MARYLAND DEPARTMENT OF HEALTH

BEHAVIORAL HEALTH ADMINISTRATION AND OPIOID OPERATIONAL COMMAND CENTER BUDGET OVERVIEW

February 15 and 16, 2018

Agenda

- Opioid Operational Command Center (OOCC) and Maryland's Coordinated Statewide Opioid Response Efforts (Clay Stamp)
- Maryland Department of Health (MDH) Prescription Drug Monitoring Program (PDMP) (Dennis Schrader)
- MDH Psychiatric Facility Expansion and Court-Ordered Placements (Dennis Schrader)
- Behavioral Health Administration (BHA) Specific Opioid Response Efforts (Barbara Bazron)

Coordinated Statewide Efforts

Opioid Operational Command Center

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2017 Mobilization

- Established state coordinating body — Opioid Operational Command Center (OOCC)
- Established local coordinating bodies
- Established planning goals and objectives, which address prevention, enforcement, and expanding access to treatment and recovery
- Shares information, educates, and issues alerts with stakeholders

Funding

- Allocated based on planning goals and objectives; driven by partner state agencies and local jurisdictions
- Created spend plan for FY18 funding, including:
  - First $10 million of Governor Larry Hogan's $50 million commitment to address the crisis announced in March 2017 (over five years)
  - First $10 million from the federal 21st Century Cures Act (over two years)
  - $2.1 million from the Governor's Office of Crime Control and Prevention

Coordinated statewide efforts: OOCC

State Programs

19 state programs in prevention, enforcement, and treatment, such as:

- $2.7 million to improve access to naloxone statewide
- $2 million to establish a 24-hour crisis center in Baltimore City
- $1.6 million to expand use of peer recovery support specialists
- $1 million to expand Screenings, Brief Intervention, and Referral to Treatment (SBIRT) to hospitals and parole, probation, and correctional facilities

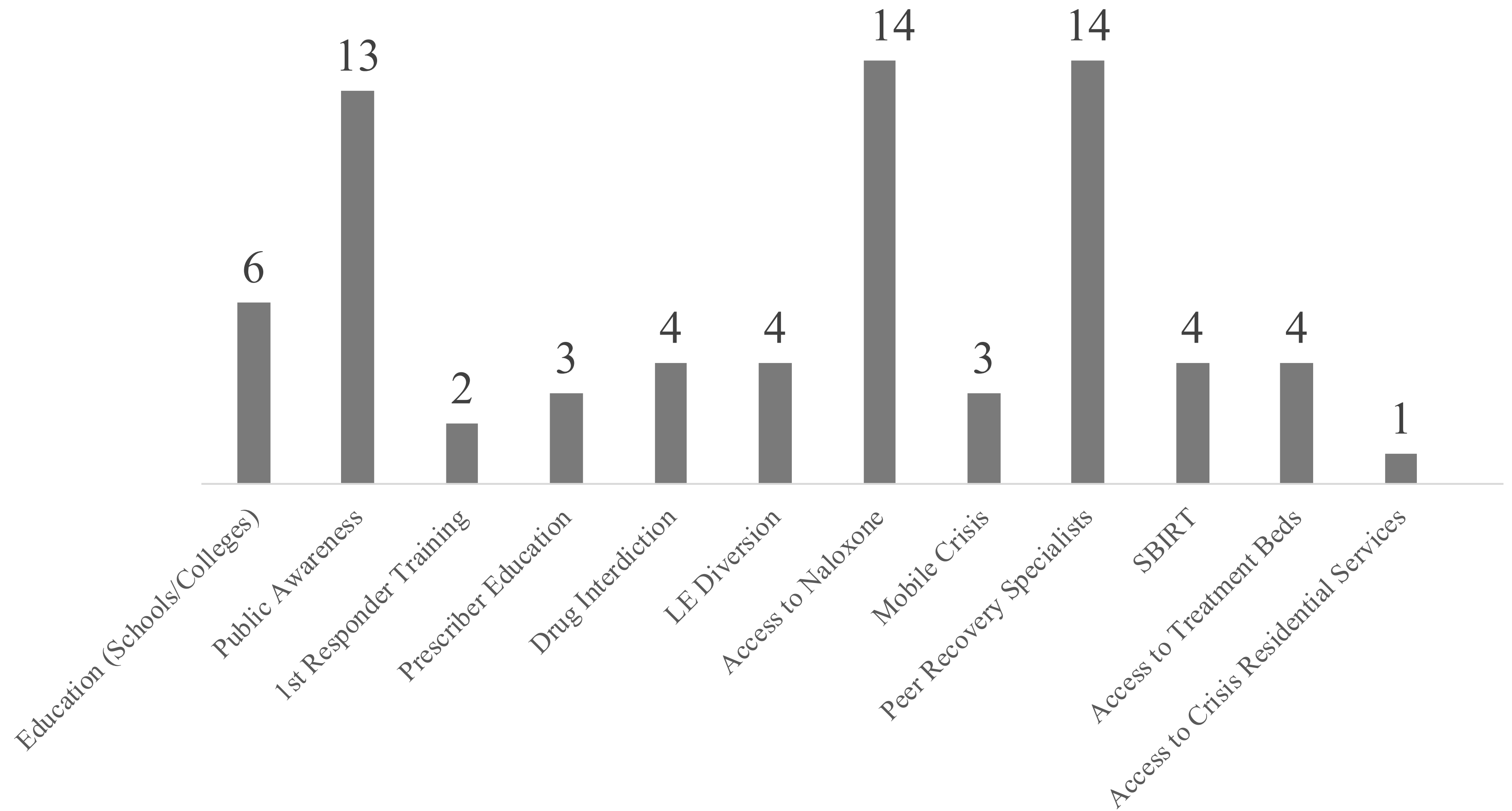
Local Programs

$4 million distributed to local Opioid Intervention Teams (OIT) to meet community-specific heroin and opioid needs, including:

- 72 projects that address prevention, enforcement, and expanding access to treatment and recovery
- Performance measures established to ensure projects are meeting indicated targets
- Second quarter performance reporting is due by end of January

Coordinated statewide efforts: OOCC

OIT Grant Projects



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Prescription Drug Monitoring Program

PDMP

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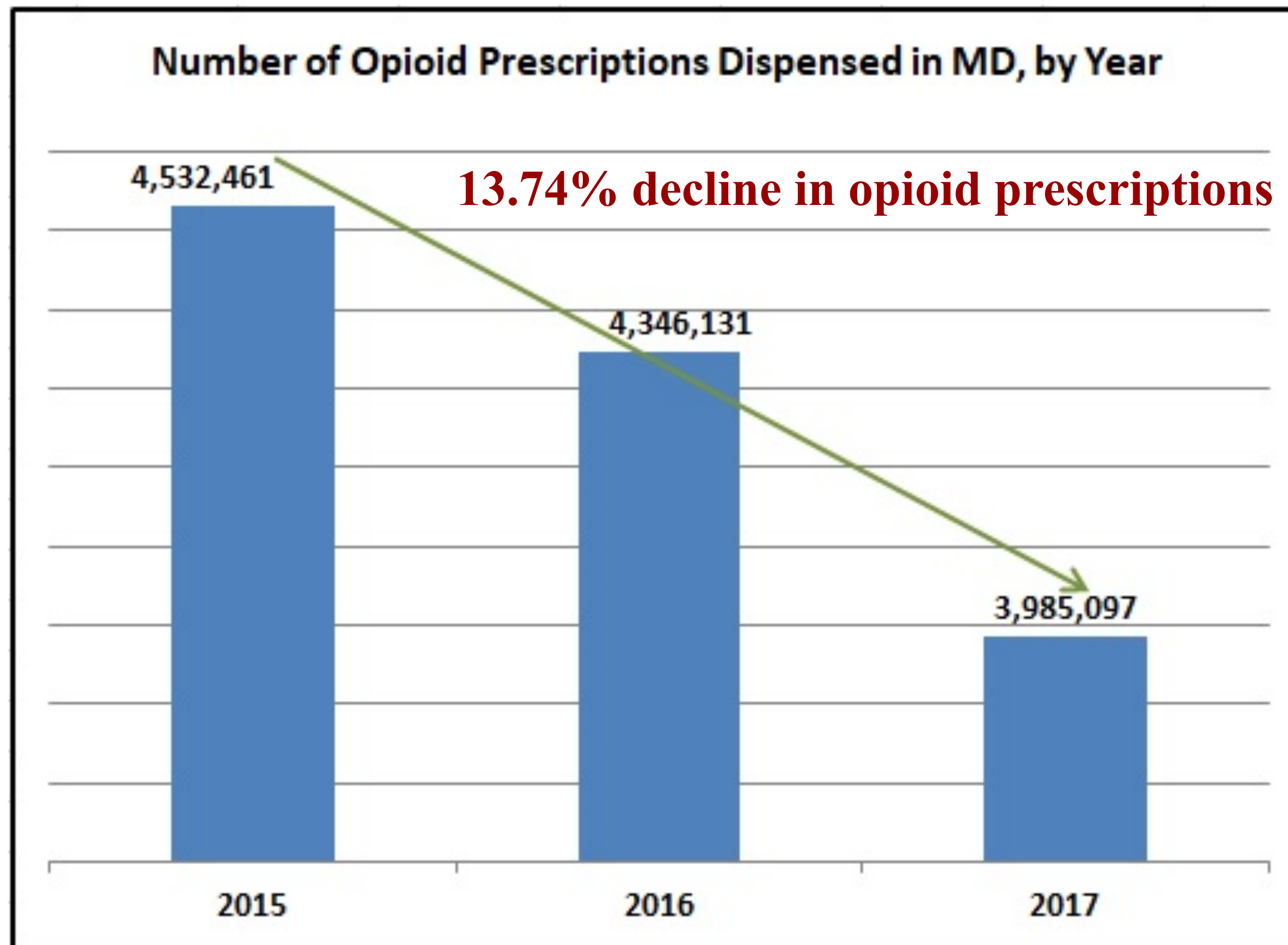
Overview



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2018 Initiatives

The Department's primary focus is on the following three initiatives:

- Achieving 100% compliance with the July 1, 2017, PDMP mandatory registration requirement of Controlled Dangerous Substances (CDS) prescribers and pharmacists as a collaborative effort between PDMP and the Office of Controlled Substance Administration (OCSA)
- Continuing outreach and education efforts on CDS prescriptions to lower the number of unnecessary or inappropriate prescriptions in Maryland
- Preparing for and achieving compliance with the July 1, 2018 PDMP mandatory use and dispensing mandate

