reiterate that the department must immediately place an individual committed to it by the Judiciary. Further, HB 385 would grant the department leeway in its placement timeline but only by 21 days. Both of these pieces of legislation are in response to a Court of Appeals case, known as *Powell*, which determined that while the Judiciary decides which individuals to commit to the department's care, they do not have the authority to dictate by when and where an individual has to be admitted to a facility, based upon the current statute.

Utilization of Crisis Services

One of the ways in which the State could prevent further episodes of forensic patients backing up within the detention centers, and again one of the recommendations that has been made but not adequately implemented by the department, is the provision of an appropriate crisis response system throughout the State. Crisis services, especially when integrated with the local law enforcement community, not only provide a more appropriate and immediate level of care to the individual in question, but also have the potential to divert the individual completely from the criminal justice process. In recognition of how important this type of system could be, the General Assembly passed Chapters 405 and 406 of 2016, requiring the Behavioral Health Advisory Council (BHAC) to develop a strategic plan for ensuring that clinical crisis walk-in services and mobile crisis teams are available

in every jurisdiction in the State on a 24-hour, 7 day-a-week basis. This plan was submitted by BHAC in November 2017.

The report contained eight recommendations, which are outlined in **Exhibit 19**. Most importantly, if implemented, these recommendations would establish a comprehensive network of crisis services throughout the State that could potentially alleviate not only the pressure on the State forensic inpatient system but also on the acute general hospitals (more in Issue 3). However, if the report had one shortcoming, it is that there was no cost estimate provided for what it would take to fully implement the plan. As such, no funding has been included in the allowance for the expansion of crisis services and, further, it is unclear as to how and when the department would be able to implement these recommendations. **The department should comment on which recommendations from the BHAC crisis report it plans to implement and provide a timeline for implementation.**

Exhibit 19
Crisis Services Recommendations

1. Establish a crisis walk-in and mobile crisis team program model for each jurisdiction or region.
2. A delegation from Maryland composed of various representatives should make a site visit to one or more of the comprehensive crisis services sites, in either San Antonio, TX, or Shelby County, TN.
3. The Behavioral Health Administration (BHA), with input from the Behavioral Health Advisory Council, local behavioral health authority directors, and other stakeholders should determine how the jurisdictions can be divided into regions for purposes of siting these services.
4. Each jurisdiction should develop an ongoing crisis services advisory group chaired by their local behavioral health authority director(s) and composed of stakeholder representatives including law enforcement and local hospitals to work on the development and implementation of their crisis plan.
5. BHA should explore the Medicaid 1915(b) and 1915(c) waivers for behavioral health crisis services as one source of a comprehensive funding strategy. Local government funding strategies and potential funding from community organizations such as hospitals and private insurance providers should also be developed.
6. BHA should develop a plan to work with the legislature regarding the necessary changes in regulation, statute, or interpretation regarding the location at which an individual must be psychiatrically evaluated when detained on an Emergency Evaluation Petition (EEP).
7. Require that each crisis walk-in center capture a set of outcome data that include at a minimum: clinical outcomes, disposition, reduction in EEPs issued, diversion rate from emergency departments, diversion rate from hospitalization, and diversion rate from the criminal justice system.
8. Require accreditation of all crisis walk-in and mobile crisis team programs.

Source: Behavioral Health Advisory Council

Staffing

As mentioned previously, DLS has conducted a staffing analysis of the residential institutions under the jurisdiction of BHA. This analysis found that, prior to the bed expansion, the department was short by approximately 49 direct care positions. It should be reiterated that this analysis, while including direct care aides and security attendants at Perkins, did not include any analysis of the main security employees at the facilities. However, previous JCR responses have indicated that there remains a shortage of security personnel.

With the submission of the fiscal 2019 allowance, DLS has done an additional analysis of the staffing need for fiscal 2019. These results are included in **Exhibit 20**. Even after the addition of new regular positions in both the working appropriation and the allowance, the BHA staffing shortage has worsened by 55 positions because of the bed expansion. Further, the staffing ratios that were used to conduct this study were based upon JCR reports and staffing analyses conducted by the department more than 10 years ago, with the most recent update happening in 2009. Since that time, according to the department, admissions to the facilities have become more forensic in nature, accounting for over 90% of all admissions. **DLS recommends adding budget bill language requesting a report containing a new staffing analysis.**

Exhibit 20
Behavioral Health Administration Clinical Staffing Assessment
Fiscal 2019

	Authorized Positions	Estimated Need	Difference
Registered Nurses	582.47	573.2	9.27
Licensed Practical Nurses	287.94	429.9	-141.96
Direct Care Aides	478.3	429.9	48.4
Psychiatrists	99.18	81.7	17.48
Psychologists	81.14	52.32	28.82
Rehabilitation	106.45	188.54	-82.09
Social Workers	100.5	84.8	15.7
Total	**1,735.98**	**1,840.36**	**-104.38**

Source: Maryland Department of Health; Department of Legislative Services

3. Private Psychiatric Capacity Fares No Better

In response to concerns that behavioral health patients were flooding acute care hospital emergency rooms and services, over the past two years, DLS has been studying the utilization and capacity of acute general hospitals for psychiatric services. DLS requested information from the Health Services Cost Review Commission (HSCRC) on the number and dispositions of psychiatric patients at all acute care general 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 2016. **Exhibit 21** provides information for both psychiatric inpatient as well as emergency department (ED) utilization. As shown in the exhibit, the number of patients within the inpatient wards as well as the EDs has declined. However, the average length of stay and average number of observation hours have been increasing, leading to more patient days and more total observation hours.

