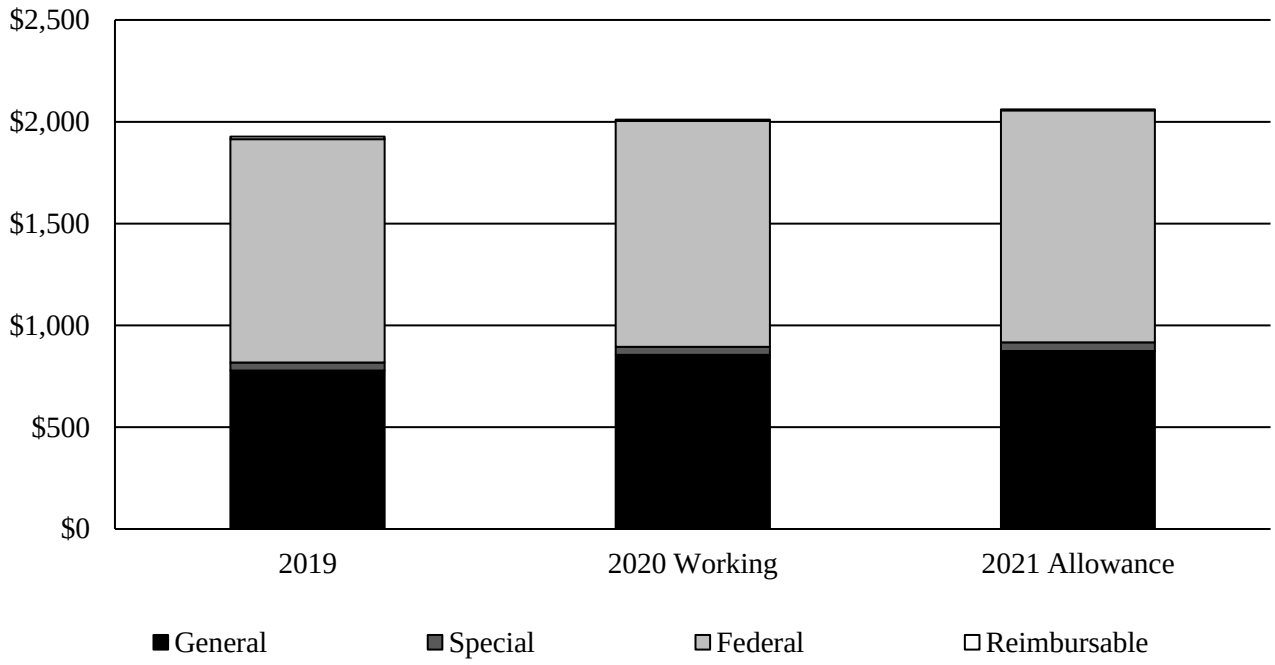
M00L
Behavioral Health Administration
Maryland Department of Health

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. The BHA budget also reflects provider reimbursements for specialty behavioral health services to Medicaid beneficiaries and the uninsured through the Public Behavioral Health System (PBHS), which is managed through an Administrative Services Organization (ASO). The BHA budget no longer reflects the State-run psychiatric facilities, which have been moved under the Maryland Department of Health (MDH) Administration budget.

Operating Budget Summary

Fiscal 2021 Budget Increases $51.5 Million or 2.6% to $2.1 Billion
($ in Millions)



Note: Numbers may not sum due to rounding. The fiscal 2019 appropriation includes fiscal 2020 deficiency for services provided in fiscal 2019. The fiscal 2020 appropriation includes deficiencies, planned reversions, and general salary increases. The fiscal 2021 allowance includes contingent reductions and general salary increases.

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- A fiscal 2020 general fund deficiency of $58.5 million is requested primarily due to higher than expected spending on psychiatric rehabilitation programs.

- In fiscal 2021, increases budgeted in the fee-for-service (FFS) components of the BHA budget for provider reimbursements are slightly offset by declining expenditures for federal grants and other programs.

- Mandated provider reimbursement rate increases are reduced from 4% to 2%. Notably, FFS expenditures for SUD are budgeted to decrease in fiscal 2021 compared to the adjusted fiscal 2020 spending level.

- The largest single change in the BHA budget, outside of the Medicaid program, is a decrease of $16 million in federal funds due to the final year of BHA's expenditures from the State Opioid Response grant.

Key Observations

- ***Psychiatric Rehabilitation Spending Increases at an Unsustainable Rate:*** Rapid growth in psychiatric rehabilitation spending driven by increased utilization has caused the need for deficiency appropriations and causes uncertainty for future budget adequacy.

- ***ASO Transition:*** Since the new ASO contract began on January 1, 2020, providers have reported significant challenges being reimbursed for their services, leaving MDH to estimate payments through April 20, 2020.

- ***Quality Measures for Providers:*** Significant service growth throughout PBHS has raised concerns regarding the appropriateness of care settings and the quality of care being provided.

- ***Audits and Accountability:*** Several audits pertaining to behavioral health have pointed to a pattern of poor oversight of various grants, programs, and procedures related to behavioral health activities.

Operating Budget Recommended Actions

1. Add language withholding funds pending a report on the Administrative Services Organization transition.

2. Add language withholding funds pending a report on patient outcomes and provider quality measures in the Public Behavioral Health System.

3. Add language withholding funds pending a report on psychiatric rehabilitation utilization and provider growth in the Public Behavioral Health System.

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

5. Amend contingent language to make the provider rate reduction based on deferring the 4% provider rate increase until January 1, 2021, rather than reducing it to 2% effective July 1, 2020.

6. Amend contingent language to make the provider rate reduction based on deferring the 4% provider rate increase until January 1, 2021, rather than reducing it to 2% effective July 1, 2020.

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

8. Amend contingent language to make the provider rate reduction based on deferring the 4% provider rate increase until January 1, 2021, rather than reducing it to 2% effective July 1, 2020.

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

10. Amend contingent language to make the provider rate reduction based on deferring the 4% provider rate increase until January 1, 2021, rather than reducing it to 2% effective July 1, 2020.

11. Amend contingent language to make the provider rate reduction based on deferring the 4% provider rate increase until January 1, 2021, rather than reducing it to 2% effective July 1, 2020.

Budget Reconciliation and Financing Act Recommended Actions

1. Amend the Budget Reconciliation and Financing Act of 2020 to defer the 4% provider rate reduction until January 1, 2021, rather than reducing it to 2% effective July 1, 2020.

2. Reduce funding for the Administrative Services Organization (ASO) contract in fiscal 2020 by $575,000 ($287,500 in general funds and $287,500 in federal funds) based on anticipated savings from the contractor for the new ASO contract being unable to meet the Go-Live date.

M00L
Behavioral Health Administration
Maryland Department of Health

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 (based on diagnosis) 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 2021 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; 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.

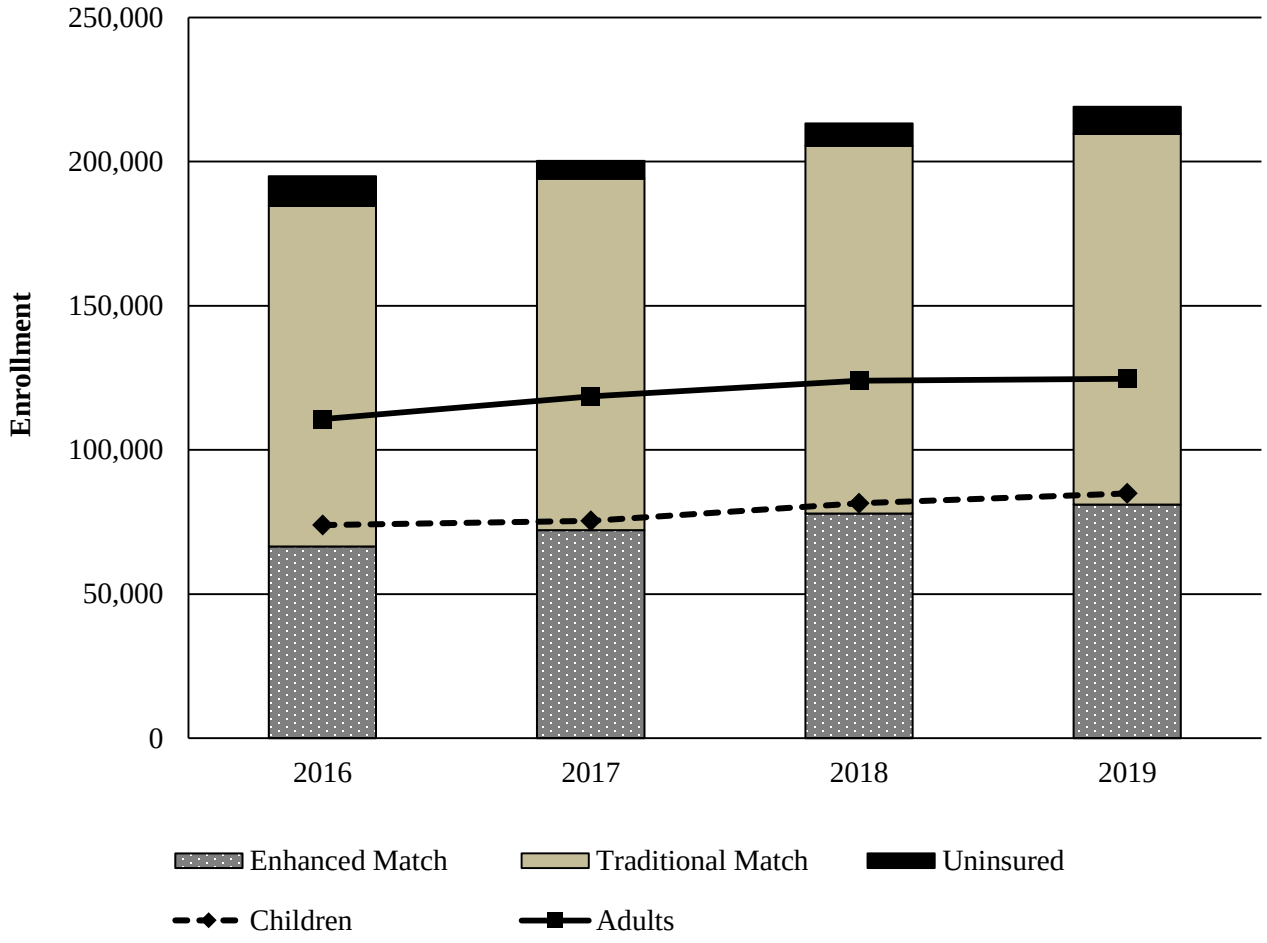
- ***SUD Services:*** Developing and operating unified programs for SUD research, training, prevention, and rehabilitation in cooperation with federal, State, local, and private agencies.

Performance Analysis: Managing for Results

1. Enrollment Trends in the Public Behavioral Health System

Over the last four fiscal years, enrollment in the Public Behavioral Health System (PBHS) has increased for both mental health and SUD services. **Exhibit 1** looks specifically at enrollment for specialty mental health services as reported by BHA, which has grown rather steadily across all enrollment groups.

