M00L
Behavioral Health Administration
Maryland Department of Health

Executive Summary

The Behavioral Health Administration (BHA) is responsible for the treatment and rehabilitation of the mentally ill, individuals with substance use disorders (SUD), problem gambling disorders, and those with co-occurring mental illness and substance use and/or problem gambling disorder.

Operating Budget Data

($ in Thousands)

	FY 18 Actual	FY 19 Working	FY 20 Allowance	FY 19-20 Change	% Change Prior Year
General Fund	$1,005,983	$1,040,462	$1,099,056	$58,593	5.6%
Adjustments	0	13,708	6,611	-7,096	
Adjusted General Fund	**$1,005,983**	**$1,054,170**	**$1,105,667**	**$51,497**	**4.9%**
Special Fund	49,996	46,409	47,114	706	1.5%
Adjustments	0	203	7	-196	
Adjusted Special Fund	**$49,996**	**$46,611**	**$47,121**	**$510**	**1.1%**
Federal Fund	988,460	1,046,728	1,127,963	81,234	7.8%
Adjustments	0	33,033	122	-32,910	
Adjusted Federal Fund	**$988,460**	**$1,079,761**	**$1,128,085**	**$48,324**	**4.5%**
Reimbursable Fund	7,456	12,986	7,096	-5,890	-45.4%
Adjustments	0	0	0	0	
Adjusted Reimbursable Fund	**$7,456**	**$12,986**	**$7,096**	**-$5,890**	**-45.4%**
Adjusted Grand Total	**$2,051,895**	**$2,193,528**	**$2,287,969**	**$94,441**	**4.3%**

Note: The fiscal 2019 appropriation includes deficiencies, a one-time $500 bonus, and general salary increases. The fiscal 2020 allowance includes general salary increases

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

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- Increases in the fiscal 2020 budget are due to increases in fee-for-service (FFS) expenditures throughout the public behavioral health system, including 3.5% provider rate increases and increased utilization.

- The Opioid Operation Command Center (OOCC) has been moved from BHA to the Maryland Emergency Management Agency, reflecting a $15 million decrease in the budget.

Personnel Data

	FY 18 Actual	FY 19 Working	FY 20 Allowance	FY 19-20 Change
Regular Positions	2,858.90	2,891.90	2,907.60	15.70
Contractual FTEs	177.32	208.13	189.71	-18.42
Total Personnel	**3,036.22**	**3,100.03**	**3,097.31**	**-2.72**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	285.36	10.18%
Positions and Percentage Vacant as of 12/31/18	347.90	12.03%

- BHA added 13.5 positions through Maryland Institute of Policy Analysis and Research conversions and another 16 contractual employees converted into regular employees throughout the State-run hospitals. This increase was partially offset by a net of 9.5 full-time equivalents (FTE) being transferred out of BHA to elsewhere in the Maryland Department of Health, 3 FTEs leaving BHA with the transfer of OOCC, and a 1.3 decrease in workload with other hospital positions.

- Targeted salary increases in the fiscal 2020 budget include raises for all psychiatrists throughout BHA.

Key Observations

- The opioid crisis continues to loom over the State and the agency with SUD treatment being a driver of expenses in FFS spending and the opioid crisis being a focus of federal grant funding received by the agency. However, opioid overdoses continue to increase statewide without signs of slowing down.

- Measurement discrepancies and challenges estimating need obscure the complete picture of mental health service provision in the State. Challenges with high levels of leave use create staffing strains in the State-run psychiatric facilities.

Operating Budget Recommended Actions

1. Add language restricting the appropriation for M00L01.02 to be expended only in M00L01.02, M00L01.03, or M00Q01.10.

2. Add narrative requesting the Behavioral Health Administration to include information on substance use disorder residential treatment, including relapses, length of stay, and completion of treatment.

3. Add language restricting the appropriation in ML01.03 to be expended only in ML01.02, ML01.03, or MQ01.10.

4. Add language restricting the appropriation in M00Q01.10 to be expended only in M00L01.02, M00L01.03, or M00Q01.10.

Updates

- BHA has established auditing practices to ensure mobile treatment services and supported employment programs that have received enhanced funding for using evidence-based practices (EBP) are being faithful to the EBP model.

- The Department of Legislative Services recommends removing the Prescription Drug Monitoring Program from the programs subject to sunset evaluation.

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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 substance use disorders (SUD), problem gambling disorders, and those with co-occurring mental illness and substance use and/or problem gambling disorder.

In fiscal 2015, funding for Medicaid-eligible specialty mental health services was moved into the Medical Care Programs Administration. In fiscal 2016 funding for SUD was carved-out from managed care and budgeted as fee-for-service (FFS) in program M00Q01.10 alongside Medicaid-eligible specialty mental health services. For the purposes of reviewing the fiscal 2020 allowance, the funding in M00Q01.10 is reflected in this analysis.

BHA's role includes:

- ***Mental Health Services:*** Planning and developing a comprehensive system of services of 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 with local core service agencies (CSA) to coordinate and deliver mental health services in the local jurisdictions statewide.

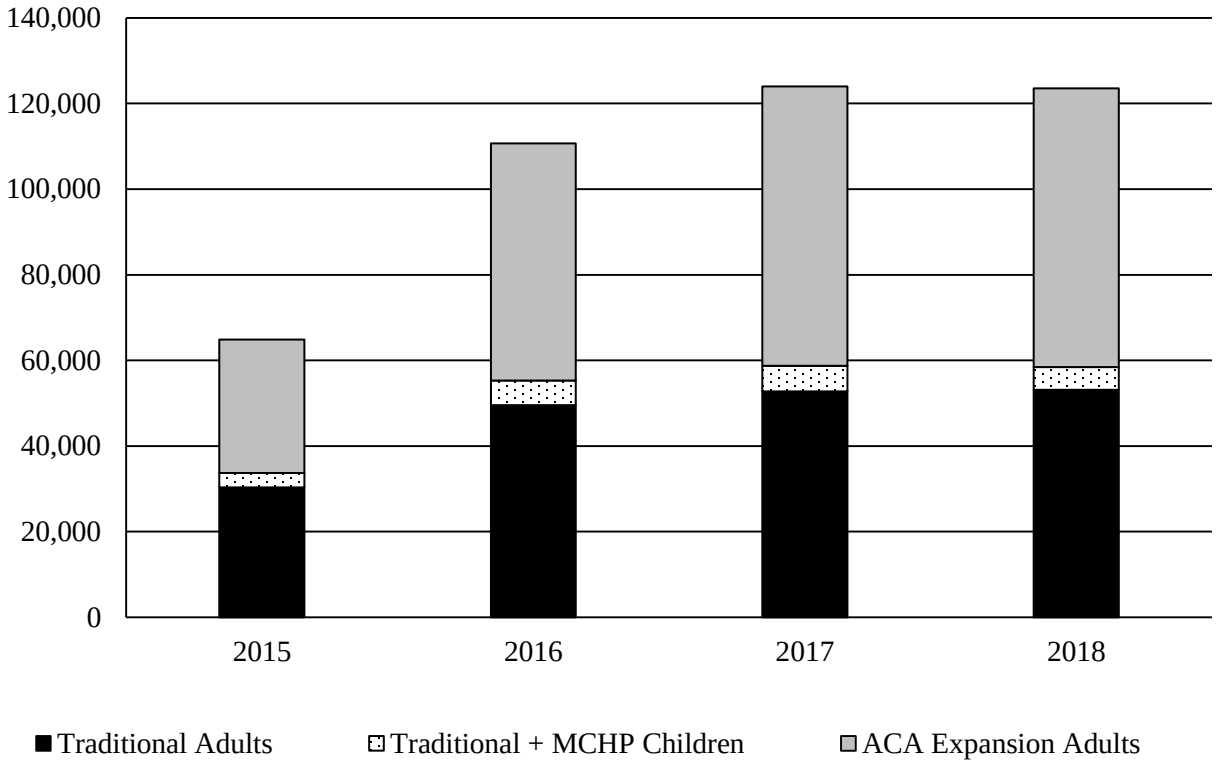
- ***SUD Services:*** Developing and operating unified programs for SUD research, training, prevention, and rehabilitation in cooperation with federal, State, local, and private agencies.

Performance Analysis: Managing for Results

1. SUD Treatment Expansion and Financing Driven by Affordable Care Act Population

As Maryland continues to struggle with the opioid crisis and treatment for SUD, the Affordable Care Act (ACA) Medicaid expansion has provided the main avenue for growth in treatment in the Medicaid program. **Exhibit 1** shows the number of consumers of SUD by broad Medicaid eligibility group from fiscal 2015 to 2018. Fiscal 2015 was the first year in which reimbursements for SUD services in the Medicaid program were provided through the Administrative Service Organization as opposed to the Medicaid managed care organizations. Fiscal 2016 was the first full year of SUD treatment in Medicaid FFS.

Exhibit 1
SUD Consumers by Enrollment Type
Fiscal 2015-2018



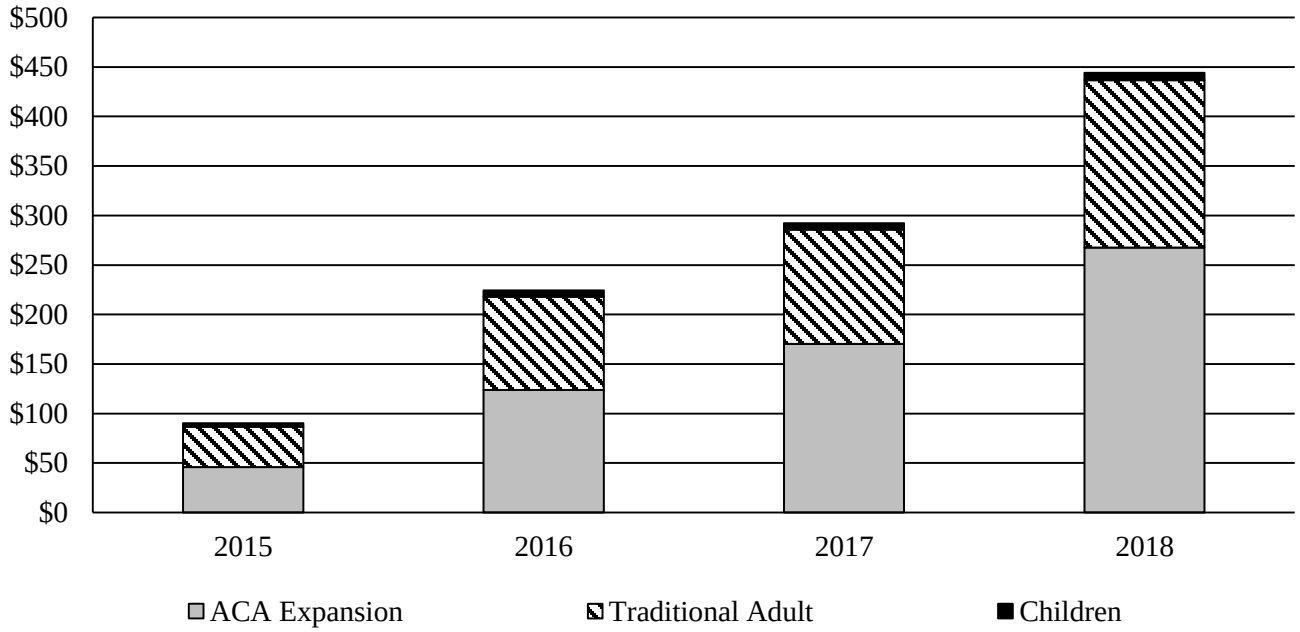
ACA: Affordable Care Act
MCHP: Maryland Children's Health Program
SUD: substance use disorder

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

Source: Maryland Department of Health

As seen in Exhibit 1, the ACA expansion population in SUD treatment has matched or exceeded the consumers using SUD services in the traditional Medicaid enrollment. SUD treatment expenditures are shown in **Exhibit 2**.

Exhibit 2
SUD Expenditures
Fiscal 2015-2018
($ in Millions)



ACA: Affordable Care Act
SUD: substance use disorder

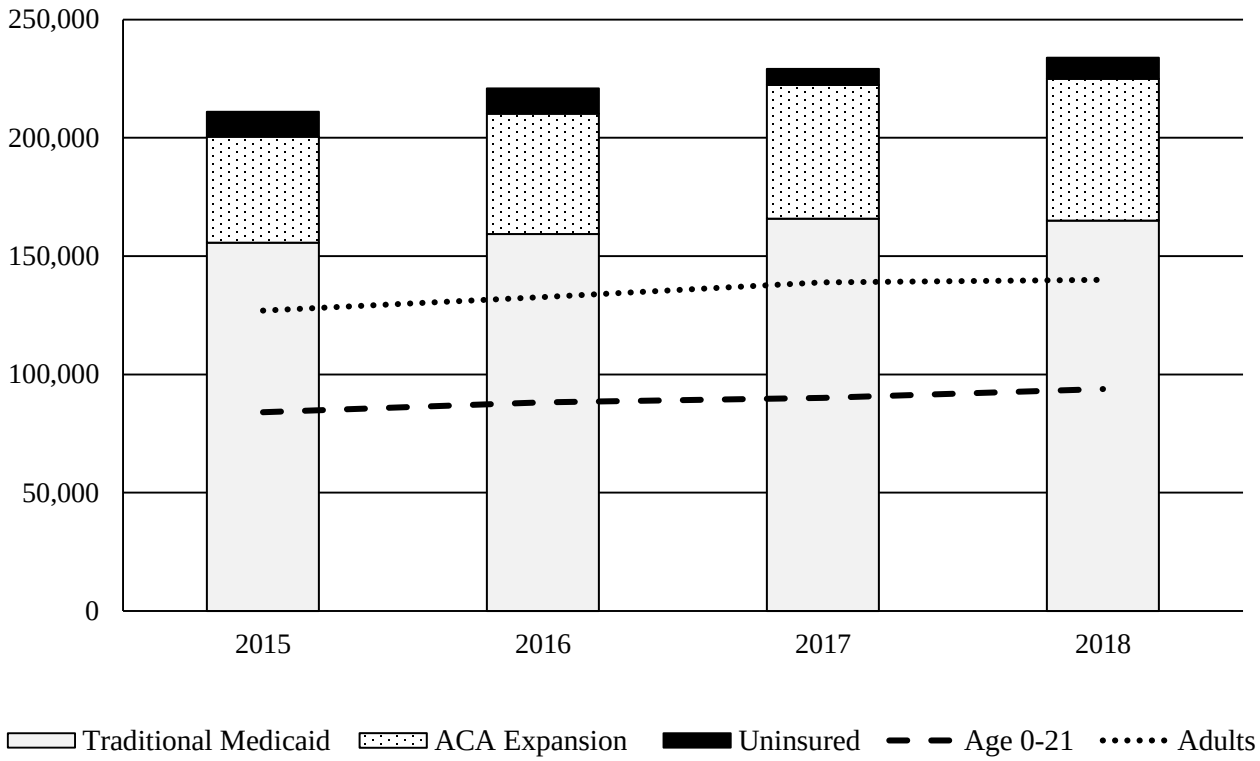
Source: Maryland Department of Health

The spending represented in the traditional adult population is paid for with 50% federal and 50% State funding. The children expenditures include Maryland Children's Health Program enrollees, who have a greater federal subsidy, as well as children matched at a 50%/50% fund split. The ACA expansion population is being supported at a much higher federal match rate. In fiscal 2018, the federal government paid for $327.8 million of the SUD treatment services in Medicaid, 77%, while the State paid $99.7 million.

2. Enrollment and Utilization in the Public Mental Health System

Enrollment in the public mental health treatment population has increased as well over the last several years, as shown in **Exhibit 3**. Unlike SUD enrollment, there is a greater share of traditional Medicaid enrollees and children with serious mental illness.

Exhibit 3
Public Mental Health Enrollment Trends
Fiscal 2015-2018



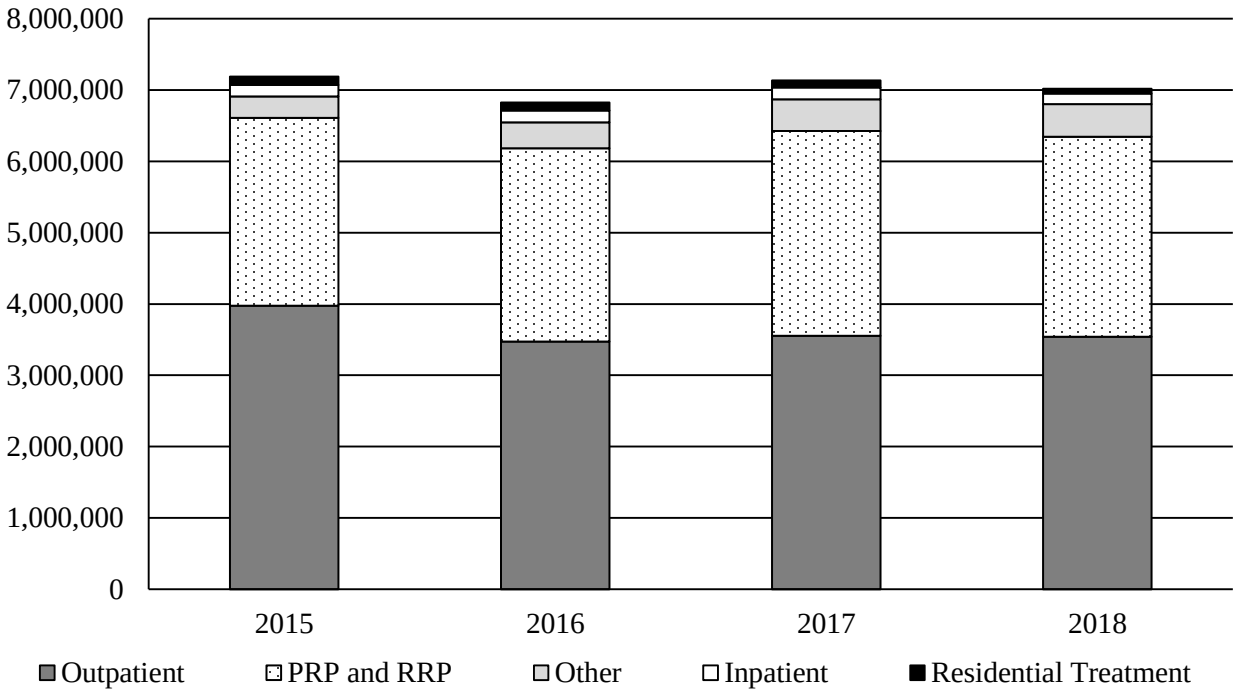
ACA: Affordable Care Act

Source: Maryland Department of Health

Exhibit 3 also shows the number of uninsured receiving public mental health services. The uninsured population is funded with general funds, and this population has been falling with the growth of the ACA expansion population and as overall healthcare coverage has increased in Maryland.

Exhibit 4 shows the services being received by individuals in the public mental health system over this same period with the overwhelming amount of services provided being outpatient and rehabilitation programs.