Exhibit 21
Psychiatric Utilization of Acute Care Hospitals
Fiscal 2013-2016

	Dispositions				Avg. Length of Stay (Days)				Total Patient Days			
Inpatient	**2013**	**2014**	**2015**	**2016**	**2013**	**2014**	**2015**	**2016**	**2013**	**2014**	**2015**	**2016**
Total	23,342	22,542	22,250	21,125	5	6	6	6	124,532	124,926	125,634	127,732
Percent Increase		-3.43%	-1.30%	-5.06%		20.00%	0.00%	0.00%		0.32%	0.57%	1.67%

	ED Visits				Observation Hours			
Emergency Department	**2013**	**2014**	**2015**	**2016**	**2013**	**2014**	**2015**	**2016**
Total	23,936	23,435	23,035	21,994	4,424	6,440	8,117	9,786
Percent Increase		-2.09%	-1.71%	-4.52%		45.57%	26.04%	20.56%

ED: emergency department

Source: Health Services Cost Review Commission

Hospitals Maintain Capacity

Further, while patients have been having longer stays both within the inpatient wards and EDs, overall bed capacity has remained relatively stable. **Exhibit 22** provides the number of licensed beds provided at each hospital that changed its capacity over this timeframe, as well as the total number of psychiatric treatment spaces within EDs that have also changed their capacity. Interestingly, while the number of licensed beds has increased, it has been concentrated at only a few hospitals. Further, more hospitals have decreased capacity than have increased capacity, resulting in a further uneven distribution of capacity across the State. In fact, if Holy Cross Germantown Hospital, the only new hospital to open during the time period, is removed then capacity increases below the rate of increase for total average bed days. This also holds true for ED capacity. Overall, ED capacity has increased by 10.5% across the State. However, the total number of observation hours have increased by 121% during the same time period. Thus, hospitals are not increasing their capacity to account for increased demand.

Exhibit 22
Psychiatric Bed Capacity Changes
Fiscal 2013-2016

	2013	2016	Change
Inpatient Licensed Beds			
MedStar Franklin Square Hospital Center	24	40	16
Northwest Hospital	14	23	9
University of Maryland Shore Medical Center at Dorchester	16	24	8
Holy Cross Germantown Hospital	0	6	6
Union Hospital	7	11	4
Peninsula Regional Medical Center	10	12	2
University of Maryland Harford Memorial Hospital	27	26	-1
Calvert Memorial Hospital	11	9	-2
Meritus Medical Center	18	16	-2
Western Maryland Regional Medical Center	20	17	-3
Laurel Regional Hospital	14	9	-5
MedStar Montgomery Medical Center	25	20	-5
Bon Secours Hospital	32	24	-8
Total*	**703**	**722**	**19**

	2013	2016	Change
Emergency Departments			
Sinai Hospital of Baltimore	2	8	6
Laurel Regional Hospital	1	4	3
MedStar Union Memorial Hospital	2	4	2
Holy Cross Germantown Hospital	0	2	2
Howard County General Hospital	7	8	1
Holy Cross Hospital	4	5	1
Total*	**143**	**158**	**15**

* Total includes all acute care hospitals throughout the State.

Source: Maryland Health Care Commission

Because of this maintained capacity, hospitals are seeing an increase in the average patient days per bed, a metric which is used by hospitals to judge their utilization as well as the number of observation hours per psychiatric treatment space in EDs. **Exhibit 23** presents the number of dispositions, average patient days, licensed beds, and average patient days per bed for those hospitals who had more than 4% of the total dispositions within the State. It is worth noting that even with the average patient days increasing at some hospitals, none of the hospitals with more than a 10% increase in average patient days per bed increased their licensed capacity, and that further the two hospitals with the largest increase actually decreased their capacity. These trends also hold true for ED utilization as well, as shown in **Exhibit 24**. This exhibit provides data on all hospitals with reported observation hours across all four fiscal years. It is worth noting that of the six hospitals presented in Exhibit 22, only MedStar Union Memorial Hospital is present in this chart of hospitals with measurable changes in observation hour utilization. This is striking because, as shown in Exhibit 24, nine hospitals have seen the number of observation hours per dedicated psychiatric space increase by over 100% and four by many magnitudes higher, and yet none of them have added dedicated psychiatric space to their EDs.

Exhibit 23
Selected Hospital Psychiatric Inpatient Utilization Data
Fiscal 2013-2016

	Dispositions		Avg. Patient Days		Licensed Beds		Patient Days Per Bed		Change 2013-16	
Hospital	**2013**	**2016**	**2013**	**2016**	**2013**	**2016**	**2013**	**2016**	**Total**	**Percent**
Meritus Medical Center	901	993	4,902	6,007	18	16	272.33	375.44	103.11	37.9%
Western Maryland Regional	1,041	955	5,492	5,820	20	17	274.62	342.35	67.74	24.7%
MedStar Southern Maryland	780	922	4,037	5,452	25	25	161.47	218.08	56.61	35.1%
MedStar Montgomery	1,189	979	6,221	5,703	25	20	248.82	285.15	36.33	14.6%
Suburban	1,035	1,000	5,335	6,036	24	24	222.30	251.50	29.20	13.1%
Sinai Hospital of Baltimore	1,010	959	5,420	6,031	24	24	225.83	251.29	25.46	11.3%
Prince George's Hospital Center	1,114	1,058	5,781	6,251	28	28	206.46	223.25	16.79	8.1%
Northwest Hospital	578	855	3,123	5,514	14	23	223.07	239.74	16.67	7.5%
Johns Hopkins Hospital	1,568	1,499	8,750	9,823	108	108	81.02	90.95	9.93	12.3%
Frederick Memorial Hospital	972	883	5,089	5,292	21	21	242.31	252.00	9.69	4.0%
MedStar Franklin Square	881	1,250	4,645	7,385	24	40	193.53	184.63	-8.91	-4.6%
UMMC Midtown Campus	1,010	891	5,700	5,363	28	28	203.57	191.54	-12.04	-5.9%
MedStar Union Memorial	1,381	1,021	7,231	6,035	26	26	278.12	232.12	-46.01	-16.5%

UMMC: University of Maryland Medical Center

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

Exhibit 24
Selected Hospital Psychiatric Emergency Department Utilization Data
Fiscal 2013-2016