Exhibit 1
Specialty Mental Health Enrollment Trends
Fiscal 2016-2019

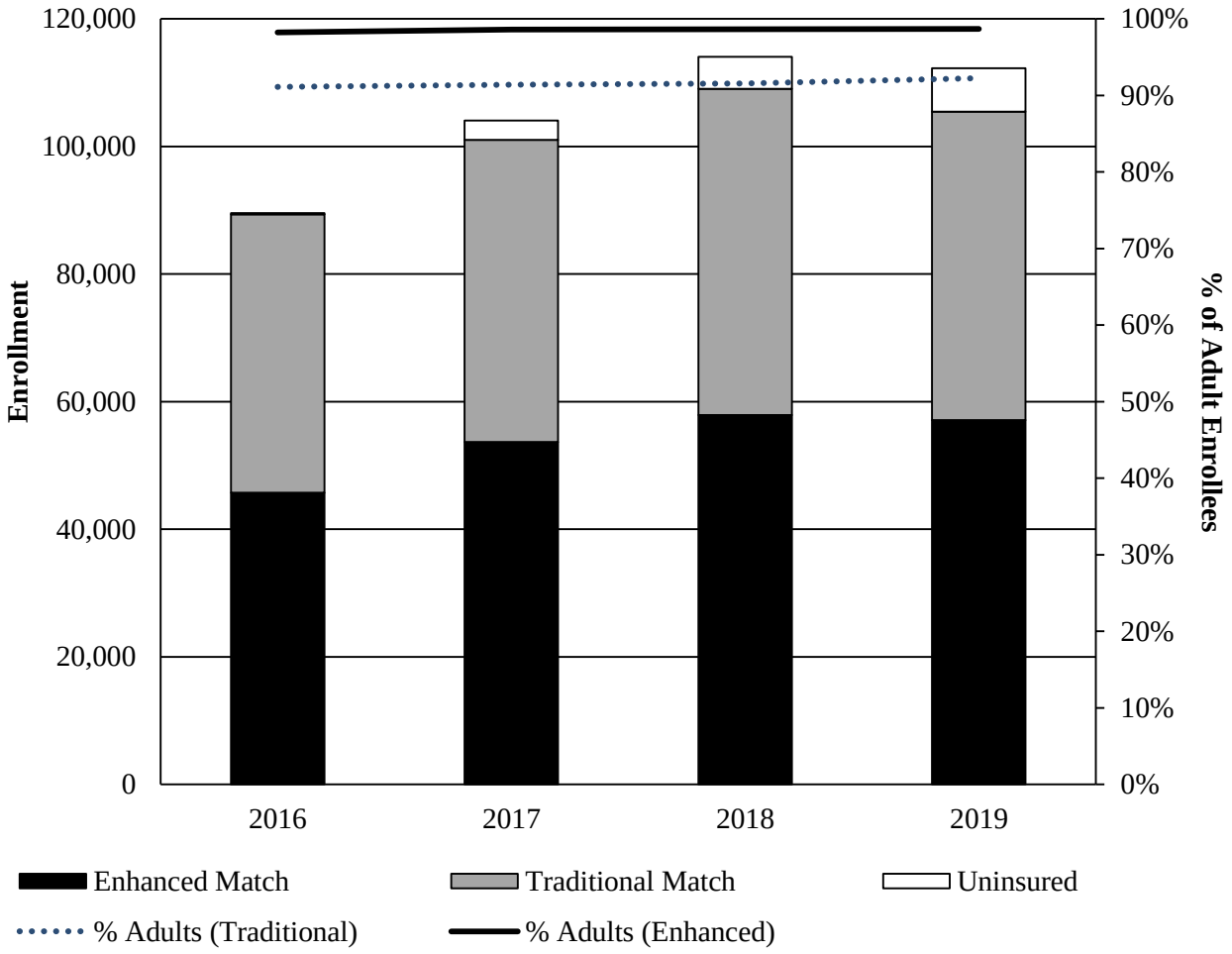


Source: Maryland Department of Health

Individuals in enhanced match enrollment categories are low-income adults eligible for Medicaid services through the Affordable Care Act (ACA) Medicaid Expansion, or children eligible through the Maryland Children's Health Program (MCHP). Both MCHP and the ACA expansion groups receive a greater share of federal fund support than the traditional enrollment groups. The traditional enrollees receive a 50/50 general to federal fund match. In fiscal 2019, roughly 40% of individuals receiving mental health services were enrolled through an enhanced match eligibility group. Mental health enrollees have also consistently been 60% adults. While year-over-year enrollment increases are fairly steady for both eligibility groups, enrollment in enhanced match eligibility groups has grown more quickly than traditional enrollees.

Alternatively, SUD enrollment has increased more quickly and has a larger share of enrollees in the ACA expansion category as shown in **Exhibit 2**. In fiscal 2019, over half of the enrollees receiving SUD treatment were in the expansion population, which is also true for every preceding year.

Exhibit 2
Substance Use Disorder Enrollees
Fiscal 2016-2019



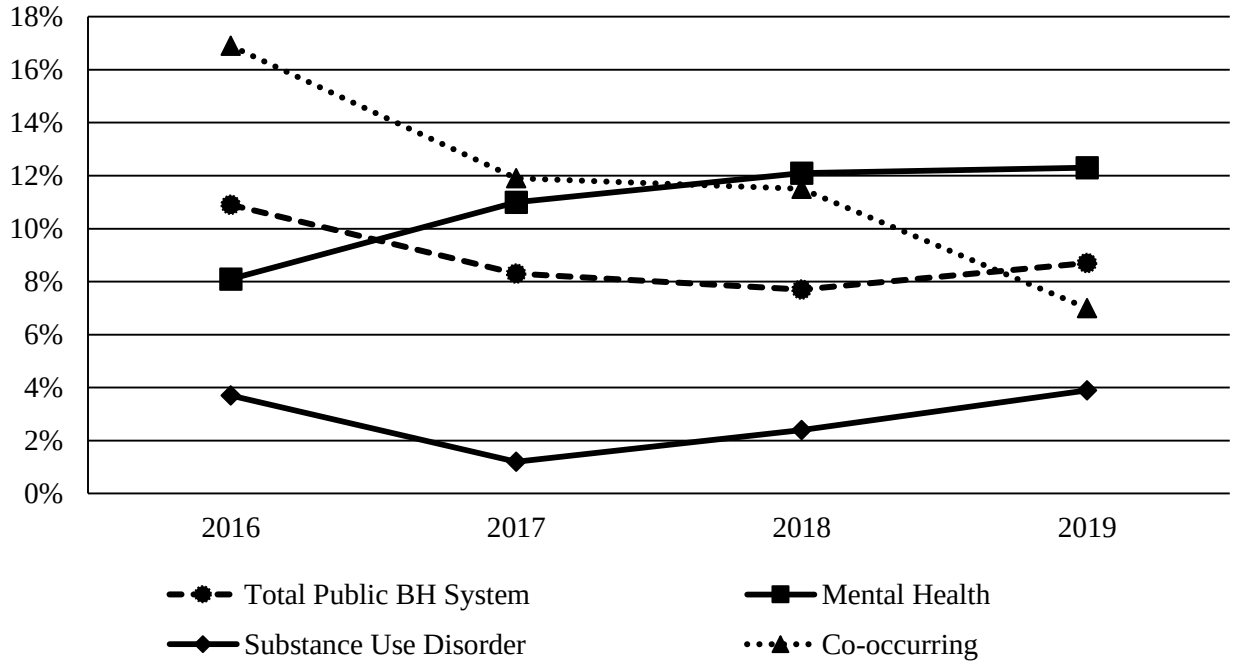
Source: Maryland Department of Health

Unsurprisingly, the overwhelming majority of Medicaid enrollees receiving SUD treatment are adults, representing over 90% of both the enhanced and traditional enrollment groups. Although current data presented displays a slight decrease in SUD enrollment for fiscal 2019, claims can be submitted up to one year after services are provided. Therefore, fiscal 2019 data should be considered incomplete until the end of fiscal 2020.

2. Outcomes in the Public Behavioral Health System

Outcome data from BHA's Outcome Measurement System (OMS) is limited to outpatient clinics and measured between a client's initial interview and the most recent interview on the same questionnaire. The utility of these outcome measures and other quality measures are discussed in greater depth in Issue 2. Although limited, the data currently available shows that improvement in functioning varies greatly based on diagnosis for individuals in PBHS over this period. **Exhibit 3** shows the difference between percent of individuals who self-reported improvements in functioning between the two interviews and those that reported deterioration in functioning to calculate the net improvement in functioning for adults in PBHS.

Exhibit 3
Net Improvement in Functioning
Fiscal 2016-2019



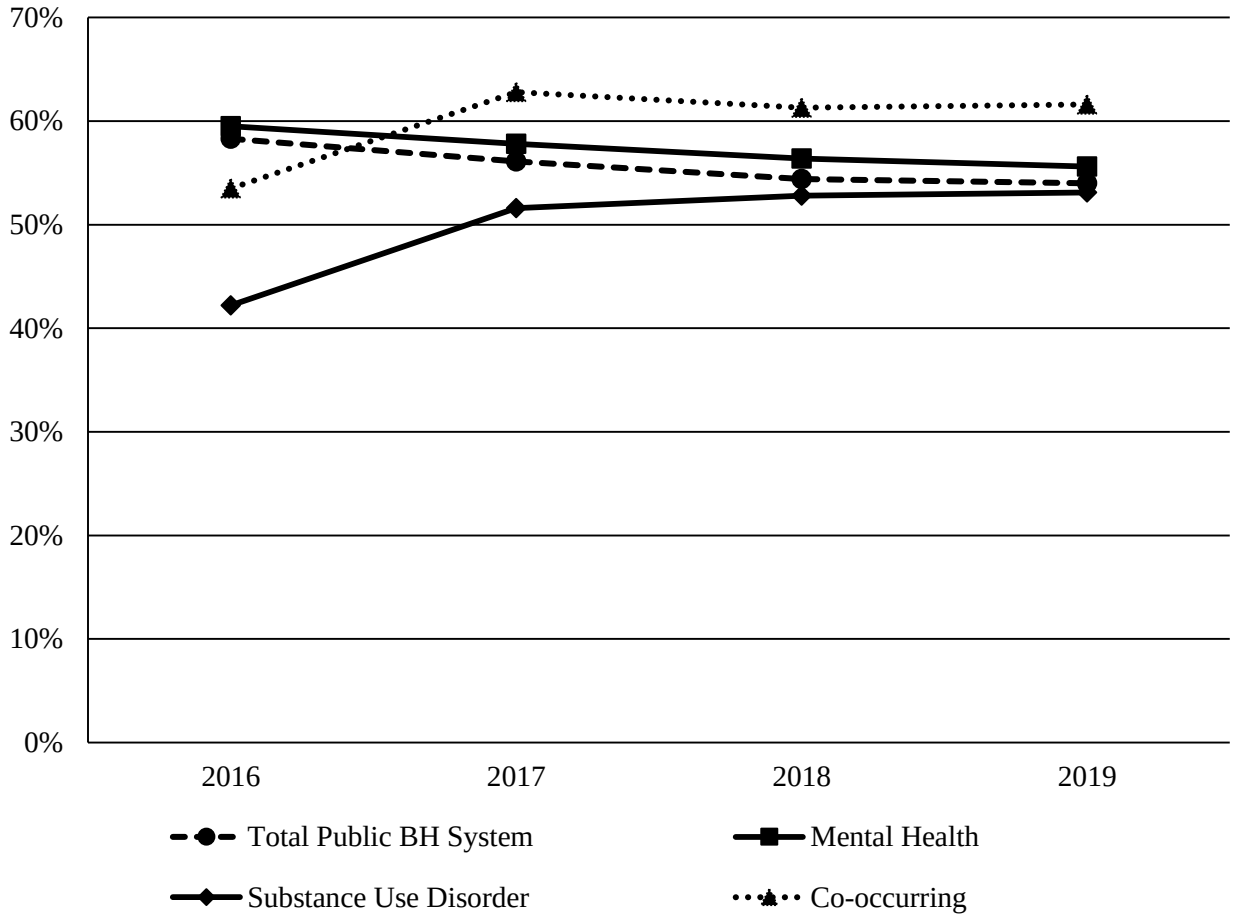
BH: behavioral health

Source: Outcome Measurement System

This calculated value for net increase in functioning has increased from fiscal 2018 to 2019 for the entire PBHS and individuals with either a substance use or mental health diagnoses. However, individuals with co-occurring diagnoses are the only group of individuals who have seen a decrease in this value over the previous year.

The challenges for individuals with co-occurring diagnoses persist in other quality of life measures. **Exhibit 4** shows that in fiscal 2019, a greater share of these adults were unemployed in both observations.

Exhibit 4
Unemployed in Both Observations
Fiscal 2016-2019

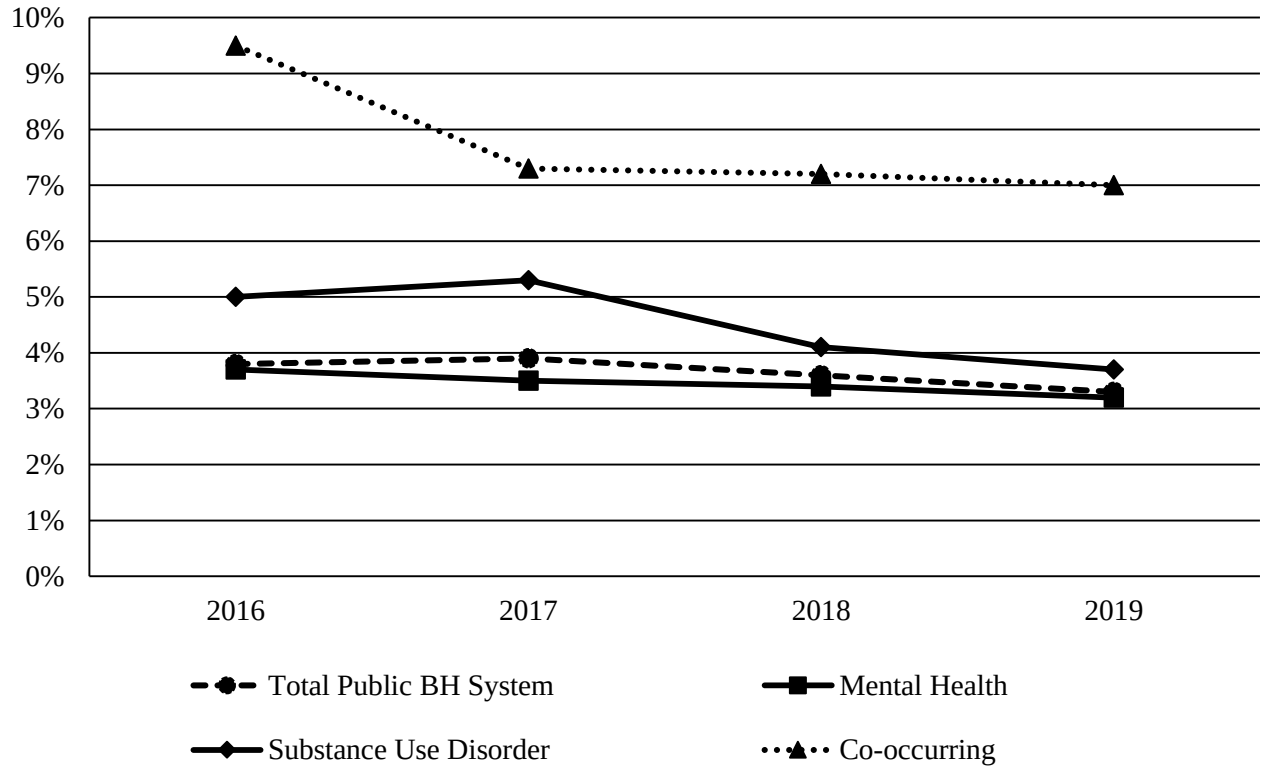


BH: behavioral health

Source: Outcome Measurement System

Adults with co-occurring diagnoses have also consistently been more likely to be homeless in both observations throughout this period, as shown in **Exhibit 5**. After a decrease of 3 percentage points in persistent homelessness for dually diagnosed adults in fiscal 2017, the rate has remained consistent at 7%.

