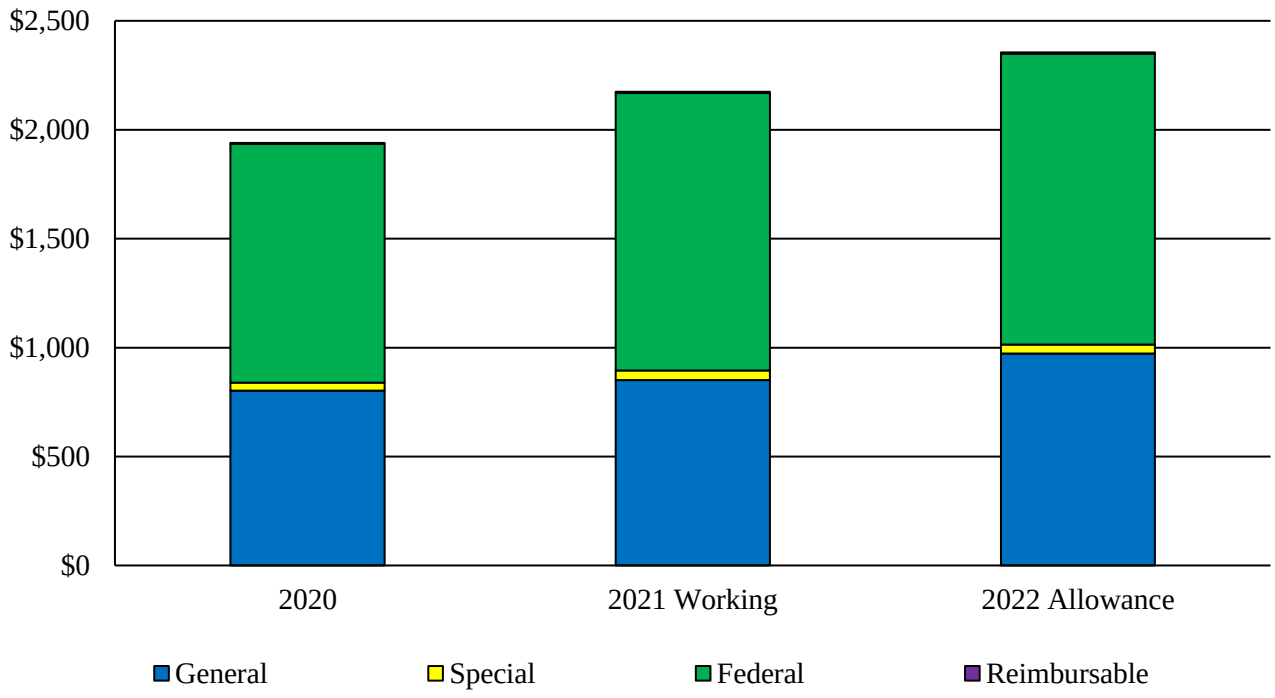
M00L
Behavioral Health Administration
Maryland Department of Health

Executive Summary

The Behavioral Health Administration (BHA) is responsible for the treatment and rehabilitation of the mentally ill, individuals with substance use disorders, 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 Administration budget.

Operating Budget Summary

Fiscal 2022 Budget Increases by $181.6 Million, or 8.4%, to $2.36 Billion
($ in Millions)



Note: The fiscal 2021 appropriation includes deficiencies and general salary increases. The fiscal 2022 allowance includes contingent reductions, annual salary reviews, and annualization of general salary increases.

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- The increase in fiscal 2022 is attributed largely to increases in provider reimbursements for PBHS, driven by increases in enrollment and utilization.

- Contingent reductions in the Governor's Budget Reconciliation and Financing Act of 2021 provide $8 million of general fund relief with fund balance transfers from the Maryland Medical Cannabis Commission ($6 million) and the Board of Licensed Professional Counselors and Therapists ($2 million).

Key Observations

- ***ASO Reconciliation and Continuing Challenges:*** The inability of the new ASO, Optum, to properly process claims at the beginning of calendar 2020 resulted in a 30-week estimated payments period that lead to provider overpayments of $300 million. With a long reconciliation process forthcoming, providers continue to struggle with the functionality of the new ASO.

- ***Pandemic Impacts on Behavioral Health Needs:*** Maryland shows signs of a worsening opioid epidemic in the wake of the COVID-19 pandemic, and early data from behavioral health resources in the State suggest growing mental health needs as well.

Operating Budget Recommended Actions

		Funds
1.	Add language withholding funds from the Maryland Department of Health Office of the Secretary pending a report on the assisted reconciliation process.	
2.	Add language withholding funds pending a report on psychiatric rehabilitation utilization and provider growth in the Public Behavioral Health System and factors contributing to the disproportionate amount of overpayments made.	
3.	Add language restricting the appropriation for M00L01.02 to be expended only in M00L01.02, M00L01.03, or M00Q01.10.	
4.	Contingent language for general fund reduction for corresponding fund balance transfer from the State Board of Examiners of Psychologists.	
5.	Add language restricting the appropriation in M00L01.03 to be expended only in M00L01.02, M00L01.03, or M00Q01.10.	

6.	Add language restricting the appropriation in M00Q01.10 to be expended only in M00L01.02, M00L01.03, or M00Q01.10	
7.	Reduce general funds by $35,000,000 to account for enhanced federal fund match in the Medicaid program.	$ 35,000,000
8.	Ongoing reporting of the functionality of the Administrative Services Organization.	
	Total Reductions	**$ 35,000,000**

Budget Reconciliation and Financing Act Recommended Actions

1. Reduce funding for the fiscal 2020 general fund accrual by $5,000,000.

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 (MH) 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 MH services. For the purposes of reviewing the fiscal 2022 allowance, the funding in M00Q01.10 is reflected in this analysis. BHA's role includes:

- ***MH Services***: Planning and developing a comprehensive system of services of the mentally ill; reviewing and approving local plans and budgets for MH programs; providing consultation to State agencies concerning MH services; establishing personnel standards; and developing, directing, and assisting in the formulation of educational and staff development programs for MH professionals. In performing these activities, the State will continue to work with local core service agencies (CSA) to coordinate and deliver MH services in the local jurisdictions statewide.

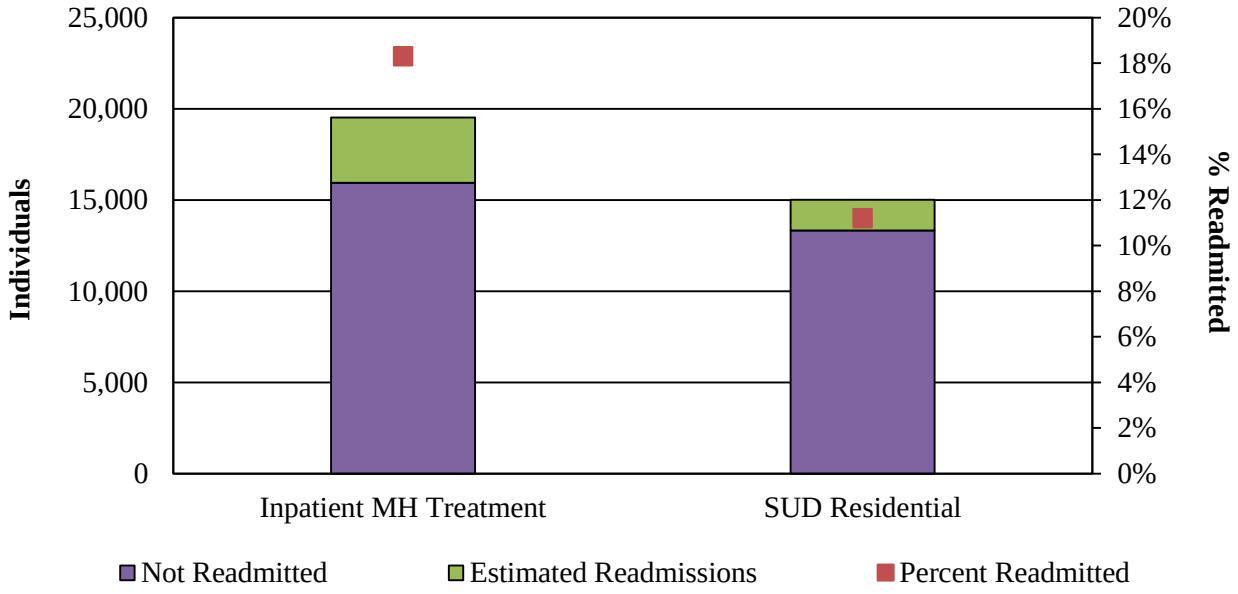
- ***SUD Services***: Developing and operating unified programs for SUD research, training, prevention, and rehabilitation in cooperation with federal, State, local, and private agencies.

Performance Analysis: Managing for Results

1. New Managing for Results for Readmission Rates

In the fiscal 2022 budget, BHA introduces a new Managing for Results (MFR) measure focusing on readmissions for inpatient MH and SUD residential care. The department is now reporting the total number of individuals in the Public Behavioral Health System (PBHS) who are discharged from an inpatient treatment facility following an admission for an MH-related condition and those discharged from SUD residential services. The department is also including the percentage of receipts in each category who are readmitted within 30 days of discharge to the same or a different facility. The Maryland Department of Health (MDH) aims to have readmissions below 18% and 20% in these measures, respectively. From these readmission rates report, the Department of Legislative Services (DLS) has calculated estimates for readmissions within each service category. These values for fiscal 2020 actuals are shown in **Exhibit 1**.

Exhibit 1
New MFR Goals: 30-Day Readmission Rates
Fiscal 2020 Actuals



MFR: Managing for Results
MH: mental health
SUD: substance use disorders

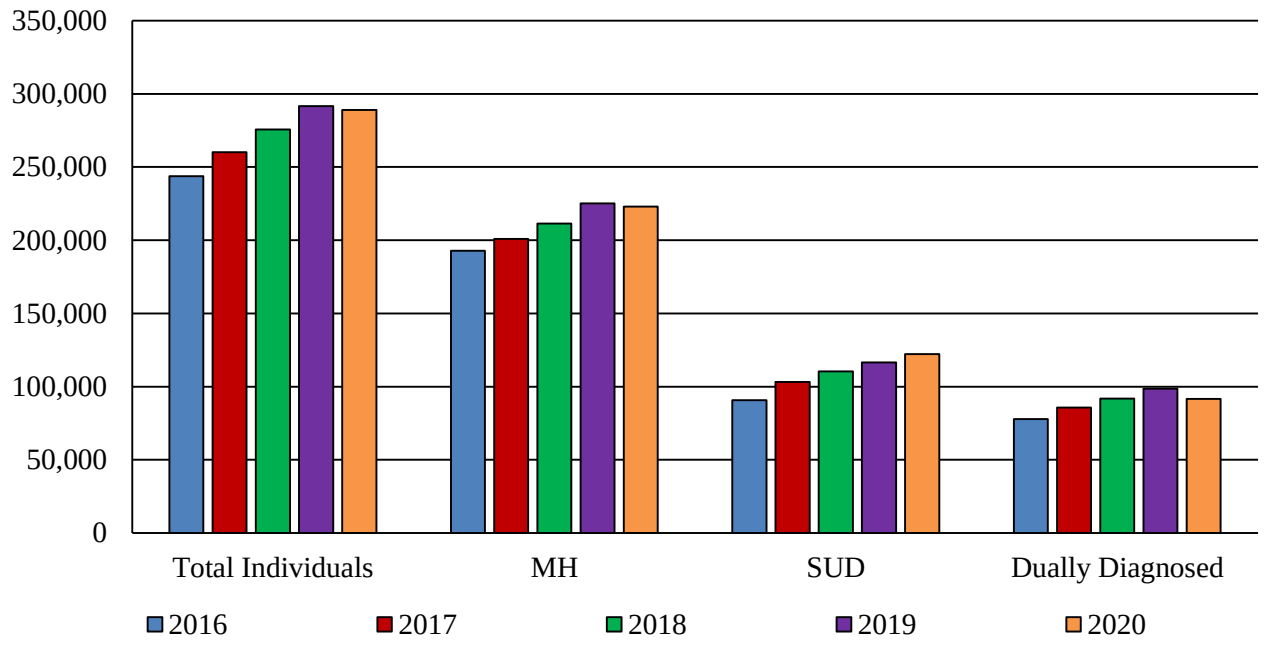
Source: Maryland Department of Health

As shown, the readmission rate for inpatient MH is currently higher than SUD residential services, with SUD residential being well below the 20% rate set by the department.

2. Declining Number of Individuals Served in Fiscal 2020

Data reported by MDH shows the total number of individuals treated in PBHS and the number treated for MH, SUD, or a dual diagnosis. The department reports a declining number of individuals in fiscal 2020 treated in total (2,713 fewer individuals treated in fiscal 2020 than 2019) as well as fewer MH and dually diagnosed individuals (2,312 and 7,098, respectively). This decline is likely driven by COVID-19 reducing utilization across the system rather than a decrease in need. These declines are partially offset by continued increases in individuals receiving SUD treatment (5,683 more individuals treated in fiscal 2020 than 2019). **Exhibit 2** shows the number of individuals treated in PBHS by diagnosis over the last five fiscal years.

Exhibit 2
Individuals in PBHS
Fiscal 2016-2020



MH: mental health
PHBS: Public Behavioral Health System
SUD: substance use disorders

Source: Governor's Budget Books

3. Unavailable Data Due to Administrative Services Organization Transition

Previously used MFR measures, such as satisfaction with treatment, individuals feeling hopeful about their future, and employment status are currently unavailable due to data lapses due to the Administrative Services Organization (ASO) transition.