Exhibit 4
Public Mental Health Service Units
Fiscal 2015-2018



PRP: Psychiatric Rehabilitation Program
RRP: Residential Rehabilitation Program

Note: Other includes mobile treatment, targeted case management, and partial hospitalization.

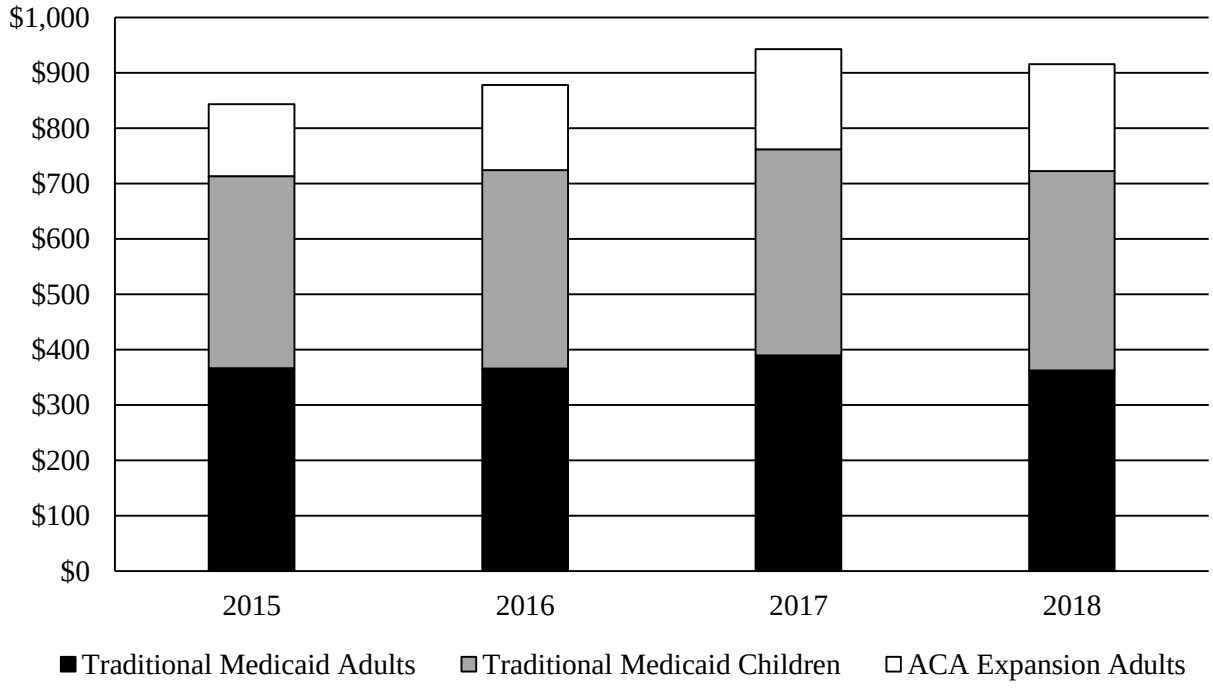
Source: Maryland Department of Health

Additionally, Exhibit 4 shows that, although enrollment has increased in the public mental health system in recent years, service units have been fairly constant, suggesting flat or declining rates of utilization.

Expenditures in the Public Mental Health System

The expenditures within the public mental health system track closely with the enrollment trends, as shown in **Exhibit 5**.

Exhibit 5
Expenditures Trends in Public Mental Health
Fiscal 2015-2018
($ in Millions)



ACA: Affordable Care Act

Note: Fiscal 2018 data is incomplete until the end of fiscal 2019.

Source: Maryland Department of Health

The expenditure data in Exhibit 5 also separates the ACA expansion population from the total Medicaid expenditures. Although this is a lower share of expenditures than for SUD services, of the $192 million of ACA expansion expenditures in fiscal 2018, only $10.6 million was paid by the State.

3. Health Outcomes in the Public Behavioral Health System

Outcome data from BHA's Outcome Measurement System is limited to outpatient clinics and measured between a client's initial interview and the most recent interview on the same questionnaire. As shown in **Exhibit 6**, the responses have been trending in a positive direction in recent years for adults. However, for children, net improvement in functioning continues to decrease.

Exhibit 6
Functioning and Quality of Life Outcomes for the Public Mental Health System
Fiscal 2013-2018

	2013	2014	2015	2016	2017	2018
Adult Mental Health Outcomes						
Net Improvement in Functioning (Percent of Total Observations)	14.3%	14.4%	4.5%	8.1%	11.0%	12.1%
Persons Unemployed in Both Observations	63.1%	61.5%	59.9%	59.5%	57.8%	56.4%
Homelessness in Both Observations	5.0%	4.7%	4.6%	3.7%	3.5%	3.4%
Children and Adolescents Mental Health Outcomes						
Net Improvement in Functioning (Percent of Total Observations)	14.1%	14.6%	14.6%	13.7%	13.2%	12.1%

Source: Maryland Department of Health

While Exhibit 6 shows that homelessness and unemployment have been decreasing across the adult population with mental health issues, **Exhibit 7** highlights how this improvement is distributed across the individuals with a mental health, SUD, or co-occurring diagnosis and the continued challenges facing the co-occurring population, who have homeless rates nearly twice that of the single-diagnosed groups and much lower rates of employment.

Exhibit 7
Improvements in the Public Mental Health System
Fiscal 2016-2018

	Total PBHS System			Mental Health			SUD			Co-occurring		
	2016	**2017**	**2018**	**2016**	**2017**	**2018**	**2016**	**2017**	**2018**	**2016**	**2017**	**2018**
Adult Behavioral Health Outcomes												
Net Improvement in Functioning (Percent of Total Observations)	10.9%	8.3%	7.7%	8.1%	11.0%	12.1%	3.7%	1.2%	2.4%	16.9%	11.9%	11.5%
Persons Unemployed in Both Observations	58.3%	56.1%	54.4%	59.5%	57.8%	56.4%	42.2%	51.6%	52.8%	53.5%	62.8%	61.3%
Homelessness in Both Observations	3.8%	3.9%	3.6%	3.7%	3.5%	3.4%	5.0%	5.3%	4.1%	9.5%	7.3%	7.2%

PBHS: Public Behavioral Health System
SUD: substance use disorder

Source: Maryland Department of Health

4. Outcomes for State-run Facilities

In addition to the support and management of the Public Behavioral Health System (PBHS), the agency also oversees the State-run psychiatric facilities: four regional adult psychiatric hospitals (Thomas B. Finan Hospital Center, Eastern Shore Hospital Center, Springfield Hospital Center, and Spring Grove Hospital Center); two Regional Institutes for Children and Adolescents (RICA) in Baltimore City and Rockville (RICA – Baltimore City and John L. Gildner – RICA, respectively); as well as one maximum security forensic facility (Clifton T. Perkins Hospital Center).

Exhibit 8 measures each State-run psychiatric hospital's performance using their 30-day readmission rate. Each facility independently has a goal to have a readmission rate below 5%. In 2018, all of the State-run psychiatric facilities were able to achieve this goal with all but one facility reducing or maintaining their 30-day readmission rate from 2017.

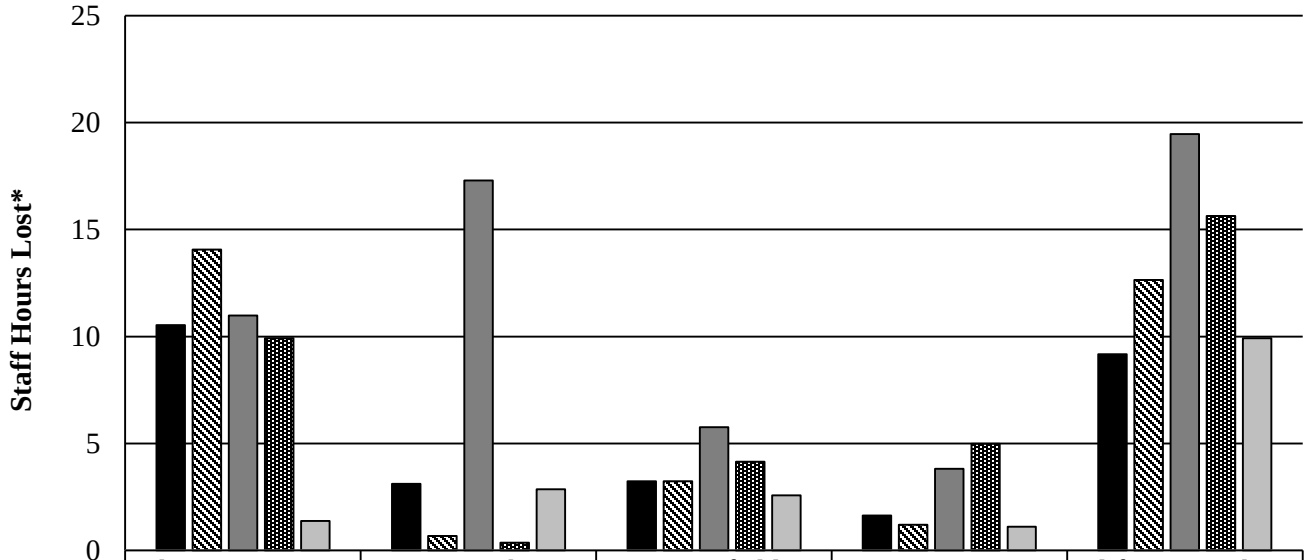
Exhibit 8
Readmission Rate for State-run Psychiatric Hospitals
Fiscal 2014-2018

30-day Readmission Rate	**2014**	**2015**	**2016**	**2017**	**2018**
Thomas B. Finan Hospital Center	1.2%	10.9%	3.8%	6.6%	3.5%
Eastern Shore Hospital Center	6.9%	2.2%	3.0%	3.2%	0.0%
Springfield Hospital Center	2.3%	2.5%	2.0%	2.9%	1.1%
Spring Grove Hospital Center	1.3%	1.6%	1.3%	1.1%	1.3%
Clifton T. Perkins Hospital Center	3.2%	3.8%	1.3%	0.0%	2.0%

Source: Governor's Fiscal 2020 Budget Books

Exhibit 9 shows the number of staff hours lost due to an injury that was sustained during the performance of an employee's job duties. Currently, the goal set for this rate is to not exceed 3 hours per 1,000 hours worked. As the exhibit shows, only one State-run facility failed to meet this goal, Perkins. Although, it did not meet this goal, Perkins did see a significant reduction in its rate of staff time lost due to injury. All but one facility (Eastern Shore Hospital Center) reduced its time lost to injury rate from 2017. Perkins also does traditionally have the most difficult patient population in the State. However, although Perkins is designated as the only forensic facility systemwide, the court-involved population make up over 90% of admissions to State facilities.

Exhibit 9
Employee Injury Rate at State-run Psychiatric Hospitals
Fiscal 2014-2018



	Thomas B. Finan Hospital Center	Eastern Shore Hospital Center	Springfield Hospital Center	Spring Grove Hospital Center	Clifton T. Perkins Hospital Center
2014	10.53	3.11	3.24	1.64	9.17
2015	14.06	0.68	3.23	1.2	12.64
2016	10.98	17.29	5.76	3.82	19.47
2017	9.92	0.36	4.15	4.98	15.63
2018	1.38	2.86	2.57	1.11	9.92

* Staff hours lost per 1,000 hours worked.

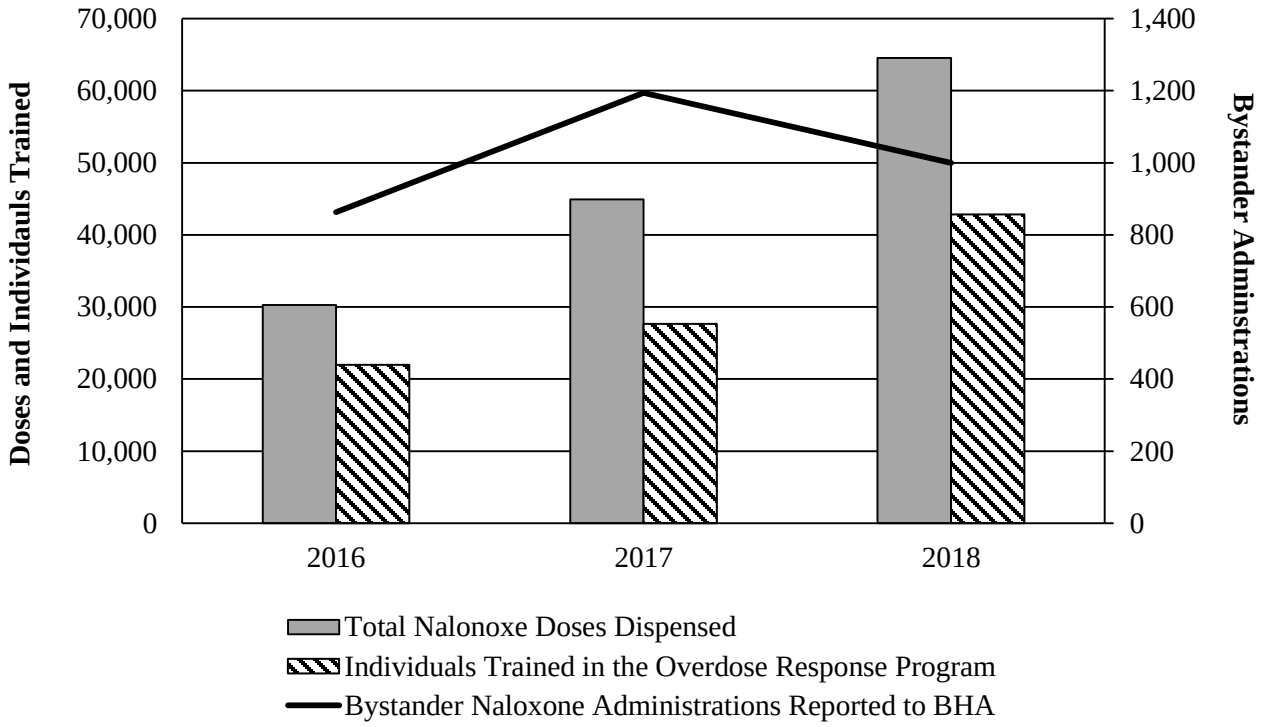
Source: Governor's Fiscal 2020 Budget Books

5. New Measures Tracking Opioid Intervention

One of the main tools that Maryland has used in combating the opioid epidemic is the expansion of Naloxone access. Naloxone can be used to reverse the respiratory failure of an opioid overdose. There is a statewide standing order for individuals in Maryland to be able to get Naloxone from any pharmacy in the State without a prescription in case of an overdose. The Maryland Department of Health (MDH) has dispensed Naloxone and trained individuals on the drug through the Overdose Response Program. Since March 2014, the Overdose Response Program has reported training 121,924 individuals and dispensing 143,276 doses of Naloxone. This focus on Naloxone distribution

is reflected in BHA's Managing for Results (MFR) goals, including increasing both bystander Naloxone administrations by 15%, and increasing training conducted by the Overdose Response Program by 5%, over the 2016 values by fiscal 2020. Bystander Naloxone administrations are uses of Naloxone to reverse an overdose reported to BHA that were administered by anyone outside of emergency medical professionals (*e.g.*, family members, friends, treatment program staff, school staff, law enforcement officers). Additionally, BHA wants to increase the number of doses of Naloxone that it distributes by 10% each year. **Exhibit 10** shows the doses dispensed, trainings conducted, and reported bystander administrations from fiscal 2016 to 2018.

Exhibit 10
Naloxone Distribution, Training, and Use
Fiscal 2016-2018



BHA: Behavioral Health Administration

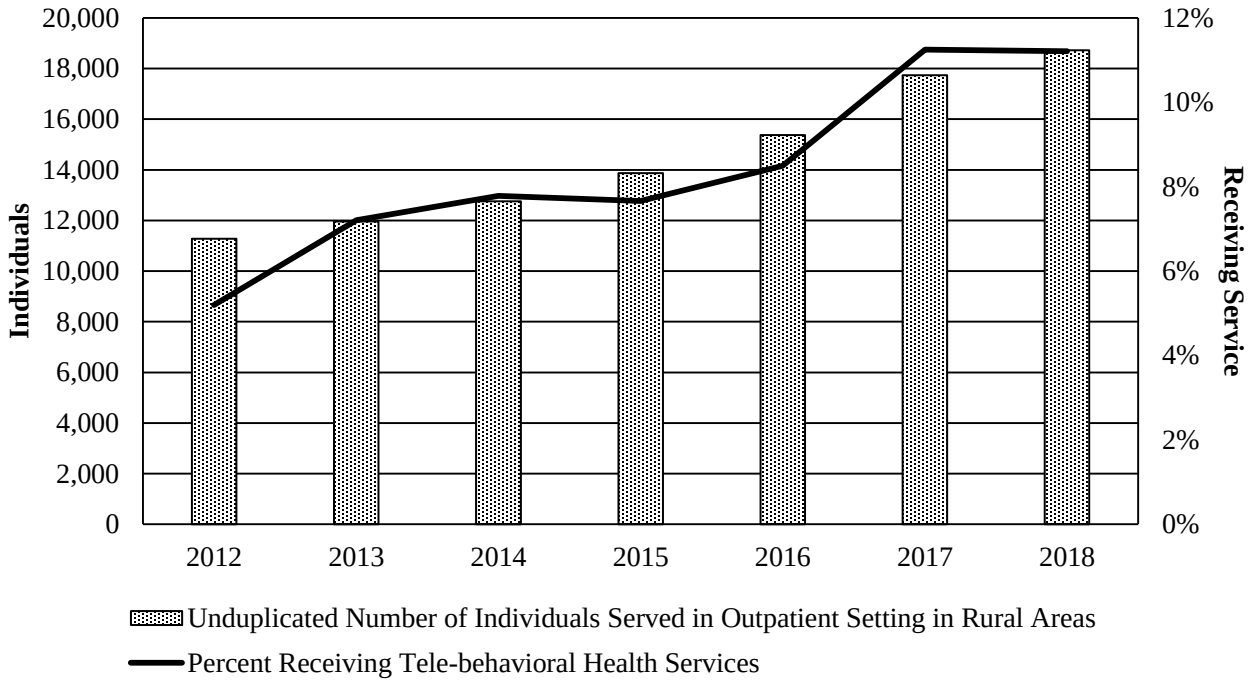
Source: Governor's Fiscal 2020 Budget Books

It is worth highlighting that individuals trained and bystander administrations are currently above their respective goals in fiscal 2018. Additionally, the doses of Naloxone distributed has well outpaced 10% year-over-year growth, averaging 46% annual growth over this period.

6. Tele-behavioral Health Services Continue to Expand in Rural Areas

BHA has also focused on improving access to behavioral health services with the expansion of tele-health and tele-psychiatric services to serve rural communities. The department hoped to expand rural tele-behavioral health services to at least 8% of individuals receiving outpatient behavioral health services by fiscal 2020. As shown in **Exhibit 11**, BHA was able to achieve this expansion in services by fiscal 2016 and continues to increase the share of individuals receiving tele-behavioral health services.