Exhibit 5
Experiencing Homelessness in Both Observations
Fiscal 2016-2019



BH: behavioral health

Source: Outcome Measurement System

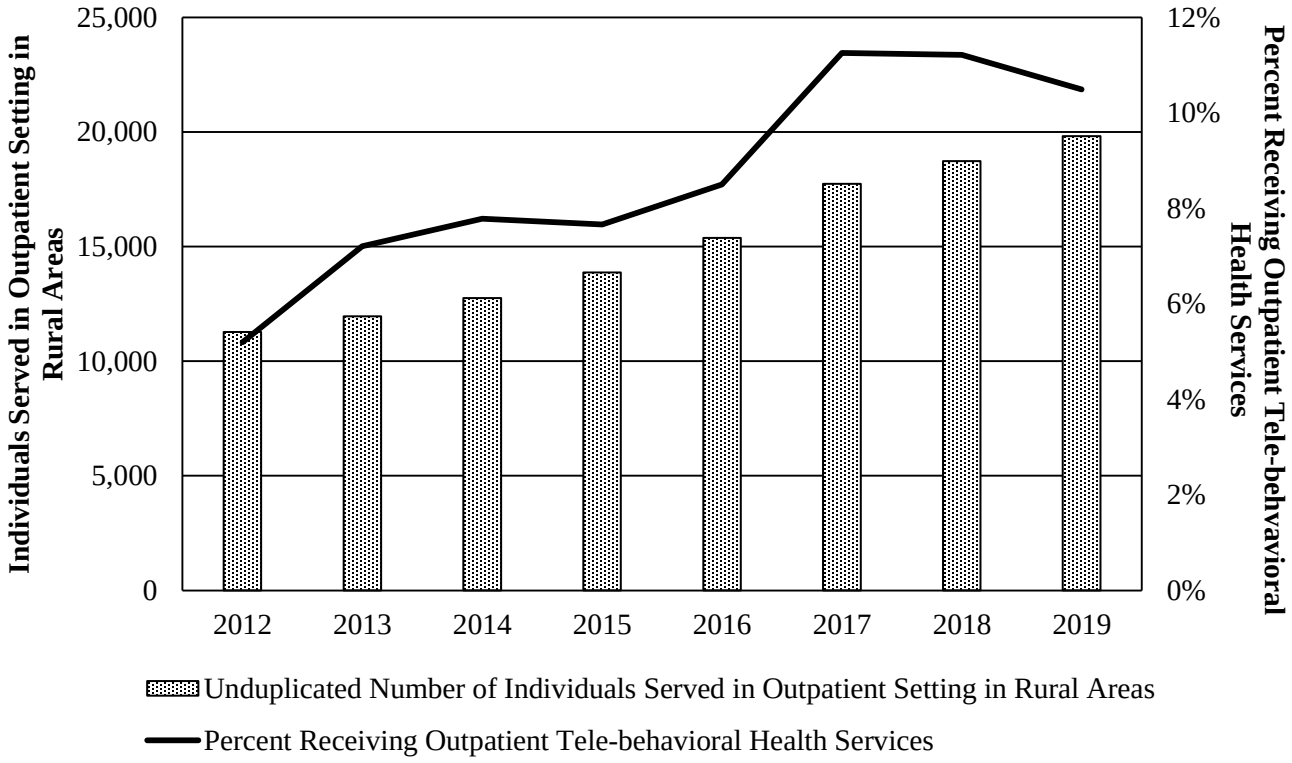
OMS data presented for fiscal 2019 is based on surveys of 8,142 adults with co-occurring diagnoses statewide and 64,979 total adults within PBHS. Based on these adults who had at least two observations to be included in this data, 1,950 adults were experiencing homelessness in both observations, and the Department of Legislative Services (DLS) estimates that a third had co-occurring diagnoses.

3. 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 6**, BHA was able to achieve this expansion in services by fiscal 2016. The share of individuals receiving tele-behavioral health services has been fairly flat since fiscal 2017, and fiscal 2019 represents a slight contraction in outpatient services delivered through tele-behavioral health.

Exhibit 6
Rural Tele-behavioral Health
Fiscal 2012-2019



Source: Governor's Fiscal 2021 Budget Books

Fiscal 2019

As previously mentioned, claims for provider reimbursements can be submitted up to one year after the service was provided. As a result, funds unspent at the end of a fiscal year are accrued to cover claims that are made in that fiscal year that have yet to be received and paid. Due to an anticipated shortfall in the fiscal 2019 accrual, fiscal 2020 funds have to cover those fiscal 2019 claims. The fiscal 2021 budget includes a $29 million deficiency ($11 million in general funds and $18 million in federal funds) to support these fiscal 2019 expenses.

Fiscal 2020

Proposed Deficiency

The budget includes a number of deficiencies addressing the fiscal 2020 budget. The largest of which is a $49.5 million total fund deficiency for Medicaid provider reimbursements: $48 million in general funds. The key driver of fiscal 2020 service growth is in Psychiatric Rehabilitation Programs (PRP). Increased levels of PRP spending account for over half of the anticipated general fund need. The growth in this particular service area is discussed in greater depth in Issue 2.

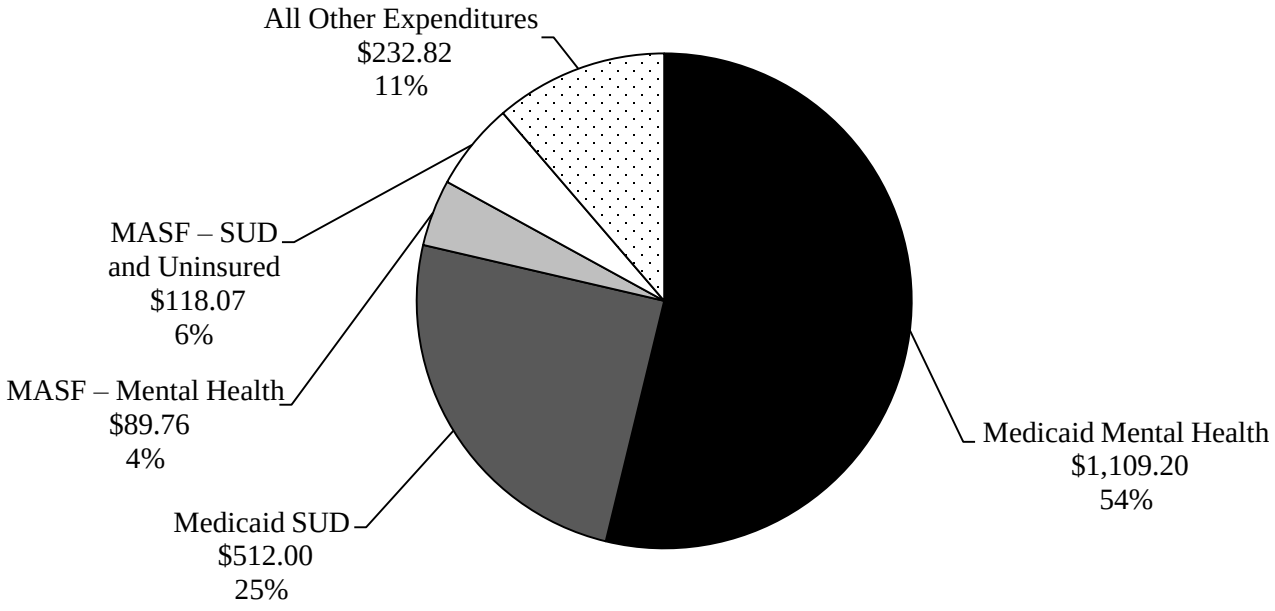
The budget also anticipates a shortfall in provider reimbursements for State-funded SUD treatment for residential and outpatient services totaling $9 million – $12.5 million in provider reimbursements and $2.5 million to backfill targeted reversions of funding restricted in fiscal 2020, partially offset by $6 million in anticipated savings from the 1115 Waiver for SUD residential services.

The Governor elected not to release funding restricted by the legislature in fiscal 2020, including $2.56 million of funding in the BHA budget related to a statewide inpatient psychiatric bed registry system and two grants – one for chronic pain management and another for tele-education on childhood neurodevelopmental and mental health identification. However, BHA intends to issue these grants and create the bed registry, and the budget also contains fiscal 2020 deficiencies to support these efforts.

Fiscal 2021 Overview of Agency Spending

The Medicaid program and other FFS expenditures represent the overwhelming majority of BHA's budget, shown in **Exhibit 7**. Medicaid expenditures have a federal match of at least 50%, depending on the type of enrollee and make up nearly 80% of the total budget. Another 10% is FFS payments for either the uninsured or the Medicaid-eligible population who are receiving non-Medicaid reimbursable services.

Exhibit 7
Overview of Agency Spending
Fiscal 2021 Allowance
($ in Millions)



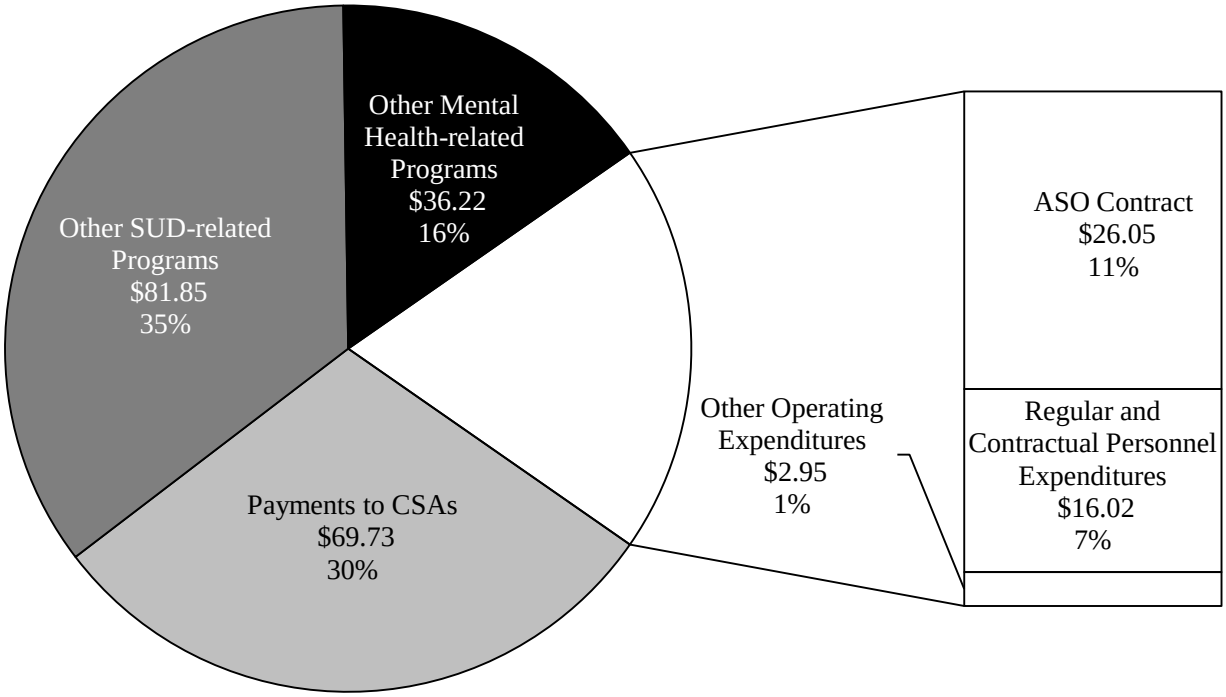
MASF: Medical Assistance State Funded
SUD: substance use disorder

Note: Includes general salary increases and reflects contingent reductions proposed in the Budget Reconciliation and Financing Act of 2020.