DLS has expressed concerns around the quality of data being collected and how these measures can be used to judge quality of providers in PBHS. The 2020 *Joint Chairmen's Report* (JCR) included a request for a report on possible performance measures to be included and considered. MDH's response included 16 possible quality measures, all of which required ASO and/or claims data. Further, 4 of the 16 measures listed were noted as still needing to be developed by ASO. DLS has also previously expressed interest in functionality beyond performance measures, including a preferred provider list or scorecard to be used by individuals in PBHS when seeking treatment to be able to identify high-quality

care. The use of quality measures to assess individual providers went unaddressed in the JCR submission. **The department should comment on the timeline for implementing and evaluating performance measures systemwide in PBHS as well as opportunities to determine individual provider quality.**

Fiscal 2020

BHA received $188,575 in reimbursable funds for COVID-19-related redeployments between the Office of the Deputy Secretary ($146,702), Program Direction Office ($22,108), and Community Services ($19,765).

Budget amendments also reorganized aspects of BHA elsewhere in MDH, including moving funding for opioid prevention to the Public Health Administration ($22.2 million in total funds, $18.8 million in federal funds, and $3.1 million in general funds) and $3.8 million in support for the Office of Court Ordered Evaluations and Placements into MDH Administration's budget under the Deputy Secretary of Operations. The BHA Medicaid program also reverted $62 million in general funds at the close of fiscal 2020. This represented an estimated downturn in expenditures of roughly 10%. The remaining funds were encumbered though the fiscal 2020 accrual.

Fiscal 2020 Accrual

At year-end closeout, MDH traditionally accrues general funds to account for claims yet to be submitted or paid that occurred during the prior fiscal year because claims can be submitted up to a year after the service has been delivered. In fiscal 2020, the department accrued $117 million. This was significantly more than traditionally accrued: when closing fiscals 2019, 2018, and 2017, the department accrued $16 million, $19 million, and $17 million, respectively. This higher level of accrual relates to the difficulties associated with the ASO transition detailed below. Through January, MDH had booked $65.4 million in claims against the fiscal 2020 accrual. It is unclear how many claims are still outstanding. In a normal year, at this point, 90% of the outstanding claims and corresponding payments would have been paid. However, given the ongoing claims resolution process, this is not a normal year. Based on claims through February 2021 continuing at their current pace, DLS estimates an accrual surplus of $5 million. **Thus, DLS is recommending a Budget Reconciliation and Financing Act action to recognize a planned reversion of $5 million. This would still provide enough funding to support outstanding claims of over $46 million during the remaining five months.**

Fiscal 2021

Proposed Deficiency

There are five total fiscal 2021 deficiencies included with the budget as introduced. Three pertain to the acceleration of the mandated provider rates for fiscal 2022 to start on January 1, 2021, rather than July 1, 2021. These collectively increase the fiscal 2021 appropriation by

$23.4 million ($11 million in general funds, $0.4 million special funds, and $12 million in federal funds). Another adds $61.6 million of federal funds anticipated from the enhanced federal fund match (federal medical assistance percentage (FMAP)) that the State is allowed to claim for certain Medicaid beneficiaries as authorized under the Families First Coronavirus Response Act (FFCRA). This increase in federal funds is entirely offset by a corresponding general fund reduction. The funding provided through the deficiency appropriation under the enhanced FMAP was anticipated at the time of budget submission, the whole of fiscal 2021. It has since been announced that this enhanced FMAP will continue through at least calendar 2021, or for six months of fiscal 2022. This extension provides general fund relief in the Medicaid component of the BHA budget, discussed further.

The final deficiency included adds federal funds from the second round of State Opioid Response (SOR) funding to the budget, totaling $48.3 million. The total funding provided through these deficiencies is listed in **Exhibit 3**.

Exhibit 3
Fiscal 2021 Deficiencies

	Total Funds	General Funds	Special Funds	Federal Funds	Reimbursable Funds
SOR II	$48,254,709			$48,254,709	
Enhanced Federal Match	0	-$61,595,868		61,595,868	
All Accelerated Rates	23,413,491	10,962,979	$438,681	11,918,528	$93,303
Total Fiscal 2021 Deficiencies Impact	**$71,668,200**	**-$50,632,889**	**$438,681**	**$121,769,105**	**$93,303**

SOR: State Opioid Response

Source: Governor's Budget Books

July 1, 2020 Board of Public Works Reductions

At the July 1, 2020 meeting of the Board of Public Works (BPW), the Governor proposed, and BPW approved, a reduction in Unemployment Insurance across State government. This resulted in a total fund reduction of $35,275 across BHA, $27,182 in general funds.

Additional Fiscal 2021 Funding Not Yet Included in the Budget

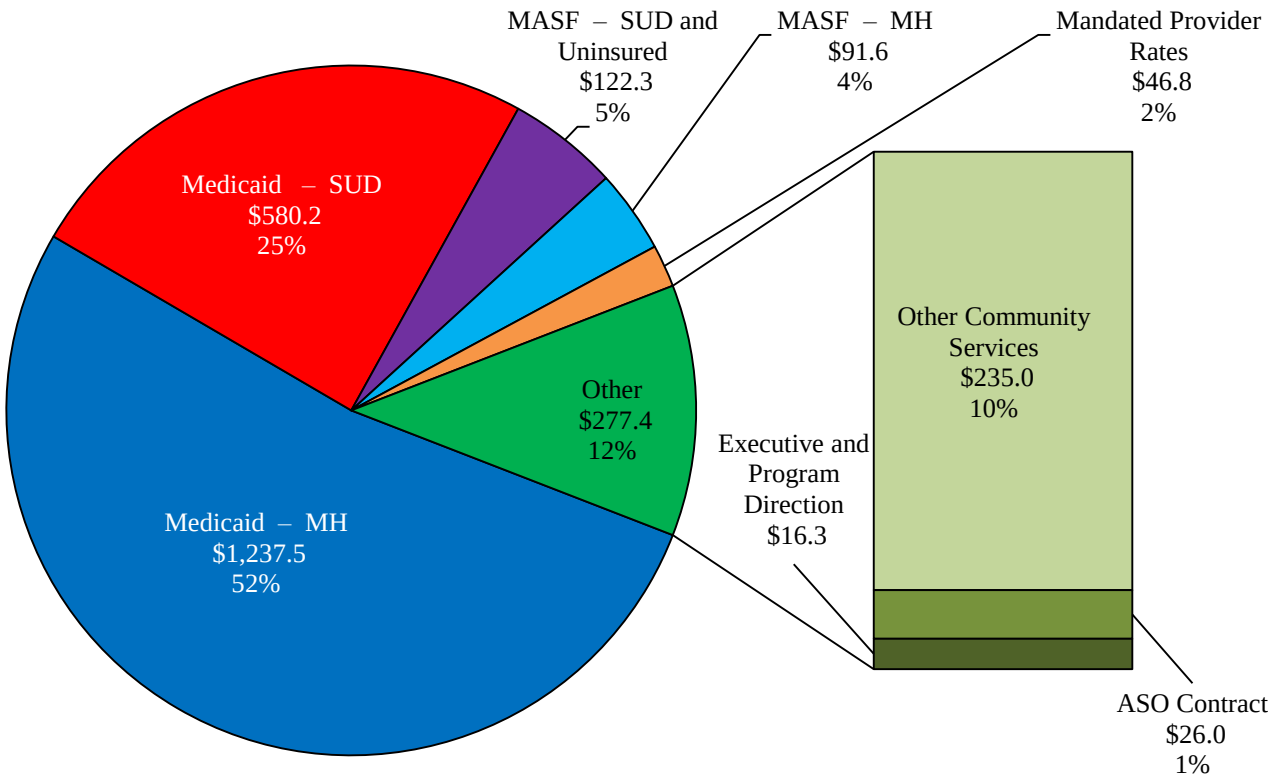
Chapter 39 of 2021, the RELIEF Act, adds $20 million to BHA: $15 million for mobile crisis and walk-in crisis services for MH and SUDs; and $5 million targeted toward 8-507 providers of SUD residential treatment for court-ordered populations. A budget amendment has been processed for fiscal 2021, however, funds are not reflected in this analysis.

The Consolidated Appropriations Act of 2021 passed by the U.S. Congress in December 2020 also provides funding to behavioral health services yet to be reflected in the budget. The legislation includes an estimated $31.9 million to Maryland through the Substance Abuse Prevention and Treatment Block Grant and another $32.6 million through the Community Mental Health Services Block Grant (CMHSBG). At least half of the funding from the CMHSBG funding is to be provided to facilities. MDH advises that this funding for facilities will still pass through the State's budget, and it is awaiting guidance from the federal government on how funding is to be allocated.

Fiscal 2022 Overview of Agency Spending

The Medicaid program and other FFS expenditures represent the overwhelming majority of BHA's budget, shown in **Exhibit 4**. 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 4
Overview of Agency Spending
Fiscal 2022 Allowance
($ in Millions)



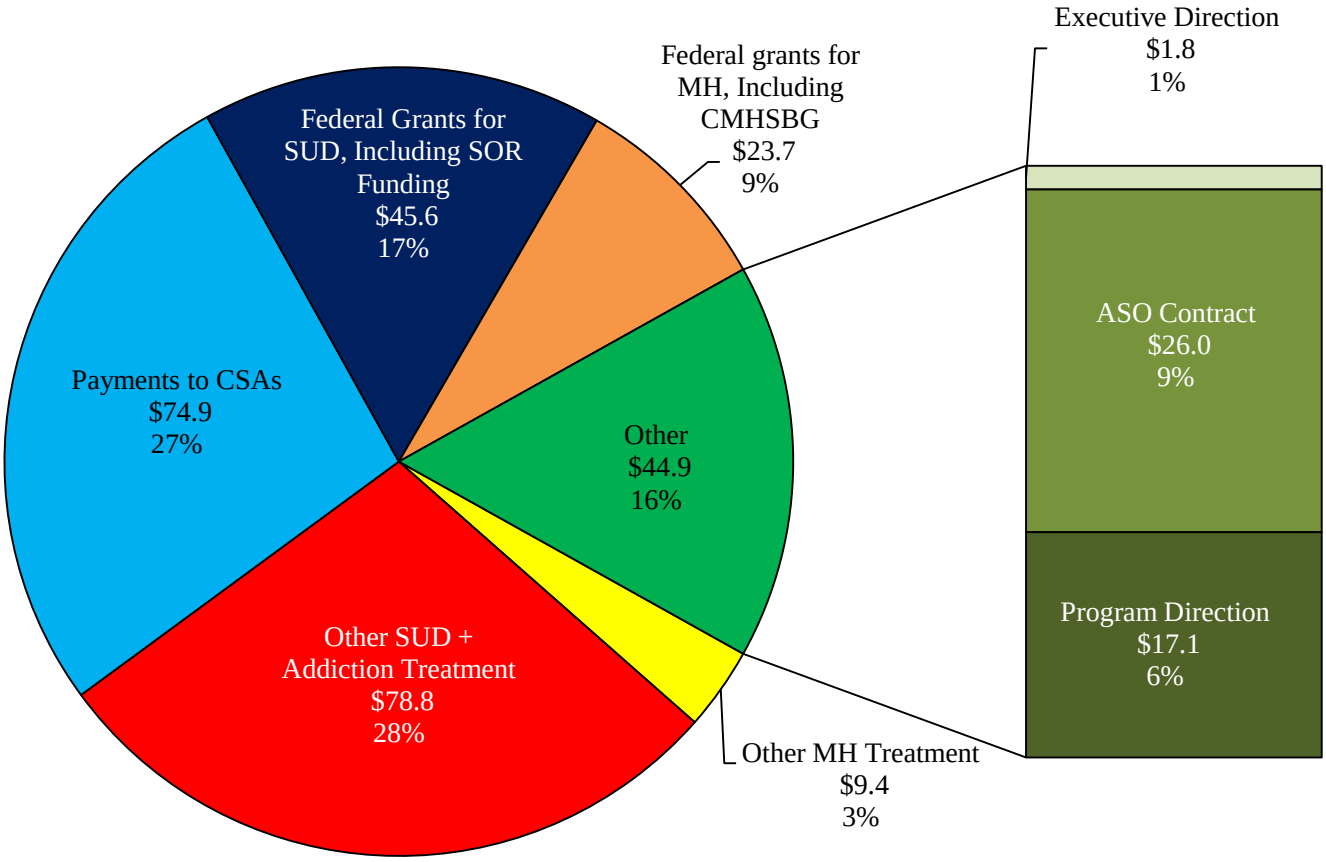
ASO: Administrative Services Organization
MASF: Medical Assistance State Funded
MH: mental health
SUD: substance use disorder

Note: Annual salary reviews and annualization of general salary increases distributed proportionately by personnel expenditures.

Source: Governor's Fiscal 2022 Budget Books

The non-FFS expenditures largely consist of programs for community services to address substance use or MH needs throughout the State, often supported 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 $45 million is administrative in nature, which includes the $26 million ASO contract. The distribution of funding outside of FFS is shown in **Exhibit 5**.

Exhibit 5
Non-FFS Expenditures
Fiscal 2022 Allowance
($ in Millions)



Source: Governor's Fiscal 2022 Budget Books

ASO: Administrative Services Organization
CMHSBG: Community Mental Health Services Block Grant
CSA: core service agency
MH: mental health
SOR: State Opioid Response
SUD: substance use disorder

Note: Annual salary reviews and annualization of general salary increases distributed proportionately by personnel expenditures.

Proposed Budget Change

The $181 million increase in the BHA budget for fiscal 2022 can be nearly entirely accounted for in FFS expenditures. Enrollment and utilization account for a net increase of $162 million, while the provider rates, after offsetting the deficiency to accelerate fiscal 2022 rates, represent a $23 million increase. Together, this $185.5 million increase in FFS expenditures is slightly offset by a net $4.6 million decrease in other grants and programs. Personnel expenditures account for a nearly $800,000 increase, as shown in **Exhibit 6**.