Exhibit 11
Rural Tele-behavioral Health
Fiscal 2012-2018



Source: Governor's Fiscal 2020 Budget Books

Fiscal 2019 Actions

Proposed Deficiency

The fiscal 2020 budget includes a number of deficiency appropriations, including $3.6 million in increases to psychiatrist salaries in fiscal 2019. The funding continues in fiscal 2020. The increases from the deficiency appropriation and the reclassification funding are shown in **Exhibit 12**.

Exhibit 12
Funding for Psychiatrists Salaries
Fiscal 2019-2020

	2019 Deficiency	2020 Reclassification
Springfield	$936,946	$1,007,247
Spring Grove	900,392	966,308
Clifton T. Perkins	720,963	781,191
Thomas B. Finan	439,416	431,061
John L. Gildner – RICA	199,149	213,660
Program Direction	153,696	190,669
RICA – Baltimore City	159,651	186,809
Eastern Shore	97,120	120,922
Total Funds	**$3,607,333**	**$3,897,867**

RICA: Regional Institutes for Children and Adolescents

Source: Governor's Proposed Budget

As shown in **Exhibit 13**, there are $83.4 million in three separate deficiencies that relate to SUD. Two deficiency appropriations pertain to service delivery: $7.8 million in general funds to fund residential, SUD FFS treatment; and $42.6 million ($14.8 million in general funds and $27.8 million in federal funds) for Medicaid provider reimbursements for services rendered in fiscal 2018. The final deficiency appropriation is $33 million in federal funds for the State Opioid Response (SOR) grant. Exhibit 13 shows these three deficiencies by fund type. Collectively, these deficiencies total to $83.4 million.

Exhibit 13
SUD-related Deficiency Appropriations

	General Funds	Federal Funds	Total Funds
Medicaid Provider Reimbursements for Services in Fiscal 2018	$14,798,839	$27,773,776	$42,572,615
State Opioid Response Grant	0	33,000,000	33,000,000
SUD Residential Treatment	7,790,617	0	7,790,617
Total Service Deficiencies	**$22,589,456**	**$60,773,776**	**$83,363,232**

SUD: substance use disorder

Source: Governor's Proposed Budget

The fiscal 2019 deficiency appropriation of $729,248 is provided for maintenance of the closed Crownsville Hospital Center: $534,355 in general funds; and $194,893 in special funds.

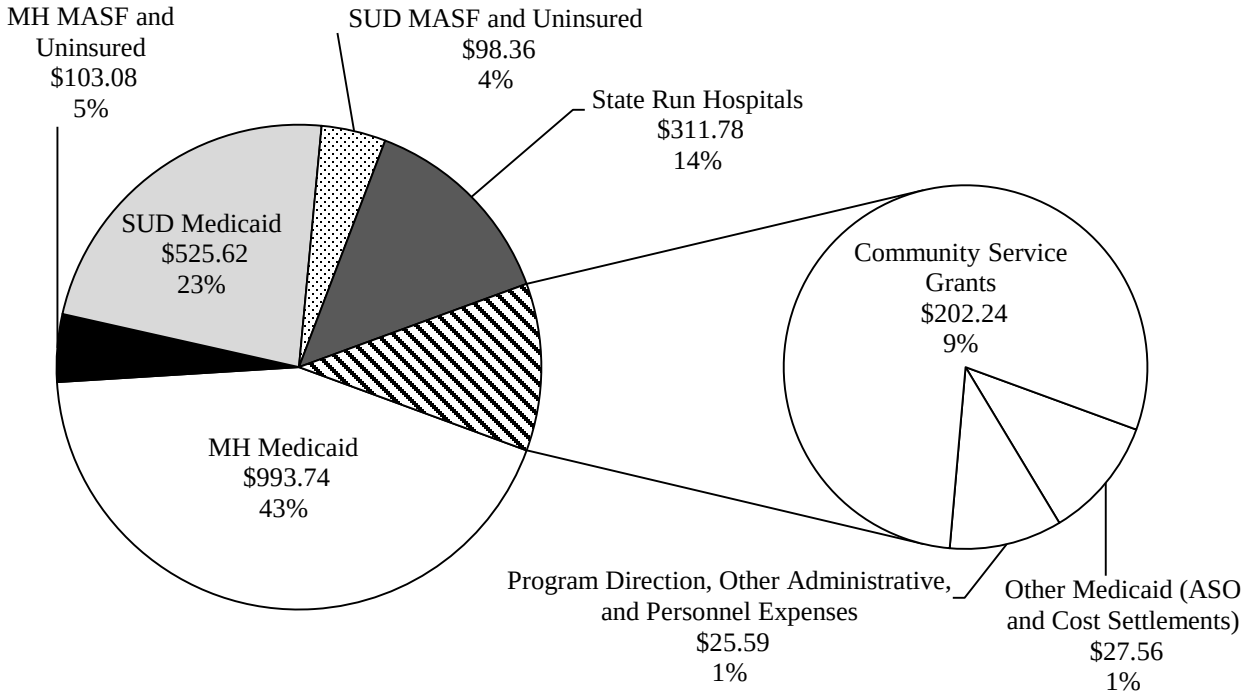
Additionally, the fiscal 2020 budget includes $1,565,978 for one-time $500 employee bonuses in fiscal 2019 and $249,551 for a 0.5% general salary increase.

Fiscal 2020 Allowance

Overview of Agency Spending

The BHA budget largely supports treatment services for individuals with mental health diagnoses and/or SUDs in Maryland. The largest share of the direct service provision is through FFS treatment for the Medicaid and uninsured populations. The Medicaid program accounts for $1.5 billion of agency spending, roughly two-thirds of the total BHA budget. State-only spending for the uninsured and the Medicaid population for non-Medicaid-eligible services total to $201.4 million, predominately in general funds. In total, three-fourths of BHA's budget is for FFS treatment, as shown in **Exhibit 14**.

Exhibit 14
Overview of Agency Spending
Fiscal 2020-2020
($ in Millions)



Total Expenditures: $2,288.00 Million

ASO: Administrative Service Organization
MASF: Medical Assistance State Funded
MH: mental health
SUD: substance abuse disorder

Source: Governor's Proposed Budget

The other direct service provision aspect of BHA's budget is the operation of State-run psychiatric facilities. These facilities collectively account for $311.8 million of agency spending. The remaining share of the budget, $255.4 million, supports grants, other service programs, and the administrative expenses of BHA. Included in the Community Service grants is $70.2 million, most of which is general funds, for the CSAs for additional service provision. Overall, the Community Services grants are 43.4% in federal funds from various federal grant programs. The Community Service grants also feature the federal funding targeted at the opioid crisis, including the $33 million in fiscal 2020 for the second year of the SOR grant.

Proposed Budget Change

As shown in **Exhibit 15**, the BHA budget is increasing by over $94.4 million, 4.3%, in fiscal 2020. This increase is driven by anticipated increases in FFS expenditures, driven by the Medicaid program, continued growth in SUD expenditures, and 3.5% rate increases from the Heroin and Opioid Prevention Effort (HOPE) and Treatment Act of 2017.

Exhibit 15
Proposed Budget
MDH – Behavioral Health Administration
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2018 Actual	$1,005,983	$49,996	$988,460	$7,456	$2,051,895
Fiscal 2019 Working Appropriation	1,054,170	46,611	1,079,761	12,986	2,193,528
Fiscal 2020 Allowance	1,105,667	47,121	1,128,085	7,096	2,287,969
Fiscal 2019-2020 Amount Change	$51,497	$510	$48,324	-$5,890	$94,441
Fiscal 2019-2020 Percent Change	4.9%	1.1%	4.5%	-45.4%	4.3%

Where It Goes:	
Personnel Expenses	**$10,943**
Fiscal 2020 general salary increase and annualization of April 1, 2019 general salary increase offset by the fiscal 2019 cost of the April 1, 2019 salary increase	$6,314
Employee and retiree health insurance premiums	5,374
Employee retirement benefits	1,907
Other increases in regular earnings	1,225
Salary and benefits for 13.5 MIPAR positions converted into regular employees	1,035
Workers' compensation	721
Salary and benefits for 16 contract employees to be converted into regular employees in Behavioral Health Administration (BHA) hospitals	592
Other adjustments for positions transferred within BHA, including in the hospital system 2 positions moved from full time to part time and a net decrease of workload by 0.3 in other positions. A total decrease of 1.3 in full-time equivalent throughout the hospitals	509
Reclassification amount budgeted to bring psychiatrist salaries to proposed 2019 levels offset by fiscal 2019 deficiency	291
Increase in regular earnings for hospital police officers personnel as a part of the State Law Enforcement Officers Labor Alliance collective bargaining	177
Increase in payments into the Law Enforcement Officers Pension System pension plan	47

Where It Goes:

Salary and benefits for 4 regular employees transferred into non-hospital positions in BHA from elsewhere in the Maryland Department of Health (MDH), offset by 3 non-hospital positions transferred out of BHA to elsewhere in MDH	11
Personnel expenses related to 3 Opioid Operation Command Center (OOCC) positions being transferred into Maryland Emergency Management Agency (MEMA)	-307
Salary and benefits for 3.5 regular employees transferred into BHA hospitals from elsewhere in MDH, offset by 14 hospital positions being transferred out of BHA	-779
Decrease in expenditures for overtime and shift work to $17.2 million; this is a $4.9 million decrease from fiscal 2018 actual overtime and shift work expenditures totaling $22.1 million	-1,475
Fiscal 2019 $500 one-time employee bonuses	-1,566
Turnover adjustment for existing positions from 8.2% to 10.18%	-3,310
Other personnel expenditures	178
Medicaid, Medicaid State Funded, and Uninsured Treatment	**$111,925**
Estimated increase in enrollment and utilization in fee-for-service (FFS) for substance abuse disorders (SUD) and mental health services, partially offset by fiscal 2019 SUD residential deficiency (See Exhibit 17)	53,869
Mandated provider rate increases (3.5%)	42,284
Miscellaneous adjustment for uncategorized Medicaid FFS provision in fiscal 2019	10,150
Hospital regulated rate assumption for Medicaid and Non-Medicaid services (1.37%)	6,017
Administrative services organization contract increase	1,718
Money Follows the Person increase	1,009
BHA Medicaid cost settlements (net)	-3,122
Administrative Expenses	**-$2,114**
Decrease in electronic health records contracts paid to the University of Maryland	-265
Decrease in contract payments to CRISP for PDMP and the predictive risk model	-439
Decrease in contract expenditures due to MIPAR conversions	-1,410
Community Services Grants	**-$9,503**
Increase in federally funded grant programs, including grants targeting assertive community treatment, screening, prevention, and improved data systems for targeting the opioid crisis and community mental health	6,707
$3 million dollars for the Crisis Response Grant program	3,000
Two new federal grants: one supporting behavioral health integration for maternal depression and children; and the other providing treatment for adolescents at a clinical high risk for psychosis	1,042
Projected increases in the problem gambling fund and marijuana citation fund for gambling addiction and substance use treatment, respectively	286
Increase in funding for Maryland's Continuum of Care, split between general funds and federal Housing and Urban Development funds to support rental assistance for homeless populations with mental health or substance abuse disorders diagnoses	218

Where It Goes:

Fiscal 2020 State Opioid Response (SOR) grant, offset by fiscal 2019 SOR grant deficiency appropriation	169
MAT PDOA Targeted Capacity Expansion, offset by end of broader MAT program	-83
Decrease in general funds supporting buprenorphine initiative in local jurisdictions	-110
Grant funded treatment for children moved into FFS	-1,275
Decrease in grants supporting substance abuse treatments in local jurisdictions, including programs supporting women and children moving to FFS	-4,261
Federal grants ending during fiscal 2020	-15,074
Other changes in grants	-123
Other Changes	**-$16,811**
Decrease in nonpersonnel operating expenditures at State-run psychiatric facilities	-138
OOCC moving to MEMA	-15,894
Other	-779
Total	**$94,441**

CRISP: Chesapeake Regional Information System for Our Patients
MAT: medication assisted treatment
MIPAR: Maryland Institute of Policy Analysis and Research
PDMP: Prescription Drug Monitoring Program
PDOA: Prescription Drug and Opioid Addiction

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

Personnel

BHA gained 29.5 new regular employees in the fiscal 2020 allowance, 13.5 of which were positions in-sourced from the Maryland Institute of Policy Analysis and Research (MIPAR). Of the MIPAR conversions, 11 will be in in the Program Direction office with the remaining 2.5 being in the Community Services program. The remaining 16 new employees are contractual conversions throughout the State-run psychiatric facilities: 1 at the Thomas B. Finan Center; 3 at RICA – Baltimore City; 9 at Spring Grove; 1 at Clifton T. Perkins; and the remaining 2 at John L. Gildner – RICA. Additionally, 3.5 regular employees were transferred into BHA hospitals from elsewhere in the department. However, the contractual conversions and the positions transferred in are offset by 14 positions being transferred out of BHA hospitals. **Exhibit 16** shows the net change in employee compliment within each program and facility in BHA. Non-hospital BHA employees gained 1.0 net FTE from transfers within MDH.

Exhibit 16
Changes in Positions throughout BHA
Fiscal 2019-2020

	Net Change in Employee Compliment
Thomas B. Finan	2.0
RICA – Baltimore City	3.0
Spring Grove Hospital	2.2
Clifton T. Perkins	-3.0
John L. Gildner – RICA	3.0
Community Services	1.5
Program Direction	16
Springfield Hospital	-6.0
Opioid Operation Command Center	-3.0
Total	**15.7**

BHA: Behavioral Health Administration
RICA: Regional Institutes for Children and Adolescents

Source: Governor's Proposed Budget

The change shown in Exhibit 16 also includes position transfers within BHA, of which there are 69 for fiscal 2020. On balance, these transfers moved a net of 3 full-time equivalents (FTE) into the Program Direction function from the various hospitals. During these transfers, 2 hospital positions were reduced from full-time to part-time FTEs, and a net decrease of 0.3 in workload occurred in 5 other hospital positions. The only other personnel change is related to the Opioid Operation Command Center (OOCC) being budgeted in Maryland Emergency Management Agency (MEMA) in fiscal 2020.

Community Behavioral Health Services

The main driver of growth within BHA's budget is related to increased FFS expenditures in PBHS. The Governor's proposed budget includes a 3.5% rate increase for community service providers as mandated by the HOPE Act, an increase of $42.3 million.

CSAs also received rate increases to pass on to recovery centers and other services paid for through CSA grants related to provision of community services.

The other significant increase within the fiscal 2020 budget is due to anticipated service increases throughout PBHS. Increases in enrollment and utilization increase the expenditures by $53.9 million in fiscal 2020. **Exhibit 17** highlights that the increase in services is driven by continued expended demand for SUD treatment, as discussed in the MFR section of this analysis.

Exhibit 17
Change in Behavioral Health Service Utilization Expenditures
Fiscal 2020

	Medicaid	Non-Medicaid	Total
Substance Use Disorder	$59,178,712	$7,867,310	$67,046,023
Mental Health	-13,062,264	-114,875	-13,177,138
Total	**$46,116,449**	**$7,752,436**	**$53,868,884**

Note: Substance use disorder (SUD) Non-Medicaid utilization increase is offset by fiscal 2019 deficiency appropriation for non-Medicaid SUD residential expenditures.

Source: Governor's Proposed Budget

Projected General Fund Adequacy

As previously discussed, one of the deficiency appropriations for BHA is a $14.8 million general fund deficiency for fiscal 2018. Current projections of Medicaid carryover for services in fiscal 2018 suggest that BHA will only expend $1.6 million of this appropriation. However, the Department of Legislative Services (DLS) projects that Medicaid services in fiscal 2019 will outpace the amount originally appropriated, and the balance of funding from the proposed fiscal 2018 deficiency will be needed in fiscal 2019. In spite of the fiscal 2019 deficiency for State-only SUD treatment expenditures, DLS projects that general funds will still be inadequate for these services and that the fiscal 2020 budget for these services may also be inadequate.

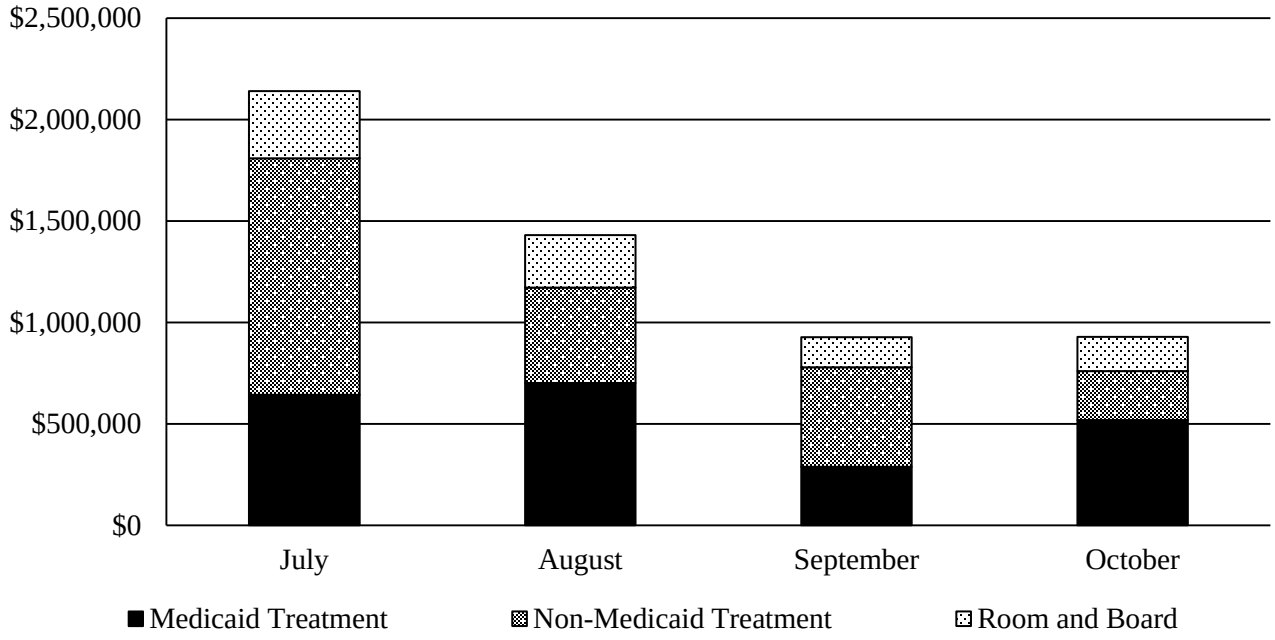
SUD Residential Services

The most significant general fund uncertainty is in Community Services for SUD and uninsured populations, specifically for SUD residential services. SUD residential services have been moving into FFS since the beginning of fiscal 2018, first with higher levels of care and nonspecialty populations. In January 1, 2018, the specialty populations of court-ordered and pregnant women were also added to FFS. As of January 1, 2019, all SUD residential is in FFS with the addition of halfway houses. During this transition to FFS, the number of residential treatment service facilities in Maryland increased from 11 in calendar 2015, to 38 by calendar 2017.