Source: Governor's Fiscal 2021 Budget Books

Without the State-run psychiatric hospitals in BHA's budget, the non-FFS expenditures within BHA largely consist of programs for community services to address substance-use or mental health needs throughout the State, often funded with federal funds. Additionally, BHA provides payments to local jurisdictions through CSAs to provide services and treatment outside of the FFS structure. Of the non-FFS expenditures, only $44 million is administrative in nature, which includes the $26 million Administrative Services Organization (ASO) contract. The distribution of funding outside of FFS is shown in **Exhibit 8**.

Exhibit 8
Non-fee-for-service Expenditures
Fiscal 2021
($ in Millions)



ASO: Administrative Services Organization
CSA: core service agencies
SUD: substance use disorder

Note: Includes general salary increases

Source: Governor's Fiscal 2021 Budget Books

Proposed Budget Change

Exhibit 9 shows the largest increases in the fiscal 2021 budget pertain to FFS expenditures, including a 2% rate increase for provider reimbursements. These increases are partially offset by the ending of funds available for State Opioid Response (SOR) grant. The SOR grant awarded to Maryland was for $66 million over two years. BHA sought an extension to spend funding unspent in the two-year grant period, $10 million in fiscal 2021, but this represents a $16 million decrease compared to fiscal 2020. BHA reports that the $10 million currently in the budget will be spent by September 2020.

Exhibit 9
Proposed Budget
MDH – Behavioral Health Administration
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2019 Actual	$767,808	$38,993	$1,078,155	$12,520	$1,897,476
Fiscal 2020 Working Appropriation	852,543	39,358	1,109,858	5,436	2,007,194
Fiscal 2021 Allowance	874,367	43,472	1,138,526	5,481	2,061,847
Fiscal 2020-2021 Amount Change	$21,824	$4,114	$28,669	$46	$54,653
Fiscal 2020-2021 Percent Change	2.6%	10.5%	2.6%	0.8%	2.7%

Where It Goes:	Change
Personnel Expenses	
Turnover adjustment	$563
Additional salary increases for psychiatrists in BHA's Program Direction partially offset by fiscal 2020 funding for psychiatrist increases	198
Fiscal 2021 general salary increase, 2% effective January 1, 2021	140
Employee retirement system	101
Fiscal 2020 January 1, 2020 1% general salary increase annualization	40
Decrease in regular earnings for BHA employees, driven by a net 0.9 FTE decrease	-30
Employee and retiree health insurance premiums	-1,376
Fee for Service	
Increase in mental health FFS utilization	57,238
2% provider rate increase	24,552
Administrative Services Organization Contract	4,868
Decrease in SUD FFS expenditures in Medicaid ($27.4 million) partially offset by budgeted increase in Residential Services and other State-funded FFS programs	-17,446
Changes in Grant Programs	
Increase in anticipated award for Community Mental Health Services federal block grant	2,813
Increase in federal funding for Maryland SBIRT grant	1,618
Behavioral Health Crisis Response Grant	1,000
Increase in the problem gambling fund	466
New federal grant for traumatic brain injury	150
Decrease in funding for local jurisdictions for Buprenorphine, due to need for additional contractual employee support. Total program decreases $71,414	-196
Other changes in continuing programs for mental health and substance use	-305

Where It Goes:	**Change**
Atypical anti-psychosis drug program budgeted with State psychiatric facilities in MDH Administration budget	-541
End of federal grants for Assertive Community Treatment and Maternal Depression Screening	-1,328
State Opioid Response grant (federal funds)	-16,277
Other Changes	
Net increase of 10.13 FTE contractual support for grant and program administrative support for the Buprenorphine Initiative (1.63), MD Healthy Transitions (1.0), MD Recovery Net (4.0), and State Opioid Response (3.5)	603
13.5 FTE increase in administrative contractual employees previously subcontracted through local jurisdictions, offset by decreases in funding to local jurisdictions and MD Veterans Affairs program	293
3.5 net contractual increase in BHA's Program Direction	186
Other contractual employee changes	56
Other operating expenses	-184
One-time funding for Kennedy Krieger Institute grants and bed registry	-2,550
Total	**$54,653**

BHA: Behavioral Health Administration
FFS: fee-for-service
FTE: full-time equivalent
MD: Maryland
MDH: Maryland Department of Health
SBIRT: screening, brief intervention, referral to treatment
SUD: substance use disorder

Note: Numbers may not sum due to rounding. The fiscal 2020 appropriation includes deficiencies, planned reversions, and general salary increases. The fiscal 2021 allowance includes contingent reductions and general salary increases.

Provider Rate Increases

The proposed 2% rate increase is half of the amount mandated by Chapters 10 and 11 of 2019 due to the changes proposed in the Budget Reconciliation and Financing Act (BRFA) of 2020. There is a contingent reduction in the budget bill of $11 million in general funds and $13 million in federal funds across the three programs that contain BHA provider reimbursements. Even without impacting the mandated out-year provider rates, DLS projects that this action will reduce provider reimbursements in the out-years significantly, with nearly $30 million fewer total funds to community providers in fiscal 2022. **DLS recommends amending the BRFA to delay the mandated 4% provider rate increase to January 1, 2021. This recommendation will maintain savings budgeted for fiscal 2021 across BHA. However, the DLS recommendation will not significantly impact provider reimbursement rates in the out-years or reduce overall FFS payments to providers beyond fiscal 2021.**

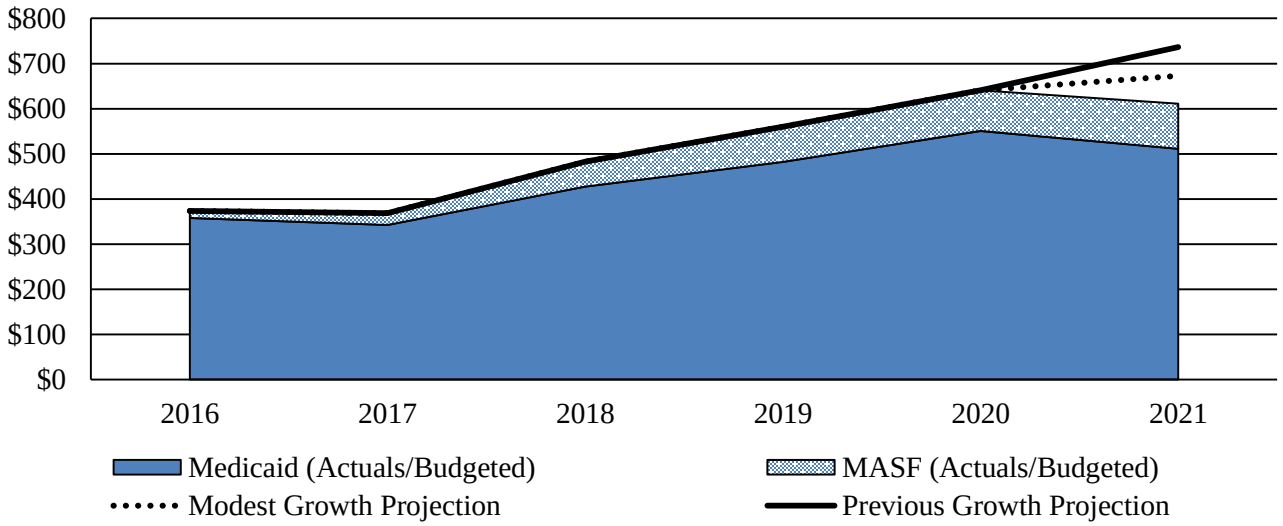
Projected General Fund Adequacy

As shown in Exhibit 9, overall expenditures budgeted for FFS expenditures increase. However, anticipated funding for SUD services, when accounting for funding available between the Medicaid program and the State-funded FFS, decrease by over $17 million. Given recent trends, this would appear unrealistic. Accounting for expected spending on mental health services, DLS is projecting a general fund deficiency of at least $14.5 million in fiscal 2021 between the behavioral health FFS programs driven by the decrease in funding available for SUD FFS. However, this appears to be a best case scenario as discussed below.

Drivers of Adequacy Concerns and Expenditure Trends

SUD Expenditures: The budgeted decrease in SUD expenditures within the Medicaid program is the main driver of concern with regard to general fund adequacy. **Exhibit 10** highlights spending trends in SUD FFS since fiscal 2016.

Exhibit 10
SUD Expenditures Trends
Fiscal 2016-2021
($ in Millions)



MASF: Medical Assistance State Funded
SUD: substance use disorder

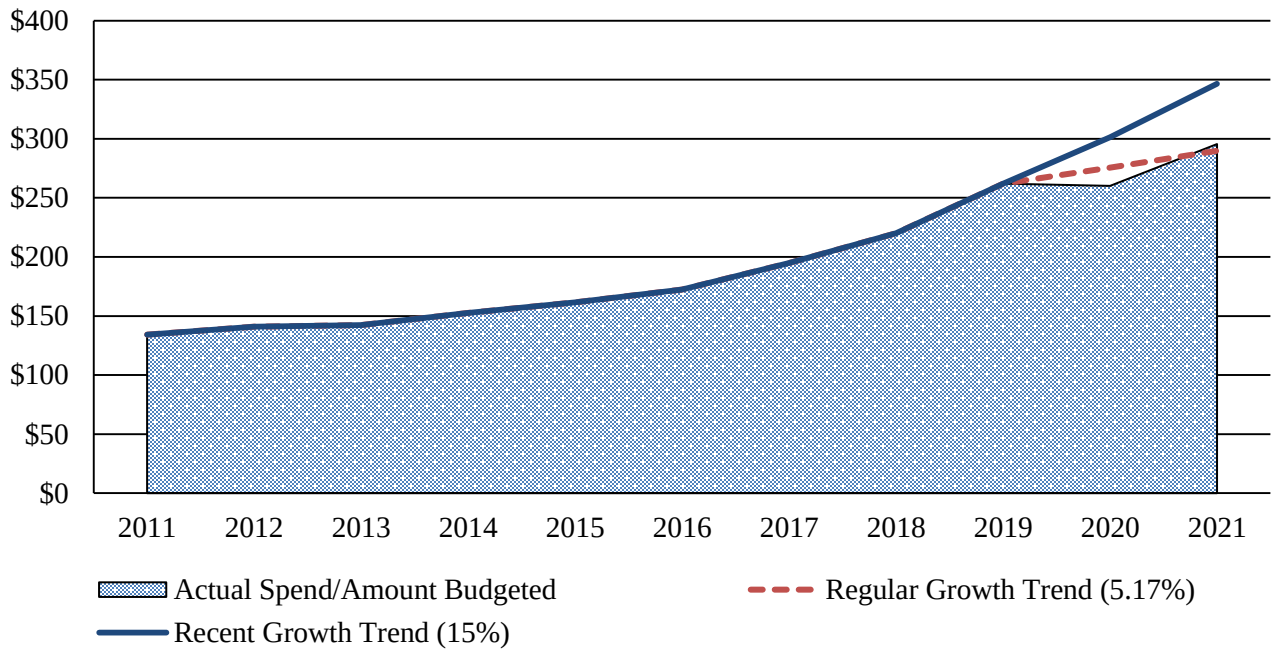
Note: Fiscal 2016 through 2018 reflect actual expenditures; fiscal 2019 and 2020 have been adjusted to reflect deficiencies to estimate total expenditures.

Source: Budget Data

Even under modest growth projections of 5% for fiscal 2021, DLS would still anticipate a $62 million total fund shortfall ($15 million general funds). However, if SUD expenditures continue on the trajectory seen in recent years, with an average of 15% growth over this period, DLS would expect the total fund need to double, creating a $126 million total fund deficiency. Previously, roughly 25% of SUD expenditures in Medicaid were State funded, due to the ACA expansion population being disproportionately represented in SUD treatment. If SUD expenditure growth continues at the current rate of 15%, DLS would anticipate the general fund deficiency growing by another $16 million in general funds.

Psychiatric Rehabilitation Expenditure Trends: As previously mentioned, PRP was the main driver of the deficiency needed in fiscal 2020. It is important to highlight that neither DLS's adequacy projections nor the fiscal 2021 allowance significantly grow spending for PRP. DLS's reluctance to forecast off current PRP trends reflect the lack of a clear explanation for the recent rapid growth (discussed in more detail below). Spending trends for PRP are shown in **Exhibit 11**.

Exhibit 11
Psychiatric Rehabilitation Spending Trends
Fiscal 2011-2021
($ in Millions)



Note: Fiscal 2011 through 2018 reflect actual expenditures; fiscal 2019 and 2020 have been adjusted to reflect deficiencies to estimate total expenditures and funding available. Growth for fiscal 2020 and 2021 is projected off 2019 estimates.

Source: Budget Data

As shown, since fiscal 2017, PRP spending has grown dramatically year-over-year, averaging 15% expenditure growth in the Medicaid program over that period.

This trend is concerning and confusing considering that PRP is a very high-intensity treatment program for individuals with serious and persistent mental illness. Considering the level of intensity, and the seriousness of the conditions of those who need these services, enrollment has generally consisted of traditional Medicaid enrollees, largely eligible through disability. As shown in Exhibit 11, until fiscal 2017, spending has been reasonably constant. From fiscal 2011 to 2016, year-over-year growth averaged just 5.17%. If spending reverts back to these historical levels, DLS forecasts enough in the budget to cover the need for PRP. However, another year of 15% growth would create a $51 million total fund need ($22 million of general funds). Concerns around growth in PRP in certain eligibility categories are discussed further in Issue 2.