Prescription drug monitoring: PDMP

2018 Priorities

Priority Topic	Ultimate Deliverable	Targeted Completion Date
PDMP Registration	Show significant jump in PDMP registration to functional full capacity	**2/1/2018**
	Chapter 147 (HB437/2016) - Section 8 - CDS/PDMP Contingencies: Activate CDS/PDMP link – No CDS registration renewal without PDMP registration	**2/15/2018**
PDMP Use Mandate	Successful activation of use mandate by meeting HB437 - Section 9 contingencies	**7/1/2018**
	Successful deployment of use mandate, with identified risks mitigated for clinical end users	**7/1/2018**
PDMP IT Platform/Product	Hire PDMP IT Platform Manager to enable comprehensive OIT support of IT-related needs of PDMP	**Spring 2018**
	Build out formal PDMP IT Roadmap for internal and external stakeholders	**Summer 2018**
OSCA Staffing/Inspections Expansion	Hiring of three pharmacists/inspectors, one pharmacy technician, one Health Policy Analyst, and three administrative support staff	**Spring 2018**
	Increased number of inspections and actions against registrants	**Calendar Year 2018**

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2017 Registration

PDMP Registration Mandate Progress

Registrant Type	Registered (as of 1/25/2018)	% Registered	% Change in Number Registered Since 9/6/2017
Prescribers	30,521	85.94%	+19.37%
Pharmacists	10,666	91.09%	+56.51%
TOTAL	41,187	87.22%	+27.19%

Removed from this list are CDS registrants known through individual outreach to have moved out of state, stopped practicing, are deceased, or otherwise intend to allow CDS to expire
Numbers represent individual practitioners, even if practitioner has >1 individual CDS registration

2017 Registration

PDMP Registration Rates for Top Prescribers*

Profession	*All* Prescribers (%)	*Top* Prescribers (%)	Sample size
Physician (MD)	85.32	97.75	668
Nurse Practitioner (CRNP)	84.69	98.29	117
Physician's Assistant (PA)	87.01	97.83	92
Doctor of Osteopathic Medicine (DO)	82.78	94.59	37
Doctor of Dental Surgery (DDS)	88.61	100	2
All Prescribers	**85.94**	**97.71**	**916**

* Top 1,000 prescribers of any CDS as reported to Maryland PDMP; removed were hospitals/institutional DEA#s and DEA#s for providers not licensed in Maryland and thus without Maryland CDS Registration = final count of 930 prescribers

Capacity, Service, and Partnerships

Court-Ordered Evaluation And Placements

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Mission and Values

We are committed to delivering the right care in the right environment for the right period of time for our patients:

- We provide treatment in the *least restrictive environment* that is appropriate for each given individual
- We operate an integrated *system of care* that encompasses a range of services across a variety of environments
- We emphasize *recovery-oriented care* that works for the patient and the public
- We leverage *community-provided services* that have become state-of-the art practice nationally over recent decades

Court-ordered evaluation and placement

Wait Lists/Cycle Times

We have cut the wait list roughly in half (more than half relative to the summertime peak) while also cutting cycle times roughly in half:

Title 3 Wait List
Pretrial Evaluation and Commitment Orders (Quantity)

Date	Quantity
March 27	24
June 19	52
September 18	28
December 11	14
February 8	3

Title 3 Cycle Times
Pretrial Commitment Orders (Days)

Month	Days
April	18
June	23
September	13
October	11
November	12
December	8
January	9

Court-ordered evaluation and placement

New Treatment Beds

Hospital Name	Beds	Completion*	Comments
Clifton T. Perkins (1)	20	April 2017	Minimum-security beds operational in April 2017
Clifton T. Perkins (2)	20	Dec. 2017	Max-security beds operational on Dec. 11, 2017
Potomac Center (1)	12	Oct. 2017	Transfer dual-diagnosis patients from BHA to DDA
Potomac Center (2)	6	Jan. 2018	Transfer dual-diagnosis patients from BHA to DDA
Eastern Shore Hospital	24	March 2018	Psychiatric inpatient beds w/ hiring under way
Bon Secours	5	Jan. 2018	Finalizing MOU for evaluations and inpatient beds
Adventist	8	Dec. 2017	Evaluations and inpatient beds now operational

Total New Beds: 95

Expansion PINs

Hospital Name	Location	Hospital Type	Beds: Jan. 2017	Beds: March 2018	PINs
Clifton T. Perkins	Jessup	Adult Maximum-Security Psychiatric	248	287	39
Eastern Shore Hospital	Cambridge	Adult Psychiatric	60	84	28
Springfield Hospital	Sykesville	Adult Psychiatric	220	220	0
Spring Grove Hospital Center	Catonsville	Adult Psychiatric	377	377	0
Finan Center	Cumberland	Adult Psychiatric	66	66	0
Potomac Center	Hagerstown	Residential DD Center	38	56	61
		Totals	**1,009**	**1,090**	**128**

Vacant PINs: We shifted 101 vacant MDH PINs to enable the priority 82-bed expansion in 2017; hiring is under way for all PINs not yet already filled

Additional PINs: We received 20 new PINs from the Governor to support the expansions

Continuous Management: MDH is continuously managing PINs to reflect its top priorities

Court-ordered evaluation and placement

Hospital System

Capacity: Expanding capacity across our entire hospital system to mitigate wait times

Leverage of Perkins: Using recent Perkins expansions to assist in placing patients in the appropriate clinical and security level of care

Workplace Safety: Promoting a culture of workplace safety for employees, achieving a 28% reduction in "struck by patient or third party" injury claims at BHA hospitals from FY15 to FY17

1853 architect's rendering of the proposed new buildings for the Maryland Hospital for the Insane at Spring Grove; construction was completed in 1872

Discharges: Addressing recently identified issues in discharge policies and practices so as to improve the rate of discharge from our hospital system

Community Advisory Board: Successfully appointed three advisory-board members with first introductory meeting held in February 2018