	Observation Hours						Observation Hours per dedicated Psychiatric Space					
Hospital Name	2013	2014	2015	2016	Change	% Change	2013	2014	2015	2016	Change	% Change
Suburban Hospital	55	121	134	524	469	852.7%	13.75	30.25	33.5	131	117	852.7%
Johns Hopkins Hospital	64	58	255	512	448	700.0%	5.8	5.3	23.2	46.5	41	700.0%
MedStar Franklin Square	144	621	655	1,027	883	613.2%	12	51.8	54.6	85.6	74	613.2%
University of Maryland Baltimore Washington Medical Center	40	228	121	238	198	495.0%	8	45.6	24.2	47.6	40	495.0%
MedStar St. Mary's Hospital	109	52	156	308	199	182.6%	54.5	26	78	154	100	182.6%
University of Maryland Prince George's Regional Medical Center	861	1,329	1,257	2,391	1,530	177.7%	172.2	265.8	251.4	478.2	306	177.7%
Frederick Memorial Hospital	70	196	241	166	96	137.1%	14	39.2	48.2	33.2	19	137.1%
University of Maryland Medical Center Midtown Campus	130	503	372	291	161	123.8%	26	100.6	74.4	58.2	32	123.8%
University of Maryland Harford Memorial Hospital	124	170	150	252	128	103.2%	62	85	75	126	64	103.2%
University of Maryland Medical Center	154	244	97	275	121	78.6%	11.8	18.8	7.5	21.2	9	78.6%
Peninsula Regional Medical Center	168	286	245	271	103	61.3%	42	71.5	61.25	67.75	26	61.3%
Western Maryland Regional Medical Center	65	130	137	60	-5	-7.7%	16.25	32.5	34.25	15	-1	-7.7%
MedStar Montgomery Medical Center	791	614	733	523	-268	-33.9%	158.2	122.8	146.6	104.6	-54	-33.9%
MedStar Union Memorial Hospital	378	512	287	458	80	21.2%	189	128	71.75	114.5	-75	-39.4%
Bon Secours Hospital	283	242	2,031	164	-119	-42.0%	56.6	48.4	406.2	32.8	-24	-42.0%
Johns Hopkins Bayview Medical Center	121	142	40	37	-84	-69.4%	17.3	20.3	5.7	5.3	-12	-69.4%

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

In fact, as shown in **Exhibit 25**, there has been just as much if not more capacity added to both the specialty private psychiatric system as well as the State system during the fiscal 2013 to 2016 period. In fact, on a percentage basis, private psychiatric facilities have added more capacity (3.8%) than all of the acute generals (2.7%).

Exhibit 25
Specialty Hospital Bed Capacity
Fiscal 2013-2016

	Inpatient Licensed Beds		
	2013	**2016**	**Change**
Specialty Psychiatric			
Brook Lane Health Services	42	57	15
Adventist Behavioral Health – Rockville	106	106	0
Adventist Behavioral Health – Eastern Shore	15	15	0
Sheppard Pratt Hospital	260	262	2
Sheppard Pratt at Ellicott City	76	78	2
Total	**499**	**518**	**19**
State Psychiatric			
Finan	66	66	0
Eastern Shore	60	60	0
Springfield	220	228	8
Spring Grove	351	355	4
Perkins	247	248	1
Total	**944**	**957**	**13**

Source: Maryland Health Care Commission

Hospitals and the Readmission Test

As previously mentioned, the increase in stays has also affected the EDs of the various hospitals. In response to the concern that hospital EDs were having capacity issues, the budget committees requested a report from HSCRC as well as the Maryland Institute for Emergency Medical Service Systems (MIEMSS) through the JCR. Within that report, HSCRC and MIEMSS both noted that while the stays for these patients, as well as behavioral health patients as a whole have been increasing, one of the main contributing factors to ED overcrowding is the decline in acute care hospital inpatient psychiatric bed capacity. Further, another reason for the increase in length of stay, including on the

inpatient side, is a focus by hospitals on reducing readmissions from high utilizers due to the quality measurements included in the All-Payer Model Contract. Because of this focus, hospitals have been holding onto their patients longer in order to reduce the risk of readmission either by seeking more robust treatment options in the community or stabilizing the patient themselves for longer than they previously would have.

In recognition of the fact that the readmission test within the All-Payer Model Contract was going to require more coordination between hospitals and the behavioral health community provider network, the budget committees and the General Assembly, along with HSCRC and other stakeholders, have been requesting reports and promoting opportunities for more coordinated activities that would help hospitals alleviate their situation. While some new activities have been put into place, obviously more could be done, but it should not be solely up to the State to force these relationships into place. Further, what the data included in this study has demonstrated is that, while psychiatric utilization has potentially placed a strain upon the State's acute care general hospitals, for the most part they have yet to respond to the changing requirements for this patient population under the All-Payer Model Contract. These hospitals need to maintain better relationships with their community providers and focus on keeping people out of the hospital and in the community where they can best be treated. **The department should comment on what steps it has taken thus far to improve the relationships between acute general hospitals and community-based behavioral health providers, and what potential actions the department may be considering in the future.**

4. Behavioral Health Integration Continues to Improve

For the past several years, MDH 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 financing 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 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. Further, within MDH the former Mental Hygiene Administration and the former Alcohol and Drug Abuse Administration merged into the newly created BHA, as codified in Chapter 460 of 2014, and the funding streams were reconfigured 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 Transfer of SUD Services to FFS

A major initiative of the integration process is the alignment of financing systems for the uninsured/underinsured and for Medicaid-ineligible services for SUD and mental health services. For the most part, the change to a FFS system under an ASO did not require any change to the specialty mental health services 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 LAAs, who then either provided the services themselves or contracted with other providers. With the transition of Medicaid-reimbursable SUD services from MCOs to an ASO, the SUD grants for the uninsured were the only treatment funds which were not reimbursed by ASO on a FFS basis. Alignment of financing is a major goal of behavioral health integration.

Exhibit 26 provides the timeline by which major SUD services either have been transferred to ASO or are scheduled to be. As seen in the chart, almost all services have been transferred over, with only halfway-house funding left to be moved. Most notably, all SUD residential treatment services, including services for the forensic population under Health-General Article 8-507 have been fully transferred to ASO, as opposed to the former system where the State contracted with a specific number of providers for a specific number of beds. By transferring these services as well as taking advantage of the federal financing available under the new HealthChoice waiver, the State should both expand the availability as well as decrease the wait time for individuals in need of these services.