Exhibit 12 summarizes DLS's concerns in terms of general fund adequacy for these two expenditure groups and highlights potential increases to deficiency estimates if rapid spending trends continue into fiscal 2021.

Exhibit 12
General Fund Adequacy – Anticipated Deficiency
Fiscal 2021
($ in Millions)

	DLS Projected Deficiency	Potential Additional Liability	High-End Deficiency Projection
SUD and Community Service Expenditures	-$15.00	-$16.00	-$31.00
PRP Expenditures	$0.50	-$22.00	-$21.50
Total	**-$14.50**	**$38.00**	**-$52.50**

DLS: Department of Legislative Services
PRP: Psychiatric Rehabilitation Program
SUD: substance use disorder

Source: Department of Legislative Services

As shown, if spending trends continue in these two areas as in fiscal 2020, DLS projects that the State would need a general fund deficiency of $52.5 million for fiscal 2021. This should not be surprising given that this is similar to the general fund deficiency need in fiscal 2020 based on current expenditure trends.

Due to concerns in fiscal 2021 adequacy and uncertainty in 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.

Personnel Data

	FY 19 Actual	FY 20 Working	FY 21 Allowance	FY 20-21 Change
Regular Positions	180.90	131.90	132.80	0.90
Contractual FTEs	26.77	18.51	45.64	27.13
Total Personnel	**207.67**	**150.41**	**178.44**	**28.03**
Vacancy Data: Regular Positions				
Turnover and Necessary Vacancies, Excluding New Positions		13.78	10.38%	
Positions and Percentage Vacant as of 12/31/19		18.50	14.03%	
Vacancies Above (Below) Turnover		4.72	3.65%	

- The most substantive personnel change pertains to contractual employees. The fiscal 2021 BHA allowance reflects 13 contractual staff being budgeted as contractual employees rather than within the contracts to CSAs. BHA reports that it has hired many of the same individuals who were subcontracted by CSAs as contractual staff. The Office of Legislative Audits (OLA) raised concerns about these interagency agreements, discussed further in Issue 3.

Issues

1. ASO Transition

On July 24, 2019, the Board of Public Works (BPW) approved the contract for an ASO to process and pay provider claims from January 1, 2020, through calendar 2024, with a two-year renewal option to extend the contract through calendar 2026. The winning bid was United Behavioral Health Services (Optum), over the current ASO, Beacon Health Options (Beacon). Optum's bid was not only scored the best price, at $72 million cheaper than Beacon's bid (estimated at $10 million less per year) but Optum was also the highest rated technical bid by the department of the two received.

The contract also included a four-month implementation period, valued at $8.8 million. Currently, the funding for the ASO contract in fiscal 2020 does not reflect funds available to support this contract component, further contributing to potential funding shortfalls in fiscal 2020. The four-month transition period under the new contract proved to be too short, as Optum was unable to meet the January 1 Go-Live date.

Shortly after the new ASO contract began, providers started to report substantial difficulties. Many providers were unable to register with Optum. Those that were able to register had difficulty submitting claims or had claims wrongfully rejected. Further still, the providers who did receive reimbursements noted inconsistencies. For example, claims paid were for the incorrect amount or without an explanation of benefits. The lack of payments, or inconsistency of payments, has created significant concerns for providers who need to make payroll and pay rent in order to keep providing services in Maryland.

To address the concern surrounding payments, a January 23, 2020 notice was issued to providers from Secretary Robert R. Neall that MDH will be processing estimated payments to providers based on average weekly payments in calendar 2019. MDH also advised DLS that mispayments from the first three weeks of the new ASO will be addressed on a separate weekly payment cycle.

The estimated payments address the immediate financial challenges facing providers. However estimated payments could be inadequate if a provider has expanded services or is a new provider. The notice also stated that providers must continue to submit claims and that estimated payments will ultimately be reconciled with the claims amount, requiring the department to either provide further payments, or recover overpayments made to providers during this period. The notice states that the department will proceed under the estimated payments structure until April 20, 2020. **In order to ensure accountability and complete understanding of the estimated payments required due to the new ASO's inability to process actual claims, DLS recommends adding budget bill language restricting $1,000,000 in general funds from the Office of the Secretary budget until a report is submitted on the totality of the estimated payments. This report should be submitted by July 1, 2020, and include the number and total amount of estimated payments, the number and total amount of overpayments and underpayments during this period, the number and total amount of claims reconciled over this period and plans to recover amounts outstanding from overpayments during this period.**

While the strategy of estimated payments mitigated the most acute problem with the ASO transition, other problems have been reported with the system. Providers have reported not receiving alerts from Optum, even though they opted in to receive them, and the system is unable to accept attachments larger than 2 megabytes. Additionally, providers have reported being unable to authorize individuals without insurance, meaning in practice that uninsured individuals with specialty behavioral health needs might not be receiving care.

As previously mentioned, the contract as approved by BPW included an $8.8 million implementation period. These funds for the implementation of the contract are 90% federal fund supported; however, DLS has been unable to identify this funding in the fiscal 2020 deficiencies or fiscal 2021 allowance. **MDH should comment on the availability of $8,838,023 ($883,802 in general funds and $7,954,221 in federal funds) to support the implementation of the ASO transition.**

In the Request for Proposals (RFP) for the ASO contract, MDH outlined liquidated damages upon implementation for failure to meet the Go-Live date. Specifically, the RFP states that, "If the Contractor does not meet the Go-Live date, the Contractor shall, in lieu of actual damages pay MDH as fixed, agreed, and liquated damages in the amount of $25,000 per calendar day for the Go-Live date until the Contractor becomes operational…" Considering that the Go-Live date has clearly not been met by Optum, DLS estimates that MDH is entitled to damages totaling at least $575,000 (from January 1 to January 23 when the notice was issued for estimated payments). **DLS recommends a BRFA action reducing the fiscal 2020 allowance for the ASO contract in the BHA budget by $575,000 ($287,500 in general funds and $287,500 in federal funds) to account for anticipated damages paid by the contractor.** It worth noting that if ASO is not fully functional until the April 20, 2020 date in the estimated payment notice, liquidated damages could total $2.75 million.

2. Quality of Care and Appropriateness of Care Settings

DLS has identified concerning instances where BHA (and Medicaid) did not seem to properly apply oversight of services being provided through PBHS. This is particularly troubling given the rate of spending growth on both mental health and SUD treatment. DLS believes that quality measures, greater monitoring of providers, and increased transparency is of the utmost importance to ensure that Marylanders are receiving high-quality and medically necessary care.

Psychiatric Rehabilitation Programs

The discussion of fiscal 2021 adequacy raised concerns about spending trends within PRP over recent years, and how unusual the substantial increase in spending is for the PRP program. Upon seeing these trends, DLS looked more closely at which enrollment categories were experiencing the most growth, shown in **Exhibit 13**.

Exhibit 13
PRP Spending by Enrollment Category
Fiscal 2018-2019

	2018	2019	Year-over-year Increase	% Change
Elderly	$5,780,758	$6,135,934	$355,176	6.14%
Pregnant Women	115,803	328,720	212,917	183.86%
Disabled Child	9,810,318	11,335,834	1,525,516	15.55%
Disabled Adult	117,054,981	124,627,754	7,572,773	6.47%
Other	3,842,969	4,156,586	313,617	8.16%
Parents/Caretakers	16,353,533	23,105,189	6,751,656	41.29%
Children	32,738,454	40,463,383	7,724,929	23.60%
Former Foster Care	513,698	536,870	23,172	4.51%
HPE – All Other	1,928	1,996	68	3.53%
Subtotal Traditional	***$186,212,442***	***$210,692,266***	***$24,479,824***	***13.15%***
ACA Expansion	$26,934,076	$35,911,623	$8,977,547	33.33%
MCHP	5,570,005	7,283,018	1,713,013	30.75%
Subtotal Enhanced	***$32,504,081***	***$43,194,641***	***$10,690,560***	***32.89%***
Total	**$218,716,523**	**$253,886,907**	**$35,170,384**	**16.08%**

ACA: Affordable Care Act
HPE: Hospital Presumed Eligibility
MCHP: Maryland Children's Health Program
PRP: Psychiatric Rehabilitation Programs

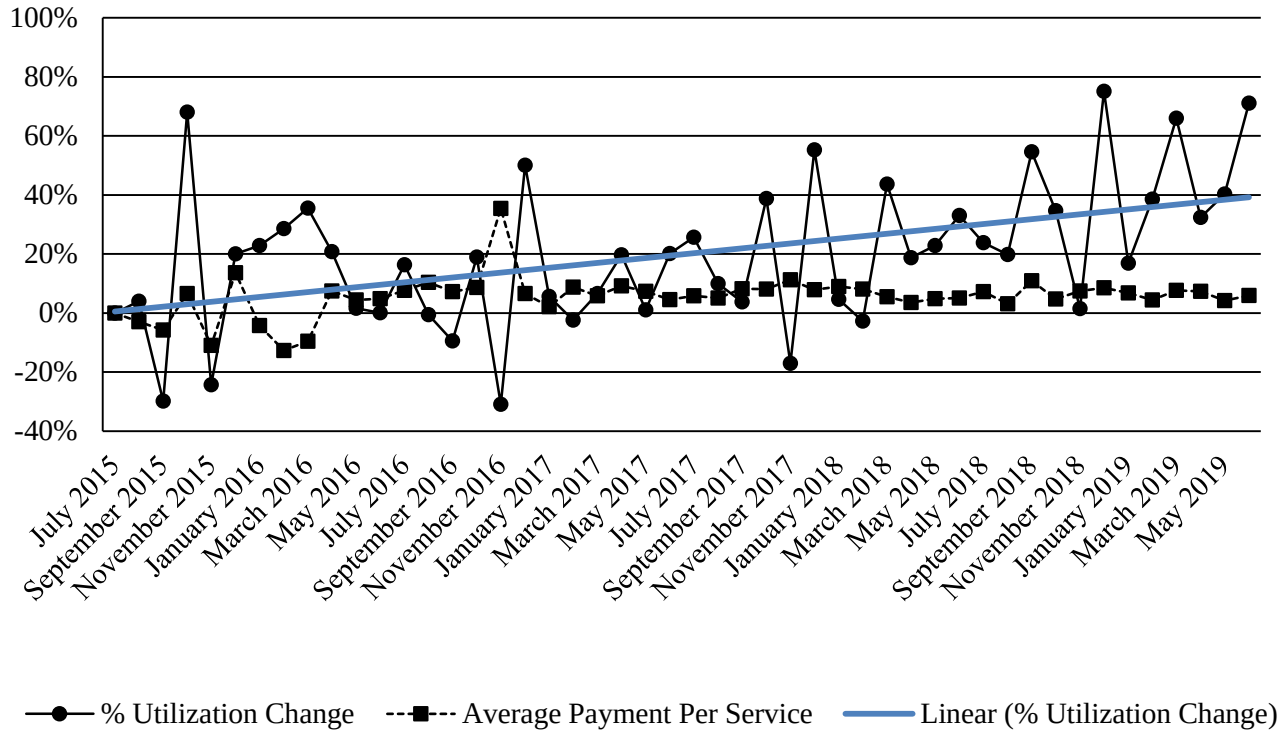
Note: Reports are from end of respective fiscal year for claims made. Does not include carryover amount through fiscal 2020 deficiency. Growth in pregnant women eligibility spending, while a substantial percentage increase, is small and may in any event be attributed to a change in assignment to that eligibility category in the second half of fiscal 2019.

Source: Maryland Department of Health

Not only did the claims data reported show higher than expected growth throughout the PRP program, but growth was most pronounced in eligibility groups that have traditionally not seen much spending on PRP services, such as children, parents/caregivers, and the ACA expansion groups. Conversely, disabled adults, the largest single group for PRP spending, grew at a fairly normal rate over this period.

Spending increases in PRP could either be attributed to increase in utilization, or more expensive services. Considering the pronounced increases in different eligibility groups, DLS attributes the PRP increases to increased utilization in PRP. This is highlighted in **Exhibit 14**, which shows the percent change for both cost per service and service utilization for each month relative to the beginning of fiscal 2016. Fiscal 2016, as shown in Exhibit 11, is the most recent year with regular spending trends.