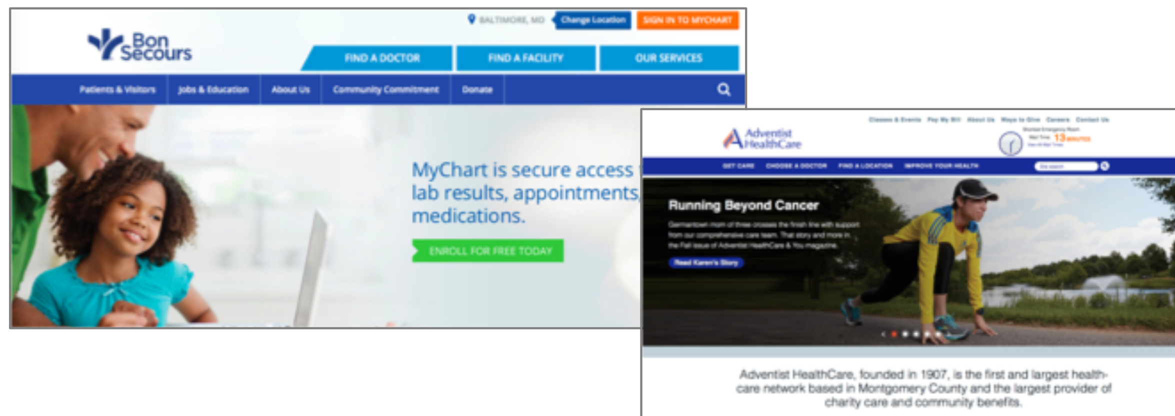
Court-ordered evaluation and placement

Community-Based Providers

Bon Secours: Five beds for diversion services agreed in August 2017 and now into operation; five beds for Title 3 mental health services are under final negotiation

Adventist: Eight beds agreed in November for mental health services, with operation and placements initiated first week of December 2017

Community Capacity: Early stage discussions are underway with additional community providers who possess demonstrated capacity to absorb MDH placements



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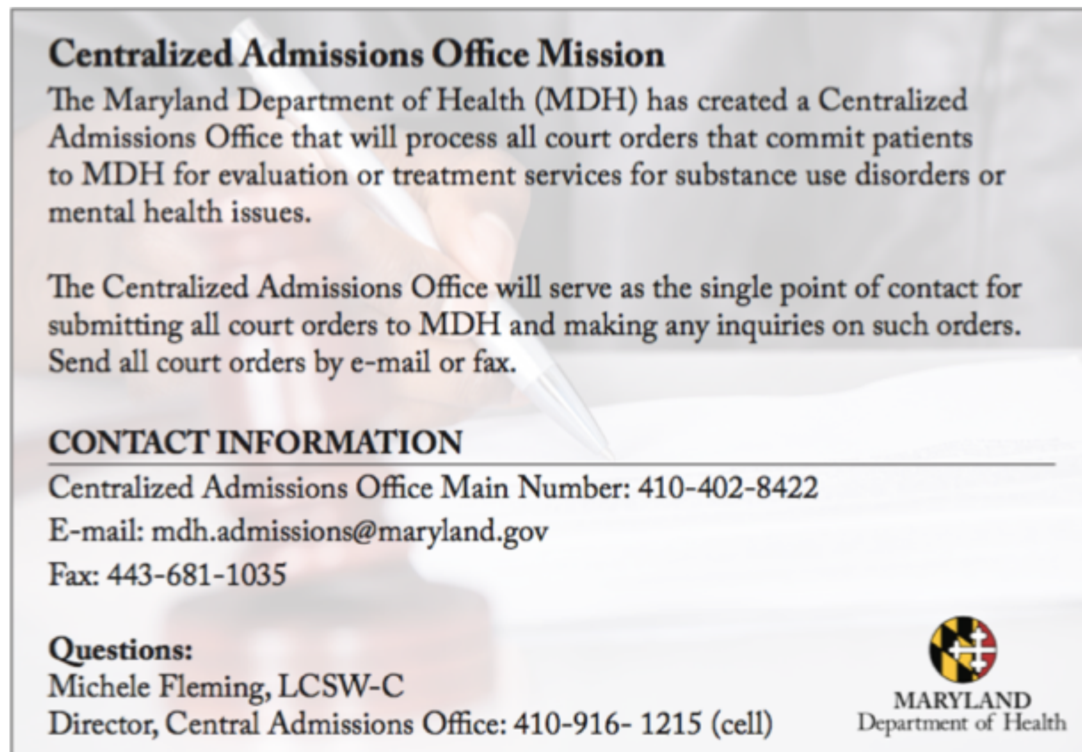
Centralized Admissions

BHA formally launched its Centralized Admissions Office (CAO) in October 2017, charged with admitting patients into our hospital system


Centralized Admissions Office Mission

The Maryland Department of Health (MDH) has created a Centralized Admissions Office that will process all court orders that commit patients to MDH for evaluation or treatment services for substance use disorders or mental health issues.

The Centralized Admissions Office will serve as the single point of contact for submitting all court orders to MDH and making any inquiries on such orders. Send all court orders by e-mail or fax.