Exhibit 26
Substance Use Disorder Treatment Services
Fee-for-service Transition Schedule

Service	Transition Date
Ambulatory Services	January 1, 2017
Non-specialty Residential Services	July 1, 2017
Specialty Residential Services (8-507, Pregnant Women)	January 1, 2018
Level 3.1 Services (Halfway House)	January 1, 2019

Source: Maryland Department of Health

Potential Combination of the Oversight Entities

One of the last vestiges of the old separate system between specialty mental health and SUD services are the local entities that help oversee the Public Behavioral Health System: the CSAs and the LAAs. Based on concerns that these systems remain separate without a clear rationale for being so

within each local jurisdiction, the budget committees requested that BHA study the issue of combining LAAs and CSAs into integrated Local Behavioral Health Authorities (LBHA), as some jurisdictions had already done, and provide a report with the department's recommendations that came from the study. The report was due on November 1, 2017, and submitted on January 9, 2018.

In the report, the department noted that with the policy imperative to fully integrate behavioral health in the State, BHA has been moving toward the strategic integration of the various administrative functions, funding streams, and local systems management. In order to complete the study, a workgroup was constructed to investigate the current system and provide a framework for considering further local integration. This workgroup began the study by interviewing groups and stakeholders for input to guide the integration process and further frame the recommendations. Importantly, the report looked at number of areas of experience within the local authorities and found that LBHAs tend to be better at various aspects of integration, including:

- several LBHAs, as they achieve greater integration, have found that they are better equipped to address the needs of the entire person due to taking a more comprehensive approach to behavioral health;

- LBHAs describe their relationships in broader terms and tend to have a broader set of relationships at both the State and local level;

- LBHAs appear to be more advanced in achieving integration regardless of the separate funding streams that still exist, mainly at the federal level;

- LBHAs appear to be more advanced in bridging cultural differences between specialty mental health and SUD communities;

- LBHAs more consistently approach conflict of interest issues surrounding the provision of services as well as oversight with ideas for how conflict can be avoided; and

- LBHAs generally appear to be more involved in furthering integration, including taking a combined approach to strategic planning, providing training and support for the full range of providers, and cultivating deeper relationships and stronger coordination with other aspects of the health care system.

Further, the study noted that within those jurisdictions that have either already combined or are in process of being combined, administrative costs are lower on average and, in particular, SUD services costs per person are higher. However, the report does make clear that not every jurisdiction is going to be able to have the same system set up, nor is having uniformity necessarily a goal that should be sought. Based on these findings, the recommendations of the report mainly revolve around BHA further supporting the integration efforts desired of the various jurisdictions, including using the guiding principles of the report to define and motivate greater integration as well as increase clarity from the State on the needs for better local systems management. Further, BHA intends to use the insights from this report to inform and refine their current approaches toward integration and develop

multi-year plans for local jurisdictions to help guide and assist local efforts. **The department should comment on the development process for the local plans.**

ASO Contract Measures Fail To Be Enforced

An important provision of the new ASO contract under the integration process is the inclusion of various outcome-based standards, which ASO was supposed to be held responsible for upholding. According to the terms of the contract, which has yet to be modified, MDH is supposed to employ appropriate Healthcare Effectiveness Data and Information Set (HEDIS) measures; beginning with year three of the contract, in order to track the performance of 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), and for each outcome standard not met, ASO will repay to the State 0.0714% of the invoice amounts for the preceding 12 months, up to a total of 0.5% if all measures were to not be met.

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, more than a year ago, MDH reported that ASO was unable to meet the required HEDIS deliverables, as ASO did not have access to the necessary somatic data. When pressed about this issue during the previous session's budget hearings, the department indicated that they were currently working on the possibility of utilizing alternative metrics that ASO would have access to in order to further evaluate ASO's performance. However, despite the fact that the contract has been modified numerous times and even extended, and despite the fact that as recently as November the department indicated that a contract modification containing new terms would be presented to BPW, no modification to the actual terms of the performance metrics contained within the contract has been made. **The department should comment on why the contract was initially signed without knowledge that the provisions were unenforceable, why the terms have yet to be modified, what new performance metrics the department is considering to include in the ASO contract, and when a modification to the contract will be done.**

5. JCR Submissions Remain Missing

As of the writing of this analysis, there are still two reports that remain unsubmitted in response to the 2017 JCR. The first is a report on limiting the availability of tobacco products to minors, while the second has already been mentioned on SUD treatment provider rates. It is worth noting that MDH has not requested an extension for either report. **The department should comment on why the reports are late without any notification that the reports would be late.**

Operating Budget Recommended Actions

1. Add the following language:

   Provided that $200,000 of the general fund appropriation in program M00A01.01 Executive Direction made for the purpose of administration may not be expended until the Maryland Department of Health (MDH) submits a report to the budget committees on the appropriate staffing levels for direct care employees within the facilities administered by the Behavioral Health Administration (BHA). The report should include (1) the number and type of appropriate direct care staff needed to fully operate specific units of the various hospitals; and (2) the amount of staff that would be required based on these standards given the bed capacity that BHA is expected to operate. The report shall be submitted by November 1, 2018, and the committees shall have 45 days to review and comment. Funds restricted pending the receipt of this report may not be transferred by budget amendment or otherwise to any other purpose and will revert to the General Fund if the report is not submitted.

   Explanation: The budget committees are concerned about the staffing levels that the department has funded given the level of bed capacity that the department desires to operate. The committees thus request that MDH submits a report on the levels of direct care staffing required at the BHA facilities, similar to the staffing study submitted in response to the 2009 Joint Chairmen's Report, which shall include both the staffing levels required to operate specific units of the various facilities as well as the amount of staff that the department will need to operate its desired bed capacity.

Information Request	**Author**	**Due Date**
BHA facility staffing study	MDH	November 1, 2018

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

   Further provided that $2,500,000 of this appropriation made for the purpose of provider reimbursements for substance use disorder residential treatment services may not be used for that purpose, but instead may only be transferred to Program M00L01.04 Opioid Operational Command Center to provide additional funding for the opioid crisis. These funds may not be transferred by budget amendment or otherwise to any other purpose and if not expended shall revert to the General Fund at the end of the fiscal year.