Exhibit 14
Percent Changes in PRP Utilization and Service Costs
Fiscal 2016-2019

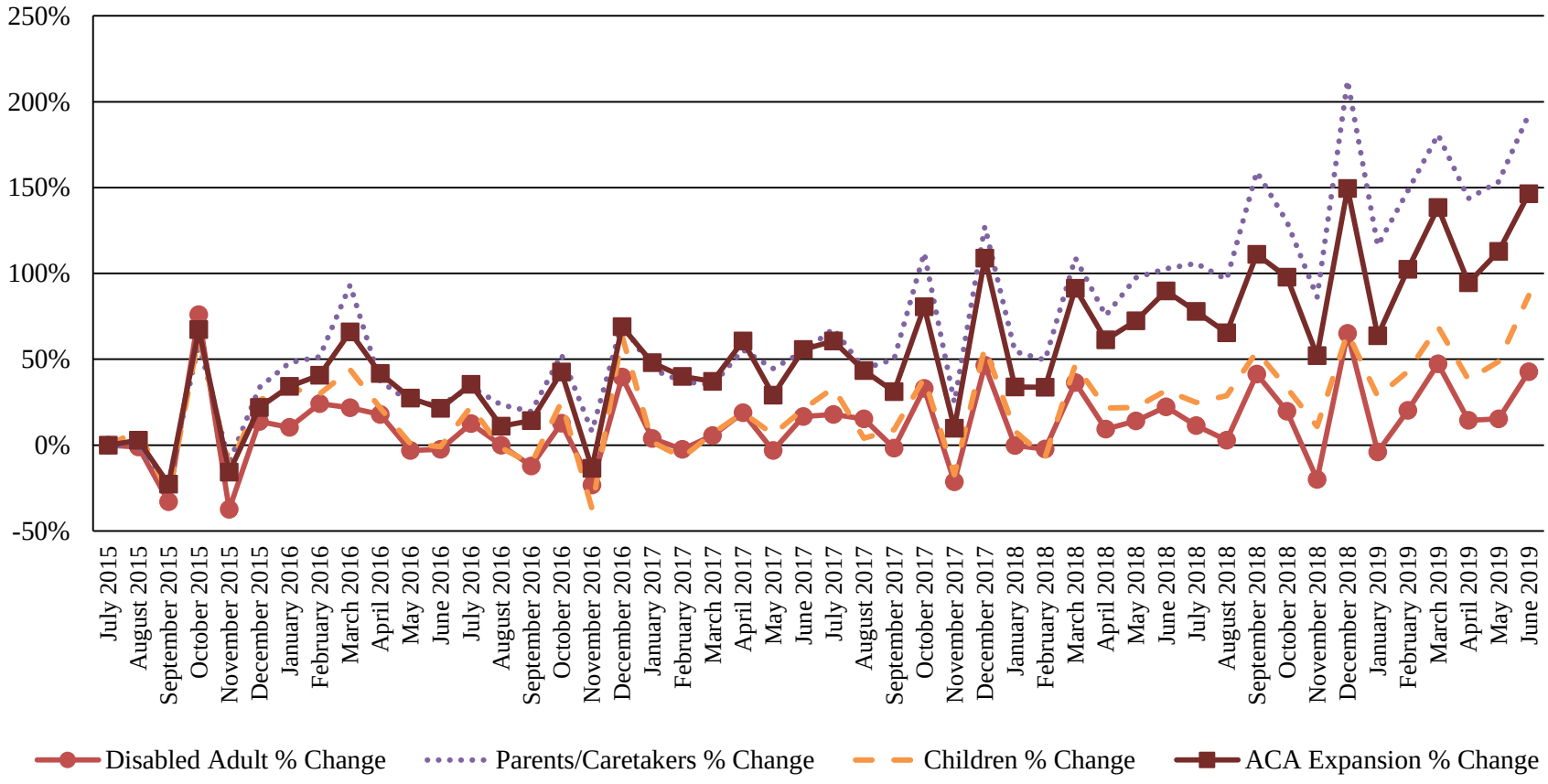


PRP: Psychiatric Rehabilitation Programs

Source: Maryland Department of Health

As shown, payments per service have increased slightly over this period but not nearly as dramatically as utilization. At the end of fiscal 2019, utilization for PRP was 71% higher than it was at the beginning of fiscal 2016. DLS looked specifically at utilization changes in the categories flagged as unusual for PRP spending and compared them to the largest traditional enrollment group, disabled adults. The percent change in service utilization across enrollment groups over this period, compared to the beginning of fiscal 2016, is shown in **Exhibit 15**.

Exhibit 15
Service Utilization Change by Enrollment Group
Fiscal 2016-2019



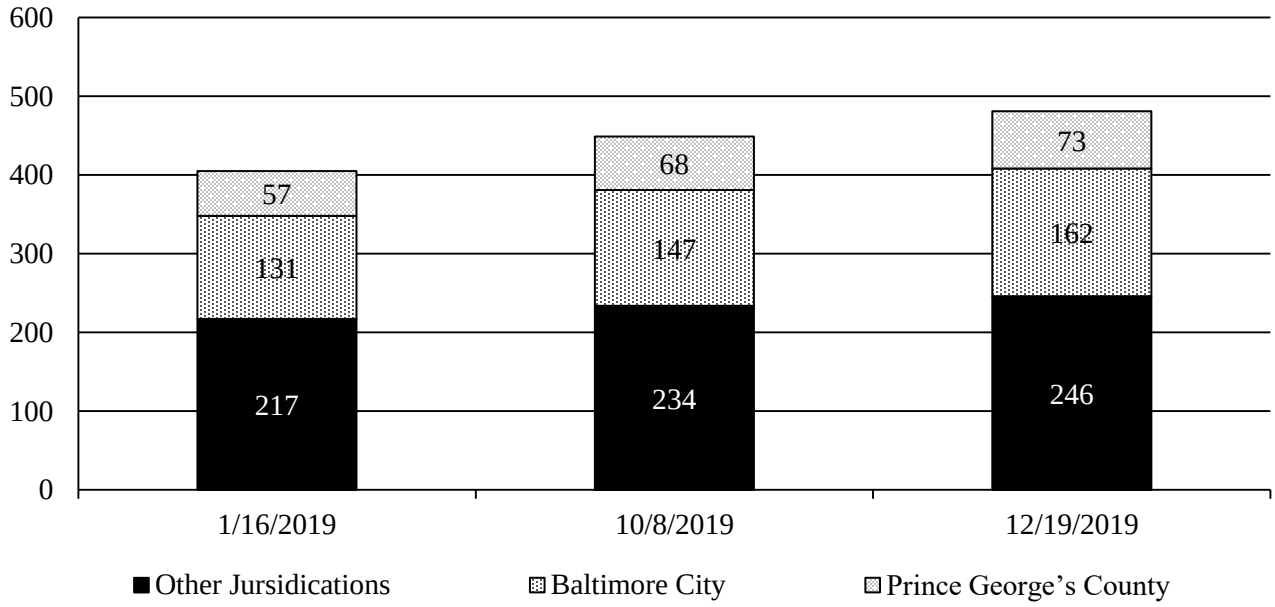
ACA: Affordable Care Act

Source: Maryland Department of Health

Utilization does increase in all four groups over this period, but the nontraditional high users of PRP services have significantly more utilization growth than the disabled adults.

DLS also wanted to examine the number of PRP providers in the State to see if there has been a noticeable change over this same period of expansion in PRP expenditures and utilization. This proved to be challenging, considering current ASO limitations. Further, when data has been provided, it is largely point-in-time data and not able to show when a provider entered into the market. DLS did find three different point-in-time counts of PRP providers in Maryland provided by MDH from *Joint Chairmen's Report* (JCR) reports and other data requests over the course of calendar 2019, shown in **Exhibit 16**.

Exhibit 16
PRP Providers
Calendar 2019



PRP: Psychiatric Rehabilitation Programs

Source: Maryland Department of Health

Over calendar 2019, Maryland saw an increase of 76 new PRP providers, roughly a 20% increase. Curiously, Baltimore City alone accounts for nearly half of the total PRP provider increase, with 31 more providers. Prince George's County also added a significant number of PRP providers over this nearly 12-month period. It is also peculiar that even though the last two observations attained by DLS are only 72 days apart, the State still managed to add 32 PRP programs, a little under 1 PRP provider every other day. Concerns around PRP in Baltimore City were flagged in a gap analysis of

Baltimore's PBHS conducted as part of the consent decree Baltimore City entered with the U.S. Department of Justice, released in December 2019. This report suggested that these programs may be proliferating, or existing practices are expanding at the expense of quality care.

Increases in expenditures and utilization, particularly in unusual eligibility categories, should have raised alarms within BHA and Medicaid and, if not these trends, the number of PRP providers billing Medicaid increasing in such a dramatic fashion should have also prompted some investigation. ASO is supposed to determine medical necessity of all services, while CSAs are supposed to review applications in their jurisdiction, and MDH should be providing oversight for both of these processes.

DLS recommends adopting budget bill language restricting $250,000 from the Deputy Secretary of Behavioral Health's budget until BHA submits a report on factors contributing to the increase in PRP spending. This report should include analysis on the increase of PRP providers and utilization growth in nontraditional enrollment categories.

SUD Treatment Quality Measures

During the 2019 legislative session, DLS expressed concerns with rapid growth in SUD services, particularly SUD residential services. SUD residential is an area of particular concern due to the high-level of care being provided and the growth in this service area. SUD residential also produces a greater general fund need than other SUD services for two reasons: SUD residential room and board costs, until recently and still in limited cases, cannot be supported through Medicaid; and the treatment component is able to be supported with federal funds through an 1115 Wavier. This waiver allows Medicaid to be billed for treatment of the Medicaid enrollees. However, this is limited to two nonconsecutive 30-day stays within a rolling calendar year. In practice, this means that treatment that is either longer than 30 consecutive days, or more frequent, is entirely State funded. A new waiver that went into effect in fiscal 2020 allows a small share of residential room and board to be billed to Medicaid. However, as of January 2, 2020, only $203,106 of the over $6.7 million in SUD residential room and board expenditures was eligible.

Aside from the financial implications of longer or more frequent stays, individuals in PBHS regularly cycling through SUD residential programs might also be a sign of the relative quality of residential services being provided. Although the population using SUD residential services is prone to relapse, and recovery is a lifelong endeavor, it would still be encouraging to be able to see individuals progressing through the continuum of care for SUD treatment.

DLS recommended budget bill language in the 2019 session for MDH to report on the number of individuals who have been readmitted to a residential treatment program and the average length of stay (ALOS). After conversations with the department, it expressed a concern that it was unable to disentangle some of the data that DLS was requesting and also concerns with submitting the data through the formal JCR process. After these discussions, MDH agreed to share a version of this data available informally with DLS. MDH provided this data to DLS once, in August 2019. While this is more information than was previously available to DLS pertaining to SUD residential treatment, it is still not particularly informative regarding the quality of SUD residential treatment being provided in Maryland. Data from this single submission is provided in **Exhibit 17**.

Exhibit 17
SUD Residential Discharges and Average Length of Stay
Fiscal 2018-2019

	Level 3.3		Level 3.5		Level 3.7		Level 3.7 WM	
Level of Care	**2018**	**2019**	**2018**	**2019**	**2018**	**2019**	**2018**	**2019**
Discharges	1,724	2,153	2,188	3,872	6,042	7,438	2,385	2,798
Average Length of Stay	23.1	26.0	30.5	24.9	16.5	17.0	4.9	4.8

SUD: substance use disorder
WM: Withdrawal management, including medical monitoring of withdrawal

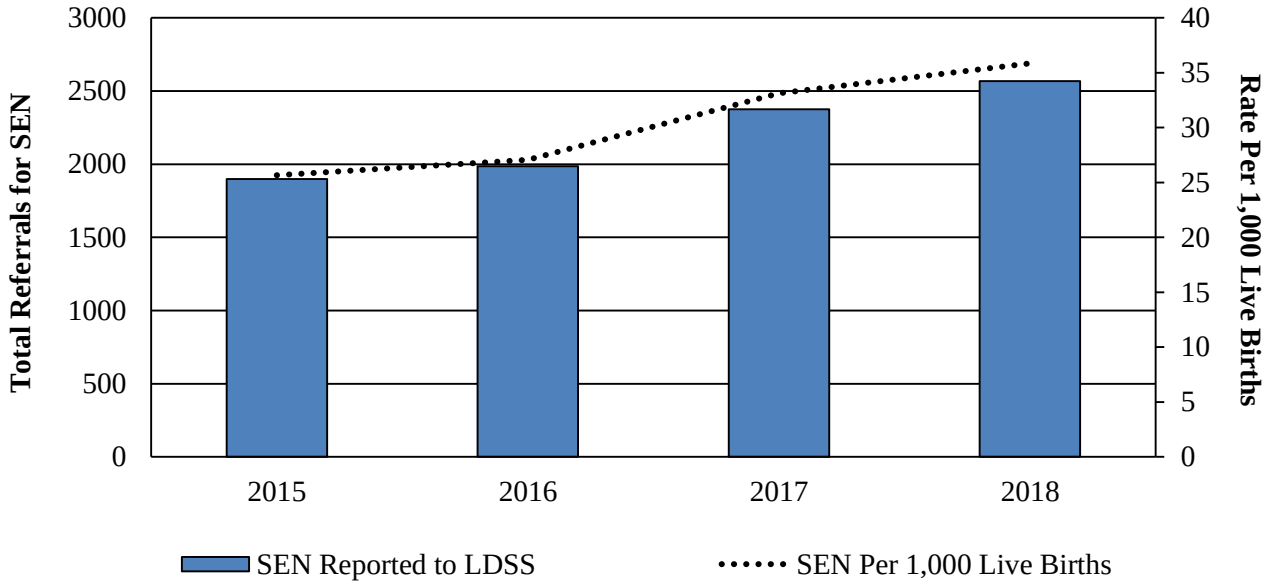
Note: Fiscal 2019 is incomplete due to the 12-month claims lag. Excludes Specialty SUD Residential Services for Court Ordered Placements and Pregnant Women/Women with Children.