Exhibit 6
Proposed Budget
MDH – Behavioral Health Administration
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2020 Actual	$802,248	$37,720	$1,094,468	$5,680	$1,940,116
Fiscal 2021 Working Appropriation	851,403	43,911	1,273,346	5,575	2,174,234
Fiscal 2022 Allowance	973,604	40,425	1,335,563	6,235	2,355,826
Fiscal 2021-2022 Amount Change	$122,201	-$3,486	$62,217	$660	$181,592
Fiscal 2021-2022 Percent Change	14.4%	-7.9%	4.9%	11.8%	8.4%

Where It Goes:	Change
Personnel Expenses	
Increase in regular employee compensation	$501
Annualization of fiscal 2021 general salary increase	114
Fiscal 2022 ASR for fiscal series positions	98
Retirement contributions	90
Employee and retiree health insurance	83
Other fringe benefit adjustments	58
Turnover adjustments	-143
Fee-for-service	
Increase in enrollment and utilization expenditures	162,031
Provider rate increase of 3.5% for fiscal 2022 partially offset by rates accelerated for six months of fiscal 2021	23,413
Other Changes	
Increase in amount budgeted to core service agencies for non-FFS service provisions	5,170
New funding for the Interagency Hospital Overstays Initiative	5,000
Increase in funding for the Community Mental Health Services Block Grant	1,628

Where It Goes:	**Change**
Decrease in problem gambling fund expenditures (special funds)	-744
Fiscal 2021 one-time funding for grants through the supplemental budget	-1,950
Fiscal 2021 deficiency for first round of SOR II funding, partially offset by second round of SOR II funding in fiscal 2022	-13,667
Other changes	-88
Total	**$181,592**

ASR: annual salary review
FFS: fee-for-service
MDH: Maryland Department of Health
SOR: State Opioid Response

Note: Numbers may not sum to total due to rounding. The fiscal 2021 appropriation includes deficiencies and general salary increases. The fiscal 2022 allowance includes contingent reductions, ASRs, and annualization of general salary increases.

FFS Provider Reimbursements and General Fund Adequacy

Forecasting the spending on provider reimbursements has proven especially challenging for fiscal 2021 and 2022 due to the unreliability of claims data provided to DLS from MDH due to the problems with the transition to the new ASO. Specific challenges with ASO are discussed at much greater length below. The following discussion focuses largely on spending trends as presented in the budget and general fund adequacy for fiscals 2021 and 2022.

Fiscal 2021 Adequacy

The total funds available for provider reimbursements for behavioral health in fiscal 2021 are nearly $1.89 billion, between support for Medicaid enrollees, Medicaid-ineligible services for Medicaid enrollees (Medical Assistance State Funded (MASF)) and the uninsured. General funds, after the deficiency for the enhanced FMAP total $703 million: $525 million in Medicaid and the remaining $178 million for MASF. Since the January 1, 2020 ASO transition, DLS and the Department of Budget and Management (DBM) have been unable or hesitant to rely on recent claims data to forecast the total spending across the system. Focusing on the Medicaid program, **Exhibit 7** shows the annualized values for the total spending before the new ASO and the most recent report submitted by the department. These annualized values are compared to funds available in fiscal 2021.

Exhibit 7
Behavioral Health Medicaid Expenditures

		Total Annualized Spending
Prior ASO:	December 2019 Report (Fiscal 2020)	$1,556,844,788
New ASO:	January 2021 Report (Fiscal 2021)	1,362,343,609
Fiscal 2021 Allowance		1,671,999,941

ASO: Administrative Services Organization

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

Of course, the ASO transition is not the only thing that changed between the two claims reports referenced above. The COVID-19 pandemic likely had impacts on service utilization; providers have received a rate increase, and Medicaid enrollment has grown significantly, all of which have impacts on spending. Based on the most recent claims data, expenditures would be 10% lower than fiscal 2020, or nearly 15% after considering rate increases. This data would suggest the ability to reduce funding in fiscal 2021 by nearly 25%. While DLS believes that it is likely that the fiscal 2021 budget is overfunded, the data issues make any estimate uncertain. DLS is assuming general fund adequacy for fiscal 2021 but is unable to estimate the amount of surplus in fiscal 2021. Budget bill language included in the fiscal 2021 budget prohibits the department from using funding for behavioral health services for anything other than behavioral health, and any surplus at the end of fiscal 2021 would revert to the General Fund.

Fiscal 2022 Adequacy

In fiscal 2022, total funding for provider reimbursements increases by $185.5 million, to a total fund amount of $2.075 billion. In the Medicaid program, this represents an 11% increase in total expenditures. DLS also anticipates an increase in expenditures in fiscal 2022, given a rebound of service utilization in hopefully post-pandemic service environment and higher enrollment. In fact, DLS projects a higher total spend than DBM, shown in **Exhibit 8**.

Exhibit 8
Fiscal 2022 Spending Projections

	Allowance	DLS Projection	DLS Projection with EFMAP
General Funds	$630,483,891	$632,715,898	$595,505,354
Special Funds/Federal Funds	1,222,661,633	1,268,532,717	1,305,743,261
Total Funds	**$1,853,145,524**	**$1,901,248,615**	**$1,901,248,615**

DLS: Department of Legislative Services
EFMAP: enhanced federal medical assistance percentage

Source: Fiscal 2022 Budget Books, DLS

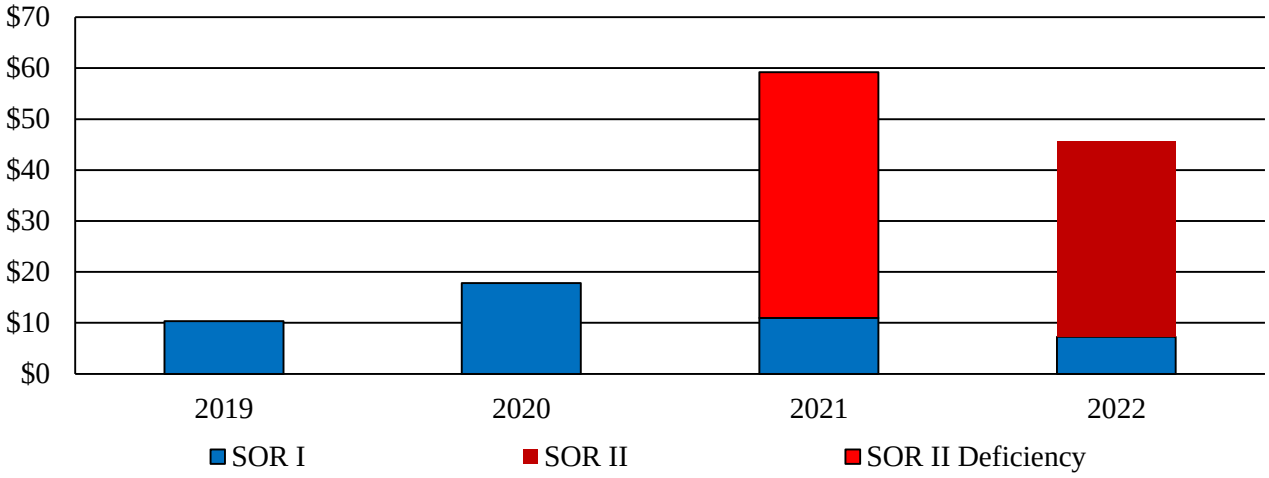
As shown, DLS would actually project a slight general fund deficiency in fiscal 2022 with increased expenditures forecasted. However, one of the reasons for DLS' spending being slightly higher than the Governor's is the recent extension of the enhanced FMAP under the declaration of a public health emergency as authorized by FFCRA through calendar 2021. This extension revised DLS's enrollment estimates up slightly in fiscal 2022 (as redeterminations are not conducted during the public health emergency), driving the difference in spending between DLS' forecast and that assumed in the budget, which did not assume the enhanced FMAP through calendar 2021. This results in general fund savings of an estimated $35 million in fiscal 2022, even after accounting for DLS' higher spending forecast. **Given the availability of the enhanced FMAP for six months of fiscal 2022, DLS is recommending reducing the general funds in the Medicaid Behavioral Health Provider Reimbursements by $35,000,000.**

Other Budget Changes

SOR Funding

Another significant change in the fiscal 2022 allowance is the reduction in SOR grant funding. The federal government has authorized two rounds of funding under the SOR grant, with the first use of SOR funding in the State budget occurring in fiscal 2019. MDH has stretched the first round of SOR funding (SOR I) into fiscal 2022 and moved much of the funding associated with prevention efforts to the Prevention and Health Promotion Administration (PHPA). The budget recognizes the first installment of the second round of SOR grants (SOR II) as a fiscal 2021 deficiency, totaling $48 million. The second installment of SOR II appears in the BHA budget for fiscal 2022 but, due to a decrease in SOR I funding available and more SOR II funding sent to PHPA in fiscal 2022, total available funding in BHA is lower than in fiscal 2021. **Exhibit 9** shows the outlay of SOR funds in BHA's budget, differentiating between the first and second round of SOR funding.

Exhibit 9
SOR Funding in BHA
Fiscal 2019-2022
($ in Millions)



BHA: Behavioral Health Administration
SOR: State Opioid Response

Source: Governor's fiscal 2022-2020 budget books

Much like the first round of SOR funding, which ultimately stretched into multiple fiscal years, DLS anticipates the department doing the same with the second round of SOR funding. DLS has been advised by the department that with an even spending of the SOR II funds available to BHA, the federal funds would ultimately stretch into fiscal 2023. Planned uses for SOR II funds are listed in **Appendix 2**, which includes several programs started with the initial round of SOR funding. Between SOR I and SOR II, Maryland will receive over $167 million to combat the Opioid Crisis. The current state of the Opioid crisis in Maryland is discussed in the Issues section of this analysis.

Contingent Reductions in Budget Reconciliation and Financing Act Provisions

The Governor's fiscal 2022 budget as introduced includes two contingent reductions to provider reimbursements in the Community Services program totaling $8 million. These funds are to be backfilled with surplus special fund balances in the Maryland Medical Cannabis Commission ($6 million) and Licensed Professional Counselors and Therapists ($2 million). In the Health Professional Boards and Commissions analysis, DLS proposed an additional fund balance transfer to BHA, $700,000 from the State Board of Examiners of Psychologists. **DLS recommends an additional contingent general fund reduction of $700,000 to BHA Community Services to correspond to the prior DLS recommendation of a fiscal 2022 fund balance transfer from the State Board of Examiners of Psychologists.**

New Funding to Address Hospital Overstays for Psychiatric Patients

The fiscal 2022 allowance also includes $5 million for a new joint initiative with the Department of Human Services (DHS) to address overstays of youth in inpatient psychiatric beds. BHA indicates that the funds are expected to be used for a potential grant program under which one or more nonprofit Residential Treatment Centers (RTC) would receive gap funding to support enhanced provider services above Medicaid RTC rates to assist with higher acuity patients. The awards would be based on the number of patients/patient days of service. MDH has released a request for expression of intent (REOI) to solicit proposals from providers in line with this grant program. Although the departments were previously unable to determine the number of beds that would be needed to address hospital overstay issues, in the REOI, MDH anticipated an initial need for 18 beds to admit and treat adolescents waiting in hospitals for placement but potentially an estimated 25 patients annually. This REOI would cover youth in a broad range of diagnostic and psychosocial/behavioral categories. To accept the grant award, a provider would have to accept patients that align with the enhanced services model. The larger issue of hospital overstays for youth is addressed in depth in the DHS – Social Services Administration analysis.

Personnel Data

	FY 20 Actual	FY 21 Working	FY 22 Allowance	FY 21-22 Change
Regular Positions	136.80	134.80	134.80	0.00
Contractual FTEs	34.49	45.64	56.05	10.41
Total Personnel	**171.29**	**180.44**	**190.85**	**10.41**
Vacancy Data: Regular Positions				
Turnover and Necessary Vacancies, Excluding New Positions		14.68	10.89%	
Positions and Percentage Vacant as of 12/31/20		14.50	10.76%	
Vacancies Below Turnover		0.18	0.13%	

- Additional contractual support provided to BHA in fiscal 2022 for program assistance under the SOR II grant, adding 13 contractual full-time equivalents. This increase is slightly offset by reductions in contractual employees elsewhere in the community services programs.

Issues

1. Estimated Payments Reconciliation and Ongoing Challenges with the New ASO

On July 24, 2019, 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 incumbent 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. 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 would be processing estimated payments to providers based on average weekly payments in calendar 2019.

These estimated payments continued through August 3, 2020, which was predominately during the COVID-19 pandemic. During the nearly 30 weeks that it took Optum to accurately and timely process claims, the department reported that it made $1.06 billion in estimated payments to providers. DLS estimates that nearly 80% of the total estimated payments were distributed during the pandemic.

While, at the time, the estimated payments did provide some stability in revenues for providers, the estimated payments ultimately need to be matched with actual services provided to be able to claim the appropriate federal fund match. Throughout the estimated payments period, providers were still submitting claims for services provided. The 2020 JCR requested a report on the ASO transition, the estimated payments processed, and the future reconciliation of these payments. In this report submitted on November 16, 2020, the department reported that $894 million of claims submitted throughout the entire estimated claims period had been authorized, meaning that on net, MDH has overpaid providers by $163 million during the nearly 30-week estimated payments window. **While the $163 million in the JCR Report was a net value of overpayments offset by underpayments, they are being handled on two entirely separate tracks by the department: underpayments added back to providers and for fiscal 2020 services, booked against the accrual, and overpayments (which are now estimated by MDH at $300 million) ultimately being addressed through the reconciliation process.**

The department notes that it will ultimately enter a reconciliation and recoupment process with providers to finalize the amount of overpayment and provide avenues for the providers to pay back the funds distributed in excess of the approved claims over the period.