   Explanation: This language restricts $2.5 million of the appropriation made for substance use disorder residential treatment services and instead only allows that funding to be transferred to the Opioid Operational Command Center (OOCC). This surplus funding is intended to backfill the general funds that are budgeted within OOCC to be used to support rate increases for community-based behavioral health providers so that more funding may be spent on the heroin and opioid crisis.

		Amount Reduction	
3.	Reduce funds for community behavioral health services due to a projected surplus of general funds in fiscal 2019.	$ 8,000,000	GF

4. Adopt the following narrative:

Opioid Crisis Fund: The budget committees request quarterly reports for fiscal 2019 on the funding plan for the funds contained in the Opioid Crisis Fund (OCF) from the Opioid Operational Command Center (OOCC) as well as the Maryland Department of Health (MDH). These reports are to include the spending plan for these funds, including the fund source for each line item, as well as any changes to the spending plan and any performance metrics that have been gathered by the OOCC from programs receiving this funding.

Information Request	**Authors**	**Due Date**
OCF quarterly reports	MDH	September 30, 2018
	OOCC	December 31, 2018
		March 31, 2019
		June 30, 2019

5. 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.

		Amount Reduction	
6.	Reduce funds for the deficiency for substance use disorder residential treatment services based upon the expected surplus of State general funds in fiscal 2018 for this service.	3,264,681	GF
	Total Reductions to Fiscal 2018 Deficiency	**$ 3,264,681**	
	Total General Fund Reductions to Allowance	**$ 8,000,000**	

Updates

1. Behavioral Health Accreditation Process Moves Forward

In accordance with Chapter 460 of 2014, MDH and BHA are moving toward an accreditation-based licensure process for all behavioral health providers. Under the regulations, all providers had to be scheduled to obtain accreditation by an approved organization no later than January 1, 2018, in order to be licensed by April 1, 2018, to provide community-based behavioral health services. In response to concerns about the ability of all providers to receive their accreditation on time, the budget committees requested a report from the department on the accreditation process. The report was to include information on the number and characteristics of the behavioral health provider community, the current status of those providers who are accredited versus those who are not accredited, and an analysis of all small- and mid-size providers to determine their progress toward accreditation and any challenges therein. The report was submitted on October 3, 2017.

In the report, the department focused on the SUD provider community since that community is where most of the unaccredited providers currently reside. Within the SUD provider network, 354 out of 427 (83%) providers are either accredited or actively engaged in the process. Of the remaining providers, 26 (6%) are actively seeking BHA assistance while 47 providers (11%) have taken no discernible action. Further, the department notes that of the 427 providers, a majority are considered mid-size or smaller, with 64% offering services in urban jurisdictions. Additionally, the report found no correlation between a provider's size, geographical location, or levels of care and their ability to seek and obtain accreditation. Finally, the department feels that the State's SUD provider network is fully prepared for the accreditation-based licensure process and does not believe that any regulatory amendments or additional provider exemptions are required to maintain treatment capacity.

2. Placement Determinations for Children with Complex Medical Needs

Language in the fiscal 2018 budget bill restricted funds in the Department of Human Services (DHS), MDH, and MSDE until a report was submitted detailing the processes in place to ensure coordination between DHS, MDH, MSDE, and any hospital serving children and adolescents with mental illness, developmental disabilities, or complex medical needs in order to find appropriate community placements or in order to find out-of-home placements for youth as well as other recommendations and information. The report was submitted in December 2017, and the funds were subsequently released.

For this analysis, it is important to note that BHA has a critical role in ensuring that these processes are maintained since BHA tracks the inpatient hospitalization of children who are in State custody with either DHS or the Department of Juvenile Services. BHA provides both DHS and MSDE a weekly report of all hospital admissions and discharges and any other relevant updates from the prior week. More information on this report and the recommendations can be found in the DHS – Social Services Administration analysis.

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

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2017					
Legislative Appropriation	$892,593	$52,112	$733,265	$7,796	$1,685,766
Deficiency Appropriation	17,971	122	155,600	0	173,693
Cost Containment	0	0	0	0	0
Budget Amendments	2,823	2,044	12,804	383	18,055
Reversions and Cancellations	-2,170	-1,380	-40,871	-281	-44,702
Actual Expenditures	**$911,218**	**$52,898**	**$860,798**	**$7,898**	**$1,832,813**
Fiscal 2018					
Legislative Appropriation	$972,744	$47,629	$955,806	$7,713	$1,983,892
Cost Containment	-39	0	0	0	-39
Budget Amendments	0	4,086	10,037	0	14,123
Working Appropriation	**$972,705**	**$51,715**	**$965,842**	**$7,713**	**$1,997,975**

MDH: Maryland Department of Health

Note: The fiscal 2018 appropriation does not include deficiencies, targeted reversions, or across-the-board reductions. Numbers may not sum to total due to rounding.

Fiscal 2017

Actual spending for the Behavioral Health Administration (BHA) in fiscal 2017 was $147,046,437 above the legislative appropriation. General funds increased by $18,625,340, mostly as a result of deficiency appropriations. In total, there were five deficiency appropriations totaling $17,971,397 in general funds for BHA, including:

- $8,000,000 for Medicaid behavioral health provider reimbursements;
- $7,000,000 to cover the cost of inpatient psychiatric services for the Medicaid-eligible population;
- $2,000,000 to augment the State's efforts to address the heroin and opioid epidemic;
- $500,000 to establish a new 20-bed unit at the Clifton T. Perkins Hospital Center; and
- $471,397 to provide for operation expenses at the Crownsville Hospital Center.

Budget amendments also added an additional $2,813,629 in general funds. Increases through budget amendment included $3,533,343 for the transfer of increment payments, $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 the State Law Enforcement Officers Labor Alliance. Budget amendments also reduced the appropriation by $1,297,812, primarily due to higher than expected vacancies.