Source: Maryland Department of Health

One caveat with this particular data is that it does not differentiate as to why someone left care. The number of discharges and ALOS are all treated as equal, regardless if someone stepped down, transferred to a different provider, or relapsed. DLS understands that paying providers is the most immediate concern for MDH; however, ensuring that quality, medically necessary care is being provided is also important.

The 2019 JCR also requested information on the availability and capacity of SUD residential treatment for pregnant women or women with children. This report found only four programs in the State with a collection of 85 beds between them. The report also discusses that these programs may limit the number of children who can stay with the mother while she is in treatment. These programs may also have fewer of these beds actually available due to workforce shortages and the additional staff needed for these specialty facilities. MDH being able to identify no more than 85 SUD residential beds for women with children is particularly concerning because the report also finds that in fiscal 2018, there were 2,568 substance exposed newborns (SEN), and the mothers of these newborns could have benefited from treatment that allowed them to stay with their child. The total number of SEN by fiscal year is shown in **Exhibit 18**. DLS took the number of SEN referrals reported and calculated rates of referrals for SEN per 1,000 live births in Maryland over this period.

Exhibit 18
Substance Exposed Newborns
Fiscal 2015-2018



LDSS: local departments of social services
SEN: substance exposed newborns

Source: Behavioral Health Administration; local departments of social services; Maryland Department of Health – Vital Statistics

As shown, both the number of SENs in Maryland and their prevalence within recent years has continued to increase, signifying a growing need for this type of specialty treatment. The referrals reported by BHA have increased by an average of 10% year-over-year during this period.

The report also provided data that shows of the women who received SUD residential services in fiscal 2019, only 5.55% received treatment in specialty services for pregnant women or women with children. These findings suggest that many women may not be receiving care in the ideal setting for them or their families.

In researching both SUD residential and PRP, DLS found it challenging to find information on the quality of care, the number of providers in the State, and the services offered by the providers registered with Medicaid. Considering the challenges that DLS encountered during this analysis, one can imagine the difficulty that an individual in PBHS would face when searching for their best treatment options, current ASO issues notwithstanding. Further, one of the recent OLA audit findings related to BHA found that Medicaid did not ensure that ASO properly authorized behavioral health services. In fact, the 2017 audit of the former ASO found that certain authorized services were not

appropriate for the client's diagnoses and that clients were being treated in inappropriate levels of care. Although MDH disagreed with this finding, taken in tandem with PRP growth trends and lack of useful SUD residential data, it suggests that the oversight of the PBHS is inadequate.

DLS recommends restricting $250,000 from the BHA Deputy Secretary budget until a report is submitted that details potential quality measures available for the department to measure the effectiveness, availability, and appropriateness of SUD and mental health treatment in Maryland. BHA should consider ways to track and evaluate client progress through the continuum of care, changes in self-administered outcome-based client surveys, and availability of different service types throughout the State. Further consideration should be given toward MDH maintaining a list of preferred providers that is updated regularly and populated with objective measures of high-quality, specialized behavioral health care. This preferred provider list should include years of operation in Maryland and any complaints of impropriety against providers. MDH should further consult and partner with local CSAs to increase network accountability at the local level.

3. Fiscal Compliance and Oversight

Since the 2019 legislative session, OLA has produced three audits pertaining to BHA: BHA itself; the former ASO; and the Opioid Operational Command Center (OOCC). While OOCC is currently organized under the Military Department, the audit encompassed a period of time where the OOCC was within BHA. **Appendices 2**, **3**, and **4** discuss the specific findings within each audit.

Throughout these audits, several examples were found of BHA not providing adequate oversight in various programs. One such instance occurred when the State university administering services for the Problem Gambling Fund let payments to the program's website lapse, allowing gambling services and trips to casinos to advertise on the resource for individuals who wanted to stop gambling. Another instance, eluded to above, found that BHA did not routinely verify behavioral health services authorized by ASO, doing so only once over the audit period. Further still, the auditors found that BHA did not monitor the local jurisdictions performance in meeting the terms of the grants issued to them, nor did it ensure that services were provided to clients by CSAs. Another finding stated that BHA failed to monitor the vendor responsible for providing care management services for children to ensure that required services were being provided.

The OOCC audit, discussed in greater depth in Appendix 4, was a result of concerns with OOCC's grant administration that was raised while OLA was conducting the BHA audit. OLA found that OOCC did not have any meaningful processes, procedures, or verifications throughout their grant process. These lack of processes existed while the OOCC was budgeted under BHA, which ultimately issued the funds approved by OOCC. The fiscal 2019 closeout audit conducted by OLA also found that MDH improperly recorded general fund expenditures totaling $420,436 for OOCC, allowing general funds to be retained for future fiscal years. These expenditures were recorded, although no goods or services were provided.

The BHA audit also discussed questionable uses of interagency agreements, particularly as it pertains CSAs. During the course of this audit, the MDH Office of the Inspector General (OIG) conducted an investigation and issued a report discussing BHA using CSAs for personnel and contracts that may have circumvented the State's personnel and procurement processes. Specifically, the OIG report focused on interagency agreements between BHA and two CSAs where BHA directed two CSAs to hire specific individuals and established their compensation. The OIG report also referenced CSAs being directed to obtain information technology services from a firm without a competitive procurement process. This contract was awarded for $1.5 million by CSA in fiscal 2018 to provide services directly to BHA. Pertaining to the personnel, the OIG report notes 13 individuals hired by CSAs at the direction of BHA who were former BHA employees or had previous relationships with the agency. The OIG report places these costs at $2.6 million for fiscal 2018. As mentioned above, these individuals are now being compensated directly from BHA as contractual employees, $1.17 million for fiscal 2021, per the OIG recommendations.

MDH was unable to share this internal OIG report with DLS during the preparation of this analysis, in part because the OIG referred these matters to the Office of the Attorney General – Criminal Division.

Operating Budget Recommended Actions

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

   , provided that $1,000,000 of this appropriation made for the purposes of executive direction may not be expended until the Maryland Department of Health submits a report to the budget committees on the administrative services organization transition and estimated payments made during the transition. The report shall be submitted by July 1, 2020, and the budget committees shall have 45 days to review and comment. Funds restricted pending the receipt of a report may not be transferred by budget amendment or otherwise to any other purpose and shall revert to the General Fund if the report is not submitted to the budget committees.

   Explanation: The Maryland Department of Health (MDH) transition to a new Administrative Services Organization (ASO), effective January 1, 2020, found many providers unable to register, submit claims, or receive proper reimbursements. MDH's short-term solution for providers is to issue estimated payments based on calendar 2019 services until April 20, 2020, when the new ASO will hopefully be ready to process claims. This language restricts funding from the MDH Secretary budget until a report is submitted detailing the full scope of the estimated payments issued during this period of transition.

Information Request	**Author**	**Due Date**
Report on estimated payments	MDH	July 1, 2020

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

   , provided that $250,000 of this appropriation made for the purposes of executive direction may not be expended until the Behavioral Health Administration submits a report to the budget committees detailing quality measures available for the treatment of specialty behavioral health services in the public behavioral health system. The report shall be submitted by October 1, 2020, and the budget committee shall have 45 days to review and comment. Funds restricted pending the receipt of a report may not be transferred by budget amendment or otherwise to any other purpose and shall revert to the General Fund if the report is not submitted to the budget committees.

   Explanation: Growth trends in the Public Behavioral Health System (PBHS) in recent years have caused concerns regarding the appropriateness of the care settings and the quality of care being provided in PBHS. This language requests that the Behavioral Health Administration (BHA) compile a report on potential quality measures that would be available and useful to ensure that Marylanders in PBHS are receiving high-quality specialty behavioral health services in the most appropriate settings.

Information Request	Author	Due Date
Quality and performance measures in PBHS	BHA	October 1, 2020

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

Further provided that $250,000 of this appropriation made for the purposes of executive direction may not be expended until the Behavioral Health Administration submits a report to the budget committees detailing the increase in psychiatric rehabilitation program expenditures and utilization. The report shall also include reasons for the significant growth in psychiatric rehabilitation program expenditures, utilization, and providers. The report shall be submitted by October 1, 2020, and the budget committees shall have 45 days to review and comment. Funds restricted pending the receipt of a report may not be transferred by budget amendment or otherwise to any other purposes and shall revert to the General Fund if the report is not submitted to the budget committees.

Explanation: Increases in psychiatric rehabilitation program (PRP) expenditures have caused the need for a deficiency appropriation in fiscal 2020. If the current growth trend continues, PRP spending could be the main cause of future budget shortfalls. This language requests that the Behavioral Health Administration (BHA) submit a report on the increases in PRP expenditures and utilization.

Information Request	Author	Due Date
Causes for the increase in PRP expenditures	BHA	October 1, 2020

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 Medicaid State 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 Medicaid State Funded Recipients or M00Q01.10 Medicaid Behavioral Health Provider Reimbursements.

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

, provided that $3,584,956 of this appropriation shall be reduced contingent upon the enactment of legislation ~~reducing~~ deferring the required provider rate increase for certain behavioral health services.

Explanation: The Budget Reconciliation and Financing Act (BRFA) of 2020 reduces the mandated 4% provider rate increase for many Medicaid providers to 2%. This language would leave the proposed reduction but make it contingent on an amendment to the BRFA deferring the 4% rate increase until January 1, 2021.

6. Amend the following language to the federal fund appropriation:

, provided that $801,541 of this appropriation shall be reduced contingent upon the enactment of legislation ~~reducing~~ deferring the required provider rate increase for certain behavioral health services.

Explanation: The Budget Reconciliation and Financing Act (BRFA) of 2020 reduces the mandated 4% provider rate increase for many Medicaid providers to 2%. This language would leave the proposed reduction but make it contingent on an amendment to the BRFA deferring the 4% rate increase until January 1, 2021.

7. 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.

8. Amend the following language to the general fund appropriation:

, provided that $1,141,973 of this appropriation shall be reduced contingent upon the enactment of legislation ~~reducing~~ deferring the required provider rate increase for certain behavioral health services.

Explanation: The Budget Reconciliation and Financing Act (BRFA) of 2020 reduces the mandated 4% provider rate increase for many Medicaid providers to 2%. This language would leave the proposed reduction but make it contingent on an amendment to the BRFA deferring the 4% rate increase until January 1, 2021.

9. 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 Medicaid State 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 Medicaid State Funded Recipients or M00L01.02 Community Services.

10. Amend the following language to the general fund appropriation:

, provided that $6,374,783 of this appropriation shall be reduced contingent upon the enactment of legislation ~~reducing~~ deferring the required provider rate increase for certain behavioral health services.

Explanation: The Budget Reconciliation and Financing Act (BRFA) of 2020 reduces the mandated 4% provider rate increase for many Medicaid providers to 2%. This language would leave the proposed reduction but make it contingent on an amendment to the BRFA deferring the 4% rate increase until January 1, 2021.

11. Amend the following language to the federal fund appropriation:

, provided that $12,219,970 of this appropriation shall be reduced contingent upon the enactment of legislation ~~reducing~~ deferring the required provider rate increase for certain behavioral health services.

Explanation: The Budget Reconciliation and Financing Act (BRFA) of 2020 reduces the mandated 4% provider rate increase for many Medicaid providers to 2%. This language would leave the proposed reduction but make it contingent on an amendment to the BRFA deferring the 4% rate increase until January 1, 2021.

Budget Reconciliation and Financing Act Recommended Actions

1. Amend the Budget Reconciliation and Financing Act of 2020 to defer the 4% provider rate reduction until January 1, 2021, rather than reducing it to 2% effective July 1, 2020.

2. Reduce funding for the Administrative Services Organization (ASO) contract in fiscal 2020 by $575,000 ($287,500 in general funds and $287,500 in federal funds) based on anticipated savings from the contractor for the new ASO contract being unable to meet the Go-Live by at least 23 days. Per the Request for Proposal for the ASO contract, the State is eligible for liquated damages of $25,000 per day until the contractor is able to meet the Go-Live date.

Appendix 1
2019 *Joint Chairmen's Report* Responses from Agency

The 2019 *Joint Chairmen's Report* (JCR) requested that the Behavioral Health Administration (BHA) prepare seven reports. Electronic copies of the full JCR responses can be found on the Department of Legislative Services Library website.

- ***Alternative Chronic Pain Management Program:*** In November 2019, the Maryland Department of Health (MDH) granted the appropriated $750,000 to the Kennedy Krieger Institute (KKI) for its Pediatric Pain Rehabilitation Program through fiscal 2020. The report also notes a 21% increase in services through this program over the last fiscal year. However, despite the expansion of services, MDH finds insufficient data available at the time of this report to determine the program's efficacy. MDH also provides in an appendix the reporting requirements requested from KKI.