FFS expenditures in SUD has also been increasing significantly from fiscal 2018 to 2019. **Exhibit 18** shows the change in expenditures each month in the component of SUD residential services that has been in FFS since fiscal 2018, from fiscal 2018 to 2019. The increase in expenditures is shown by the three cost drivers in Residential Services: Medicaid treatment; Non-Medicaid (Medical Assistance State Funded and Uninsured) treatment; and room and board. Collectively, over the first

four months of fiscal 2019, SUD residential services expenditures have increased by $5.4 million over fiscal 2018, $3.3 million of which is State-funded.

Exhibit 18
Increase in SUD Residential Expenditures
July to October: Fiscal 2018-2019

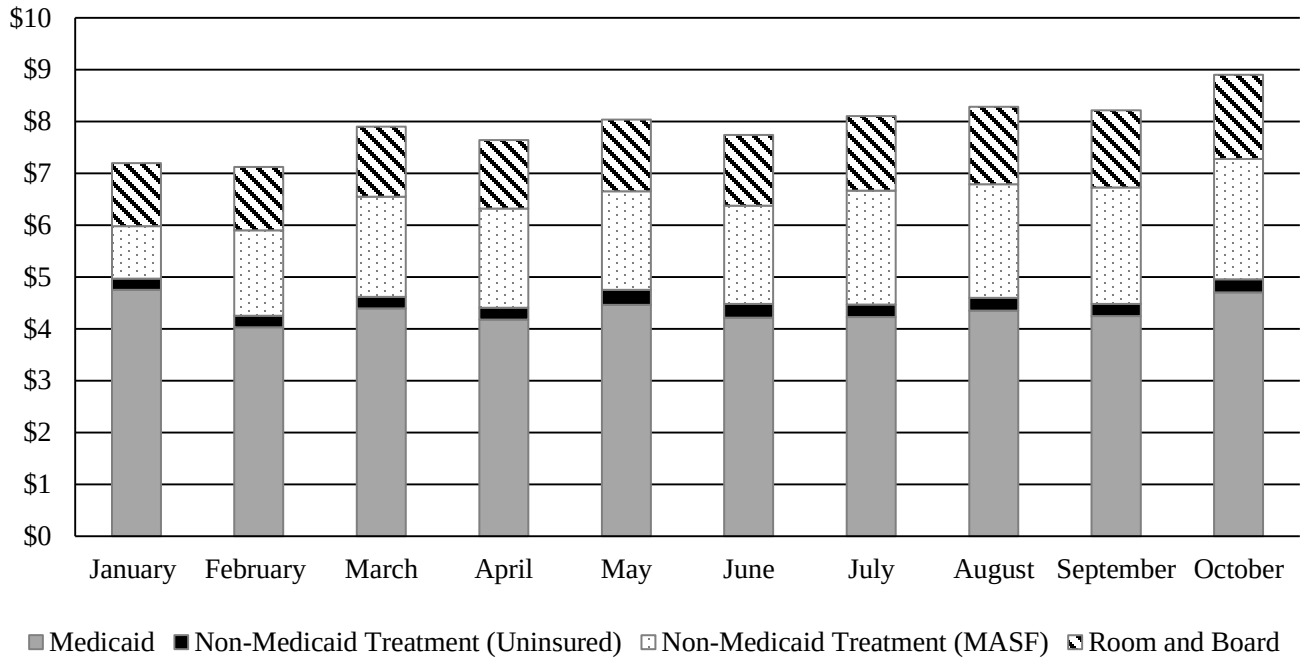


SUD: substance use disorder

Source: Maryland Department of Health

Medicaid support of SUD residential treatment for most populations is limited to 2 nonconsecutive 30-day stays within a rolling year. Treatment expenses for additional or longer stays for Medicaid enrollees are funded with State funds. Further, Medicaid does not pay for room and board expenses, even if they are funding the treatment for the enrollee. It is SUD residential service State-funded services where expenditures are more erratic when compared to the previous fiscal year. Currently, data from December of 2018 shows October fiscal year-to-date non-Medicaid treatment services expenditures were 71% higher than at the same point in time in fiscal 2018. Monthly spending trends for calendar 2018 through October are shown in **Exhibit 19**.

Exhibit 19
SUD Residential Expenditures
Calendar 2018
($ in Millions)



MASF: Medical Assistance State Funded
SUD: substance use disorder

Source: Maryland Department of Health

The fiscal 2020 allowance has a $3.0 million increase in State-funded SUD residential treatment in fiscal 2020 after factoring in the fiscal 2019 deficiency appropriation of $7.8 million. DLS estimates that this will be insufficient given the current rate of growth in SUD residential treatment spending and the addition of new populations into FFS for a full fiscal year. **In order to get a better understanding of trends in SUD residential treatment, DLS recommends adding language requiring BHA to report monthly on the number of individuals relapsing or being readmitted to residential treatment, the average length of stay for individuals in SUD residential treatment, and the rate of individuals completing the treatment program by July 1, 2020.**

The significant recent growth in behavioral health service expenditures in the State, in particular SUD treatment, makes forecasting out-year spending more volatile and is the main cause for concerns regarding the adequacy of the appropriation for services provided in fiscal 2019 and 2020. **Due to the**

uncertainty in the out-year spending, DLS recommends adding language to the budget bill that restricts the appropriations that fund behavioral health services to be used only for that purpose.

Federal Behavioral Health Grants

Another significant change in the fiscal 2020 budget is in federal grants targeting the opioid crisis. In fiscal 2020, the Opioid State Targeted Response (STR) Grants, which supported Maryland Opioid Rapid Response program have ended. However, BHA has continued several of the initiatives started with STR funding with new federal funds awarded to Maryland for fiscal 2019 and 2020, SOR grants. SOR grants are over $33 million per year for two years. The State's plan for spending SOR funds and the initiatives supported by SOR funding are shown in **Exhibit 20**.

Exhibit 20
State Opioid Response Grant Expenditures
Fiscal 2019-2020

	2019	2020
Infrastructure/Administration	$1,102,372	$808,579
Total Data and Performance Measurement	640,971	635,492
Expansion of the Comprehensive Hospital Substance Use Response Program, including SBIRT, OSOP, and MAT Initiation in Hospital Emergency Departments	2,863,250	1,565,000
Crisis Services to Local Jurisdictions	14,495,597	15,520,426
MAT with Criminal Justice Population/Reentry	2,174,714	2,283,850
SAP Team	**145,611**	**365,380**
SBIRT for K-12 Schools	100,000	100,000
SBIRT for Obstetrics and Gynecology Practices	682,500	773,750
Start Talking Teacher Training	87,844	
Public Awareness	**1,656,000**	**673,000**
Naloxone Distribution for Local Health Departments and/or Community Agencies	**2,690,820**	**2,345,475**
SBIRT for College Medical and Counseling Centers	35,000	175,000
Expansion of Consultation and Technical Assistance for Health Care Providers	**300,000**	**720,000**
Medical Patient Engagement	265,000	1,465,200
Harm Reduction Grant	3,580,224	3,581,226
Young Adult Specific Recovery Housing	298,395	298,395
Recovery Residences – Adults and Older Adults	1,536,199	1,536,199
Sign Language Interpreter	138,999	138,999
Healthy Beginnings Initiative – Pregnant Women and Women with families Who Use Opioids and Have Multiple Comorbidities	**54,973**	**131,936**
Adolescent Community Reinforcement Approach	120,938	51,499

	2019	2020
Workforce Development and Training: MAT Training	**200,000**	
Total SOR Grant Expenditures	**$33,169,407**	**$33,169,406**

MAT: medication assisted treatment
OSOP: Overdose Survivors Outreach Program
SAP: substance abuse prevention
SBIRT: screening, brief intervention, referral to treatment
SOR: State Opioid Response

Note: Bold font indicates programs started under State Targeted Response Grants, continued with SOR funding.

Source: Maryland Department of Health

BHA has two smaller federal grants budgeted in fiscal 2020 to expand existing services and initiatives, totaling $1,041,954: $650,000 was awarded to BHA from the Health Resources and Services Administration to expand the existing Behavioral Health Integration in Pediatrics Primary Care program to include screening for mental health disorders for pregnant and postpartum women; and the remaining funds focusing on targeted, evidenced-based interventions for adolescents and young adults at clinical high risk for the onset of a psychotic illness such as schizophrenia.

Other Changes

The other significant change in the fiscal 2020 budget for BHA involves OOCC and the associated funding directed by OOCC moving from BHA to MEMA. This is represented by a decrease of nonpersonnel expenses of $15,893,717. OOCC's funding, and the opioid crisis more broadly, are discussed in the first Issue of this analysis.

Additionally, MDH has discussed reorganizing some of its programs focusing on overdose and addiction prevention out of BHA and into the Public Health Administration, including the Prescription Drug Monitoring Program (PDMP) and the Overdose Response Program. These changes have yet to be reflected in the budget of either agency. **MDH should comment on the timeline for this reorganization, the budgetary implications, and how this reorganization will benefit the department's response to the opioid crisis.**

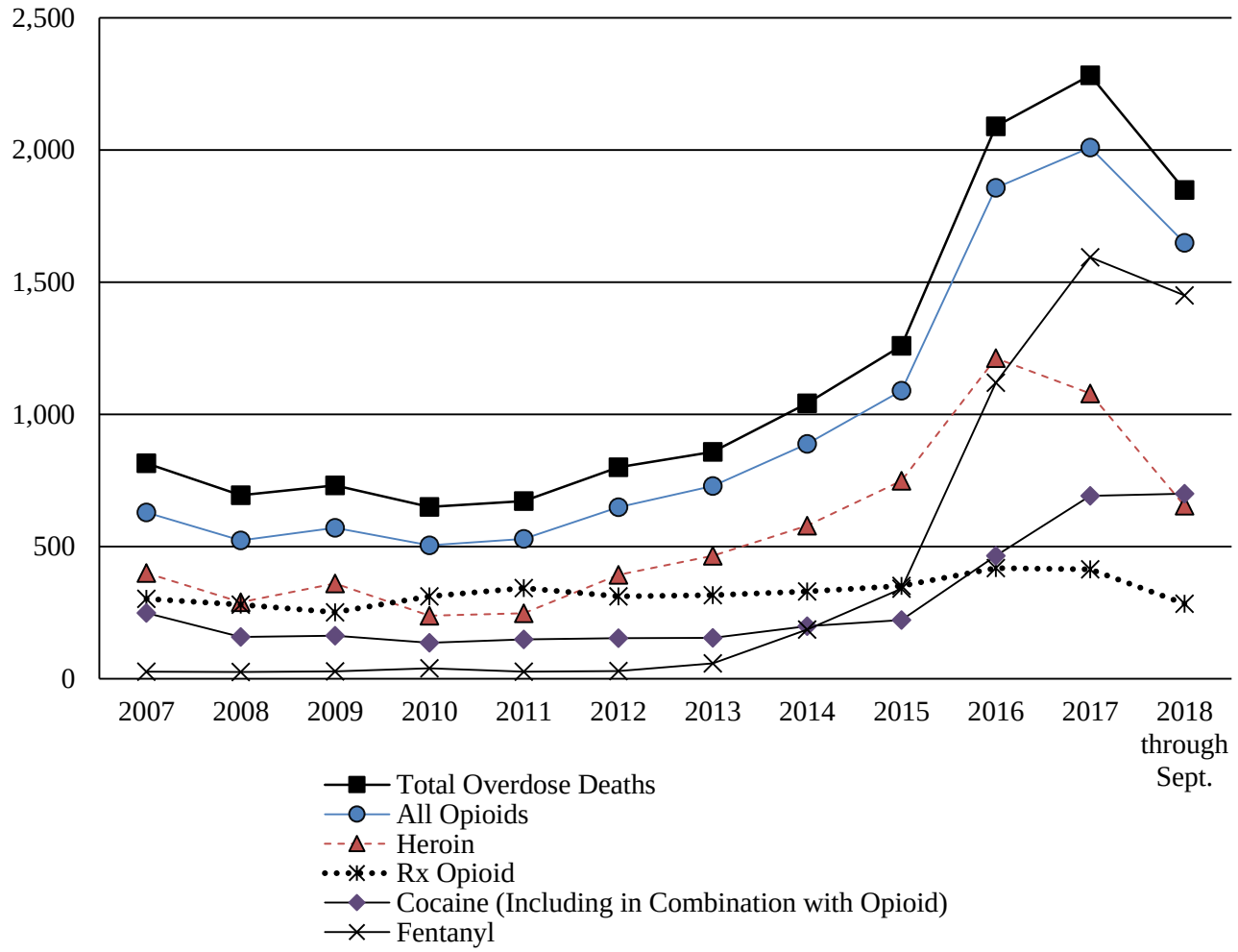
Issues

1. The Opioid Crisis – Continued Struggle Against Fentanyl

Maryland continues to be as one of the states hit hardest hit by the opioid crisis with 2017 setting records for overdose and intoxicant deaths. This was the seventh year in a row that drug- and alcohol-related intoxication deaths increased in the State, reaching an all-time high of 2,282. Of these deaths, 88% (2,009 deaths) were opioid related. So far, data from 2018 does not show any reprieve in overdose deaths in the State. This rise in overdose deaths can be attributed to the growth in the use of fentanyl, which was involved in 1,594 overdose deaths in 2017 and 1,449 deaths through September 2018, a 23.5% increase over the same period in 2017. In 2017, heroin deaths decreased for the first time since 2010, falling by 11% over 2016 (1,212 in 2016 to 1,078 in 2017), and this trend looks to continue into 2018, with a 22.7% decrease through September 2018 over the same period in 2017. Unfortunately, the falling heroin overdose deaths are outweighed by the statewide increase in fentanyl overdoses. Service providers in the State attribute the decrease in heroin-related deaths to be a function of substitution within the drug supply and not the result of a positive anti-heroin intervention.

Exhibit 21 highlights overdose deaths in the State for January through September since 2007. Total overdose deaths track closely with deaths attributed to any opioid, showing how prevalent opioid-related deaths are in total overdose deaths statewide. The figures for cocaine include overdoses that involved cocaine and another substance. Fentanyl was involved in 70% of cocaine overdoses and heroin in nearly 50% of cocaine overdoses in 2017.

Exhibit 21
Overdose Deaths by Related Substances
Calendar 2007-2018 YTD



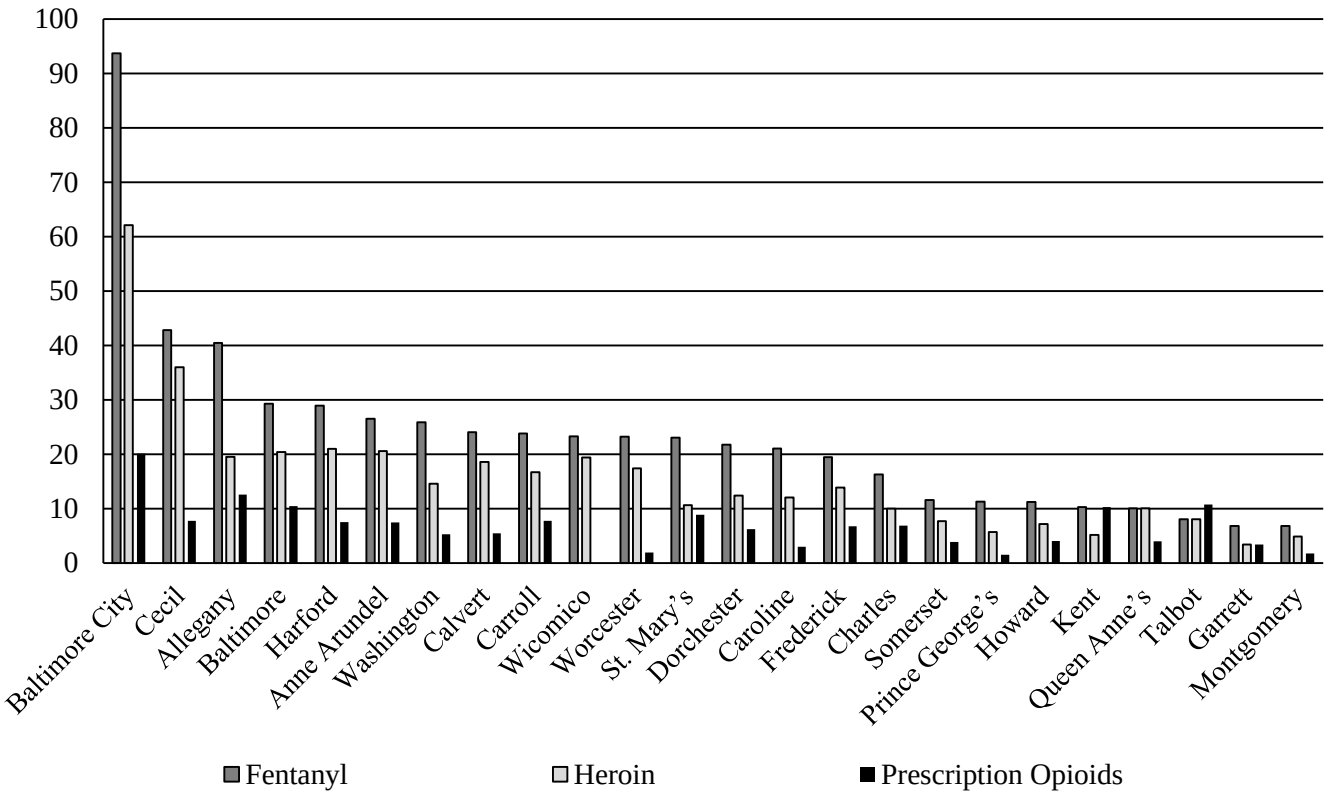
Rx: medical prescriptions
Sept.: September
YTD: year to date

Source: Maryland Department of Health

Exhibit 22 shows the overdose rates for fentanyl, heroin, and prescription opioids by jurisdiction in 2017. Baltimore City experienced the highest rate of overdose death totals for prescription drugs (20 overdose deaths per 100,000 people), fentanyl (94 deaths per 100,000 people), and heroin (62 deaths per 100,000 people) as well as all opioids (113 deaths per capita). Cecil County, the jurisdiction with the second highest overdose death rates related to heroin and fentanyl, experienced

overdose rates of approximately half that of those experienced in Baltimore City in 2017 in the three substances measured.