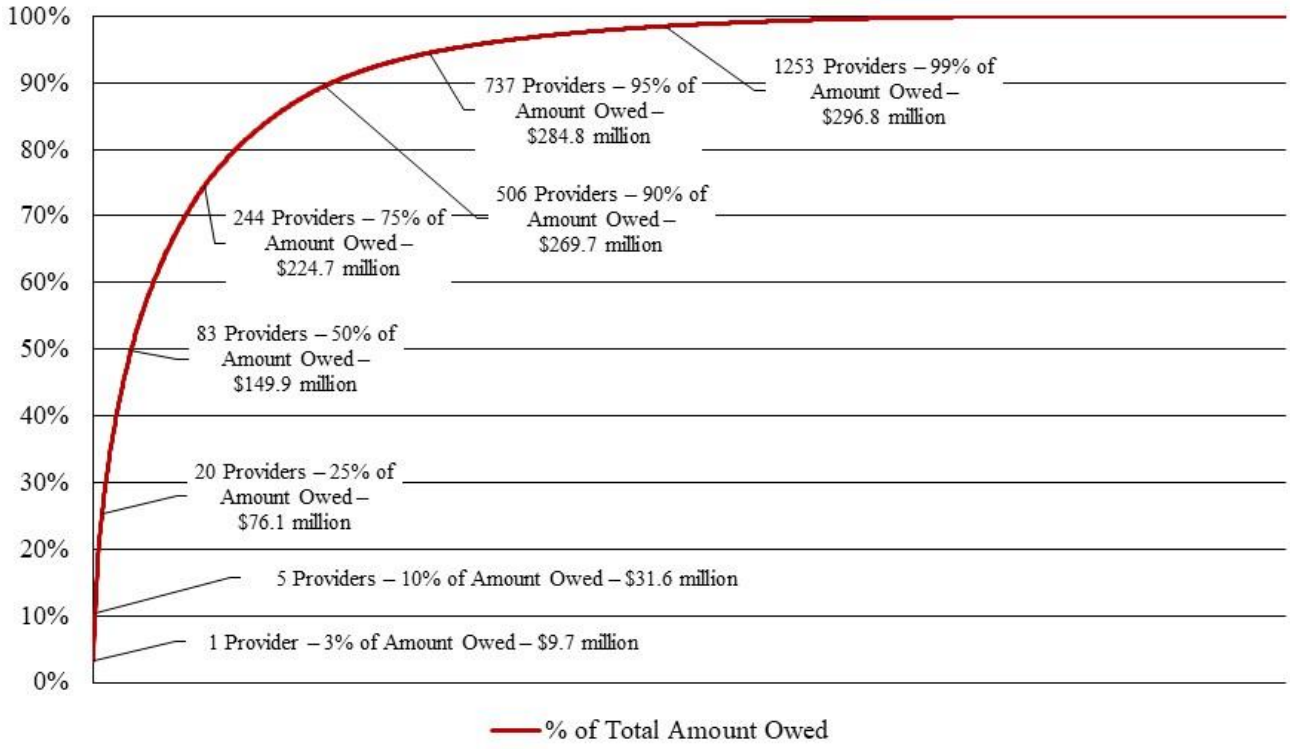
DLS's concerns around the new ASO are multiple – including the share of underpayments reconciled at present, the distributional impact of overpayments throughout the PBHS, data reliability on the ASO's accounting of overpayments, and continued reported problems with the ASO claims system.

Distribution of Overpayments by Provider Size

In efforts to understand the distributional impact of overpayments during this estimated payments period, and by proxy the extent to which the pandemic impacted utilization across provider types, DLS received additional data from MDH on the estimated payments and overpaid amounts. This data, current as of February 1, 2021, contains 2,606 individual observations, understood to be providers as grouped by tax identification. Each observation contains which provider type(s) are associated with the observation (*e.g.*, a single provider could be a psychiatric rehabilitation program (PRP) and an outpatient mental health clinic, and it is not possible to distinguish payments between those two types of services), the total amount that observation received in estimated payments, and the amount that has been adjudicated to offset the estimated payments. From there, ASO has been able to calculate an outstanding balance amount. In the dataset used for this analysis, the outstanding balance across PBHS totals $300 million, which is $75 million more than the corresponding amount reported in the November JCR report.

The dataset contains nearly 60 different provider types. The discussion below will focus on provider types of interest, either due to larger dollar amounts owed or paid, or scope of the particular provider types within PBHS. As shown in **Exhibit 10**, based on the data on the amount owed by individual providers, 20 providers owe 25% of the outstanding balance and reflect a variety of services that are provided by certain larger providers compared to single-service providers, which account for the majority of providers (72%) but only 33% of estimated overpayments..

Exhibit 10
Distribution of Amounts Owed, Entire PBHS
(Cumulative Amounts Labeled)

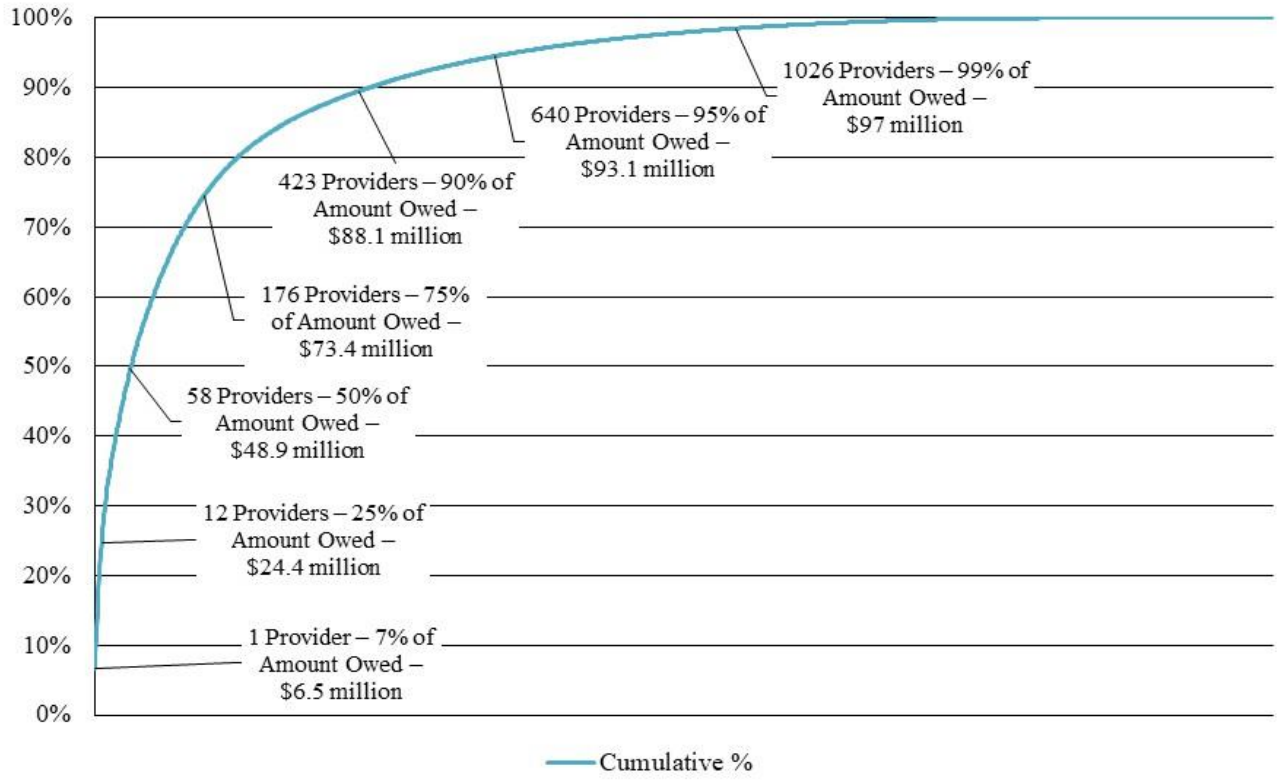


Source: Maryland Department of Health; Department of Legislative Services

Distribution of Overpayments by Provider Type

While large providers likely bear a disproportionate burden of the overpayments, one-third of the amount projected to be owed is by providers with only one provider type associated (henceforth referred to as single providers). These single providers collectively owe MDH $98 million, varying from $6.5 million to virtually nothing. The distribution of single providers by provider type, amounts received in estimated payments, and owed collectively across the provider types are listed in **Appendix 3**. The amount owed by these single providers follows a similar distribution pattern as the entire sample, shown in **Exhibit 11**.

Exhibit 11
Distribution of Amount Owed, Individual Providers
(Cumulative Amounts Labeled)



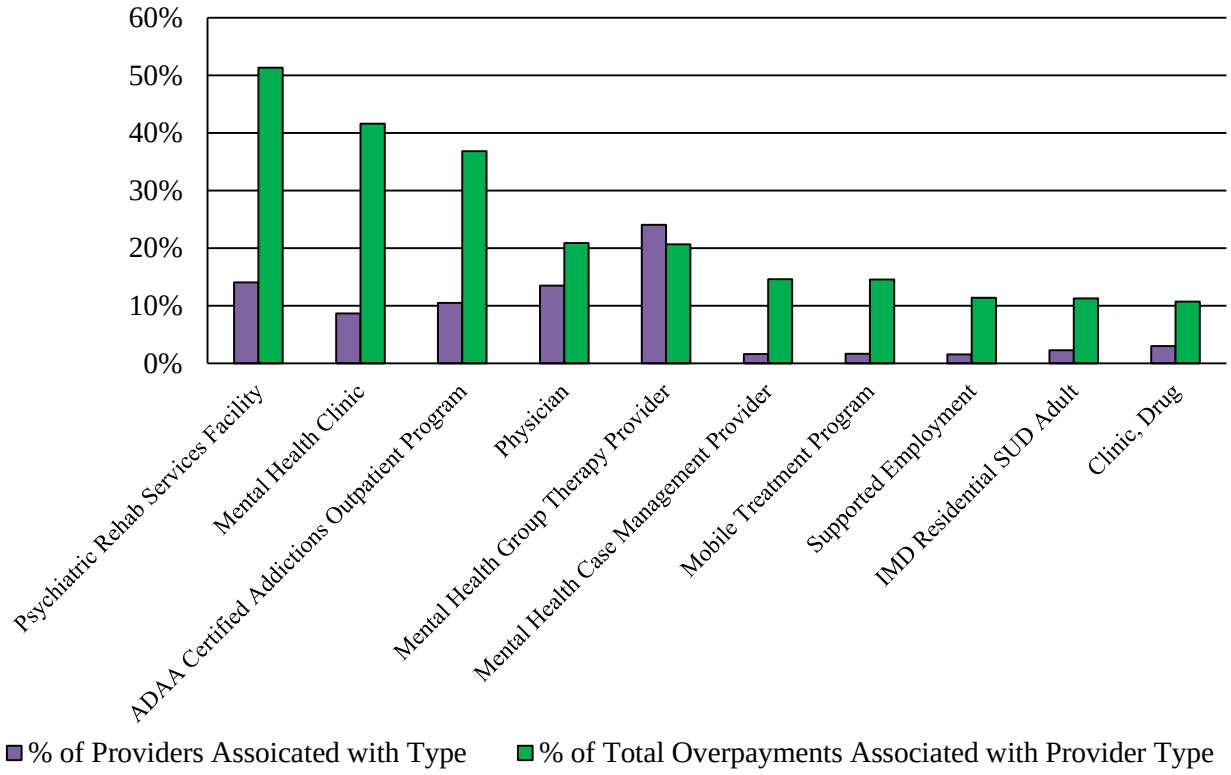
Source: Maryland Department of Health; Department of Legislative Services

Given that the estimated payments were distributed based on calendar 2019 services, and DLS anticipates that service utilization decreased during the estimated payments period due to COVID-19, providers and provider types who owe MDH more are those more likely to be impacted by the pandemic creating barriers to service provision (*e.g.*, limiting number of individuals able to be safely treated in a residential facility) and challenges in access (*e.g.*, clients unable to have reliable access to technology needed for telehealth visits). As these estimates payments are resolved, other factors such as improved utilization review could also have an impact on actual utilization, but the extent of this is at present unknown.

Of the 58 single providers that owe the most to MDH, PRPs represent 16 of them, and PRP providers collectively across all single providers owe the most of any provider type, nearly $20 million. This is nearly twice what the next group of providers (Drug Clinics) collectively owe ($10.3 million).

When expanding the scope beyond single providers, observations that include PRPs are associated with over half of the total amount owed by PBHS, while only consisting of 14% of total observations. **Exhibit 12** shows the top 10 provider types, in amounts owed to MDH. It is important to note that because, as stated above, an individual observation can include multiple provider types, and the relative overpayment cannot be precisely ascribed to a particular type of service. However, at the most general level, it seems to confirm the data from Exhibit 11 that PRPs are likely the providers that owe the most funding.

Exhibit 12
Provider Types with Highest Amount Owed



ADAA: Alcohol and Drug Abuse Administration
IMD: Institutions for Mental Disease

Note: Amounts owed by providers with multiple provider types associated are counted under all associated provider types. As a result dollar counts are duplicative.

Source: Maryland Department of Health; Department of Legislative Services

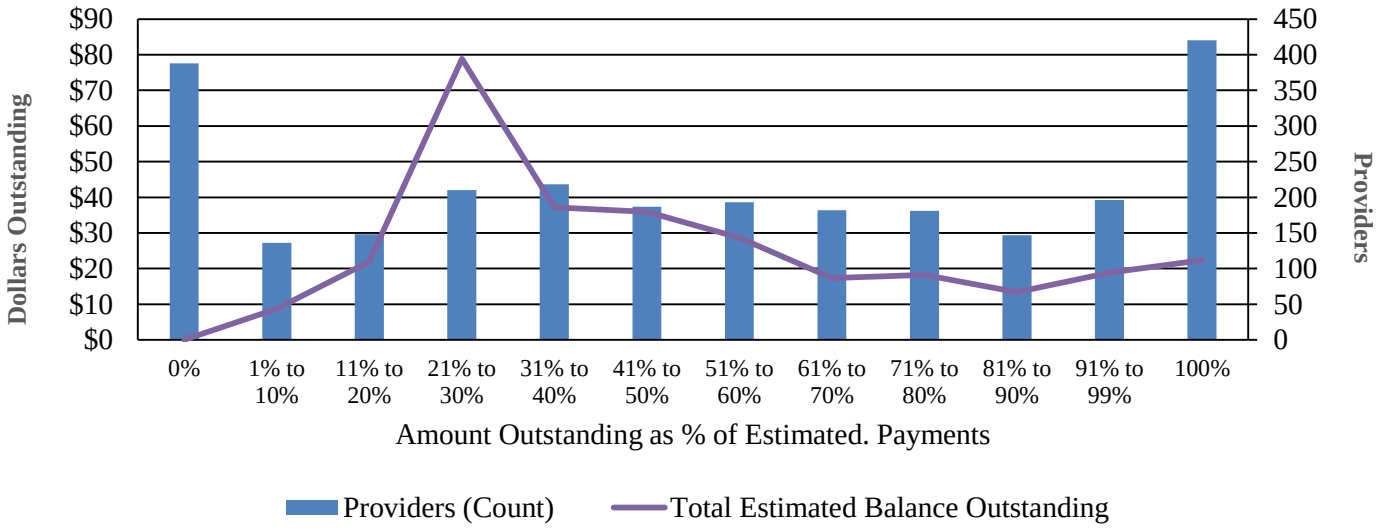
As mentioned above, the data provided to DLS has observations that associated multiple provider types with an individual provider, meaning that it is not possible to distinguish payments between those two types of services. Therefore, amounts exhibited above sum to over 100%, because dollars associated with a provider who has multiple provider types are counted with both types listed.