- ***Certified Community Behavioral Health Clinics:*** MDH submitted a report discussing the goals and objectives of the two facilities in Maryland chosen for the Certified Community Behavioral Health Clinic (CCBHC) expansion grants provided by the Substance Abuse and Mental Health Services Administration, totaling $7.3 million over two years. MDH notes that the two programs in Maryland were selected because these programs had existing service components that meet the requirements to be a CCBHC. MDH also noted that it is monitoring the experiences and advancements made by these programs to incorporate into the outpatient mental health clinic model of which the two CCBHC programs are already a part of.

- ***Ibogaine Treatment Study:*** BHA, with the assistance of the Pharmaceutical and Therapeutics Committee of the Spring Grove Hospital, reviewed five different scientific studies. Four of the studies reviewed were observational trials, and the fifth was a case report, and while these studies did find some positive results, BHA notes that ibogaine is associated with serious adverse events, including 27 reported deaths between 1991 and 2015. Further, the studies reviewed took place outside of the United States, which is required, considering that ibogaine is a Schedule I substance, which precludes any domestic research.

- ***Occupational Therapy in Behavioral Health Services:*** In the report provided, BHA notes that currently, Maryland Medicaid only reimburses community-based providers for occupational therapy services provided to children under age 21 as part of the early and periodic screening, diagnostic, and treatment. For adults in the Medicaid program, occupational therapy services are only covered and reimbursed in the hospital setting.

- ***Rural Tele-education for Childhood Neurodevelopmental and Mental Health Disorders:*** MDH notes its intent to provide a $1.8 million grant to KKI to provide a tele-education-based curriculum on children's neurodevelopmental and mental health identification and management for rural and school-based health care clinicians. Prior to the award of funds, BHA will complete

a scope of work and conditions for the grant, one of which will require KKI to subcontract with a Maryland Historically Black College and University.

- ***Serious and Persistent Mental Illness (SPMI) Medication Adherence:*** The committees requested that BHA submit a report by December 1, 2019, on individuals within PHBS with SPMIs and the expenses related to treating this population, including increased expenditures due to nonadherence to medication. This report was submitted on January 3, 2020 and detailed increases in service utilization by the nonmedication adherent and estimated the cost of nonadherence from $3,252 to $19,363 per patient. MDH also discussed technologies available for improving medication adherence such as long-acting injectable (LAI) medications, smart bottles or dispensers, and mobile applications, among other solutions. However, MDH was unable to conclusively identify cost savings in these strategies with the exception of LAI medications for patients with schizophrenia.

- ***Site of Use Drug Disposal Solutions:*** BHA detailed the resources available to local jurisdictions for drug deactivation, including through two grants that are provided by the Public Health Services Administration. These grants, Prevention Services and Opioid Misuse Prevention, were awarded to all 24 and 18 jurisdictions, respectively. BHA noted that these grants provide the ability for each jurisdiction to choose drug disposal methods that work best for them and reports that 12 counties have used these funds, at least in part, to disseminate site of use drug deactivation systems.

- ***Substance Use Disorder (SUD) Residential Services for Women with Children:*** BHA detailed the specialty services available as well as SUD treatment broadly for women in the PBHS. This report is discussed in further depth in Issue 2: Quality of Care and Appropriateness of Care Settings.

Appendix 2
Audit Findings – Behavioral Health Administration

Audit Period for Last Audit:	July 1, 2014 – November 12, 2017
Issue Date:	July 9, 2019
Number of Findings:	4
Number of Repeat Findings:	0
% of Repeat Findings:	0%
Rating: (if applicable)	n/a

Finding 1: The Behavioral Health Administration (BHA) did not adequately monitor core service agencies (CSA) to verify actual performance as required by the grant agreements. When this monitoring was performed, The Office of Legislative Audits (OLA) found that it did not ensure that the required services were provided to the clients. Additionally, BHA did not verify the accuracy of the information reported by the grantees nor recover or adjust funding when CSA was unable to meet established performance measures.

Finding 2: BHA did not adequately monitor a State university administering a problem gambling program on behalf of BHA to ensure the public awareness services were provided. OLA did find that BHA was monitoring the training and treatment programs provided, but failing to monitor the public awareness campaign was particularly problematic when the website for public awareness of the program lapsed. During this 10-day window when the program's website was not operational, the webpage was instead populated by casino advertisements.

Finding 3: BHA did not monitor the State vendor responsible for providing care management services to children with intensive needs and did not ensure payments to the vendor were proper. BHA assumed responsibility for this contract from the Governor's Office of Children (GOC), which noted that the vendor lacked documentation for required case management phone calls, but BHA did not perform similar monitoring or follow-up. OLA also found BHA did not conduct any site visits or other follow-up after assuming responsibility for the contract. BHA also paid the vendor $2.875 million without obtaining adequate documentation. This included $300,000 more than was stipulated in the contract. This $300,000 was agreed to be provided to BHA from GOC for BHA's expenses related to administration of the contract itself.

Finding 4: BHA did not ensure that an external third party properly safeguarded sensitive client data collected through the Prescription Drug Monitoring Program (PDMP). Data from PDMP was shared with other states through an agreement with the National Association of Boards of Pharmacy, and OLA found that this agreement did not require third-party contractors to obtain independent security reviews to ensure data was safeguarded.

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

Appendix 3
Audit Findings – Administrative Service Organization

Audit Period for Last Audit:	July 1, 2015 – December 31, 2018
Issue Date:	January 13, 2020
Number of Findings:	4
Number of Repeat Findings:	1
% of Repeat Findings:	25%
Rating: (if applicable)	n/a

Finding 1: The Medical Care Programs Administration (Medicaid) did not ensure that the Administrative Services Office (ASO) properly authorized behavioral health services and that the bases for the authorizations were adequately documented. Medicaid advised the Office of Legislative Audits (OLA) that the Behavioral Health Administration (BHA) conducted the audits of ASO to verify the authorizations on an annual bases. However, OLA found that BHA conducted these audits only once during the audit period.

Finding 2: **Medicaid did not direct ASO to recover certain provider overpayments identified during audits, did not ensure ASO recovered overpayments once directed to do so, and did not ensure that deficiencies identified by provider audits were corrected. OLA identified overpayments totaling $35,000 in the provider audits tested.**

Finding 3: Medicaid did not have a process to verify that adjustments to provider payments processed by ASO were proper. OLA found that ASO processed approximately 13,000 adjustments over this period, which resulted in total changes to provider payments equaling $35 million.

Finding 4: Intrusion detection prevention system coverage did not exist for encrypted traffic, and sensitive personally identifiable information was stored without adequate safeguards.

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

Appendix 4
Audit Findings – Opioid Operational Command Center

Audit Period for Last Audit:	January 24, 2017 – June 30, 2019
Issue Date:	February 12, 2020
Number of Findings:	5
Number of Repeat Findings:	0
% of Repeat Findings:	0%
Rating: (if applicable)	n/a

Finding 1: The Opioid Operational Command Center (OOCC) did not have written policies and procedures for the selection of grantee, amounts awarded, and the monitoring of grantees. The Office of Legislative Audits (OLA) found numerous deficiencies with virtually every aspect of the grant process, raising questions about the integrity of the grants awarded and related payments. OLA found that OOCC did not notify the public of availability of grant funds, lacked documentation for an evaluation process, had no process to verify assertions in the grant proposal, and did not ensure grantees were in good standing with the U.S. Internal Revenue Service or authorized to do business in the State. OOCC did not have a process to ensure grant expenditures were valid, or that deliverables outlined in the grant proposal were received. OOCC also did not collect any performance data from grantees prior to May 2019. OLA believes that these deficiencies throughout the entire grant process contributed to the questionable grant awards issued by OOCC in the following findings.

Finding 2: OOCC did not have adequate justification for a $750,000 grant awarded to a nonprofit organization for the purchase of a country club and golf course. OLA noted that the Maryland Department of Health (MDH) Office of Inspector General investigated this award based on a tip submitted to the Waste, Fraud, and Abuse hotline and has referred the matter to the Governor's Chief Counsel and Attorney General's Criminal Division. After concerns were raised by OLA to MDH senior management who would be responsible for distributing the grant funds, it advised that the funds would not be distributed.

Finding 3: OOCC awarded a $100,000 grant to an out-of-state nonprofit organization that transferred almost all of the funds to a for-profit company owned by management of the nonprofit. Further, the daily rate paid to the nonprofit was higher than the rate proposed in the grant agreement without a reasonable explanation as to why, and more than half of the required services were not provided. OLA also found that the nonprofit and the private companies that funds were transferred to were not registered to do business in Maryland.

Finding 4: OOCC awarded a $40,959 grant to a nonprofit organization that was inconsistent with the related grant proposal and certain grant expenditures appeared questionable.

Finding 5: MDH and BHA improperly recorded certain expenditures on behalf of OOCC retaining general fund appropriations in future years.

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

Appendix 5
Object/Fund Difference Report
Maryland Department of Health – Behavioral Health Administration

Object/Fund	FY 19 Actual	FY 20 Working Appropriation	FY 21 Allowance	FY 20 - FY 21 Amount Change	Percent Change
Positions					
01 Regular	180.90	131.90	132.80	0.90	0.7%
02 Contractual	26.77	18.51	45.64	27.13	146.6%
Total Positions	**207.67**	**150.41**	**178.44**	**28.03**	**18.6%**
Objects					
01 Salaries and Wages	$ 16,510,975	$ 13,624,167	$ 13,080,205	-$ 543,962	-4.0%
02 Technical and Special Fees	1,528,028	705,327	2,719,199	2,013,872	285.5%
03 Communication	191,974	157,089	155,729	-1,360	-0.9%
04 Travel	159,476	72,427	81,580	9,153	12.6%
06 Fuel and Utilities	328	0	0	0	0.0%
07 Motor Vehicles	0	4,308	2,052	-2,256	-52.4%
08 Contractual Services	1,877,190,751	1,933,891,540	2,069,582,957	135,691,417	7.0%
09 Supplies and Materials	1,007,650	59,087	59,390	303	0.5%
10 Equipment – Replacement	154,276	2,000	1,000	-1,000	-50.0%
11 Equipment – Additional	24,546	0	0	0	0.0%
12 Grants, Subsidies, and Contributions	635,000	0	0	0	0.0%
13 Fixed Charges	73,208	61,014	67,225	6,211	10.2%
Total Objects	**$ 1,897,476,212**	**$ 1,948,576,959**	**$ 2,085,749,337**	**$ 137,172,378**	**7.0%**
Funds					
01 General Fund	$ 767,808,209	$ 795,335,448	$ 885,306,336	$ 89,970,888	11.3%
03 Special Fund	38,993,241	39,357,560	43,470,775	4,113,215	10.5%
05 Federal Fund	1,078,154,983	1,108,448,370	1,151,491,117	43,042,747	3.9%
09 Reimbursable Fund	12,519,779	5,435,581	5,481,109	45,528	0.8%
Total Funds	**$ 1,897,476,212**	**$ 1,948,576,959**	**$ 2,085,749,337**	**$ 137,172,378**	**7.0%**

Note: The fiscal 2020 appropriation does not include deficiencies, planned reversions, or general salary increases. The fiscal 2021 allowance does not include contingent reductions or general salary increases.

Appendix 6
Fiscal Summary
Maryland Department of Health – Behavioral Health Administration

Program/Unit	FY 19 Actual	FY 20 Wrk Approp	FY 21 Allowance	Change	FY 20 - FY 21 % Change
Deputy Secretary – Behavioral Health Administration	$ 1,809,172	$ 1,995,124	$ 1,846,299	-$ 148,825	-7.5%
Program Direction and Community Services	408,808,307	399,663,866	418,059,362	18,395,496	4.6%
Medical Care Programs Administration	1,486,858,733	1,546,917,969	1,665,843,676	118,925,707	7.7%
Total Expenditures	**$ 1,897,476,212**	**$ 1,948,576,959**	**$ 2,085,749,337**	**$ 137,172,378**	**7.0%**
General Fund	$ 767,808,209	$ 795,335,448	$ 885,306,336	$ 89,970,888	11.3%
Special Fund	38,993,241	39,357,560	43,470,775	4,113,215	10.5%
Federal Fund	1,078,154,983	1,108,448,370	1,151,491,117	43,042,747	3.9%
Total Appropriations	**$ 1,884,956,433**	**$ 1,943,141,378**	**$ 2,080,268,228**	**$ 137,126,850**	**7.1%**
Reimbursable Fund	$ 12,519,779	$ 5,435,581	$ 5,481,109	$ 45,528	0.8%
Total Funds	**$ 1,897,476,212**	**$ 1,948,576,959**	**$ 2,085,749,337**	**$ 137,172,378**	**7.0%**

Note: The fiscal 2020 appropriation does not include deficiencies, planned reversions, or general salary increases. The fiscal 2021 allowance does not include contingent reductions or general salary increases.