Exhibit 22
Overdose Death Rates by Selected Substances by Jurisdiction
Calendar 2017
(Rate Per 100,000)

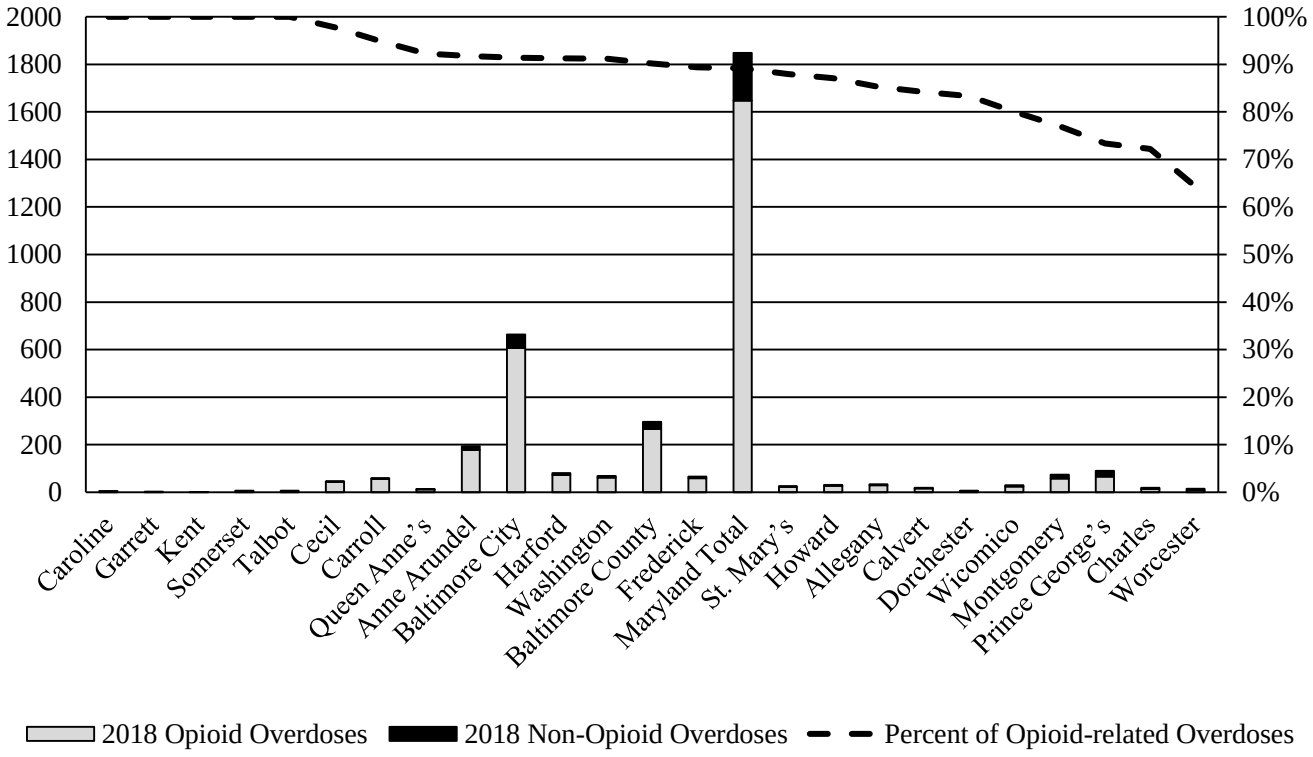


Source: Maryland Department of Health

Exhibit 23 shows the prevalence of opioid overdose deaths relative to the total drug- and alcohol-related intoxication deaths that occurred in 2017 by each jurisdiction. Any opioid was involved in over 88% of the drug- and alcohol-related intoxication deaths statewide with opioid-related deaths occurring over 90% of the time in nine jurisdictions. Every jurisdiction but one (Worcester County) had at least 70% of their drug- and alcohol-related intoxication deaths being opioid-related in 2017. Fentanyl is the most-prevalent of the opioids, being involved in nearly 70% of overdose deaths statewide and at or above 75% of overdose deaths in five jurisdictions (Baltimore City, and Allegany, Cecil, Somerset, and St. Mary's counties), and over 50% of all overdose deaths in all but three counties

(Kent, Talbot, and Garrett). Fentanyl is the most prevalent substance in overdose deaths in all but one jurisdiction (Talbot County).

Exhibit 23
Opioid Prevalence in Overdose Fatalities
Calendar Year To Date through September 2018



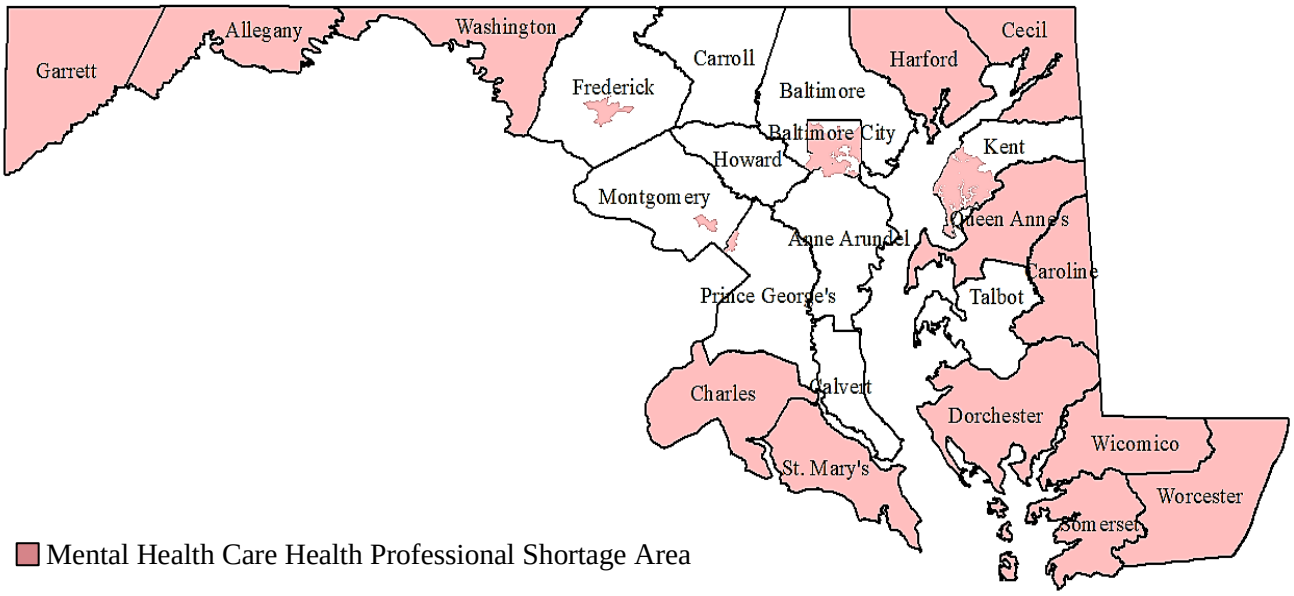
Source: Maryland Department of Health

Federal Actions to Address the Opioid Crisis

In October 2018, President Donald J. Trump signed the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act. This comprehensive legislative package includes provisions aimed at treatment and enforcement and even provides some additional funding to address the opioid crisis. Treatment measures in the SUPPORT Act include a waiver of the Institutions for Mental Disease (IMD) Exclusion for Residential SUD treatment, similar to that already granted to the State through an amendment to its HealthChoice waiver. The SUPPORT Act also expands which providers can prescribe buprenorphine to physician assistants, nurse practitioners, and other specialized nurse providers. It also increased the prescribing

capability for qualified physicians to 275 patients. The SUPPORT Act includes a provision for the federal Department of Health and Human Services to create a loan repayment program for SUD treatment professionals in Mental Health Care Health Professional Shortage Areas (HPSA) and those counties hit hardest by the opioid crisis. According to the Bureau of Health Workforce, Maryland has 22 Mental Health Care HPSAs, shown in the shaded areas of the State in **Exhibit 24**.

Exhibit 24
Map of Mental Health Care Health Professional Shortage Areas



Source: Federal Bureau of Health Workforce

The SUPPORT Act also reauthorizes STR to the Opioid Crisis grants from the federal 2016 21st Century Cures Act (Cures Act). In 2017, Maryland was awarded a $10 million per year, two-year grant from the Cures Act, which is currently in its second year. For the moment, the Cures Act funding is not included in the budget, and much of the work that was funded through the Cures Act is being continued with the SOR federal grant to avoid lapses in programming. Additional funding in the bill is provided for research into new and non-addictive painkillers and a grant program for Comprehensive Opioid Recovery Centers.

Maryland Actions to Address the Opioid Crisis

Legislative Response

During the 2018 session, the General Assembly of Maryland passed several acts to improve treatment, prevent further opioid addiction, and enforce the legal distribution and prescribing of opioids.

Several acts passed during the 2018 session specifically addressed the prescribing of opioids. Chapter 214 of 2018 requires providers to complete a recognized continuing education course related to the prescribing or dispensing of controlled dangerous substances (CDS) as a qualification for an issuance or renewal of registration to dispense CDS. Chapter 216 of 2018 requires that patients be advised of the risks and benefits associated with opioids when prescribed an opioid. Chapter 211 of 2018 requires MDH to identify a method to establish a tip line for individuals to report suspicious prescribing or overprescribing of medication.

Legislation was also enacted in 2018 to expand treatment capacity in the State. Chapter 323 of 2018 requires the Secretary of Health to convene a workgroup to make findings and recommendations on the reimbursement of peer-recovery specialists. Chapter 487 of 2018 requires insurance carriers to ensure that all enrollees have access to local health departments, including their behavioral health services. Chapter 209 of 2018 establishes the Behavioral Health Crisis Response Grant program and requires mandatory appropriations of $3 million, $4 million, and $5 million in fiscal 2020, 2021, and 2020, respectively, for grants to local behavioral health authorities. The fiscal 2020 budget includes the $3 million as mandated.

Enforcement measures include Chapter 593 of 2018, which requires registered distributors of CDS to report any suspicious order of a CDS to MDH and the Office of the Attorney General. In addition, Chapter 149 of 2018 authorizes emergency medical services providers to report the incident of an overdose to the State's overdose detection mapping application program.

Two pieces of legislation enacted at the 2017 session play a significant role in the State's efforts to provide treatment, prevention, and overdose response to those suffering from the opioid crisis, namely Chapters 571 and 572 of 2017, the HOPE Act, and Chapter 573 of 2017, the Heroin and Opioid Education and Community Action Act (Start Talking Maryland Act).

Many of the provisions outlined in the HOPE Act are already underway, including:

- BHA was to establish crisis treatment centers that provide individuals in an SUD crisis with access to clinical staff by June 1, 2018. The pilot site for the Stabilization Center model is currently operational in Baltimore City with services having started on April 2, 2018. Currently, the Stabilization Center has a 15-bed capacity;

- MDH is to establish and operate a toll-free health crisis hotline – Maryland 2-1-1, Press 1;

- Each hospital, by January 1, 2018, was to have a protocol for discharging a patient who was treated for a drug overdose or identified as having an SUD. The emergency discharge protocols required by the HOPE Act were recently evaluated by MHA and it found that:

  - 100% of hospitals were offering Naloxone access, either by dispensing directly from the emergency department or by providing a prescription;

  - 84% of hospitals facilitated a referral for patients who screen positive for SUD to treatment;

  - 80% of hospitals were universally screening for SUD among all patients who present to emergency departments; and

  - 73% of hospitals were incorporating peer recovery services into their processes for treating and discharging patients treated for an opioid overdose and those who screened positive for SUD;

- the Department of Public Safety and Correctional Services is to increase the provision of SUD treatment, including medication assisted treatment (MAT), in prisons and jails; and

- authorized the provision of Naloxone through a standing order and the establishment of guidelines to coprescribe Naloxone to high-risk individuals.

Executive Branch Response

- ***OOCC:*** Governor Lawrence J. Hogan, Jr.'s Administration has continued efforts to respond to the opioid epidemic through OOCC. OOCC directs approximately $10 million annually to support opioid intervention initiatives.

  Included in the OOCC directed funding is support for local opioid intervention teams (OIT) in all 24 local jurisdictions that will receive $4 million in total funding for fiscal 2019 and fiscal 2020. Projects funded through the OIT grants aim to accomplish at least one of four goals: (1) prevent new cases of SUD; (2) improve early identification and intervention; (3) expand access to treatment and recovery; and (4) enhance data collection, sharing, and analysis. Included in these goals are projects that seek to expand Naloxone access, increase public awareness, support education and training, and facilitate referrals and connections to treatment and recovery support services. OOCC also launched the public awareness campaign Before It's Too Late, which aims to mobilize resources for prevention, treatment, and recovery.

- ***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. In a report submitted on February 13, 2018, MDH compared Maryland Medicaid's SUD treatment rates to those in Delaware; Pennsylvania; Virginia; Washington, DC; and West Virginia. MDH found that, out of 40 procedure codes related to SUD, Maryland had the highest (7) or within $1 of the highest (11) in the region. However, as the report notes, what is covered, duration of services, and fee schedule based on facility type vary across states analyzed. Additionally, since this study was conducted, the HOPE Act's 3.5% provider rate increase went into effect. The 3.5% rate increases occurred in five codes in which Maryland Medicaid already had the highest reimbursement rate or otherwise did not improve Maryland's ranking.

In fiscal 2019, the Maryland Medicaid program began operating under a waiver to the IMD exclusion. This waiver allows the State to receive federal reimbursements for the provision of residential treatment for up to two 30-day stays per year. Removing the IMD exclusion moves SUD residential treatment from a primarily State-funded benefit to a widely available benefit for all Medicaid-eligible beneficiaries.

The administration has supported and funded programs throughout the government that aim to assist in the opioid crisis. **Exhibit 25** tracks the funding to address the opioid crisis in Maryland since 2018.

Exhibit 25
Overview of Funding to Combat the Opioid Crisis
Fiscal 2018-2020

	2018	2019	2020
Maryland Department of Health			
SUD Fee-for-service (FFS) Expenditures for Medicaid and Uninsured Populations	$494,975,231	$523,268,660	622,491,015
Federal State Opioid Response Grant	n/a	33,169,407	33,169,406
Treatment Services Grants to Local Jurisdictions	20,952,868	27,837,877	26,576,969
Funding to Local Jurisdictions for Buprenorphine Access and Initiative	3,544,304	3,544,304	3,492,253
Substance Abuse Treatment Services (Reimbursable Funds from DHS)	3,054,854	3,411,581	3,411,581
Drug Treatment Courts (Reimbursable Funds from Judiciary)	1,800,000	1,800,000	1,800,000

	2018	2019	2020
Prescription Drug Monitoring Program	1,160,818	2,044,031	1,348,150
Overdose Response Program	975,155	1,262,985	1,011,864
Implementing a Good Samaritan Law Public Awareness Campaign	697,653	697,653	697,653
Providing Recovery Support Specialists to Assist Pregnant Women with Substance Use Disorders (Moved to FFS in fiscal 2020)	622,622	622,622	0
Funding for Care Coordination, Recovery Peer Services, and MAT for Individuals Coming from the ER Outreach and Induction Treatment (Fiscal 2018 to 2019) and Targeted Expansion of MAT to Pregnant Women and Women with Dependent Children (Fiscal 2020)	810,865	696,774	614,193
Maryland Opioid Rapid Response (Federal STR Grant)	9,892,316	8,364,036	0
Subtotal	***$538,486,686***	***$606,719,930***	***$694,613,084***
Department of Public Safety and Corrections			
Substance Abuse Treatment Services within Correctional Facilities	$55,907	$2,693,878	$2,693,878
Substance Abuse Treatment Assessment at MRDCC		351,721	360,000
Subtotal	***$55,907***	***$3,045,599***	***$3,053,878***
State Police			
Multijurisdictional State Police Heroin Investigation Unit	$200,000	$200,000	$200,000
Designating HIDTA the Central Repository for Maryland Drug Intelligence	75,000	75,000	75,000
Subtotal	***$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)	$270,000	$270,000	$270,000
Safe Streets	180,000	180,000	180,000
Subtotal	***$450,000***	***$450,000***	***$450,000***
Opioid Operational Command Center (OOCC)			
Other Grants Targeting Opioid Interventions, Including $4 Million Annually to Local OIT	$10,148,601	$15,893,717	$10,273,246
OOCC Personnel and Operating Expenses	365,112	307,264	532,301
Subtotal	***$10,513,713***	***$16,200,981***	***$10,805,547***

	2018	2019	2020
Maryland State Department of Education			
Start Talking Maryland Act	$0	$3,000,000	$0
Local School Websites to Promote Drug and Heroin Awareness	100,000	100,000	100,000
Subtotal	***$100,000***	***$3,100,000***	***$100,000***
Grand Total	**$549,881,306**	**$629,791,510**	**$709,297,509**

DHS: Department of Human Services
ER: emergency room
HIDTA: high intensity drug trafficking areas
MAT: medication assisted treatment
MRDCC: Maryland Reception, Diagnostics and Classification Center
OIT: opioid intervention team
STR: State Targeted Response
SUD: substance use disorder

Source: Governor's Proposed Budget

2. Inpatient Psychiatric Capacity

The fiscal 2019 budget included funding to expand capacity at the State-run psychiatric facilities. However, capacity in private and acute hospitals remains a concern throughout the State. To better understand the capacity throughout Maryland and the relevant demand for inpatient psychiatric beds, BHA was required by the budget committees to conduct a study reporting the number of inpatient psychiatric beds in the three sectors that provide inpatient mental health services: acute general hospitals; private psychiatric hospitals; and State psychiatric facilities. The study looked at discharges, psychiatric patient days, lengths of stay, number of beds, and occupancy rate to determine the total capacity of the sector. The study also looked at the changes in inpatient psychiatric capacity statewide since fiscal 2013 to 2017. Although finding that capacity has remained fairly constant since fiscal 2013, the department did not make any recommendations regarding the appropriate amount of inpatient psychiatric capacity throughout the sectors, in part due to measurement discrepancies of bed capacity and occupancy.

When preparing this report, BHA elected to use licensed beds when measuring capacity for acute general hospitals and private psychiatric hospitals but used operational beds when calculating capacity for State-run hospitals. BHA asserts that this distinction is made because the private facilities have their own autonomy to staff a licensed bed into an operational bed if they so choose. In the report, BHA asserts that the difference between licensed and operational beds is not that different, at least for the acute general hospitals, claiming only 53 more licensed beds than operational beds in fiscal 2017.

However, across the acute general hospitals, this would represent a 5% increase in the occupancy rate for fiscal 2017, which is not insignificant. Furthermore, BHA does not provide the difference between licensed and operational beds at the private psychiatric hospitals. Lacking this information makes it impossible to validate the claims made by BHA that this is the best way to measure capacity in the State.

Several other factors, outside of merely having licensed beds, potentially impact inpatient psychiatric capacity: for example, availability of psychiatric staff, both in the public and private sector, would be an important consideration regarding Maryland's inpatient psychiatric capacity. Additionally, BHA elected to measure the demand for inpatient psychiatric services exclusively by inpatient psychiatric patient days throughout the State. This measure potentially underestimates treatment needs in the State by not counting individuals who are treated in other settings but who may be better suited for a higher level of care. Lastly, the report lacked a discussion of the population in each facility type throughout the entire sector. According to BHA, roughly 98% of admissions into State facilities are forensic with the remaining 2% being voluntary admissions. With such a significant share of the patient mix in State facilities being court ordered to an inpatient psychiatric facility, it is unsurprising that their occupancy rate is near 100% annually. While the court-ordered population is an important component of the need for inpatient psychiatric treatment in the State, the nature of that population only being able to receive treatment in State facilities obscures the role which the State can play with regard to voluntary commitments.