In addition, at closeout, $9,826 was added to cover costs at the institutions, while $2,169,512 was reverted back to the General Fund, mainly due to a restricted item in the budget bill that was not spent.

Special funds increased by $785,929 above the legislative appropriation. Budget amendments added $2,044,212 in special funds, including:

- $730,823 for Problem Gambling Fund expenses;
- $500,000 for a donation to the Prescription Drug Monitoring Program (PDMP);
- $362,557 for a mental health housing initiative;
- $250,514 in Marijuana Citation Fund activities;
- $190,000 for prior grant activities;

- $5,637 to cover increased costs for the Catonsville Education Center at the Regional Institute for Children and Adolescents (RICA) – Baltimore facility;

- $3,002 to cover increased costs for salaries at RICA – Baltimore;

- $1,026 to realign salary reductions as a result of Section 20; and

- $653 for increment payments.

There was also a deficiency appropriation of $122,003 for the Crownsville Hospital Center. Special fund cancellations totaled $1,380,286, mainly due to vacancies as well as slow startup times for projects within PDMP.

Federal funds increased by $127,533,065 above the legislative appropriation. The majority of this increase was due to a deficiency appropriation of $155,600,000 for Medicaid behavioral health provider reimbursements. An additional $12,804,134 was added by budget amendment, including $11,303,176 in additional provider reimbursements, $1,401,568 for prescription drug overdose services, $68,515 for increment payments, $28,028 for dietary supplies, and $2,847 for the School Breakfast Program. Cancellations totaled $40,871,069, mainly due to lower than anticipated provider reimbursements.

Reimbursable funds increased by $102,103 above the legislative appropriation. Budget amendments added $383,288, including $174,779 in payments for dietary and teacher services at RICA – Gildner from the Department of Juvenile Services (DJS) and the Maryland State Department of Education, as well as $137,265 from the Office of Preparedness and Response and $71,244 from the Department of Human Services (DHS) for programs within the community services budget. Cancellations totaled $281,185, mainly due to the expiration of an agreement between BHA and DJS and DHS to provide services for children.

Fiscal 2018

To date, the working appropriation for BHA has increased by $14,083,726, which includes increases of $10,036,843 in federal funds and $4,086,000 in special funds, offset by a decrease of $39,117 in general funds. The federal fund increase is for the 21st Century Cures Act funding for fiscal 2018, which was not added to the fiscal 2018 budget in time for last session. The special funds were added in order to backfill general funds that were reduced in accordance with the cost containment actions proposed in the budget bill for fiscal 2018. Finally, the general fund reduction is due to the cost containment action previously discussed in the analysis.

Appendix 2
Hospital and Forensic Recommendations

Recommendations	Actions
JCR Report – Deinstitutionalization (July 1999)	
1. Fund and implement a $57 million community-based mental health initiative, which will be offset by $16.8 million in facility savings.	No
2. Reduce the average daily population in State psychiatric hospitals by 310 people over the next five years.	Yes
3. Reduce the Maryland Hospital Association workforce by 452 FTEs between fiscal 2002 and 2004.	Yes
4. Reconfigure over the next five years from 1,532 beds to 1,186 beds.	Yes
5. Reduce acreage occupied by Crownsville, Springfield, and Spring Grove hospital operations and transform the remaining acreage to over uses in accordance with Smart Growth principles.	No
6. Centralize administrative functions for Crownsville, Springfield, and Spring Grove to obtain efficiencies of operation.	No
2003 Budget Analysis – Close Upper Shore Hospital Center (March 2003)	
DLS recommends the closure of the Upper Shore Hospital Center.	Yes, but not until 2010
JCR Report – Hospital Closure and Reconfiguration (October 2003)	
1. Close the Crownsville facility in 12 months.	Yes
2. Add new 48-bed wing to Clifton T. Perkins.	Yes, but not until fiscal 2010
3. Privatize the Walter P. Carter Center.	Closed in October 2009
4. Consider other reconfiguration options involving privatization, including youth residential treatment centers.	n/a
JCR Report – Forensic Services (November 2006)	
1. Continuing to develop partnerships between local health authorities, law enforcement officials, and correctional officials to promote alternatives to incarceration, including the development in Baltimore City of a crisis intervention unit or center where police can bring evaluees for emergency psychiatric evaluations.	Crisis center in Baltimore City currently underway
2. Coordinating re-entry programs for jail and prison inmates needing mental health services upon their release.	Ongoing
3. Continuing to expand awareness among all players in the legal community on both new competency requirements as well as substance use disorder commitments.	Ongoing

Recommendations	**Actions**
Staffing Study (January 2007)	
1. Trends in staffing levels need to be monitored routinely and frequently at each facility with reports provided at the monthly CEO meetings.	No
2. Facilities should be discouraged from reclassifying clinical positions to support or administrative classifications.	Most reclassifications have been the other way
3. Consideration should be given to modifying the staffing standard to incorporate 1 additional social worker and 1 additional rehabilitation services worker in units that show increased patient needs for services related to community reintegration.	No
4. The department should initiate a process with the Personnel Services Administration to conduct a routine annual comparison of State salaries for clinical staff to comparable private-sector and federal government salaries.	No
5. The department should communicate regularly with Personnel Services Administration regarding strategies for recruitment and retention of staff.	No
6. Staff should be encouraged and enabled to pursue continuing education whether within or outside of the workplace, with particular emphasis on evidence-based practices, cultural competence, and services for special sub-populations of patients.	No
7. Consideration should be given to more extensive use of paraprofessional staff within some disciplines.	No
8. Increasing the numbers of consumer support specialists in the system would bring a new source of staff and assist with difficulties related to recruitment.	No
2008 Budget Analysis – Close RICA-Southern (March 2008)	
1. Close RICA – Southern	Yes, but in fiscal 2010
JCR Report – Forensic Services (February 2008)	
1. Creation of a centralized Office of Forensic Services.	Yes
2. Increased funding and development of services.	Beginning to happen in fiscal 2018
3. Improved compliance with statutory requirements and oversight of programs assigned responsibility to provide court-ordered services.	Yes
4. Implementation of a forensic training curriculum under the auspices of the proposed Office of Forensic Services.	Unknown
5. Promulgation of forensic regulations.	No