CONTACT INFORMATION

Centralized Admissions Office Main Number: 410-402-8422

E-mail: mdh.admissions@maryland.gov

Fax: 443-681-1035

Questions:
Michele Fleming, LCSW-C
Director, Central Admissions Office: 410-916- 1215 (cell)

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This card was sent via email to the courts, detention center administrators, community providers, and other key stakeholders

Court-ordered evaluation and placement

Updating Policy

Evaluations: We have enlisted a range of stakeholders (the courts, advocacy groups, providers, clinicians, and counsel) to assess and recommend a modernized evaluation method for competence to stand trial, and criminal responsibility for ensuring consistent, effective processes are afforded to all defendants in all jurisdictions (definitive vs. screening evaluation)

Placements: We have revised our policy for triaging and prioritizing individuals for admission into the MDH hospital system and its enlisted community partners based on a combination of:

- clinical evaluation
- time on wait list
- source of referral

Behavioral Health Administration

Opioid Response Efforts

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Goals

As the opioid crisis presents a major public health threat, much of the State's response activities/initiatives are being led by MDH

The primary goals and objectives of MDH's response to the opioid epidemic follow the strategic goals outlined by the OOCC:

1. Prevent new cases of opioid misuse and addiction
2. Improve early identification of and intervention with opioid addiction
3. Expand access to services that support recovery and prevent death and disease progression
4. Enhance data collection, sharing, and analysis to improve understanding of and response to the opioid epidemic

Goal 1: Prevention

Using CURES and OOCC funding, MDH accomplished the following:

- "Talk to Your Doc" Public Awareness Campaign
- Developed an Anti-Stigma Public Awareness Campaign
- Increased Office of Controlled Substances Administration's Regulatory Compliance (HOPE Act Mandate)

Additional efforts undertaken by MDH:

- Established the Medicaid Opioid Drug Utilization Review program
- Recognized Overdose Awareness Week
- Funded local prevention specialists for public education and awareness, and implementation of primary prevention
- Required provider registration for and use of PDMP

Goal 2: Early Intervention

Using CURES and OOCC funding, MDH accomplished the following:

- Opioid Use Disorder Information Distribution (HOPE Act Mandate)
- Supported expansion of universal SBIRT in hospital emergency departments
- Supported SBIRT implementation in detention centers
- Supported hiring of peers to work with crisis residential treatment programs
- Established Buprenorphine consultation service for prescribers to support clinical care of patients and inductions at crisis settings
- Worked to identify and implement improvements to Maryland's Behavioral Health Crisis Hotline (HOPE Act Mandate)

Goal 2: Early Intervention

Additional efforts undertaken by MDH:

- Increased Recovery Support Coordinators for pregnant and post-partum women
- Expanded Medication-Assisted Recovery Services (MARS)-trained peer recovery support specialists (PRSS)
- Continued the Maryland Medication-assisted Treatment and Recovery Support Initiative (MD MATRS)

Goal 3: Treatment

Using CURES and OOCC funding, MDH accomplished the following:

- Supported the development of a crisis treatment center for mental health/SUD services (HOPE Act Mandate)
- Expanded residential treatment capacity (HOPE Act Mandate)
- Facilitated the direct distribution of Naloxone to all 24 jurisdictions
- Implemented harm reduction outreach to high risk areas in selected portions of Maryland

Goal 3: Treatment

Additional efforts undertaken by MDH:

- Medicaid reimbursement for residential substance use disorder services
- Removed barriers to accessing Naloxone for at risk individuals and those in a position to offer assistance
- Expanded the number of certified peer recovery specialists
- Transferred residential treatment for pregnant women and women with dependent children to fee-for-service

Goal 4: Data Sharing

Using CURES and OOCC funding, MDH accomplished the following:

- Supported the distributed Opioid Intervention Team Grants

Additional efforts undertaken by MDH:

- Expansion of Maryland's PDMP program
- Quarterly overdose fatality reports
- Developed data dashboards for local health departments using OCME and PDMP data (Opioid Indicators Dashboards)
- Predictive Risk Model to Combat Overdose Grant (PRECOG) and Red Flags Project to identify patient risk and provider behavior of concern
- Enhanced State Surveillance of Opioid-Involved Morbidity and Mortality: CDC Grant

Community Services

Diversion Services: Expanded jail diversion services through a private/public partnership with Bon Secours Hospital (Outpatient Civil Commitment Program)

Peer Specialists: Increased the number of peers/recovery specialists in the State (N=226); this includes 193 community-based and 33 hospital-based peer specialists (Bon Secours, Mercy, MedStar Harbor Hospital, MedStar Union Memorial Hospital, Johns Hopkins Bayview, University of Maryland-Midtown, MedStar Montgomery, MedStar Franklin Square Medical Center, MedStar Good Samaritan Hospital)

Peer Support Services: Expanded SBIRT and peer outreach services for individuals at-risk of or who have overdose in five hospital emergency departments (Meritus, Greater Baltimore Medical Center, Northwest, St. Agnes, and Upper Chesapeake Hospitals)

Development of Comprehensive Young Adult MAT program: Two 12-16 bed recovery houses providing MAT to young adults 18-26 years

Community Services

Adolescent Clubhouses: Eight BHA funded adolescent clubhouses across seven jurisdictions; serving approximately 2500 youth and their families annually, developing focused initiative on young adult peer specialist

Naloxone Availability: Increased the supply of Naloxone with funding from the Cures Act grant and Opioid Operations Command Center (OOCC) funded by Governor Hogan; Naloxone project $1.5M

Clinical Support Services: Launched a new clinical consultation service for buprenorphine prescribers, in partnership with the University of Maryland, to support care delivery

Crisis Beds and Services: Funded additional crisis beds for individuals with substance use disorders that include buprenorphine induction (Allegany County, Baltimore City, Anne Arundel County, and Kent County)

Student Assistance Program: Implemented Evidence-based Botvin Life Skills Prevention Curriculum in middle and high schools

The Maryland Department of Health's Responses to the DLS FY 2019 Behavioral Health Administration Budget Analysis February 15, 2018 (House) and February 16, 2018 (Senate)

The department should comment on the status of the late JCR report [regarding SUD treatment rates]. (pg. 4, 29)

The Department submitted the JCR report regarding SUD treatment rates on February 14, 2018. The report was late due to internal review. The Department apologizes for not sending an extension request to the General Assembly.