In an appendix to the report, the Maryland Hospital Association (MHA) submitted a letter that referenced a report conducted by MHA that uses claims data to identify patients with a primary behavioral health diagnosis (including SUD) for all units of the 29 hospitals with inpatient psychiatric services. This analysis found that the hospitals provided roughly 245,000 days of inpatient psychiatric care, which is nearly 80,000 more inpatient psychiatric days than BHA found in its analysis. Considering this additional inpatient psychiatric care and evaluating on licensed beds in the acute general hospitals, as BHA did for this analysis, the hospitals are at 90.7% capacity, significantly higher than the 61.5% found by BHA in fiscal 2017. When MHA's number of patient days is used to calculate occupancy rate compared to operational bed capacity, the measurement used by BHA for State-run facilities, the occupancy rate for acute general hospitals in fiscal 2017 is 97.7%. This discrepancy in measurement creates an entirely different picture of the role that acute general hospitals are able to play in the provision of inpatient psychiatric services and presents the possibility that they may already be near or at capacity. **Exhibit 26** highlights these measurement discrepancies, specifically when looking at the acute general hospital capacity. While the report submitted by BHA notes that their calculation of patient days is likely to be conservative with regard to acute general hospital patient days, a difference of this significance is substantial enough to question whether or not the State currently has the capacity to meet the inpatient psychiatric needs of Marylanders.

Exhibit 26
Measurement Discrepancy in Inpatient Psychiatrist Treatment Capacity

	Beds	Possible Patient Days	Reported Inpatient Psychiatrist Days		Occupancy Rate	
			BHA Analysis	MHA Analysis	BHA Analysis	MHA Analysis
Licensed	740	270,100	166,213	245,000	61.54%	90.71%
Operational	687	250,755	166,213	245,000	66.29%	97.70%

BHA: Behavioral Health Administration
MHA: Maryland Hospital Association

Source: Maryland Department of Health, Maryland Hospital Association

The referenced MHA study also found that lack of bed space in the preferred placement setting for a patient was the cause of the delay in placement for 34% of the patients who were delayed, suggesting that capacity is lower than BHA's findings. Further, the largest share of preferred placements in MHA's sample was inpatient psychiatric units at 24%. These two findings taken in tandem suggest some shortfall in the inpatient psychiatric capacity in the State.

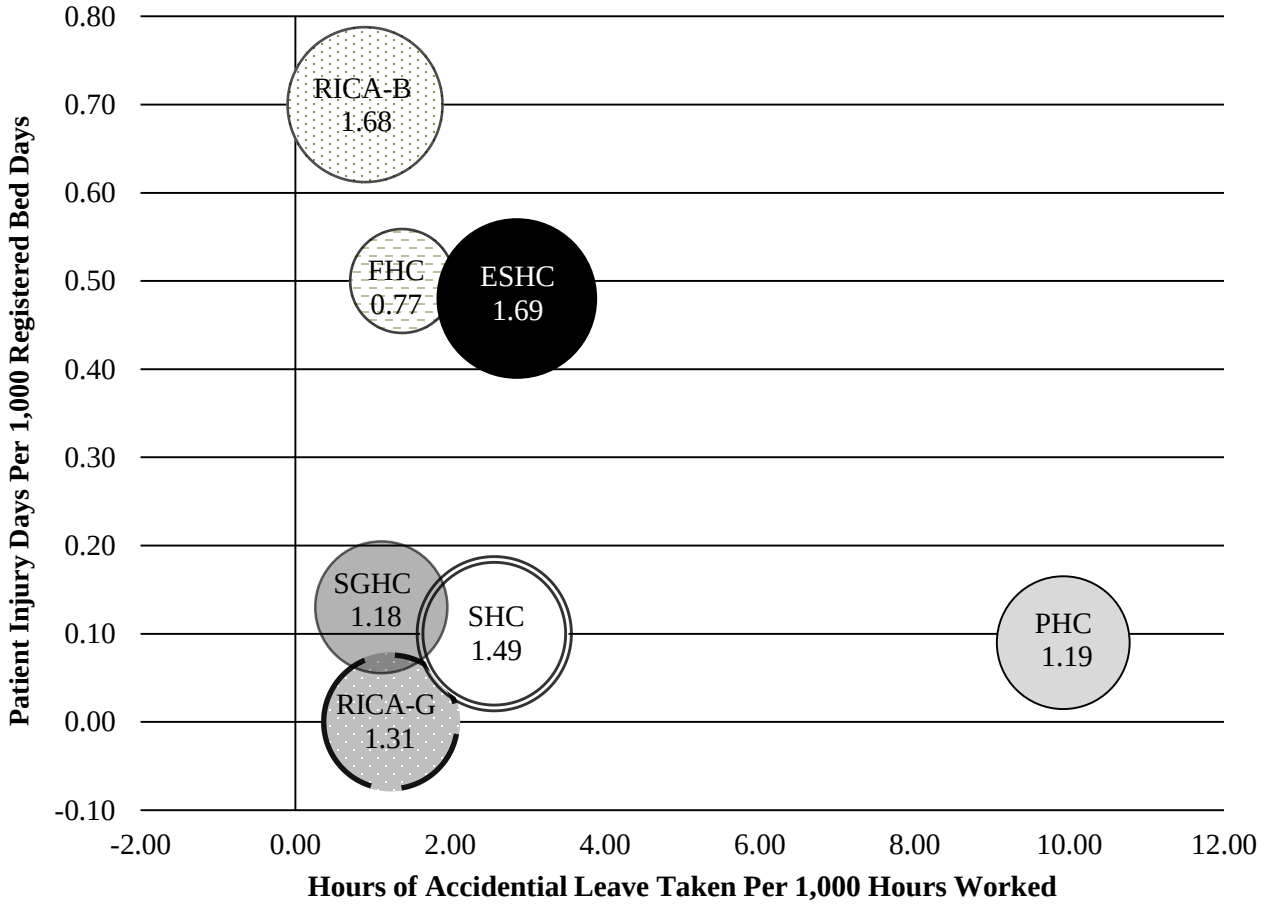
The department should comment on why it elected to use different measurement techniques when evaluating the private versus the public sector; what difference, if any, exists between operational and licensed beds for private psychiatric hospitals; and its recommendation as to how to best determine and uniformly measure inpatient psychiatric capacity and demand throughout the State.

3. BHA Facility Staffing

The 2018 *Joint Chairmen's Report* (JCR) required MDH and BHA to submit a report on the desired levels of direct care staff needed at the State-run psychiatric facilities. The most recent evaluation of staffing levels by the department was conducted in 2007. The current report did not identify staffing levels as a problem with regard to patient and staff safety and identified literature that suggests that increased staffing levels can result in less safe patient care. **Exhibit 27** shows the reported ideal staffing levels for each BHA facility on a staff-per-patient ratio. A larger circle identifies more direct care staff reported required to care for one patient in the facility. Overall, staff-to-patient ratios were calculated using the staffing model provided by BHA, divided by the patient census for each facility. This calculation includes required staffing for care units overnight. Additionally, BHA inflated the total staff calculation by a factor of 1.4 to reflect coverage required seven days per week. The staffing model and figures reported generally do not consider changes in patient acuity, employees taking leave or calling in sick, or other factors that could impact the staffing need. It is also worth noting

that the report does adjust staffing levels needed within some of the BHA facilities relative to the anticipated level of care and acuity for patients generally in those units.

Exhibit 27
BHA Facility Staffing Need, and Employee and Patient Injury Rates



BHA: Behavioral Health Administration
ESHC: Eastern Shore Hospital Center
FHC: Thomas B. Finan Hospital Center
PHC: Clifton T. Perkins Hospital Center
RICA-B: Regional Institutes for Children and Adolescents – Baltimore City
RICA-G: John L. Gildner – Regional Institutes for Children and Adolescents
SGHC: Spring Grove Hospital Center
SHC: Springfield Hospital Center

Note: Data displayed in the circles are the overall staff-to-patient ratios. The size of the circle identifies the amount of direct care staff required to care for one patient.

Source: Maryland Department of Health; Governor's Budget Books

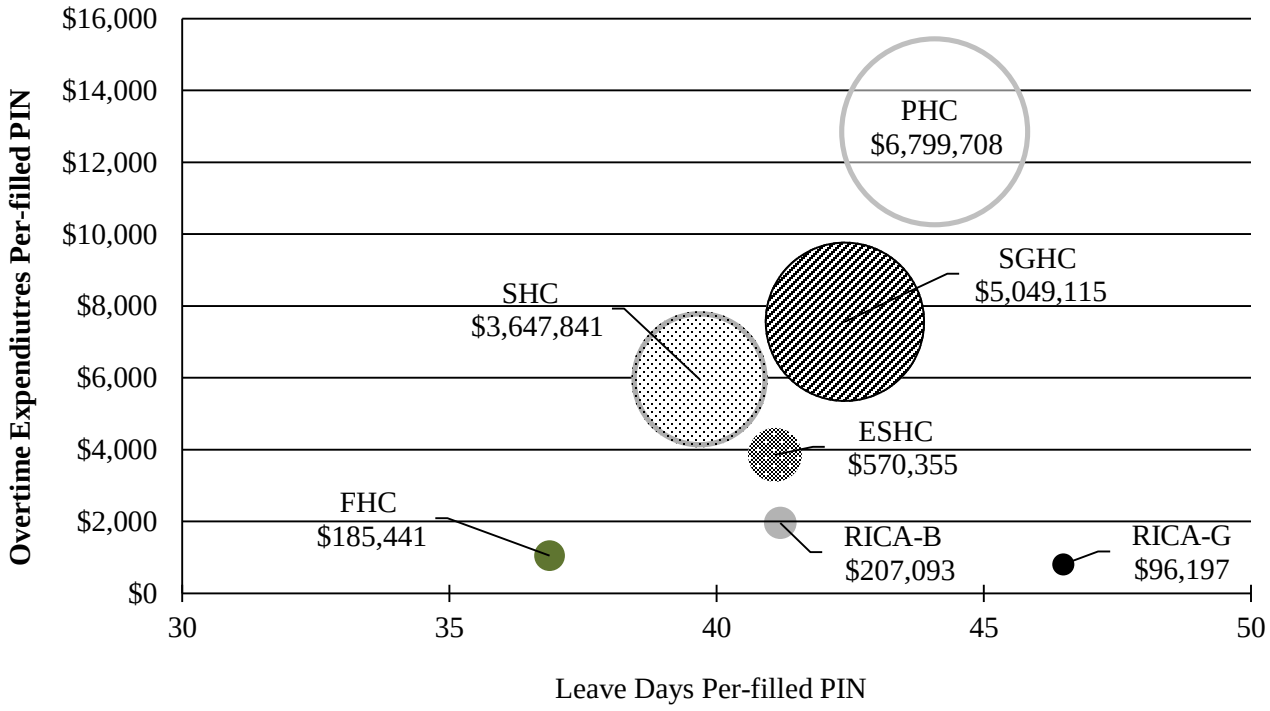
Exhibit 27 also places these ideal staff-to-employee ratios along coordinates that reflect the employee amount of accidental leave taken per 1,000 hours worked and patient injury days per 1,000 registered bed days. Interestingly, the reported necessary staff-to-patient ratio does not correlate with type of facility, or respective injury rates, with the Spring Grove and Clifton T. Perkins facilities having nearly the same required staffing levels but with much higher staff injury rates at Perkins.

The report identifies other limitations within their baseline staffing model, including vacancy rates, turnover, training, and uncharacteristically high levels of leave used by employees. In calendar 2017, BHA reports over 700,000 hours of leave being used, or 41 days per staff member in the facilities. BHA estimates that the leave taken by hospital employees in 2017 is the equivalent of the work of 330 FTEs. **Exhibit 28** shows the total amount of overtime used in each facility in fiscal 2017, plotted relative to the per filled position leave and overtime dollars per filled position. Clifton T. Perkins has the highest per position overtime as well as most overtime paid throughout the hospitals while having the second highest leave rate per employee. Generally, high levels of leave use are associated with higher levels of overtime spending.

The report goes on to suggest that increased levels of staffing is not the solution to decreasing patient assault and instead highlights environmental factors and staff and patient characteristics that are more strongly correlated. Other factors identified included spatial density and patient flow of the facility, staff experience, and the patient's acuity and past history of violence.

Given the high use of leave throughout the State-run psychiatric facilities, the agency should comment on its confidence in the ability to adequately staff the facilities with its current resources and other measures being taken to reduce overtime expenditures.

Exhibit 28
Amount of Overtime and Leave Use
Fiscal 2017



ESHC: Eastern Shore Hospital Center
FHC: Thomas B. Finan Hospital Center
PHC: Clifton T. Perkins Hospital Center
PIN: position identification number
RICA-B: Regional Institutes for Children and Adolescents – Baltimore City
RICA-G: John L. Gildner – Regional Institutes for Children and Adolescents
SGHC: Spring Grove Hospital Center
SHC: Springfield Hospital Center

Note: Data displayed in the circles reflect the total overtime expenditures of each State-run psychiatric facility.

Source: Maryland Department of Health

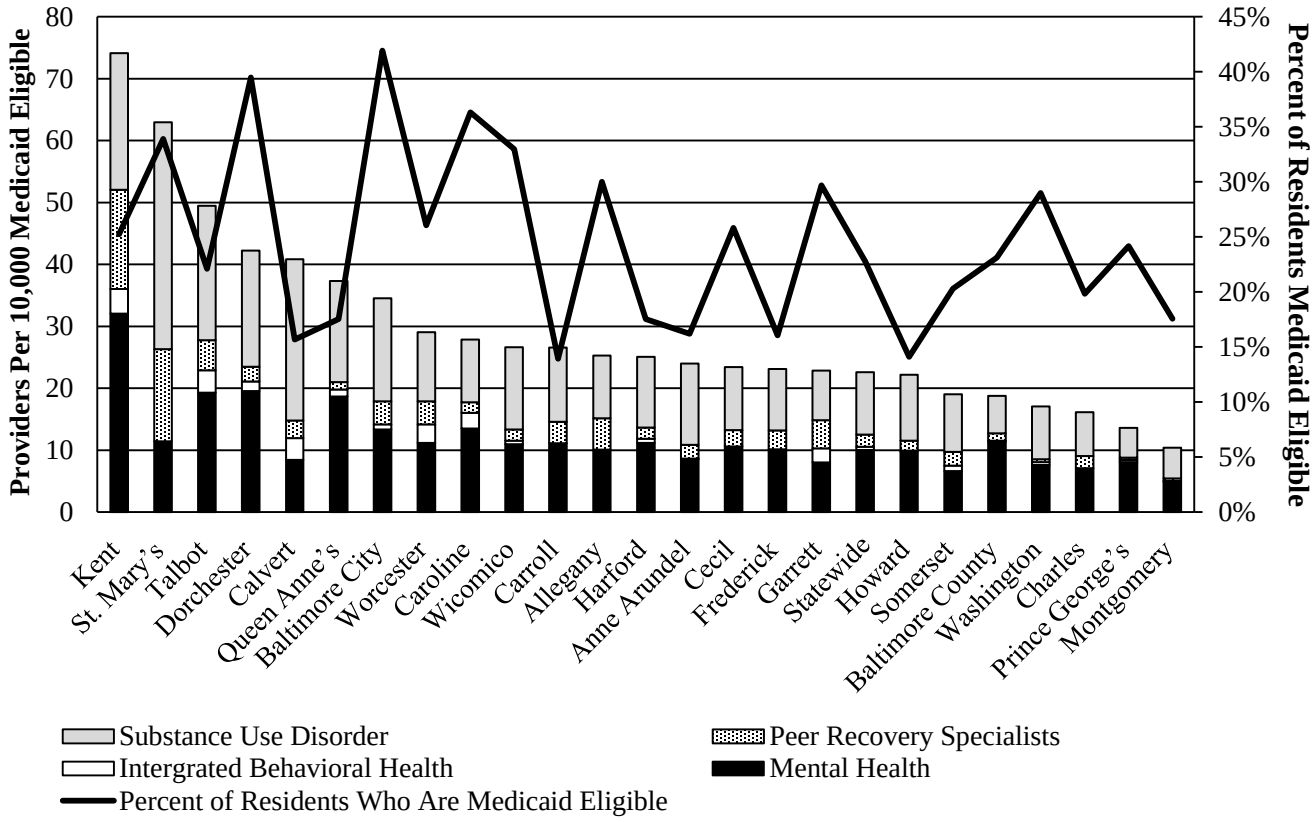
4. Statewide Behavioral Health Workforce Capacity

The 2018 JCR also requested a report from BHA regarding the overall status of workforce capacity in the State's PBHS. This report was also tasked with assessing the strengths and weaknesses

of the current PBHS and making recommendations related to closing identified service gaps and ways to further strengthen Maryland's PBHS.

The report included data on the types of treatment that are available to individuals by jurisdiction. **Exhibit 29** condenses the number of service providers by jurisdiction into four groups: mental health; SUD; peer recovery specialists; and integrated behavioral health (SUD and mental health diagnosis). The total number of providers is then scaled to the average number of Medicaid eligible per jurisdiction and represents services offered per estimated 10,000 Medicaid eligible.