Recommendations	**Actions**
JCR Report – Analysis of Housing Issues (April 2009)	
1. Generate 1,800 rent subsidies between fiscal 2010 and 2014.	Partially, although unclear how many subsidies were generated
2. Continue to expand the production of affordable units and the use of existing affordable housing units.	Partially yes, although more cooperation could be done
3. Target rent subsidies to the highest priority target populations served by the Mental Hygiene Administration (now BHA) and DDA.	Partially yes, although lack of housing stock prevents full implementation
4. Strengthen planning and advocacy efforts at the local, State, and federal levels and with the private sector to increase affordable housing opportunities.	Yes
JCR Report – Staffing Study Follow-up (January 2010)	
1. Continued to identify a 25% shortage of available staff.	No action taken
Consultant's Report on Perkins Hospital (January 2012)	
1. Leadership (9 recommendations) – intended to address leadership deficiencies and establish greater accountability.	Yes
2. Communication and Coordination of Care (12 recommendations) – focused on improvements, such as regular treatment team meetings and the involvement of all appropriate staff at the ward level.	Yes
3. Training (11 recommendations) – improving the content, intensity, and opportunity to implement in a training environment.	Yes
4. Staffing (11 recommendations) – improving staffing patterns to account for coverage needs and sudden changing of assignments.	Yes, as well as adding up to 93 new positions
5. Access to Care (9 recommendations) – additional hours of programming were recommended as well as addressing the wait times for some services.	Yes
6. Risk Management (6 recommendations) – improving the risk assessments regarding the histories of aggressive behavioral of patients.	Yes
7. Changing Nature of Patients Served (5 recommendations) – recommended the adoption of different approaches into the treatment regimen to focus on the integration of individuals with a history of imprisonment.	Yes
8. Environmental Safety (2 recommendations) – made minor recommendations about the physical plant security of the facility (although a comprehensive review of the physical plant and other security issues was not undertaken).	Yes
9. Quality Improvement (2 recommendations) – recommendations made in the report should be evaluated through a formal team-based quality improvement process.	Yes

Recommendations	**Actions**
10. Patient and Staff Rights (6 recommendations) – the utilization of the Recovery Model of Care should be improved to ensure that rights to safety apply equally to staff and patients.	Yes
Cannon Design Report – State Hospital Capacity (December 2011)	
1. Increase inpatient capacity to support current and projected demand.	Only recently, see below
2. Upgrade or replace aging beds.	No
3. Improve visibility and education for community services.	Yes
4. Implement the comprehensive community services investment strategy, including peer-supported networks, telepsychiatry, alternative community beds, forensic monitoring, expansion of sequential intercepts, and restructure financial incentives to increase provider risk for outcomes.	Partially, mainly through peer-support
5. Partner with local businesses to provide employment options for individuals leaving the hospital.	No
6. Invest in quality, affordable, and supportive housing.	Yes, but partially
7. Implement electronic medical records across all state hospitals and community providers.	Current project pending
8. Expand use of telehealth and teleassessment.	Some
9. Utilize RFID and passive badge systems to monitor patient activity and provide security access.	Yes
JCR Report – Capacity and Forensic Services (December 2014)	
1. Add 100 beds to the State-supported psychiatric system.	Yes, but only 95 beds
2. Conduct an additional assessment of 8-505 and 8-507 order wait times.	Pending
3. Update the most recent study on the demand for substance use disorder treatment services since the implementation of the federal ACA.	No
4. Expedite the building of the forensic database to better capture the information provided in the report.	Yes
5. Develop Managing for Results outcomes to measure the performance of the Office of Forensic Services.	No
6. Develop a joint behavioral health and criminal justice system for the identification of high utilizers of services of both systems.	No
7. Increase staffing for psychiatric evaluations, especially at Spring Grove, by approximately 10 FTEs.	No

Recommendations	**Actions**
Forensic Services Workgroup (August 2016)	
1. Increase bed capacity within MDH, including the immediate opening of 24 inpatient beds and 24 "step-down" beds.	Currently working towards a 95-bed expansion project
2. Increase the availability of community crisis services, including an immediate statewide assessment of currently available services.	Ongoing, report expected this winter
3. Expand the capacity of the Office of Forensic Services.	Expanded by 7 members in 2017
4. Increase outpatient provider capacity to meet the needs of forensic patients.	Yes
5. Centralize the MDH forensic process.	Yes, through creation of a new office
6. Increase education to reduce stigma.	Yes
JCR Report – Hospital Security (November 2016)	
1. Evaluate the classification system for security personnel (in lieu of the recommendation of the CEOs to increase staffing).	No
2. Standardize the uniforms for police and security personnel.	Yes
3. Expand the Special Police Commission scope and jurisdiction to encompass every building and facility owned or leased by MDH.	Yes
4. Purchase new radios through the Maryland FiRST program.	Yes
5. Make vehicles safer and begin purchasing new vehicles to replace aging ones.	Yes
6. Improve training for police and security officials, including de-escalation techniques and Mental Health First Aid.	Yes
7. Relocate the main security checkpoint at Perkins.	Yes

ACA: Affordable Care Act
BHA: Behavioral Health Administration
CEO: chief executive officer
DDA: Developmental Disabilities Administration
DLS: Department of Legislative Services
FTE: full-time equivalent
JCR: *Joint Chairmen's Report*
MDH: Maryland Department of Health
RICA: Regional Institute for Children and Adolescents
RFID: Radio Frequency Identification

Appendix 3
Audit Findings
Regional Institute for Children and Adolescents – Baltimore

Audit Period for Last Audit:	March 24, 2104 – May 14, 2017
Issue Date:	January 2018
Number of Findings:	5
Number of Repeat Findings:	1
% of Repeat Findings:	20%
Rating: (if applicable)	n/a

Finding 1: The Regional Institute for Children and Adolescents (RICA) – Baltimore did not maintain an admission team to make admission determinations as required by State regulations, and certain critical documentation was not maintained.