In the instance of PRPs, DLS has had longstanding concerns about the level of service utilization with these providers. PRPs were also frequently associated with the provider types who owe second and third most to the department. Recent growth in PRP expenditures were such a significant concern during the 2020 legislative session that budget bill language restricted funds pending a report on the increase in PRP expenditures. This report has yet to be submitted. **Considering PRPs' prevalence in amounts owed and the still outstanding previously requested report on PRP expenditures, DLS recommends adding language restricting funding pending a report on PRPs, including any steps that have already been taken by the department or the new ASO to address preexisting concerns.**

Distribution of Providers by Amounts Owed

To consider how providers have been able to offset the amounts of estimated payments received by providers, DLS has calculated the share of balance outstanding (overpayments to providers) as a percentage of estimated payments. While this calculation overstates the amount owed by providers as it does not include offsetting amounts owed to providers by the State, it is nonetheless informative in terms of the where the largest concentration of overpayments may lie. Under this calculation, providers identified as 0% are those who have been able to match up claims made during the estimated payment period exactly with estimated payments received. Conversely, providers identified as 100% have not submitted any claims during the estimated payments and owe the entire value of estimated payments to the department. The number of providers within a given range of amount still outstanding is shown in **Exhibit 13,** as well as the total amounts still owed by that grouping of providers.

Exhibit 13
Distribution of Providers by Amounts Owed
($ in Millions)



Source: Maryland Department of Health; Department of Legislative Services

As shown, roughly the same number of providers have been able to account for their entire estimated payment balance (388) as those providers who have not been able to submit any claims against the estimated payments (420). While the largest number of providers still owe the entire estimated payment amount, this only totals to $22.3 million of the outstanding balance. The group with the most dollars outstanding as overpayments are those with 21-30% of outstanding payments that have not been matched up against claims. These 210 providers collectively owe $78.8 million against $305 million received in estimated payments. These providers are often larger providers who individually received up to $45 million in estimated payments. Of these 210 providers, 54 received over $1 million in estimated payments and 8 over $10 million. PRPs in this group were associated with 59 providers, 28% of the group, who collectively owe $55 million, 67%, of the $78.8 million in estimated payments received. Again, this is consistent with the other analyses of what type of provider has the most overpayments.

Reconciliation

The department is currently undertaking a reconciliation process with providers to come to agreement on the final amount owed by each provider. This process began in December 2020 and is slated to continue for six months to May 2021. During this period, the department will furnish providers with submitted and rejected claims data to come to agreements on a final amount owed by individual providers. DLS is concerned with the administrative burden placed on even the savviest billing departments, who also likely have the most total dollars outstanding. Further, as previously mentioned, the total sum of overpayments considered by DLS in this analysis is $300 million, $75 million more than what was denoted in the November JCR. **Considering the moving target on total overpayments and the various factors that contribute to overpayments, DLS is recommending budget bill language restricting $1,000,000 in general funds from the MDH Secretary's Budget until a report is submitted detailing the accounting processes used by the department in the assisted reconciliation process. This report should include a detailed list of reports furnished to providers to assist reconciliation, the processes used to verify that rejected claims were done so accurately, and any additional accounting assistance the department has used, or offered to providers.**

Ongoing Challenges with the Functionality of ASO

Compounding the difficulties faced by the providers with the assisted reconciliation process are reports of ongoing difficulties with ASO since the end of estimated payments. These include certain reports being unavailable to providers to assist in revenue management, wrong providers being paid for certain claims, and an inability to process insurance retroactively. In many instances, this leads to improper amounts being distributed to providers, which reportedly will be reconciled in a process separate from the reconciliation discussed above regarding estimated payments. Further, these challenges appear to disproportionately impact the currently uninsured individuals seeking care due to concerns with future payments under Medicaid coverage, leaving fewer options for these vulnerable individuals. MDH recently announced three months of fines of $80,000 against the contractor, in part due to ongoing challenges with the functionality of the current system.

Given reported ongoing problems with the new ASO since the end of estimated payments, DLS is recommending committee narrative on the progress of the new ASO's functionality. This report should be a series of reports, the first of which, in consultation with the providers in PBHS identifies which reports and features are required for a fully functional ASO. Subsequent reports should identify progress made on each of these features, identify what is not fully functional, the steps needed to reach functionality, and the estimated completion date. The first of these reports should be submitted by July 1, 2021, and subsequent reports shall be submitted quarterly through fiscal 2022, or until full functionality is achieved if earlier.

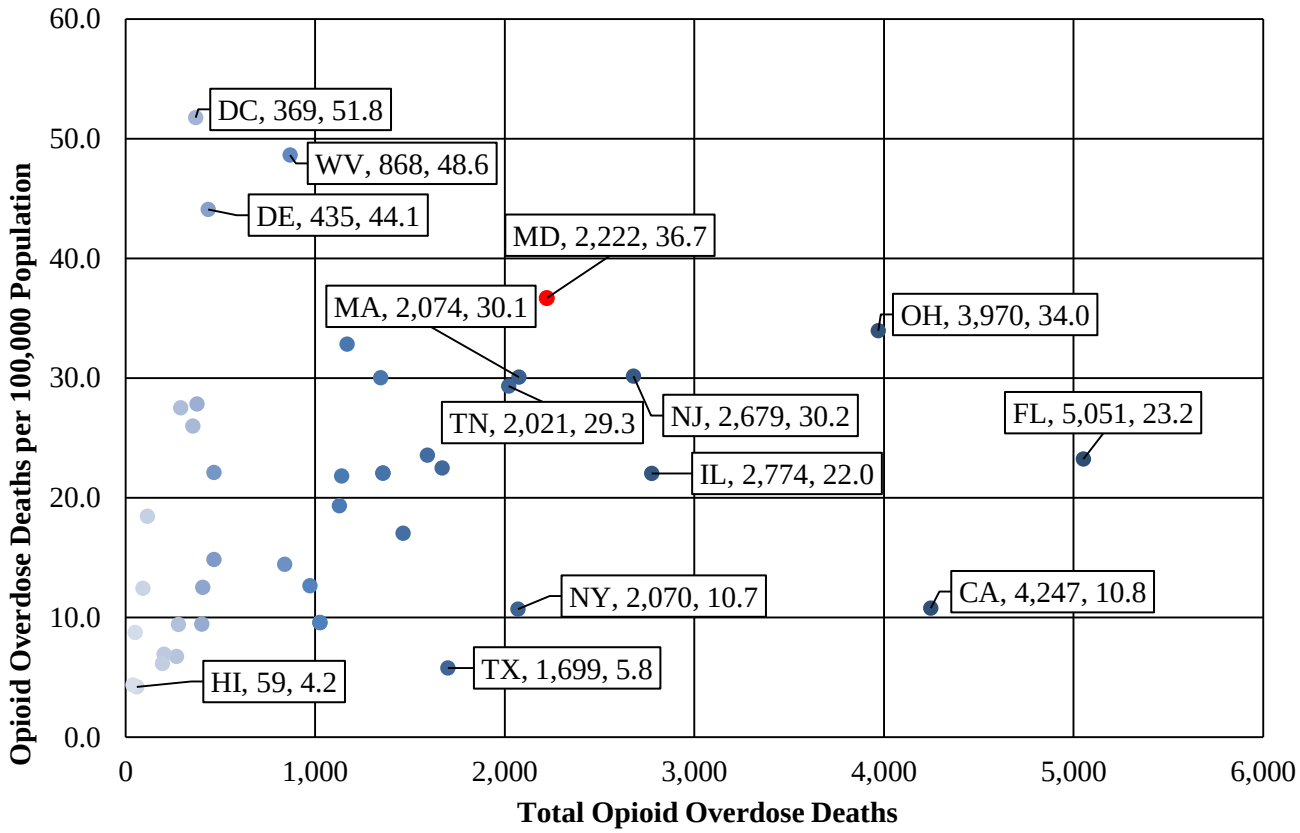
2. Behavioral Health Impact of COVID-19 Pandemic

Many researchers have posited that the COVID-19 pandemic could exacerbate already troubling national behavioral health trends due to increased economic stress, social isolation, and decreased access to mental health services and other community supports. Although the full impact of the pandemic on Marylanders' behavioral health is unknown, early trends such as overdose data and call volume to mental health resources indicate significant behavioral health issues.

Overdose Deaths Increasing Amidst the Pandemic

Maryland continues to be among the states hit hardest by the opioid epidemic. U.S. Centers for Disease Control and Prevention (CDC) data for the 12-months ending June 2020, the most recent data available, finds Maryland with the fourth highest opioid fatalities on a per population basis at 36.7 deaths per 100,000 residents. Maryland only trails neighboring jurisdictions: Washington, DC (51.8 deaths per 100,000 residents); West Virginia (48.6); and Delaware (44.1). The CDC reporting for this period found that Maryland had more total opioid-related fatalities than much larger states, including New York and Texas. This data is available through the National Vital Statistic System Rapid Release counts of overdoses, and the CDC cautions that the data is provisional and may ultimately undercount the total drug fatalities for a given period. The most recent 12-month ended period used for this analysis also shows the highest value for opioid-related overdose deaths nationwide. As discussed below, this national trend is likely exacerbated by the COVID-19 pandemic. **Exhibit 14** shows the 41 states with opioid-related overdose data in the 12 months ending June 2020. Maryland ranked sixth highest in total overdose fatalities and fourth highest in the rate of fatalities. Ohio, New Jersey, Massachusetts, and Tennessee also rank in the top ten for both measures.

Exhibit 14
Per Population and Total Opioid Deaths by State
12 Months Ending June 2020
(Total/Rate)

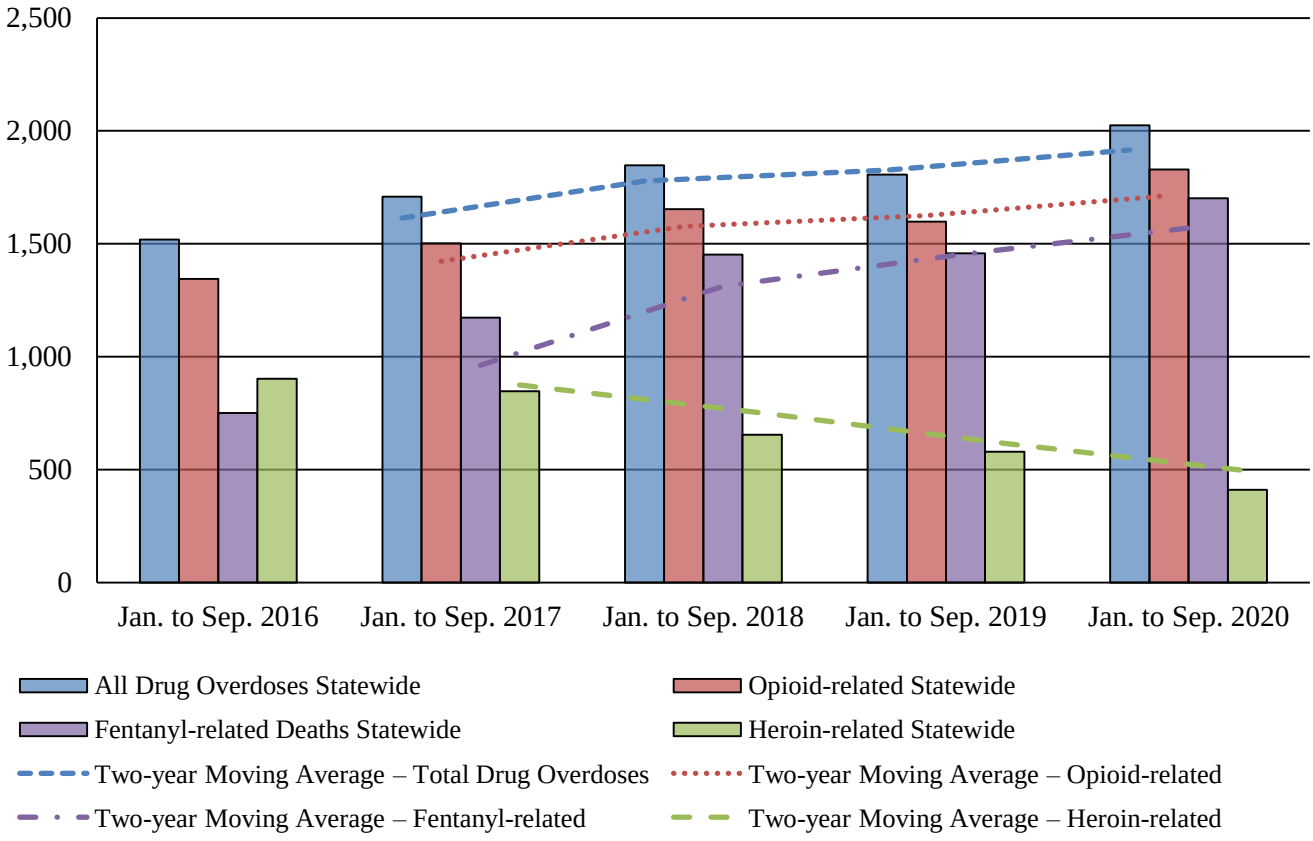


CA: California
DC: Washington, DC
DE: Delaware
FL: Florida
HI: Hawaii
IL: Illinois
MA: Massachusetts
MD: Maryland
NJ: New Jersey
NY: New York
OH: Ohio
TN: Tennessee
TX: Texas
WV: West Virginia

Source: Centers for Disease Control and Prevention; US Census Bureau; Department of Legislative Services

Using Maryland-specific data produced by MDH and the Opioid Operational Command Center (OOCC), the State showed some improvements in 2019, when overdose fatalities were lower than the previous year for the first time since reporting became available in 2010. Nevertheless, 2019 was still the second highest year on record for overdose fatalities in the State after 2018. Early reporting from the first three quarters of calendar 2020 suggests that 2020 will ultimately increase over calendar 2019 and may even surpass 2018 levels. Data from OOCC for the first nine months of the last five calendar years are shown in **Exhibit 15**.