Exhibit 29
Providers by Jurisdiction
Calendar 2018
(Providers Per 10,000 Medicaid Eligible)

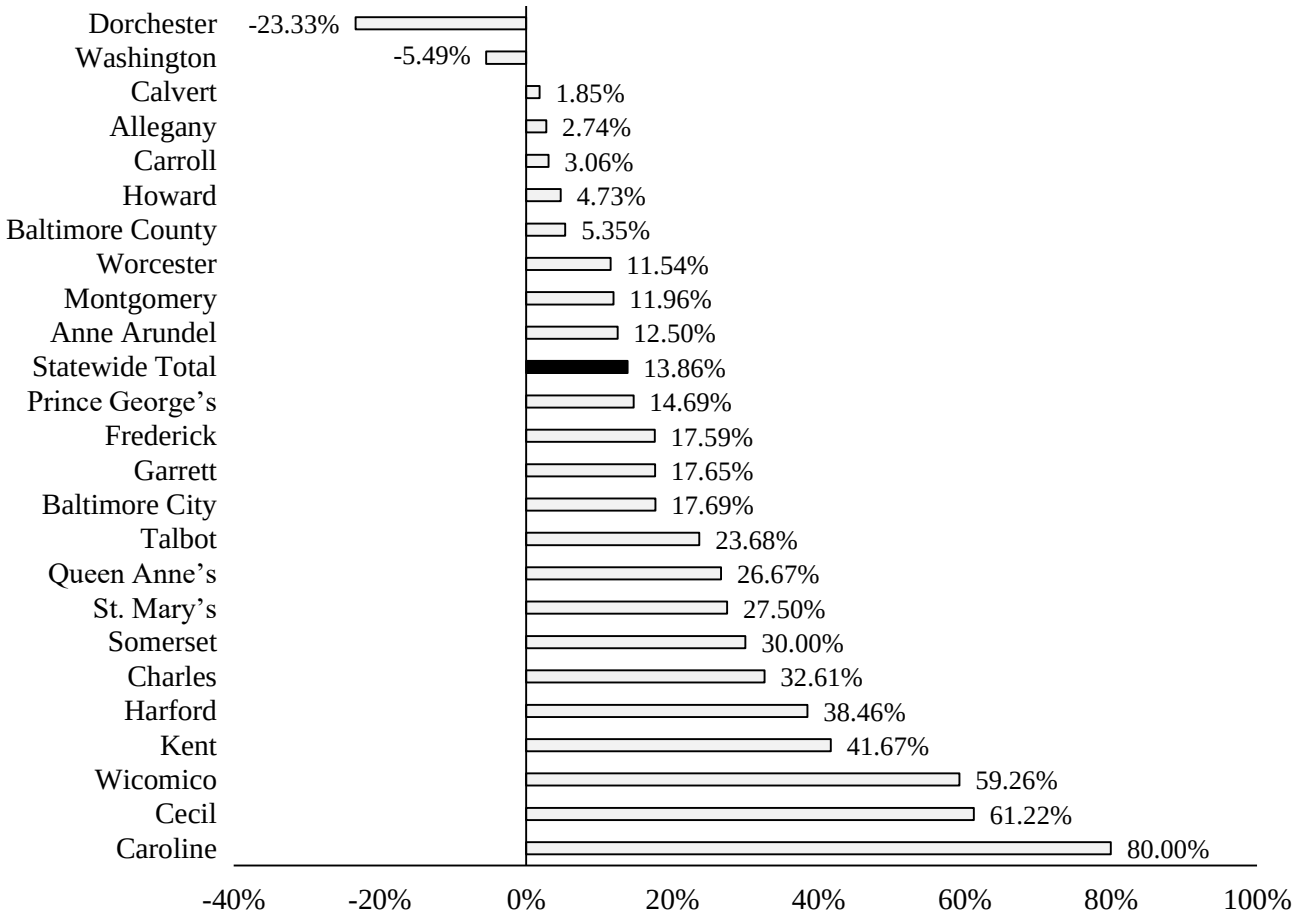


Source: Maryland Department of Health

Exhibit 29 also overlays the approximate share of that jurisdiction's population that is Medicaid enrollees as a proxy for demand.

The report also highlights changes in the number of service providers per jurisdiction from 2015 to 2017, which is shown in **Exhibit 30**. Over the period of time analyzed by BHA, the overwhelming majority of jurisdictions increased their capacity to provide behavioral health services with only two, Dorchester and Washington counties, decreasing.

Exhibit 30
Change in Behavioral Health Providers
Calendar 2015-2017



Source: Maryland Department of Health

In the analysis of the workforce capacity, BHA identified a study conducted by the Community Behavioral Health Association of Maryland that highlighted two challenges regarding the statewide workforce: recruitment in rural areas; and the retention of staff in more densely populated areas. The analysis conducted by BHA highlights work being done by its Office of Workforce Development and Training, including promoting workforce development programs, internships, financial assistance

opportunities for students who choose a career in PBHS, and collaboration with local CSAs and provider networks.

Strengths and Weaknesses and Recommendations

Lastly, the report identified strengths and weaknesses and made recommendations regarding Maryland's PBHS. The strengths identified included evidence-based practices (EBP), such as supported employment and assertive community treatment (ACT) (further discussed in Update 1), the availability of Targeted Case Management (TCM) for mental health in all jurisdictions, MAT for opioid use disorder being available statewide despite being underutilized due to stigma surrounding MAT, and an increasing peer recovery specialist network.

The report also highlighted two main weaknesses of PBHS: workforce shortages statewide, particularly with regard to psychiatrists, addictionologists; and nurses specializing in behavioral health. The workforce shortages are not exclusively limited to rural parts of the State with the opioid crisis putting a strain throughout PBHS. BHA notes that increased use of telemedicine and the workforce development strategies supported by the Maryland Opioid Rapid Response can increase the capacity of the existing workforce as well as increase individuals working in PBHS.

The other major challenge identified by BHA was the transportation needs of those who rely on PBHS, particularly in rural communities. BHA reports attempting to overcome these challenges through the use of mobile treatment services (MTS), care coordination, Medicaid transportation, and peer recovery specialists providing transportation.

In order to combat these weaknesses within PBHS, BHA outlined several strategies to build the capacity of the BHA workforce. Recommendation to address workforce shortages included:

- increasing the use of telemedicine to assist with service delivery and MAT, particularly in rural communities;

- further integrating mental health and substance use providers; and

- encouraging collaboration with public and private providers regionally.

BHA noted further financial assistance from the federal government for providers who are willing to work in HPSA (see Exhibit 24 in Opioid Issue Section) will help increase capacity. Recommendations regarding transportation challenges included increasing crisis support and mobile services, increasing funding to local PBHS to expand transportation services offered by local providers, and enrolling consumers in care coordination programs that provide transportation assistance through Medicaid.

BHA should comment on which of these recommendations are currently underway, what recommendations are being initiated, and what recommendations are being considered. Further, BHA should comment on the resources being committed to these recommendations, steps being

taken to meet the service gaps identified, and performance measures being used to track progress in addressing service needs identified in this report.

5. HOPE Act Rate-setting Study

The HOPE Act mandated MDH to review Maryland Medicaid rates for all community-based behavioral health services provided through the Medicaid program. This required MDH, as the first step of reviewing rates, to conduct an independent cost-driven, rate-setting study to set community provider rates for community-based behavioral health services that includes a rate analysis and an impact study that considers the actual costs of providing community based behavioral health services.

Additionally, the HOPE Act required the department to submit an interim report by December 1, 2018, and the final report on December 1, 2019. A draft interim report was provided to DLS that highlighted the sample size selected for the study, the methodologies to be used, and the schedule of activities to meet the December 1, 2019 deadline. This report identified providers being sampled, including outpatient mental health clinics, SUD programs, community-based partial hospitalization, mobile treatment, opioid treatment, psychiatric rehabilitation, home and community-based services (1915(i)), and TCM. The sample of programs reportedly selected represent 236 of 793 possible providers. Each provider group will receive a cost report and instructions as facilitated by the contractors. The cost report and instructions are based on the federal Centers for Medicare and Medicaid Services' Certified Community Behavioral Health Clinics cost report and will be modified as needed for each provider type.

The schedule as identified has all cost reports due by February 22, 2019, and provides six months for data analysis by the contract firm before furnishing MDH with a report in August 2019. **The department should comment on the status of the interim report, any substantive changes from the draft report, and progress toward meeting the December 1, 2019 deadline.**

Operating Budget Recommended Actions

1. Add the following language:

   Provided that these funds are to be used only for the purposes herein appropriated, and there shall be no transfer to any other program or purpose except that funds may be transferred to programs M00L01.03 Community Services for State Medicaid Fund Recipients or M00Q01.10 Medicaid Behavioral Health Provider Reimbursements. Funds not expended or transferred shall be reverted or canceled.

   Explanation: This language restricts the entire appropriation for substance use disorder treatment, uninsured treatment, or other community service grants for that purpose or for provider reimbursements in M00L01.03 Community Services for State Medicaid Fund Recipients or M00Q01.10 Medicaid Behavioral Health Provider Reimbursements.

2. Adopt the following narrative:

   Substance Use Disorder Residential Treatment: Given the significant increase in the use of substance use disorder (SUD) residential treatment services, the committees request monthly reports on the number and percent of individuals in SUD residential treatment who have relapsed, the average length of stay in SUD residential treatment, and the share of individuals who have completed their SUD treatment.

Information Request	**Author**	**Due Date**
SUD Residential Treatment performance outcomes	Behavioral Health Administration	Monthly, starting July 1, 2019

3. Add the following language:

   Provided that these funds are to be used only for the purposes herein appropriated, and there shall be no transfer to any other program or purpose except that funds may be transferred to programs M00L01.02 Community Services or M00Q01.10 Medicaid Behavioral Health Provider Reimbursements. Funds not expended or transferred shall be reverted or canceled.

   Explanation: This language restricts the entire appropriation for Medicaid State Funded Mental Health Services for that purpose or for provider reimbursements in M00L01.02 Community Services or M00Q01.10 Medicaid Behavioral Health Provider Reimbursements.

4. Add the following language:

Provided that these funds are to be used only for the purposes herein appropriated, and there shall be no transfer to any other program or purpose except that funds may be transferred to programs M00L01.03 Community Services for State Medicaid Fund Recipients or M00L01.02 Community Services. Funds not expended or transferred shall be reverted or canceled.

Explanation: This language restricts the entire appropriation for Medicaid behavioral health provider reimbursements for that purpose or for provider reimbursements in M00L01.03 Community Services for State Medicaid Fund Recipients or M00L01.02 Community Services.

Updates

1. Fidelity Audits of Supported Employment and ACT

The 2018 JCR requested that BHA submit a report on the effect of fidelity audits on EBPs in the State. For the purposes of this analysis, EBPs refer to supported employment and ACT programs. The report submitted by BHA reviews EBPs in the State, fidelity audits of these programs, and data regarding the prevalence of these practices throughout PBHS. BHA provides enhanced rates for programs using EBPs, and, in order to qualify, a program must submit to a fidelity audit conducted by BHA-designated assessors. Initially, programs are eligible for a one-year EBP designation. If at any point, the program fails to meet full fidelity standards but meets lower thresholds, it may qualify for six-month conditional status and still receive enhanced rates of reimbursements. However, if a program fails to meet this lower threshold, it is ineligible to receive the enhanced rates. Additionally, if after two consecutive periods of conditional eligibility and failing to meet full fidelity on the third, the program is deemed ineligible. Conversely, programs that meet full fidelity standards on consecutive annual audits are eligible to be reviewed on a biannual basis until they fail to meet full fidelity standards.

Fidelity assessors receive annual in-person training and have professional experience related to behavioral health treatment. Fidelity assessments are also conducted by at least two assessors for inter-rater reliability with each assessor reviewing the program independently with the team of raters required to reach a consensus for each item.

ACT

ACT is an enhanced, more robust version of MTS. Both ACT and MTS are available 24/7 to patients and seek to provide treatment outside of a hospital setting and bring services to the patient in the least intensive setting that can meet their clinical needs. ACT is differentiated from traditional MTS by assisting with holistic health care needs and collaborating with the families of the patient. ACT teams are also proactive in engaging and retaining individuals within the program. ACT teams generally serve 50 to 120 patients with 10 or fewer patients per staff member.

Exhibit 31 shows the reported share of programs meeting the ACT standards for EBPs and the number found to be conditionally approved.

Exhibit 31
EBPs in Mobile Treatment
Calendar 2017-2018

	2017	2018
Total Mobile Treatment Teams Operating in the State	32	33
Mobile Treatment Teams designated as ACT	20	23
Conditional EBP Approvals	4	3
Percent of Operating as EBP	75%	79%

ACT: assertive community treatment
EBP: evidence-based practice

Source: Maryland Department of Health

Supported Employment

Supported employment programs in Maryland provide job development, job coaching, and ongoing employment support for individuals with serious mental illness. EBP-supported employment programs differentiate themselves by using the individual placement and support model that aims to find individuals competitive employment within the community that would be available to individuals with or without a disability. EBP-supported employment does not require participants to complete mandatory vocational evaluations, work trials, or work preparation courses. The focus of these EBP-supported employment programs is to find individuals with serious mental illnesses a job based on their strengths, interests, experiences, and motivations. EBP-supported employment's aim is to find a natural fit between the job-seekers and the jobs in the community.

Once the individual secures a job, EBP-supported employment services continue to provide ongoing support based on an individual's needs, including assistance in retaining the job, securing a new or better job, and establishing a career trajectory. EBP-supported employment integrates the employment specialist within a multidisciplinary mental health treatment team. Supported employment programs in Maryland have seven mutually exclusive, reimbursable phases: (1) pre-placement; (2) job development; (3) placement in a competitive job; (4) intensive job coaching; (5) ongoing support services; (6) psychiatric rehabilitation; and (7) clinical coordination

Exhibit 32 shows the reported share of supported employment programs meeting the EBP standards and the number found to be conditionally approved.

Exhibit 32
EBPs in Supported Employment
Calendar 2017-2018

	2017	2018
Total Supported Employment Programs Operating in the State	63	61
Supported Employment Programs Designated as EBP	25	28
Conditional EBP Approvals	11	7
Percent Operating as EBP	57%	57%

EBP: evidence-based practice

Source: Maryland Department of Health

2. PDMP Sunset Review

The mission of Maryland's PDMP is to (1) assist prescribers, dispensers, and public health professionals in the identification and prevention of prescription drug abuse and the identification and investigation of unlawful prescription drug diversion; and (2) to promote a balanced use of prescription monitoring data. Chapter 166 of 2011 established PDMP with the requirement to monitor the prescribing and dispensing of all Schedule II through V CDS. Prescribing occurs when a health care practitioner writes a prescription for a CDS, while dispensing occurs when a pharmacist or other licensed dispenser fills the prescription and gives the prescription to a patient. Dispensing does not include a situation in which a prescription drug is administered directly to a patient by a health care provider.

For each monitored prescription drug dispensed, a dispenser must electronically submit data to PDMP in accordance with regulations adopted by the Secretary of Health. Dispensers include not only pharmacies but also physicians, podiatrists, and dentists holding a permit from their respective licensing board allowing them to dispense prescription drugs.

PDMP Mandatory Registration and Use

Mandatory Registration

Mandatory registration requires that anyone authorized to prescribe CDS sign up as a clinical user. This allows prescribers to access PDMP data but does not require any further action. Chapter 147 of 2016 required all practitioners authorized to prescribe CDS (including physicians, physician assistants, nurse practitioners, nurse midwives, dentists, podiatrists, and veterinarians with CDS prescriptive authority) and all pharmacists to register with PDMP by July 1, 2017.

Exhibit 33 shows the percentage of prescribers and pharmacists that were registered with PDMP by October 2016 (one year prior to the mandate) and by August 2018 (10 months following the effective date of the requirement).

Exhibit 33
Use and Users of PDMP

	Individuals Subject to Mandate	Registered Users	Percentage Registered
Prescribers			
Registered October 2016	33,807	20,331	60.13%
Registered August 2018	36,976	32,024	86.61%
Pharmacists			
Registered October 2016	11,296	3,573	31.63%
Registered August 2018	11,854	10,768	90.84%
Total Registered October 2016	**45,103**	**23,904**	**53.00%**
Total Registered August 2018	**48,830**	**42,792**	**87.60%**

PDMP: Prescription Drug Monitoring Program

Source: Maryland Department of Health

Over this period, registered users increased by 26.5 percentage points for prescribers and nearly 59.2 percentage points for pharmacists, resulting in an overall system increase of 34.6 percentage points in registered user to all but 12.4% of required users being registered with PDMP.

Chesapeake Regional Information System for Our Patients (CRISP) and PDMP staff continue to conduct outreach through health occupations licensing boards, professional organizations, and health care facilities to educate providers on how to comply with the registration mandate. In November 2017, PDMP staff sent individual letters to over 13,000 providers regarding their noncompliance with registration. Another round of letters was sent in advance of the mandated use effective date of July 1, 2018.

As of February 15, 2018, the Office of Controlled Substances Administration in MDH began withholding new or renewal CDS registrations to prescribers who were not registered with PDMP. This policy should result in an increase in registered prescribers as CDS registrations expire and come up for renewal.

Mandatory Use

As of July 1, 2018, prescribers are required to query PDMP prior to beginning a course of treatment that includes prescribing or dispensing an opioid or a benzodiazepine. Prescribers must

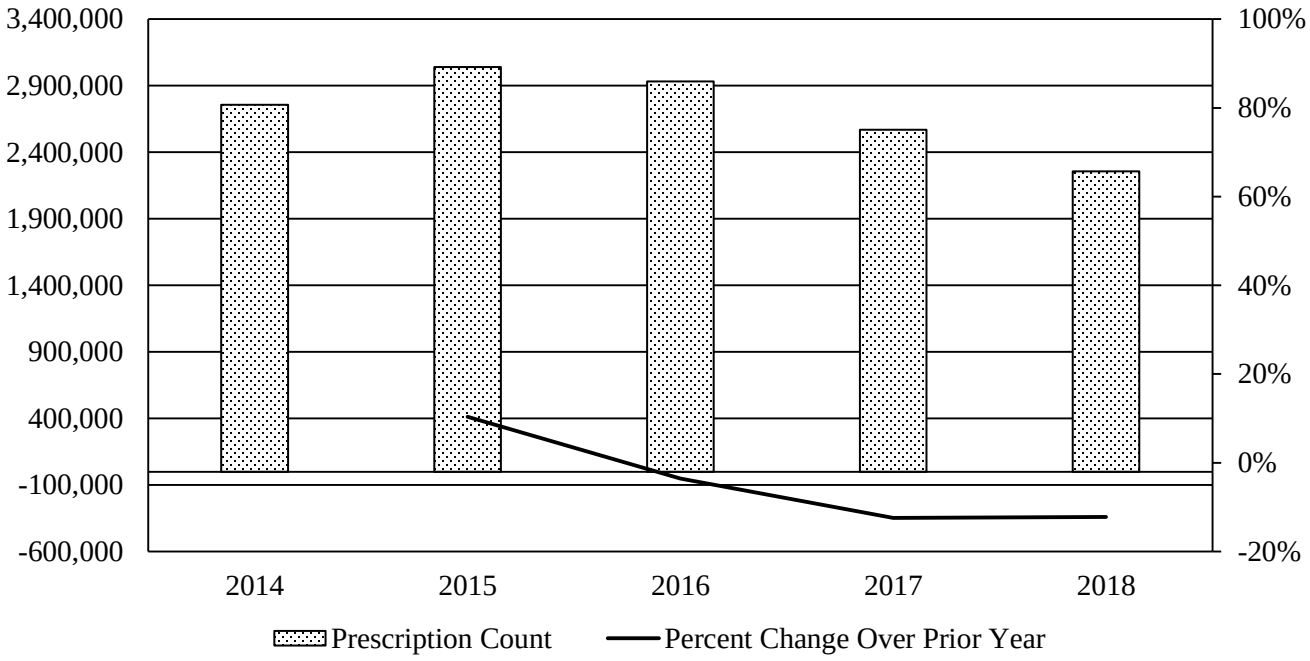
continue to query PDMP every 90 days thereafter while the course of treatment continues with limited exceptions.

Many of the complaints related to registering for and using PDMP before the mandatory use requirement related to the extra time required to log in to a separate system that was often slow and unreliable. However, when PDMP became integrated with CRISP, many of these concerns were alleviated. Feedback from a Maryland State Medical Society representative indicated that members found that the integration of PDMP into CRISP has provided much faster access.

Decrease in Opioid Prescriptions

Exhibit 34 highlights the number of opioid prescriptions dispensed during the first nine months of each year from 2014 through 2018 and the percent change in prescriptions over the previous year. After increasing by 10.34% from 2014 to 2015, the number of opioid prescriptions began decreasing in 2016. The decrease from 2015 to 2016 was modest, but the number of prescriptions has fallen by more than 12% over the previous year in both 2017 and 2018.