The department should also comment on when OOCC can be expected to make funding decisions for fiscal 2019 and when local jurisdictions and other providers can expect to receive their funds based on that timeline. (pg. 4, 33)

In preparation for FY19, the Opioid Operational Command Center (OOCC) has already undergone a process to review and validate the Opioid Intervention Team (OIT) Grant funding formula. It is the OOCC's intention to notify jurisdictions of their FY 2019 funding amounts by spring, 2018. It is the OOCC's intention that OIT Grants will be fully awarded to all jurisdictions prior to the beginning of the fiscal year, and that funds will be available for drawdown beginning July 1, 2018.

Further, the Department of Legislative Services (DLS) recommends the adoption of committee narrative continuing to request quarterly reports from OOCC on spending from the Opioid Crisis Fund. (pg. 4, 33)

The OOCC concurs with the recommendation.

The department should comment on which recommendations from the BHAC crisis report it plans to implement and provide a timeline for implementation. (pg. 4, 35)

The Behavioral Health Administration (BHA) is committed to creating comprehensive crisis response centers (CCRC) that provides a rich range of crisis stabilization services to individuals with a primary mental health diagnosis and/or co-occurring substance use and mental health disorders experiencing an acute behavioral health crisis. BHA launched a CCRC workgroup on January 30, 2018 to work with BHA and Behavioral Health Systems Baltimore, Inc. to develop and implement a plan for the development of a CCRC at MedStar Harbor Hospital. The planning group include representatives from the Department, BHSB, Baltimore City Police Department, Baltimore City Emergency Medical Services, Harbor Hospital staff, Maryland Hospital Association, and the Behavioral Health Advisory Council.

Timeline: Six meetings will take place for the development of CCRC. **Goal 6 months for development of the program plan for the center with and and anticipated launch in FY19. (Recommendation 1)**

The Behavioral Health Administration has awarded funding from the MORR grant authorized through the 21st Century Cures Act to develop a 24/7, 35 bed Crisis Stabilization Center in Baltimore City. The Stabilization Center will offer a safe place for individuals under the influence of drug and/or alcohol use. Short-term Interventions such as, buprenorphine induction, medical screening, and monitoring will be available. In addition, recipients will be offered the opportunity to connect with ongoing behavioral health treatment, peer recovery support, and case management. A case manager or peer recovery specialist will be assigned to the person to provide follow-up services and facilitate connection to care.

Behavioral Health Systems Baltimore issued a RFP for the Center in November 2017. Tuerk House was selected as the vendor and will be responsible for operating the Center. Individuals will be transported to the facility by Emergency Medical Services (EMS) and Baltimore Crisis Response, Inc. (BCRI). BCRI will provide linkage to on-going community-based care following discharge from the Center.

The Tuerk House facility is currently being renovated to accommodate this new service. This has been designated as the temporary location for the project and will accommodate 15 beds. Bed capacity will be expanded to 35 in the Center's permanent location, which is planned to be at the Hebrew Orphan's Asylum located next door to the Tuerk House.

Timeline: Services are projected to begin April 1, 2018 at the Tuerk House location.

Allegany and Cecil Counties have expressed an interest in developing a crisis stabilization center. Allegany is in the preliminary stages of development. Cecil County seeks to establish a 16 bed crisis center to serve reaching nearly 5,000 clients, annually through walk-in and mobile crisis outreach.

In addition to the development of the crisis stabilization center, BHA awarded MORR grant funding to four jurisdictions: Baltimore City, Allegany, Anne Arundel, and Kent Counties to develop crisis beds co-located within Level 3.7 residential treatment facilities. Eight crisis services providers were selected within the four selected jurisdictions. A total of 161 beds are projected to be developed through this funding. Currently, 58 of these crisis beds are operational. From November 2017 to January 30, 2018, eighty-nine individuals were served. In addition to crisis services, Care Coordination was provided by Peer Support Specialist to assist individuals to connect to community services. (**Recommendation 1)**

BHA, in collaboration with MABHA and the BHAC Crisis Services subcommittee will work to implement the recommendations of the BHAC Crisis Services report. BHA's primary interest is the establishment of the mobile crisis teams and walk-in centers in each jurisdiction **(Recommendation 1)**. Currently, there are three walk-in centers and 12 mobile crisis teams funded at a total of nearly $3.3 million. Based on available funding, needs assessment, and service readiness, BHA will work with jurisdictions to prioritize implementation of the recommended services. Preliminary analysis is expected to be completed by April 30, 2018.

BHA and representation from the Maryland Association of Behavioral Health Authorities (MABHA) participate on the BHAC. BHA and MABHA representative will work with the council and other stakeholders to determine how jurisdictions can be divided into regions for purposes of developing these services to maximize geographic access to crisis services for citizens throughout the State. **(Recommendation 3)**

In addition, BHA will work with MABHA to develop jurisdictional advisory groups **(Recommendation 4)**. BHA will present to MABHA the goals, objectives, and guidelines of the advisory group at their April meeting or next available opportunity, based on their agenda. BHA will reach out to BHAC to further explore the intention of the recommendation.

BHA is invested in collecting data to better understand utilization and outcomes. BHA will work with the newly established advisory groups to research and develop data collection tools **(Recommendation 7)**. BHA will communicate (via email and/or in-person) with the two sites identified by BHAC as comprehensive, crisis services sites **(Recommendation 2)**.

In addition to the five recommendations discussed, BHA will work with Medicaid to further explore the feasibility of **Recommendation 5**. Also, BHA's Accreditation Workgroup will provide guidance on **Recommendation 8**. The Workgroup has advised that the process is, at minimum, one year.