Exhibit 15
January to September Overdose Deaths, Statewide
Calendar 2016-2020 (January through September of Each Year)

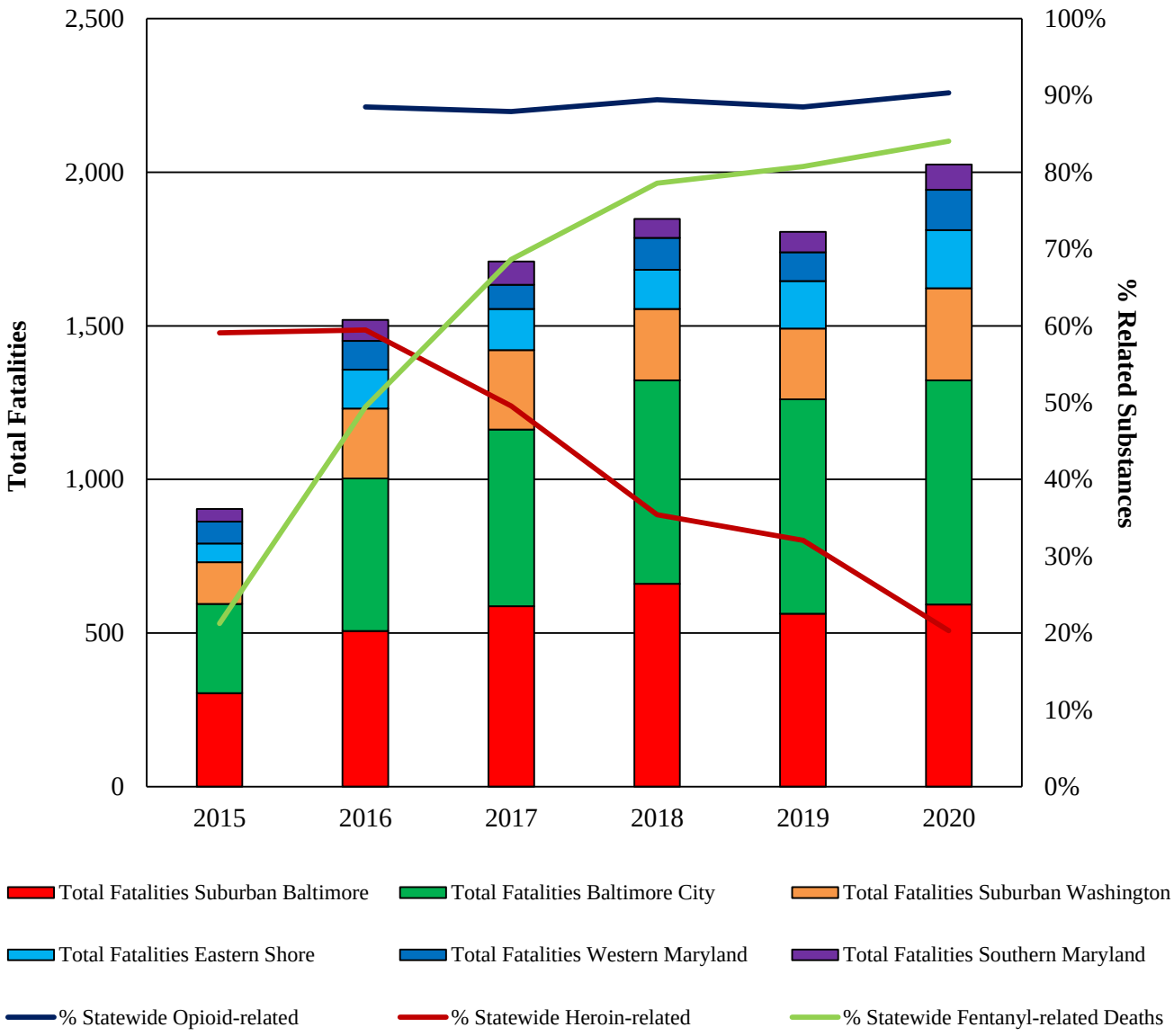


Note: Opioid-, Fentanyl-, and Heroin-related counts are not mutually exclusive.

Source: Opioid Operational Command Center; Department of Legislative Services

As shown, declines in heroin-related fatalities are continuing into calendar 2020, but this is more than offset by increases in fentanyl-related deaths. Additionally, the current number of all overdoses, as well as fentanyl- and opioid-related overdoses, is exceeding the levels shown during this same period for 2018. Opioid-related overdoses make up 90% of all overdoses seen thus far in the State for 2020, and fentanyl is involved in 85% of the State's overdoses. **Exhibit 16** shows these overdoses over this period by region in Maryland and the statewide share of substances involved for each period reported.

Exhibit 16
January to September Overdose Deaths, by Region and Related Substances
Calendar 2016-2020 (January through September of Each Year)



Note: Eastern Shore (Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester counties); Southern Maryland (Calvert, Charles, and St. Mary's counties); Suburban Baltimore (Anne Arundel, Baltimore, Carroll, Harford, and Howard counties); Suburban Washington (Frederick, Montgomery, and Prince George's counties); Western Maryland (Allegany, Garrett, and Washington counties)

Source: Opioid Operational Command Center; Department of Legislative Services

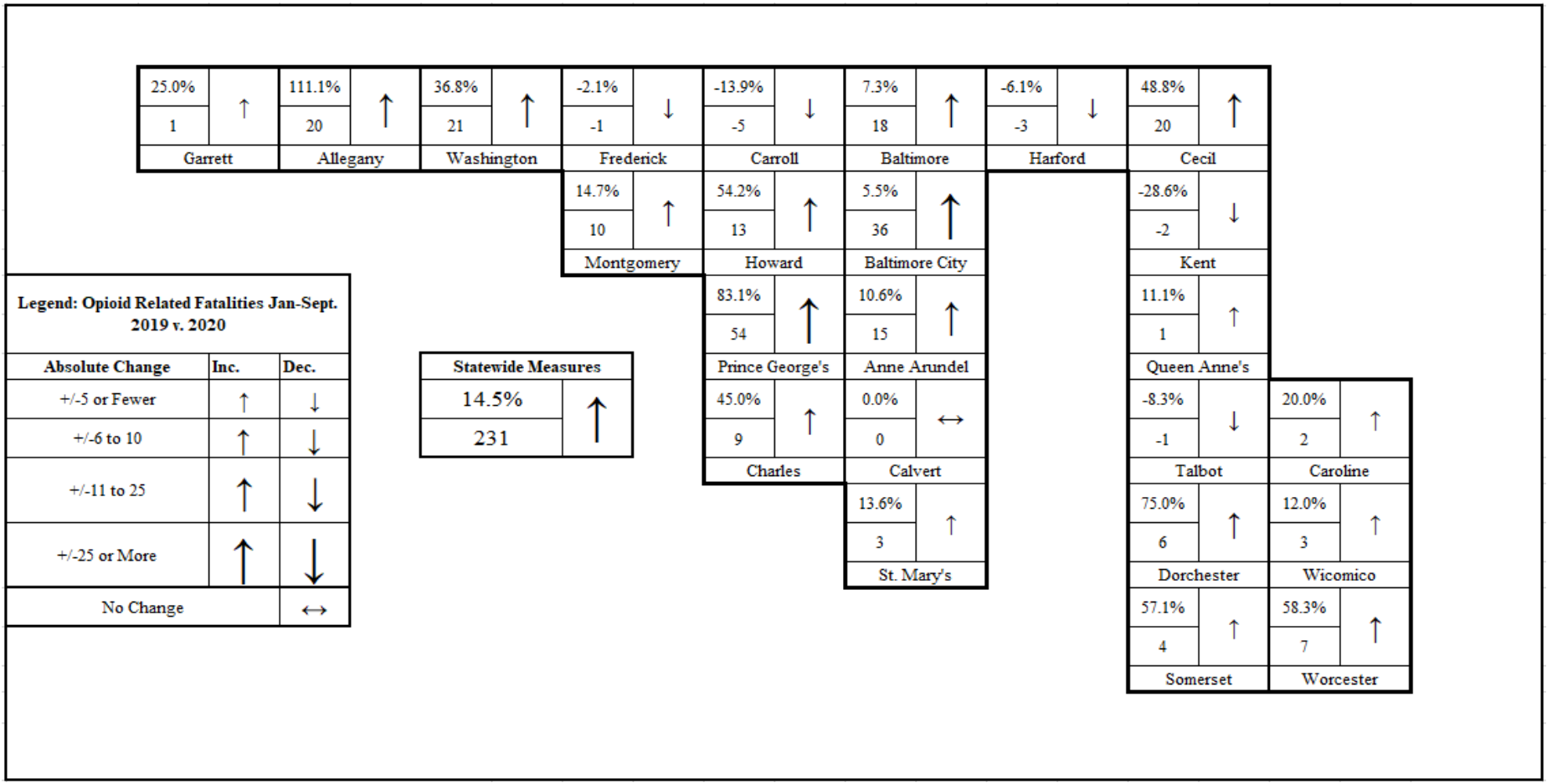
As shown, while opioids have consistently contributed to the overwhelming majority of overdose deaths in the State (88% to 90% in any given period), the prevalence of fentanyl has supplanted heroin in statewide overdose deaths, while total drug overdose fatalities in the State have also increased. Further, Baltimore City alone has accounted for the plurality of overdose deaths in any given period and accounts for 36% of the deaths so far in the State for calendar 2020.

While Baltimore City is consistently the hardest-hit jurisdiction in terms of overdoses, nearly all other jurisdictions also saw increases for calendar 2020, leading to the 231 more opioid-related fatalities experienced in the State over the same period, a 14% increase. **Exhibit 17** shows the change in opioid-related overdose fatalities in each jurisdiction for the first three quarters of 2020 when compared to the same period of 2019.

Exhibit 17

Change in Opioid-related Fatalities by Jurisdiction

January to September, Calendar 2019 vs. 2020

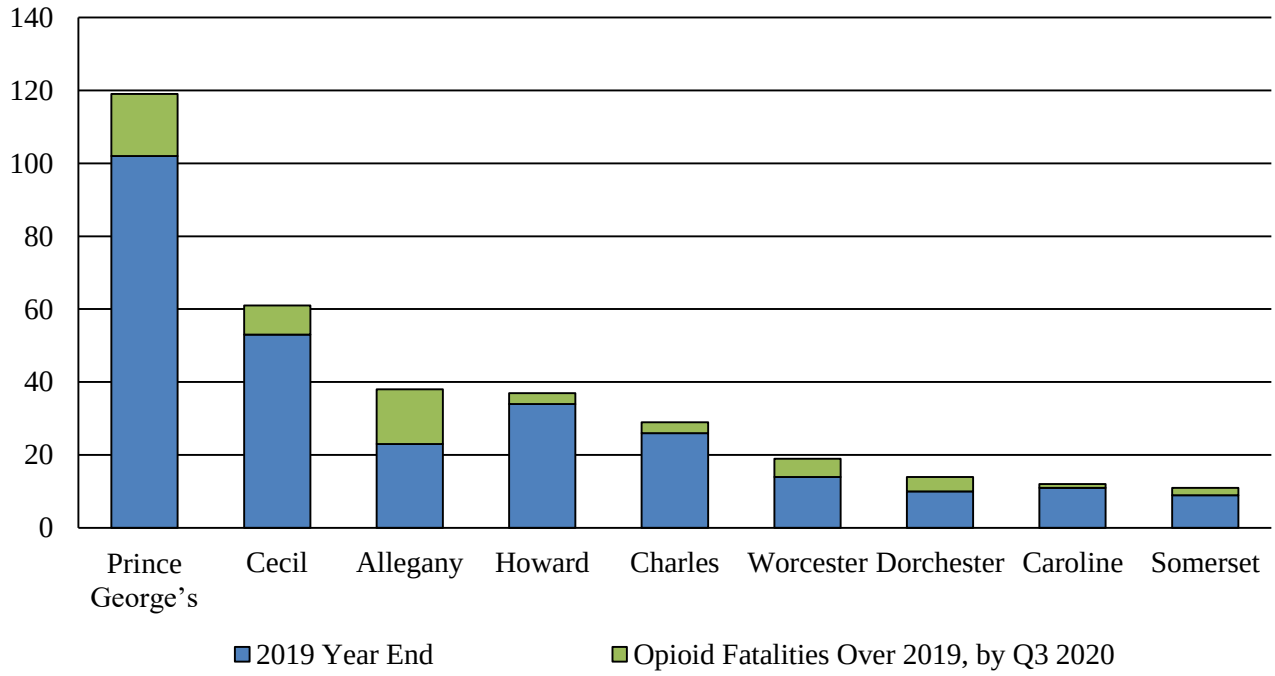


Source: Opioid Operational Command Center; Department of Legislative Services

As shown, only five jurisdictions (Carroll, Frederick, Harford, Kent, and Talbot counties) are experiencing fewer opioid-related fatalities than 2019.

Of note, Prince George's County, traditionally a jurisdiction with a fairly low rate of overdoses on a per capita basis, is accounting for the greatest increase in overdoses of any individual jurisdiction, outpacing Baltimore City. At this point in calendar 2019, Prince George's County had 65 opioid-related deaths, and currently is reporting 119, nearly doubling the prior period and already surpassing the number of overdoses experienced in the whole of 2019 (102). Eight other jurisdictions have also already surpassed the number of opioid overdoses experienced in 2019. These nine total jurisdictions are shown in **Exhibit 18** as well as the increase over the final values for calendar 2019.