Exhibit 34
Opioid Prescriptions
January to September 2014-2018

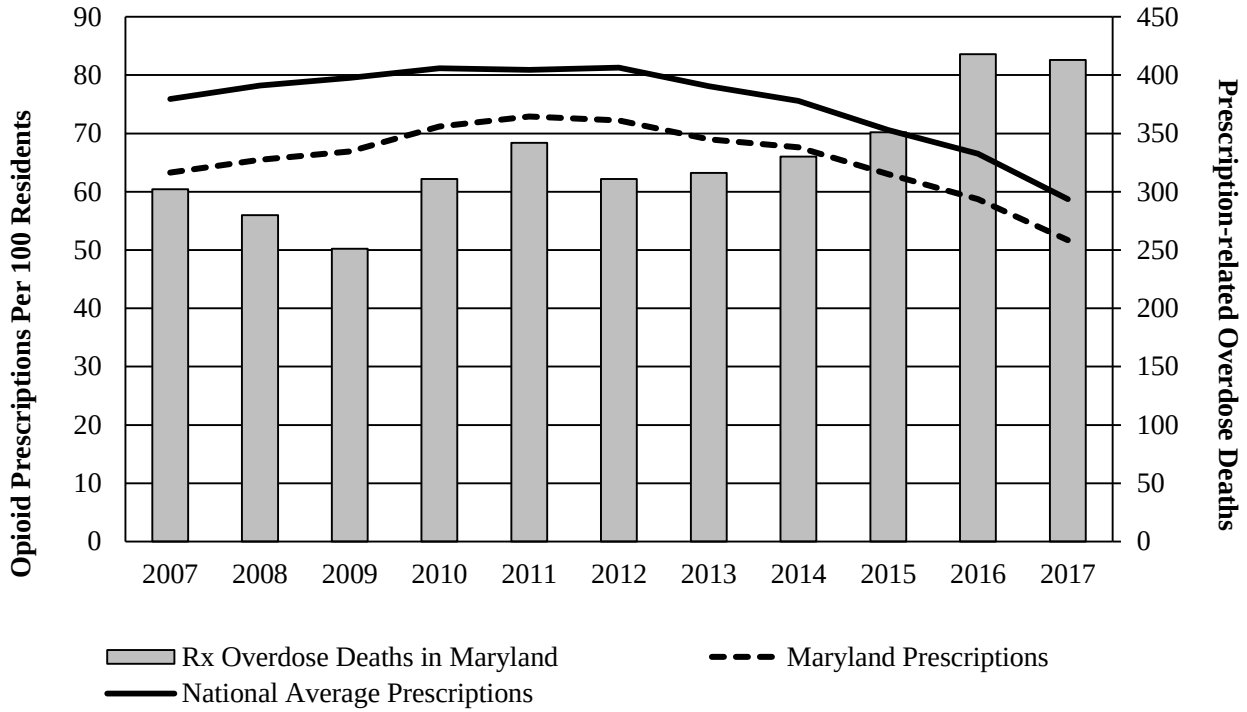


Note: 2018 data reflects prescriptions dispensed January 1 through September 30 of each year. Opioid prescriptions include all prescriptions containing a medication in the opioid class of drugs except medications containing buprenorphine in a formulation indicated for the treatment of opioid use disorder.

Source: Maryland Department of Health

Exhibit 35, using data from the federal Centers for Disease Control and Prevention, shows that the rate of opioid prescriptions in the State per 100 residents have tracked closely with the national average and has been consistently below throughout the opioid crisis. Exhibit 35 also shows that overdose deaths related to prescription opioids in the State remain fairly constant and have actually increased in recent years, while the rate of opioid prescriptions has continued to fall. This highlights that while PDMP is effective in decreasing the number and rate of opioid prescriptions, more still needs to be done to address the overdose deaths at the heart of the State's opioid epidemic.

Exhibit 35
Rate of Opioid Prescription and Pharmaceutical Related Overdose Deaths
Calendar 2007-2017



Rx: medical prescriptions

Source: Centers for Disease Control and Prevention; Maryland Department of Health

Sunset Evaluation of PDMP

Implementation of PDMP began in July 2011, and the program became fully operational in 2014. The program is subject to review under the Maryland Program Evaluation Act. In the 2018 interim, DLS undertook a review of PDMP. That review contains 15 recommendations. These recommendations address PMDP's advisory council, mandatory use, investigative users, policy issues,

and the PDMP user's experience. However, the primary recommendation is the removal of PMDP from the list of governmental units subject to sunset evaluation under the Maryland Program Evaluation Act and repeal of the program's termination date. An additional overall recommendation was made for PDMP to include updates on the eleven nonstatutory recommendations. All of the recommendations made by DLS are listed in **Exhibit 36**.

Exhibit 36
DLS Recommendations for PDMP

Technical Advisory Committee (TAC)

1. PDMP should institute a formal training program for new advisory board members on the responsibilities of members, including meeting protocols, and an overview of PDMP. This training should be applied consistently to new appointees on the advisory board.

2. As the role of TAC is clarified and the committee becomes operational, PDMP should establish written protocols for TAC, including meeting requirements and the procedures for reviewing unsolicited reports and investigative data requests. PDMP should require at least one in-person meeting of TAC each year.

3. In the annual report required under § 21-2A-05 of the Health – General Article in 2019, PDMP should report to the General Assembly on TAC. The report should include (1) the written protocols for TAC meetings and procedures for reviewing unsolicited reports and investigative data requests; (2) a summary of TAC meetings since the implementation of Chapter 147 of 2016; and (3) recommendations on any changes necessary for TAC to meet the needs of PDMP.

Mandatory Registration and Use

4. PDMP should continue outreach efforts to prescribers and pharmacists and monitor such efforts until functional full compliance with the mandatory registration mandate is achieved.

Investigative Users

5. Statute should be amended to remove the requirement for the vote of a quorum of the board or disciplinary panel when a licensing entity requests prescription monitoring data.

6. The Maryland Board of Physicians should continue to work with PDMP to address concerns regarding the accuracy of PDMP data.

Best Practices and Policy Issues

7. To allow more meaningful analysis, PDMP should collect additional data, specifically provider specialty information, before implementing unsolicited reporting on prescribers and dispensers.

8. PDMP should work with the State Board of Pharmacy to determine the feasibility of gathering information on the identification of the individual picking up a monitored prescription at the time that it is dispensed.

9. Statute should be amended to allow authorized users of other states' prescription drug monitoring programs to access Maryland's prescription monitoring data.

10. Interstate data sharing agreements should be modified to ensure access of Maryland's PDMP users to other connected states' prescription drug monitoring program data.

User Experience and Feedback

11. PDMP should work with CRISP to simplify the PDMP user experience, specifically the log-in process and password issues. PDMP and CRISP should investigate the feasibility of implementing single sign-on and improving password issues related to resetting the password.

12. PDMP should continue to expand upon educational outreach efforts for registrants. This education should include a clear explanation of the individuals who are required to use PDMP, how to use PDMP, the exceptions to using PDMP, and information on the other states from which prescription drug monitoring data can be accessed and how to access the information.

13. PDMP should work with the State Board of Veterinary Medical Examiners to provide clear information to veterinarians who are required to register with PDMP as a condition of receiving their CDS license on whether and how veterinarians are to access PDMP.

Overall Recommendations

14. Statue should be amended to remove PDMP from the list of government units subject to sunset evaluation under the Maryland Program Evaluation Act and to repeal the programs termination date.

15. In the annual report required under §21-2A-05 of the Heath – General Article in 2020, PDMP should report to the Senate Finance Committee and the House Health and Government Operations Committee on the program's implementation of the nonstatutory recommendations contained in this report.

CDS: controlled dangerous substance
CRISP: Chesapeake Regional Information System for Our Patients
DLS: Department of Legislative Services
PDMP: Prescription Drug Monitoring Program

Source: Department of Legislative Services

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

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2018					
Legislative Appropriation	$972,744	$47,629	$955,806	$7,713	$1,983,892
Deficiency/Withdrawn Appropriation	28,311	0	84,756	0	113,067
Cost Containment	-39	0	0	0	-39
Budget Amendments	5,323	5,452	10,056	225	21,056
Reversions and Cancellations	-357	-3,085	-62,157	-482	-66,081
Actual Expenditures	**$1,005,983**	**$49,996**	**$988,460**	**$7,456**	**$2,051,895**
Fiscal 2019					
Legislative Appropriation	$1,038,143	$46,407	$1,046,698	$12,986	$2,144,234
Budget Amendments	2,319	2	30		2,352
Working Appropriation	**$1,040,462**	**$46,409**	**$1,046,728**	**$12,986**	**$2,146,586**

Note: The fiscal 2019 appropriation does not include deficiencies, a one-time $500 bonus, or general salary increases. Numbers may not sum to total due to rounding.

Fiscal 2018

Actual spending for the Behavioral Health Administration (BHA) in fiscal 2018 was $68,003,651 above the legislative appropriation. General funds made up nearly half of that increase, $33,238,836. This general fund increase was largely through eight deficiency appropriations, totaling $32,051,607:

- $3,599,360 to the substance use disorder (SUD) treatment and mental health treatment for the uninsured, $3,264,681 of which is for fee-for-service residential treatment;
- $1,640,656 for the Medically Assisted State Funded Mental Health Services;
- $1,277,998 to behavioral health hospitals throughout the State to cover operational costs:
  - $223,866 to Regional Institute for Children and Adolescents – Baltimore;
  - $392,289 to the Eastern Shore Hospital Center;
  - $559,091 to Clifton T. Perkins Hospital Center; and
  - $102,752 to the John L. Gildner Regional Institute for Children and Adolescents;
- $733,593 for maintaining the Crownsville Hospital Center; and
- $24,800,000 for Medicaid behavioral health provider reimbursements.

Special funds and federal funds also received deficiency appropriations, increasing the fiscal 2018 budget by $6,273 and $84,820,000, respectively. The special fund increase of $6,273 also went to the maintenance of the Crownsville Hospital Center, while the $84,820,000 in federal funds were for provider reimbursements for Medicaid recipients.

These deficiency appropriations were partially offset by Section 19 of the fiscal 2019 Budget Bill that withdrew $3,810,936 due to a surplus in the health insurance account, $3,740,324 in general funds, $64,299 in federal funds, and the remaining $6,313 from special funds.

Budget amendments increased the appropriation to BHA a further $21,056,442. This increase consisted of $5,323,419 in general funds, $5,451,970 in special funds, $10,056,394 in federal funds, and $224,659 in reimbursable funds.

Much of the general fund increase to BHA occurred at closeout, with $5,177,416 in general funds being added to the appropriation. These increases were concentrated in the State mental health facilities with a net of $6,909,049 in general funds appropriated to eight facilities. The largest such increase was $2,408,043 to Spring Grove Hospital Center. The only decrease in the appropriation during closeout to the State behavioral health facilities was a reduction of $115,808 to the Crownsville

Hospital Center's maintenance costs. An additional $3,235,785 was appropriated to fund Medically Assisted State Funded Mental Health Services. These increases were offset by $5,011,128 in general fund reductions at closeout, the largest of such, $4,879,679, was reduced from the program that supports SUD treatment and mental health treatment for the uninsured and other community services.

The majority of the special fund increase, $4,086,000, were used to replace general funds used for mental health services. Of this increase, $1,086,000 replaced general funds to outpatient mental health services and were available for appropriation due to excess revenues in the Senior Prescription Drug Assistance Program's fund balance. The remaining $3,000,000 replaced general funds that went to mobile mental health treatment. These funds were available due to a reduction in the Maryland Community Health Resource Commission's special fund appropriation.

The federal fund increase is due almost entirely to BHA's receipt of a $10,036,843 from the Substance Abuse and Mental Health Services Administration as part of the 21st Century Cures Act. This funding all went to the Maryland Opioid Rapid Response program with $8,129,879 supporting treatment needs and the remaining $1,906,964 targeting prevention efforts.

The Board of Public Works cost containment measures decreased the BHA budget by $39,117 in general funds.

BHA canceled and reverted $66,080,618 in fiscal 2018. Federal funds saw the largest cancellation of $62,157,352. Much of this federal fund cancelation was $60,612,826 of lower than anticipated federal Medicaid attainment. BHA canceled $3,084,872 in special funds: $1,705,125 from the various State hospitals; and $1,055,550 in community services special funds. General fund reversions were $356,749.

Fiscal 2019

The fiscal 2019 budget increased by $2,351,596 over the legislative appropriation by budget amendments. These increases are entirely personnel related and due to centrally budgeted cost-of-living increases, annual salary review for security attendants, and raises collectively bargained by the State Law Enforcement Officers Labor Alliance. Of the total increase, $2,218,149 is provided to the State-run hospitals, while the remaining $133,447 of the increase, including all of the federal funds, supported the increases in earnings throughout the rest of the administration.

Appendix 2
Audit Findings
Springfield Hospital Center

Audit Period for Last Audit:	January 28, 2015 – May 29, 2018
Issue Date:	December 2018
Number of Findings:	1
Number of Repeat Findings:	0
% of Repeat Findings:	0%
Rating: (if applicable)	n/a

Finding 1: Springfield Hospital Center did not procure fresh produce and certain medical supplies in accordance with State procurement regulations and MDH policies.

Eastern Shore Hospital Center

Audit Period for Last Audit:	March 31, 2014 – May 20, 2018
Issue Date:	December 2018
Number of Findings:	1
Number of Repeat Findings:	0
% of Repeat Findings:	0%
Rating: (if applicable)	n/a

Finding 1: Eastern Shore Hospital Center did not have adequate procedures in place to ensure the propriety of time recorded by one individual into the statewide personnel system on behalf of numerous other employees.

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

Appendix 3
Object/Fund Difference Report
MDH – Behavioral Health Administration

Object/Fund	FY 18 Actual	FY 19 Working Appropriation	FY 20 Allowance	FY 19 - FY 20 Amount Change	Percent Change
Positions					
01 Regular	2,858.90	2,891.90	2,907.60	15.70	0.5%
02 Contractual	177.32	208.13	189.71	-18.42	-8.9%
Total Positions	**3,036.22**	**3,100.03**	**3,097.31**	**-2.72**	**-0.1%**
Objects					
01 Salaries and Wages	$ 250,198,636	$ 252,912,676	$ 262,538,429	$ 9,625,753	3.8%
02 Technical and Spec. Fees	12,014,327	11,625,660	11,113,987	-511,673	-4.4%
03 Communication	621,753	603,666	613,010	9,344	1.5%
04 Travel	258,112	237,258	237,497	239	0.1%
06 Fuel and Utilities	8,719,395	8,938,380	9,018,217	79,837	0.9%
07 Motor Vehicles	881,578	763,451	876,987	113,536	14.9%
08 Contractual Services	1,763,222,930	1,855,974,355	1,981,984,312	126,009,957	6.8%
09 Supplies and Materials	13,414,612	14,378,511	13,862,948	-515,563	-3.6%
10 Equipment – Replacement	1,465,166	381,714	203,446	-178,268	-46.7%
11 Equipment – Additional	244,030	43,878	74,509	30,631	69.8%
12 Grants, Subsidies, and Contributions	108,803	198,733	179,065	-19,668	-9.9%
13 Fixed Charges	587,357	527,443	526,544	-899	-0.2%
14 Land and Structures	158,599	0	0	0	0.0%
Total Objects	**$ 2,051,895,298**	**$ 2,146,585,725**	**$ 2,281,228,951**	**$ 134,643,226**	**6.3%**
Funds					
01 General Fund	$ 1,005,982,801	$ 1,040,462,413	$ 1,099,055,844	$ 58,593,431	5.6%
03 Special Fund	49,996,077	46,408,664	47,114,487	705,823	1.5%
05 Federal Fund	988,460,356	1,046,728,423	1,127,962,536	81,234,113	7.8%
09 Reimbursable Fund	7,456,064	12,986,225	7,096,084	-5,890,141	-45.4%
Total Funds	**$ 2,051,895,298**	**$ 2,146,585,725**	**$ 2,281,228,951**	**$ 134,643,226**	**6.3%**

MDH: Maryland Department of Health

Note: The fiscal 2019 appropriation does not include deficiencies, a one-time $500 bonus, or general salary increases. The fiscal 2020 allowance does not include general salary increases.

Appendix 4
Fiscal Summary
MDH – Behavioral Health Administration

Program/Unit	FY 18 Actual	FY 19 Wrk Approp	FY 20 Allowance	Change	FY 19 - FY 20 % Change
01 Secretary for Behavioral Health and Disabilities	$ 1,835,344	$ 1,902,173	$ 1,959,874	$ 57,701	3.0%
01 Program Direction	21,964,837	20,846,980	20,720,195	-126,785	-0.6%
02 Community Services	265,668,716	267,950,361	316,139,853	48,189,492	18.0%
03 Community Services for Medicaid Recipients	86,118,189	86,893,320	88,452,392	1,559,072	1.8%
04 Opioid Operational Command Center	10,513,712	16,200,981	0	-16,200,981	-100.0%
01 Services and Institutional Operations	20,876,221	20,520,933	20,936,801	415,868	2.0%
01 Services and Institutional Operations	15,937,397	15,636,837	17,006,881	1,370,044	8.8%
01 Services and Institutional Operations	20,582,363	21,270,901	22,295,280	1,024,379	4.8%
01 Services and Institutional Operations	74,947,368	73,787,233	73,993,518	206,285	0.3%
01 Services and Institutional Operations	86,891,786	84,180,378	85,371,219	1,190,841	1.4%
01 Services and Institutional Operations	67,806,893	69,650,993	71,478,518	1,827,525	2.6%
01 Services and Institutional Operations	12,550,409	13,243,125	14,484,080	1,240,955	9.4%
01 Behavioral Health Administration	1,971,829	1,349,388	1,472,371	122,983	9.1%
10 Medicaid Behavioral Health Provider	1,364,230,234	1,453,152,122	1,546,917,969	93,765,847	6.5%
Total Expenditures	**$ 2,051,895,298**	**$ 2,146,585,725**	**$ 2,281,228,951**	**$ 134,643,226**	**6.3%**
General Fund	$ 1,005,982,801	$ 1,040,462,413	$ 1,099,055,844	$ 58,593,431	5.6%
Special Fund	49,996,077	46,408,664	47,114,487	705,823	1.5%
Federal Fund	988,460,356	1,046,728,423	1,127,962,536	81,234,113	7.8%
Total Appropriations	**$ 2,044,439,234**	**$ 2,133,599,500**	**$ 2,274,132,867**	**$ 140,533,367**	**6.6%**
Reimbursable Fund	$ 7,456,064	$ 12,986,225	$ 7,096,084	-$ 5,890,141	-45.4%
Total Funds	**$ 2,051,895,298**	**$ 2,146,585,725**	**$ 2,281,228,951**	**$ 134,643,226**	**6.3%**

MDH: Maryland Department of Health

Note: The fiscal 2019 appropriation does not include deficiencies, a one-time $500 bonus, or general salary increases. The fiscal 2020 allowance does not include general salary increases.