The department should comment on what steps it has taken thus far to improve relationships between acute general hospitals and community-based behavioral health providers and what potential actions the department may be considering in the future. (pg. 4, 44)

BHA has implemented three programs in select hospitals around Maryland: Screening, Brief Intervention and Referral to Treatment (SBIRT), Overdose Survivors Outreach, and Hospital-Based Buprenorphine Initiative. All three of these target those who have overdosed or are at risk of overdosing. The models embed peers in the Emergency Department who are responsible for coordinating with medical staff and accessing treatment for the individuals. Outreach occurs when the individual leaves the Emergency Department without immediate admission to substance use disorder treatment services. To date, 15 hospitals have or are in the process of implementing SBIRT and outreach. Six hospitals have implemented buprenorphine induction. All projects, particularly the buprenorphine induction, require close working relationships between the Emergency Department and community-based treatment providers.

In collaboration with the Maryland Hospital Association, BHA held 5 webinars through the summer/fall, 2017, for hospital emergency department staff. Subjects included naloxone prescribing/dispensing upon discharge, Screening, Brief Intervention, Referral to Treatment, medication-assisted treatment, buprenorphine induction, and opioid-related requirements impacting hospital-based providers.

BHA's Office of Child, Adolescent, and Young Adult Services, in conjunction with the statewide network of local government Child and Adolescent Coordinators, developed a standard referral form for Targeted Case Management (TCM): Care Coordination for Children and Youth.

The purpose was to streamline the referral process from hospitals and other providers across the State. Providers of TCM and the local jurisdictional child and adolescent coordinators were strongly encouraged to conduct targeted outreach to hospitals serving children and youth in their service areas for the purpose of increasing referrals as a part of the hospital discharge planning process.

The Department wrote a letter of support to Maryland Health Commission to support Adventist's CON application. Specifically, the CON application seeks to combine both Adventist Behavioral Health & Wellness (ABH) psychiatric services in Rockville and the Washington Adventist Hospital (WAH) psychiatric beds from Takoma Park into Shady Grove Medical Center (SGMC), an acute general hospital. Currently, the services provided to adults at the ABH and WAH facilities are not eligible for a Medicaid match due to the federal Medicaid Institutions for Mental Diseases (IMD) rules. Once the beds are located at the acute general facility, the services will be eligible for a federal Medicaid match.

In addition, the Department plans on further expanding its Medicaid SUD residential waiver program to include psychiatric IMDs. While CMS was clear it would not approve psychiatric IMD services under the waiver, CMS has indicated that it may be possible to include those individuals being treated in psychiatric IMDs who have a primary diagnosis of SUD. The additional federal matching dollars should allow the Department to expand treatment in psychiatric IMDs. This would free up capacity in the acute general hospitals.

The department should comment on the development process for the local plans. (pg. 5, 47)

BHA is working in collaboration with the local authorities including the Core Services Agencies (CSAs), Local Addiction Authorities (LAAs), and Local Behavioral Health Authorities (LBHAs) to develop a strategy for systems integration at the jurisdictional level. BHA established the BHA Systems Integration Advisory Group to guide this process. The Advisory Group is comprised of representatives of CSAs, LAAs, LBHAs, consumer advocacy community, behavioral health providers, public health, Medicaid, primary care and forensics/justice. BHA has worked with this body and other key stakeholders to develop guiding principles for strategic integration of behavioral health at the systems level. The Advisory Group is providing input to the development of a multi-year plan to support local behavioral health systems management integration. The plan is intended to help local jurisdictions address technical and operation issues such as: communicating the value-proposition for system management; stages of integration and elements of integrated systems management. Because each region is unique regarding its population base, geography current agency structures and organizational histories, the approach to integrating local systems management for the behavioral health system will differ among Maryland's 24 jurisdictions. A blueprint that includes information and parameters for local jurisdictions systems management activities to achieve integration will be developed in concert with the Advisory Group and other stakeholders by July 2018. This represents a significant systems change activity which will take several years to successfully complete.

The department should comment on why the contract was initially signed without knowledge that the provisions were unenforceable, why the terms have yet to be modified, what new performance metrics the department is considering to include in the ASO contract, and when a modification to the contract will be done. (pg. 5, 47)

The contract has always contained performance measures related to typical duties of an Administrative Service Organization which include call center metrics, claims payment, and measures that are specific to the daily function of behavioral health administration. In 2013 as the RFP was in development, a decision was made to include health improvement related performance metrics and attach them to HEDIS measures. It was not known at the time that HEDIS data was not available in the frequency and within the timelines that would be required for the ASO to make an impact on the measures. The problem was first identified in late 2015 but at the time, it was thought a resolution could be found. By the end of 2016, it was determined that the data share was not going to be feasible. Work on developing new measures began in 2017 and were completed by December of 2017. These new measures are based on data that is obtained in real-time by the ASO.

The modification was approved January 17, 2018 (final approval letter received 2/13/2018). The measures will be implemented during this contract year (2018) with a one-time assessment to determine improvement or failure to improve by the end of the final contract year (2019).
The new measures include:

1. Follow up after behavioral health hospitalization
2. Mental Health Readmission rate (this measure was in the original contract and has continued to be tracked)
3. Initiation and Engagement of Newly Diagnosed consumers with substance use disorder
4. Individuals diagnosed with schizophrenia and antipsychotic medication adherence
5. Adherence of antidepressant medication use for consumers diagnosed with major depression post inpatient hospitalization

The department should comment on why the reports [on limiting the availability of tobacco products to minors and on SUD treatment rates] are late without any notification that the reports would be late. (pg. 5, 47)

The Department submitted the reports regarding SUD treatment rates and on limiting the availability of tobacco products to minors on February 14, 2018. The reports were late due to internal review. The Department apologizes for not sending an extension request to the General Assembly.