Exhibit 18
Opioid Fatalities Already Surpassed 2019 Totals
January to September 2020 Compared to Calendar 2019



Q3: third quarter

Source: Opioid Operational Command Center; Department of Legislative Services

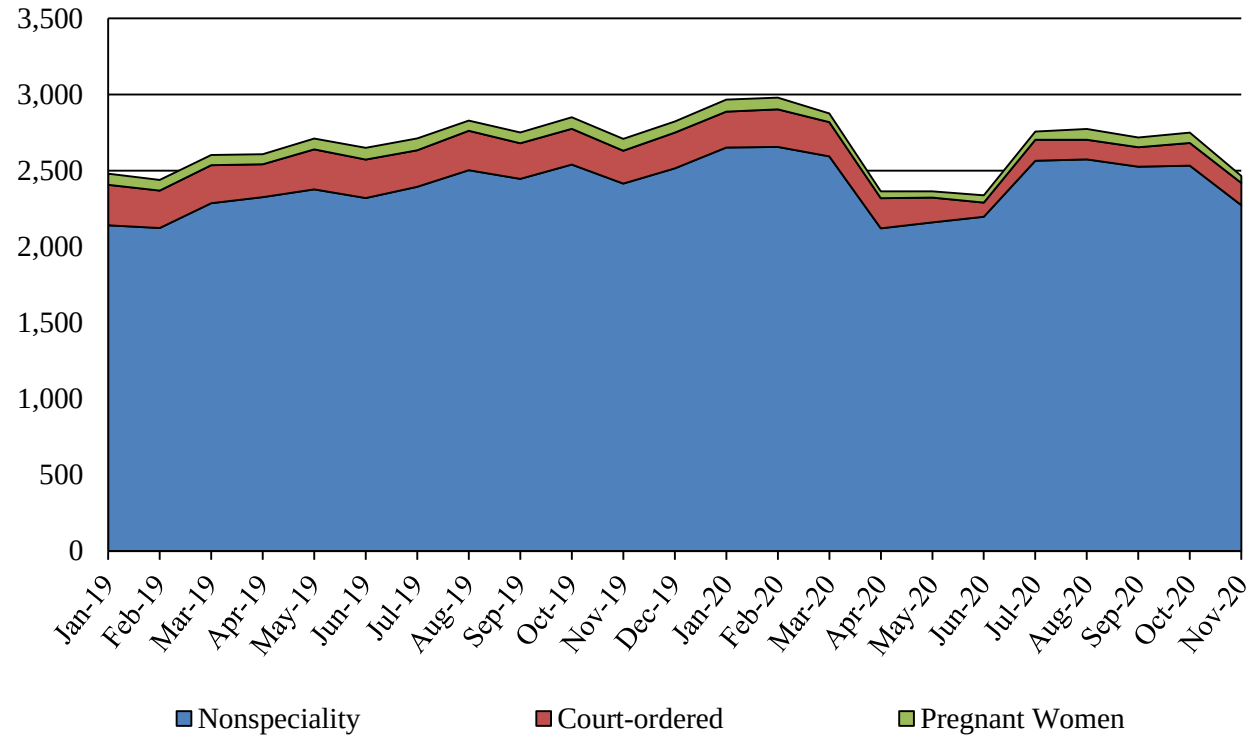
Five of these nine counties are located on the Eastern Shore, which collectively have already experienced more overdose deaths than in all of 2019: 171 as of the third quarter of 2020, 11 more than the 160 experienced in 2019.

The full years' worth of data on calendar 2020 is still yet to be reported by OOCC but, as shown, the encouraging decrease in overdose deaths for calendar 2019 seems to ultimately have been overtaken by the increased economic stress and social isolation brought on by COVID-19.

Disruption of Services Due to COVID-19

In addition to the stressors from COVID-19 that may have contributed to an increase in overdose fatalities, individuals seeking care may have found it more difficult to access during the pandemic. While utilization across PBHS is still difficult to fully capture given ASO limitations, MDH was able to provide detail on SUD residential data to DLS. **Exhibit 19** shows the total number of individuals who received SUD residential services in a given month for calendar 2019 and 2020.

Exhibit 19
SUD Residential Individuals Served
Calendar 2019-2020



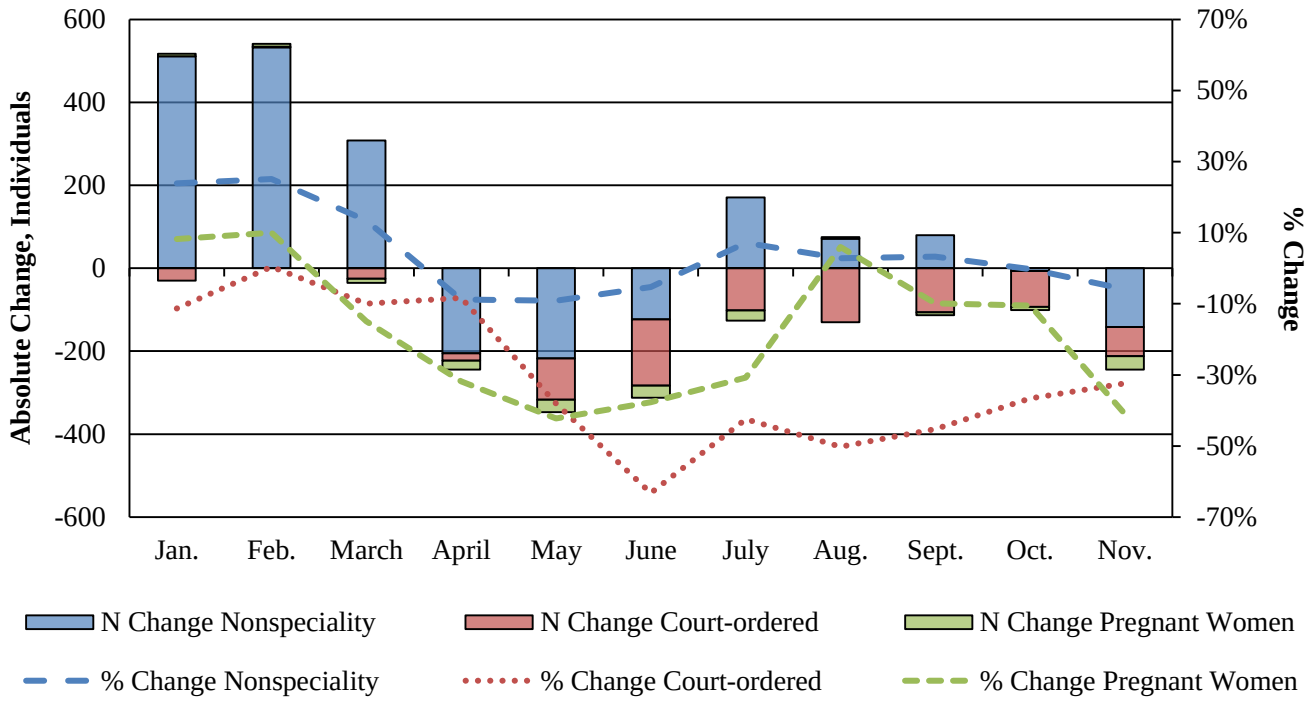
SUD: substance use disorder

Note: SUD residential data based on claims paid, and may ultimately be incomplete. Claims may be paid up to a year after provision of services.

Source: Maryland Department of Health

As shown, after the onset of the pandemic, individuals receiving SUD residential services experienced an immediate decline. However, interestingly, these services, at least for nonspecialty populations, were able to recover to prior year levels fairly quickly. **Exhibit 20** shows the absolute change in individuals and percentage change in SUD residential in calendar 2020 for the corresponding month in calendar 2019.

Exhibit 20
Change in SUD Residential Individuals Served
Calendar 2019 vs. 2020



SUD: substance use disorders

Note: SUD residential data based on claims paid, and may ultimately be incomplete. Claims may be paid up to a year after provision of services.

Source: Maryland Department of Health

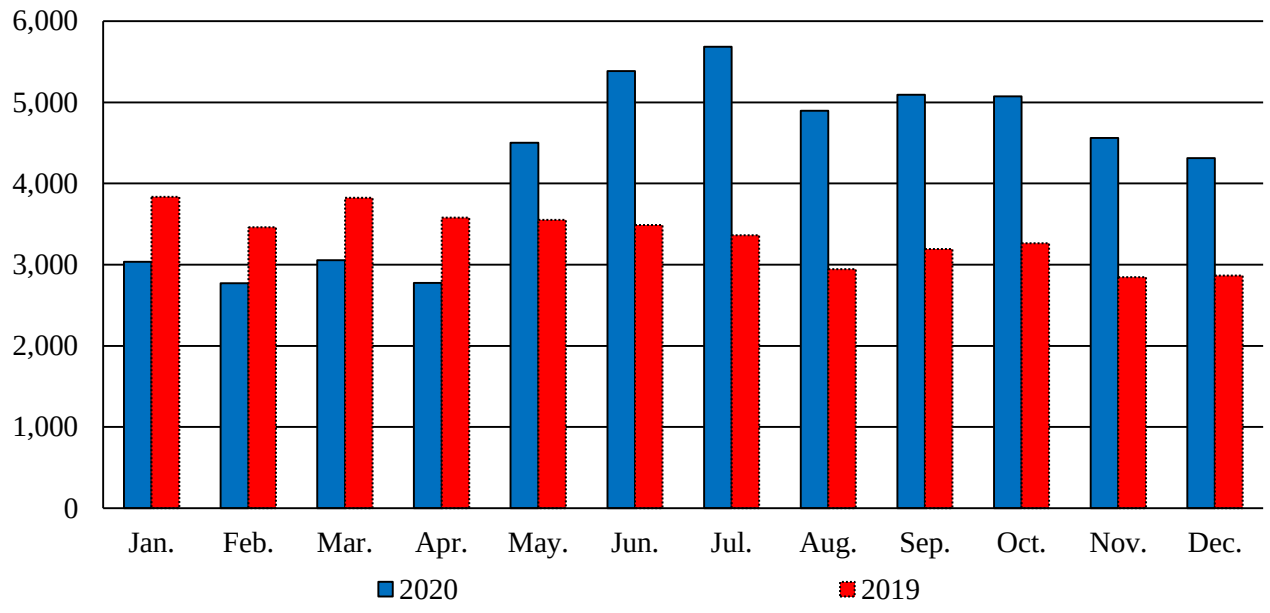
While nonspecialty populations returned to previous levels later in the summer, court-ordered residential services (8-507s) and pregnant women have been slower to recover, with 8-507s in particular experiencing downturns month over month since the onset of the pandemic. In addition to the general decrease in services across residential providers due to COVID-19-related health and safety restrictions, 8-507s are also experiencing a downturn due to courts slowing the processing of individuals and drug arrests being down on the whole during the course of the pandemic. In the RELIEF Act, $5 million was provided to support 8-507 SUD residential programs.

COVID-19's Impact on Mental Health

Traditionally, data on suicide has lagged well behind the overdose data available to the State. Prior to the COVID-19 pandemic, rates of suicide had been increasing both nationally and in Maryland. In 2018, 650 people died from suicide in Maryland, a rate of 10.2 per 100,000 residents. While Maryland has consistently been below the national suicide rate and has a lower rate than all but four states, the rate of suicide for Marylanders has increased every year from 2015 to 2018 (the most recent national data available). The *Journal of American Medicine* pointed to several risk factors for suicide that the pandemic is likely compounding, including economic stress and reduction in labor force participation due, in part, to parents caring for children learning from home; social isolation caused by social distancing; and increased barriers to adequate mental health care, similar to the risk factors likely exacerbating the opioid epidemic noted above.

Given the difficulty in collecting and reporting quality and timely data around mental health care and suicide, the full scope of COVID-19's impact on Marylanders' mental health will likely take even longer to understand than its impact on SUD discussed above. However, data that is available raises cause for concern. For example, Here2Help, the behavioral health crisis hotline in Baltimore City, shows much higher call volumes in calendar 2020 compared to calendar 2019 (see **Exhibit 21)**.

Exhibit 21
Here2Help Hotline Call Volume
Calendar 2019 v. 2020



Source: Behavioral Health Systems Baltimore

Since June, every single month in 2020 has had an at least 50% increase in calls to Here2Help over 2019. July has the greatest difference, with 2,322 more calls in 2020 than 2019, a nearly 70% increase.

Operating Budget Recommended Actions

1. Add the following language:

   Further 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 (MDH) submits a report to the budget committees on the assisted reconciliation process to establish amounts owed by providers to MDH. The report shall be submitted by August 1, 2021, 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 nearly eight-month estimated payments period required due to the failed launch of the new Administrative Services Organization resulted in overpayments to providers of over $300 million. This language restricts funding pending a report on the process used by the department to assist the providers in reconciling amounts owed to the department. This report should include a detailed list of reports furnished to providers to assist reconciliation, the processes used to verify that rejected claims were done so accurately, and any additional accounting assistance the department has used or offered to providers.

Information Request	**Author**	**Due Date**
Report on reconciliation process	MDH	August 1, 2021

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

   , provided that $500,000 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, 2021, 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 in prior years have resulted in PRPs owing a disproportionate amount to the department from the estimated payments period. One possible cause for this disparity would be actions already taken by the Behavioral Health Administration (BHA) to increase oversight over these provider types. This language requests that BHA submit a report on the increases in PRP expenditures and utilization seen in prior years and factors contributing to the overpayments to PRP providers.

Information Request	Author	Due Date
Causes for increases in PRP expenditures and steps already taken to increase PRP oversight	BHA	October 1, 2021

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 M00L01.03 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 Fund Recipients or M00Q01.10 Medicaid Behavioral Health Provider Reimbursements.

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

Further provided that this appropriation shall be reduced by $700,000 contingent upon enactment of legislation authorizing the transfer of excess special fund balance from the State Board of Examiners of Psychologists.