Finding 2: There was a lack of segregation of duties in collection processing and accounts receivable recordkeeping.

Finding 3: **RICA – Baltimore did not use a competitive procurement process for certain services, as required.**

Finding 4: RICA – Baltimore did not have a process to ensure that all vendor amounts billed agreed to the related contractual terms and conditions.

Finding 5: RICA – Baltimore did not report unprovided for payables totaling $700,000 to the Comptroller of Maryland at the 2015 fiscal year-end, as required.

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

Appendix 4
Object/Fund Difference Report
Maryland Department of Health – Behavioral Health Administration

Object/Fund	FY 17 Actual	FY 18 Working Appropriation	FY 19 Allowance	FY 18 - FY 19 Amount Change	Percent Change
Positions					
01 Regular	2,810.65	2,857.90	2,891.90	34.00	1.2%
02 Contractual	169.34	186.92	183.17	-3.75	-2.0%
Total Positions	**2,979.99**	**3,044.82**	**3,075.07**	**30.25**	**1.0%**
Objects					
01 Salaries and Wages	$ 249,184,437	$ 250,929,732	$ 252,380,591	$ 1,450,859	0.6%
02 Technical and Spec. Fees	11,460,120	10,861,641	10,824,428	-37,213	-0.3%
03 Communication	559,363	593,087	595,161	2,074	0.3%
04 Travel	254,409	198,200	220,189	21,989	11.1%
06 Fuel and Utilities	8,785,288	9,083,368	8,938,380	-144,988	-1.6%
07 Motor Vehicles	922,852	744,646	761,166	16,520	2.2%
08 Contractual Services	1,546,320,360	1,710,800,534	1,856,812,622	146,012,088	8.5%
09 Supplies and Materials	13,603,474	13,658,852	14,378,815	719,963	5.3%
10 Equipment – Replacement	770,903	249,051	329,714	80,663	32.4%
11 Equipment – Additional	204,007	48,349	37,878	-10,471	-21.7%
12 Grants, Subsidies, and Contributions	156,744	310,617	198,733	-111,884	-36.0%
13 Fixed Charges	590,569	497,296	527,443	30,147	6.1%
Total Objects	**$ 1,832,812,526**	**$ 1,997,975,373**	**$ 2,146,005,120**	**$ 148,029,747**	**7.4%**
Funds					
01 General Fund	$ 911,218,335	$ 972,704,848	$ 1,039,876,896	$ 67,172,048	6.9%
03 Special Fund	52,898,421	51,715,020	46,409,699	-5,305,321	-10.3%
05 Federal Fund	860,797,797	965,842,455	1,046,732,300	80,889,845	8.4%
09 Reimbursable Fund	7,897,973	7,713,050	12,986,225	5,273,175	68.4%
Total Funds	**$ 1,832,812,526**	**$ 1,997,975,373**	**$ 2,146,005,120**	**$ 148,029,747**	**7.4%**

Note: The fiscal 2018 appropriation does not include deficiencies, targeted reversions, or across-the-board reductions. The fiscal 2019 allowance does not include contingent reductions or cost-of-living adjustments.

Appendix 5
Fiscal Summary
Maryland Department of Health – Behavioral Health Administration

Program/Unit	FY 17 Actual	FY 18 Wrk Approp	FY 19 Allowance	Change	FY 18 - FY 19 % Change
01 Deputy Secretary for Behavioral Health and Disabilities	$ 1,850,180	$ 2,080,546	$ 1,900,667	-$ 179,879	-8.6%
01 Program Direction	20,132,132	22,356,744	20,840,622	-1,516,122	-6.8%
02 Community Services	257,111,870	270,038,627	270,400,257	361,630	0.1%
03 Community Services for Medicaid Recipients	79,523,971	81,241,748	86,893,320	5,651,572	7.0%
04 Opioid Crisis Fund	500,000	10,500,000	13,700,000	3,200,000	30.5%
04 Thomas B. Finan Hospital Center	20,615,162	20,910,588	20,553,836	-356,752	-1.7%
05 Reginal Institute for Children and Adolescents – Baltimore City	14,120,531	14,540,343	15,610,265	1,069,922	7.4%
07 Eastern Shore Hospital Center	19,795,502	20,060,998	21,238,573	1,177,575	5.9%
08 Springfield Hospital Center	74,262,858	74,731,341	73,827,795	-903,546	-1.2%
09 Spring Grove Hospital Center	86,637,772	85,712,363	84,150,739	-1,561,624	-1.8%
10 Clifton T. Perkins Hospital Center	66,688,129	67,141,925	69,149,388	2,007,463	3.0%
11 John L. Gildner Regional Institute for Children and Adolescents	11,885,179	12,053,180	13,237,604	1,184,424	9.8%
15 Services and Institutional Operations	1,797,609	1,383,909	1,349,932	-33,977	-2.5%
10 Medicaid Behavioral Health Provider Reimbursements	1,177,891,631	1,315,223,061	1,453,152,122	137,929,061	10.5%
Total Expenditures	**$ 1,832,812,526**	**$ 1,997,975,373**	**$ 2,146,005,120**	**$ 148,029,747**	**7.4%**
General Fund	$ 911,218,335	$ 972,704,848	$ 1,039,876,896	$ 67,172,048	6.9%
Special Fund	52,898,421	51,715,020	46,409,699	-5,305,321	-10.3%
Federal Fund	860,797,797	965,842,455	1,046,732,300	80,889,845	8.4%
Total Appropriations	**$ 1,824,914,553**	**$ 1,990,262,323**	**$ 2,133,018,895**	**$ 142,756,572**	**7.2%**
Reimbursable Fund	$ 7,897,973	$ 7,713,050	$ 12,986,225	$ 5,273,175	68.4%
Total Funds	**$ 1,832,812,526**	**$ 1,997,975,373**	**$ 2,146,005,120**	**$ 148,029,747**	**7.4%**

Note: The fiscal 2018 appropriation does not include deficiencies, targeted reversions, or across-the-board reductions. The fiscal 2019 allowance does not include contingent reductions or cost-of-living adjustments.