Add budget bill language requesting a report on the appropriate staffing levels required at the facilities operated by the Behavioral Health Administration. (pg. 5, 48)

The Department concurs with the recommendation.

Add budget bill language restricting surplus funds [$2.5 million GF] to only be spent on opioid crisis initiatives through the Opioid Operational Command Center. (pg. 5, 48)

The Department respectfully disagrees with the recommended reduction because it is based on a DLS projection that the FY 2019 Allowance for behavioral health community services will have a projected surplus that is available for redirecting to the Opioid Operational Command Center. Please refer to the Department's written response below discussing the Department's contentions with DLS' projection.

DLS recommends deleting the deficiency appropriation for SUD residential treatment services [$3,264,681 GF] and reducing general funds by $8 million in fiscal 2019. DLS also recommends withholding an additional $2.5 million for the Opioid Crisis Fund to backfill funds used for rates from that program. (pg. 5, 6, 24)

The Department respectfully disagrees with the recommended reductions because in the current climate of Maryland's opioid crisis, the reductions would limit the Department's ability to provide substance use disorder residential treatment services to individuals in need of treatment inclusive of court-ordered placements and pregnant women with children.

After discussions with DLS clarifying its methodology for projecting a $6.8 million GF surplus in FY 2018 and $10.5 million GF in FY 2019, the Department would offer the following observations:

- The DLS projection seems to rely on billing data from the Department's Administrative Services Organization, Beacon, that does not reflect grant-funded services included in the Behavioral Health Administration's FY 2018 and FY 2019 budgets. For example, while levels 3.3, 3.5, and 3.7 residential services transitioned from grant funding to fee for service this fiscal year, level 3.1 services will not transition to fee for service until January 1, 2019 and is not currently reflected in Beacon's billing data; $3.9 million GF is included in the FY 2019 Allowance for level 3.1 residential services. A portion of the Specialty residential services for pregnant women with children and for court-ordered placements were also grant funded to the local jurisdictions for the first six months of FY 2018, which would not be reflected in the billing data; these have projected costs of $2 million GF in FY 2018 and an annualized cost of $4 million GF in FY 2019.

- Billing data for standard adult beds' SUD residential treatment services only reflects six months of a transition to fee for service, which the Department believes is too preliminary to confidently project a surplus in this spending area for the next 18 months. The billing data through December 2017 did not reflect a catch-up payment to a provider that spanned multiple months that was paid out at the end of January 2018 totalling $1.4 million and an annualized cost of $2.8 million GF in FY 2018 and FY 2019.

- While the transition to fee for service for SUD residential treatment services allows for Medicaid reimbursement, Medicaid reimbursement is only eligible for two nonconsecutive 30 day stays in a rolling year for treatment. Treatment beyond the initial

30 days of a stay along with all room and board costs are entirely funded with general funds in the Behavioral Health Administration's budget. The Department projects that the relatively small amount of general fund savings from Medicaid reimbursement will be needed to cover the room and board and cost related to additional days of clinical care beyond the allowed 30 days that are required by individuals who meet medical necessity criteria for this service.

- The Department projects that the transition to fee for service for court-ordered placements and pregnant women with children will increase enrollment up to the State's physical bed capacity for these two bed types, which is 276 beds for court-ordered placements and 110 beds for pregnant women with children. Without prior experience in transitioning these bed types to fee for service to project forward, the Department believes enrollment will increase based on its work in establishing a dialogue with judges and affiliated personnel concerning the availability of this service and BHA's ability to place individuals promptly.

Add budget bill language restricting Medicaid behavioral health provider reimbursements to that purpose. (pg. 5, 49)

The Department respectfully disagrees with the recommendation because it prohibits the Department from shifting any general fund savings from Medicaid-funded behavioral health services to non-Medicaid-funded behavioral services. In the event that non-Medicaid-funded behavioral services increase in demand and cost during the fiscal year, the restriction language forces the Department to cover the costs by shifting general funds away from other unrelated spending areas that support public health and the developmentally disabled. Additionally, the restriction language limits the Behavioral Health Administration and the Medicaid Administration's flexibility in managing their generally funded budgets, which is especially important as these two administrations continue to adjust to unpredictable trends in substance use disorder residential treatment services' transition to fee for service.

The Department should comment on the project being undertaken by MSA, how the department intends to pay for their portion of the study, and further comment on why operating funds were not placed in the allowance if the department no longer seeks to dispose of the property. (pg. 25)

At the request of the 2017 Joint Chairmen's Report, the Department is currently procuring a consultant to help develop the Department's master facilities plan that will help inform the Department on how to proceed with the Crownsville property. In this context the Department is not actively pursuing any specific development project at the current moment for the Crownsville property, and an interagency agreement with the Maryland Stadium Authority to conduct a property assessment is currently on hold. The Department also has no plans to cancel any existing leases with tenants on the Crownsville property.

With uncertainty in recent years around the Crownsville property's disposal, the Department of Budget and Management and the Maryland Department of Health agree that the Crownsville

property's Allowances should provide a bare-minimum level of support from the onset and then be reevaluated mid-fiscal-year for adequacy. The Crownsville property's FY 2018 working budget follows this practice: After budgeting only $549,810 TF for Crownsville's DBM-controlled Statewide costs last session for the FY 2018 Allowance, a deficiency of $739,886 TF is provided this session to cover Crownsville's other operating costs to maintain the property for the rest of the fiscal year. Crownsville's FY 2019 Allowance follows suit.