Explanation: This language provides a general fund reduction for the Community Service program contingent on a corresponding Budget Reconciliation and Financing Act recommendation made by the Department of Legislative Services to transfer surplus fund balance totaling $700,000 to the Behavioral Health Administration from the State Board of Examiners of Psychologists.

5. 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.

6. 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.

	Amount Reduction	
7. Reduce general funds by $35,000,000 to account for six months of extended enhanced federal fund match in the Medicaid program.	$ 35,000,000	GF

8. Adopt the following narrative:

Ongoing Reporting on the Functionality of the New ASO: Given the reports of ongoing struggles with the new Behavioral Health Administrative Services Organization (ASO) over a year after the initial go-live date, the budget committees request ongoing status updates of its functionality. The budget committees are requesting a series of reports, the first of which, in consultation with the providers in the Public Behavioral Health System, identifies which reports and features are required for a fully functional ASO. Subsequent reports should identify progress made on each of these features, identify what is not fully functional, the steps needed to reach functionality, and the estimated completion date. The first report should be submitted by July 1, 2021, and subsequent reports shall be submitted quarterly through fiscal 2022, or until full functionality is achieved.

Information Request	**Author**	**Due Dates**
Status of ASO functionality	Maryland Department of Heath	July 1, 2021; Oct. 1, 2021; Jan. 1, 2022; April 1, 2022
Total General Fund Reductions		**$ 35,000,000**

Budget Reconciliation and Financing Act Recommended Actions

1. Recognize reversion of $5.0 million in fiscal 2020 general funds from the behavioral health provider reimbursement accrual.

Appendix 1
2020 *Joint Chairmen's Report* Responses from Agency

The 2020 *Joint Chairmen's Report* (JCR) requested that the Behavioral Health Administration prepare five reports. Electronic copies of the full JCR responses can be found on the Department of Legislative Services Library website. Of the five reports requested, only two have been submitted. Past-due JCR reports across the Maryland Department of Health (MDH) are discussed in the MDH – Administration analysis.

- ***Report on the Estimated Payments Period under the New Administrative Services Organization:*** This report was submitted on November 16, 2020, and is discussed at length in the Issue 1 of this analysis.

- ***Quality and Performance Measures in the Public Behavioral Health System:*** This report was submitted on November 6, 2020, and is discussed in the third Managing for Results section of this analysis.

- ***Report on the Increasing Utilization and Expenditures in Psychiatric Rehabilitation Programs (PRP):*** At the time of writing, this report has yet to be submitted. However, historic trends in PRP spending are discussed in Issue 1 of this analysis.

- ***Report on Assertive Community Treatment Standards:*** At the time of writing, this report has yet to be submitted.

- ***Report on Substance Use Disorders Residential Treatment limitations in the Medicaid Program:*** At the time of writing, this report has yet to be submitted.

Appendix 2
Planned Uses of SOR II Funding

New Programs

Program Name	Short Description/Jurisdiction, When Applicable	Amount
Adolescent and Young Adult Services Expansion	Expand capacities and access for meeting the expanding needs of adolescents and young adults with OUD and stimulant misuse needs	$8,010,629
Centralized Crisis Call Center	Create and provide 24/7/365 days centralized call center/hotline for opioid and mental health crisis	1,132,400
Harford Crisis Hotline	Call center for Harford County	327,500
HBCU Workforce Initiative	Provide specialized training, coaching, and mentoring supports to students enrolled in behavioral health-related programs	900,000
Substance Use Disorder Workforce Expansion (SUDWE) Fellowship	SUDWE will allow the University of Maryland School of Social Work (MSW) to expand its reach of workforce development programs to two other MSW programs in Maryland, Salisbury State University and Morgan State University	1,061,863
Evidence-based Initiatives to Native Americans and Tribes	Provide Tribes and Tribal organizations access to culturally relevant and evidence-based supports	500,000
Expansion of Residential Substance Abuse Treatment for Women with Children	A start-up grant will be provided through a competitive procurement process to a vendor to develop or expand residential substance use disorder treatment services for pregnant women and women with children	240,935
Medication Adherence Technology	Use of a mobile health platform to improve medication adherence in 35 Opioid-Treatment Programs	279,280
Medication Adherence Technology	Take-home electronic pill dispenser for Methadone pilot program in Baltimore City	47,616
New Programs Subtotal		***$12,500,223***

Continuing Programs

Program Name	Short Description/Jurisdiction, When Applicable	Amount
Crisis Beds	Allegany County	$266,836
Crisis Beds	Carroll County	1,730,377
Crisis Beds	Kent County	1,151,940
Crisis Beds Subtotal		***$3,149,153***
Crisis Stabilization/Mobile Crisis Response	Anne Arundel County	$1,337,504
Crisis Stabilization/Mobile Crisis Response	Baltimore City	2,665,680
Crisis Stabilization/Mobile Crisis Response	Calvert County	2,231,865
Crisis Stabilization/Mobile Crisis Response	Cecil County	904,461
Crisis Stabilization/Mobile Crisis Response	Howard County	1,122,050
Crisis Stabilization/Mobile Crisis Response	Washington County	493,504
Crisis Stabilization/Mobile Crisis Response Subtotal		***$8,755,064***
Intensive Care Coordination	Anne Arundel County	$212,548
Intensive Care Coordination	Baltimore City	92,438
Intensive Care Coordination	Wicomico County	50,120
Intensive Care Coordination Subtotal		***$355,106***
MAT in Detention Centers	Baltimore County	$623,566
MAT in Detention Centers	Calvert County	279,574
MAT in Detention Centers	Harford County	116,344
MAT in Detention Centers	Howard County	381,396
MAT in Detention Centers	Kent County	110,454
MAT in Detention Centers	Montgomery County	678,470
MAT in Detention Centers	Prince George's County	242,000
MAT in Detention Centers	Queen Anne's County	4,995
MAT in Detention Centers	St. Mary's County	395,865
MAT in Detention Centers Subtotal		***$2,832,664***
Recovery Housing	Anne Arundel County	$288,130
Recovery Housing	Calvert County	119,483
Recovery Housing	Caroline County	114,000
Recovery Housing	Dorchester County	144,300
Recovery Housing	Howard County	117,128

Program Name	Short Description/Jurisdiction, When Applicable	Amount
Recovery Housing	Kent County	271,465
Recovery Housing	St. Mary's County	15,000
Recovery Housing	Wicomico County	50,120
Recovery Housing	Worcester County	160,732
Recovery Housing Subtotal		***$1,280,358***
Safe Stations	Anne Arundel County	1,035,175
Safe Stations	Wicomico County	321,712
Safe Stations	Worcester County	246,866
Safe Stations Subtotal		***$1,603,753***
Screening Brief Intervention and Referral to Treatment (SBIRT)	Training through MDPCP to primary care practices	$54,000
SBIRT	Statewide training of peer recovery coaches, nurses, and social workers	200,000
SBIRT	Training in hospitals emergency department settings	930,000
SBIRT Subtotal		***$1,184,000***
Workplace Development for Persons in Recovery	Fund to provide funding to organizations with the goal of developing training programs that credential individuals impacted by the opioid crisis in industry specific and "in-demand" areas	$13,750
Workplace Development for Persons in Recovery	Expand the statewide availability of free training that offers CEUs for individuals seeking their Certified Peer Recovery Specialist credential	50,000
Workplace Development for Persons in Recovery	Funding to cover the costs associated with certification of peer recovery specialists	525,000
Workplace Development for Persons in Recovery Subtotal		***$588,750***
Data Management/SOR Evaluation	Conduct data collection, analysis and evaluation activities as required by the SOR II Grant	$695,498
Harm Reduction	Coordinates an outreach team for deployment into high-need areas and to engage high-risk individuals, provide Overdose Response Program services, Recovery Support Services, Naloxone Distribution, and Education	7,500,000

Program Name	Short Description/Jurisdiction, When Applicable	Amount
Healthy Beginnings	Program in Calvert County for pregnant women, women with children, and postpartum women who are struggling with an OUD	131,936
Naloxone Distribution	Supports the ongoing needs of local health departments to provide naloxone through online ordering for up to a six-month supply and target naloxone distribution to high-need areas and communities	4,875,000
Public Awareness	Video Library of Faces & Stories of both people who live with addiction and their loved ones will be created for 30-second PSAs	1,922,740
Other Programs, Subtotal		***$15,125,174***
Continuing Programs Subtotal		***$34,874,022***
Announced Funding Total, SOR II		**$47,374,245**

Planned Year 2 Program

Program Name	Short Description/Jurisdiction, When Applicable
Grants Management	Continued support and implementation of enhanced grant management system
Hub and Spoke Model	BHA will pilot a Hub and Spoke model: "Hubs" being OTPs; and "Spokes" being MAT in the community
Maryland Addictions Consultation Service	Expansion of Consultation and Technical Assistance for Health Care Providers, the consultation service is a "warm line" that is operated by the University of Maryland School of Medicine Department of Psychiatry
Medical Patient Engagement	This project, in Baltimore City will continue to connect patients with effective care prior to their discharge from an acute hospital
Outreach Sign Language	This initiative will continue to employ Outreach/Sign language interpreters to work with a Deaf Addictions treatment team, filling a critical gap in services for individuals who have an OUD or stimulant use disorder

BHA: Behavioral Health Administration
CEU: Continuing Education Unit
HBCU: Historically Black Colleges and Universities
MAT: Medication Assisted Treatment
MDPCP: Maryland Primary Care Program
OUD: Opioid Use Disorder
OTP: Opioid Treatment Program
PSA: public service announcement
SOR: State Opioid Response

Source: Maryland Department of Health

Appendix 3
Full Amounts Outstanding for Individual Provider Types

Provider Type	Total Estimated Payments	Total Amount Offsetting	Total Amount Outstanding	Single Provider Types
Psychiatric Rehab Services Facility	$38,122,380	$18,833,665	$19,285,476	103
Clinic, Drug	31,516,224	21,121,841	10,394,384	29
Laboratory	24,320,073	14,724,290	9,595,783	56
Hospital – Acute	13,657,182	6,024,134	7,633,048	58
HMO/Pace	6,477,591	2,259	6,475,332	1
ADAA Certified Addictions Outpatient Program	16,423,982	10,748,040	5,675,941	47
Mental Health Group Therapy Provider	9,626,641	4,136,170	5,490,470	226
Social Worker	8,184,472	2,828,362	5,356,111	490
Physician	8,562,302	3,667,571	4,894,731	155
Certified Professional Counselor	8,167,424	3,626,071	4,541,291	443
Applied Behavior Analysis	13,750,199	9,407,807	4,342,392	36
Maryland Recovery Net	3,839,316	286,860	3,552,456	38
Residential Treatment Center	4,984,731	2,271,485	2,713,246	5
Mental Health Clinic	10,683,362	8,105,112	2,578,250	12
IMD Residential SUD Adult	6,041,685	4,573,743	1,467,942	9
Psychologist	1,338,219	369,521	968,698	92
Hospital – Special Other Acute	1,728,613	808,611	920,002	1
Nurse Practitioner	1,473,114	625,889	847,225	59
Brain Injury Waiver	6,592,224	5,801,602	790,622	3
Mental Health Case Management Provider	3,882,177	3,400,855	481,322	2
Clinic, Federally Qualified Health Center	1,281,593	1,123,279	158,314	5
Hospital – Special Other Chronic	114,584	0	114,584	1
Nurse Psychotherapists	143,377	42,173	101,204	6
Physician	57,855	0	57,855	3
Partial Hospitalization Program	43,233	0	43,233	1
Clinic, General	343	0	343	1
Gambling Addiction	0	0	0	1
Ambulance Company	0	0	0	1

ADAA: Alcohol and Drug Abuse Administration
IMD: Institutions for Mental Disease
HMO: health maintenance organizations

Source: Maryland Department of Health

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

Object/Fund	FY 20 Actual	FY 21 Working Appropriation	FY 22 Allowance	FY 21 - FY 22 Amount Change	Percent Change
Positions					
01 Regular	136.80	134.80	134.80	0.00	0%
02 Contractual	53.00	45.64	56.05	10.41	22.8%
Total Positions	**189.80**	**180.44**	**190.85**	**10.41**	**5.8%**
Objects					
01 Salaries and Wages	$ 14,091,847	$ 13,315,186	$ 13,903,781	$ 588,595	4.4%
02 Technical and Spec. Fees	2,354,272	2,710,901	3,499,872	788,971	29.1%
03 Communication	122,843	155,729	135,180	-20,549	-13.2%
04 Travel	64,393	81,580	71,569	-10,011	-12.3%
07 Motor Vehicles	0	2,052	0	-2,052	-100.0%
08 Contractual Services	1,920,192,381	2,086,032,957	2,337,747,152	251,714,195	12.1%
09 Supplies and Materials	2,177,848	59,390	52,470	-6,920	-11.7%
10 Equipment – Replacement	164,800	1,000	1,000	0	0%
11 Equipment – Additional	158,044	0	0	0	0.0%
12 Grants, Subsidies, and Contributions	750,000	0	0	0	0.0%
13 Fixed Charges	39,899	67,225	63,935	-3,290	-4.9%
Total Objects	**$ 1,940,116,327**	**$ 2,102,426,020**	**$ 2,355,474,959**	**$ 253,048,939**	**12.0%**
Funds					
01 General Fund	$ 802,248,105	$ 901,926,458	$ 981,347,579	$ 79,421,121	8.8%
03 Special Fund	37,719,737	43,471,196	32,422,267	-11,048,929	-25.4%
05 Federal Fund	1,094,468,036	1,151,546,785	1,335,471,920	183,925,135	16.0%
09 Reimbursable Fund	5,680,449	5,481,581	6,233,193	751,612	13.7%
Total Funds	**$ 1,940,116,327**	**$ 2,102,426,020**	**$ 2,355,474,959**	**$ 253,048,939**	**12.0%**

Note: The fiscal 2021 appropriation does not include deficiencies or general salary increases. The fiscal 2022 allowance does not include contingent reductions, annual salary review adjustments, or annualization of general salary increases.