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FISCAL AND POLICY NOTE
Enrolled - Revised

Senate Bill 967

(Senator Klausmeier, *et al.*)Finance and Education, Health, and
Environmental Affairs

Health and Government Operations

Heroin and Opioid Prevention Effort (HOPE) and Treatment Act of 2017

This emergency bill consolidates into one bill provisions that make more readily available certain prescription drugs for opioid use disorders and opioid overdose reversal; enhance local oversight of overdoses; broaden authority of the Department of Health and Mental Hygiene (DHMH) relating to controlled dangerous substance (CDS) registration; develop additional services to treat individuals with substance use disorders, including expanding the scope of drug courts and the health crisis hotline and establishing crisis treatment centers; and ensure community behavioral health providers receive rate adjustments. The bill also expresses legislative intent that the \$10.0 million for the opioid crisis fund in the fiscal 2018 operating budget be used to implement the bill's provisions.

Most provisions take effect June 1, 2017. A prior authorization provision takes effect January 1, 2018.

Fiscal Summary

State Effect: No effect in FY 2017. Minimal increase in Maryland Insurance Administration (MIA) special fund revenues in FY 2018. DHMH general fund expenditures increase by \$1.4 million in FY 2018 and \$22.6 million in FY 2019; federal fund revenues and expenditures increase by \$18.6 million in FY 2019 due to the Medicaid match. Judiciary general fund expenditures increase by \$2.0 million in FY 2019. Future year expenditures primarily reflect the compounding effect of the rate increase and ongoing costs. **This bill establishes a mandated appropriation beginning in FY 2019.**

(\$ in millions)	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
SF Revenue	-	\$0	\$0	\$0	\$0
FF Revenue	-	\$18.6	\$36.9	\$52.8	\$52.8
GF Expenditure	\$1.4	\$24.6	\$42.2	\$59.8	\$59.9
FF Expenditure	-	\$18.6	\$36.9	\$52.8	\$52.8
Net Effect	(\$1.4)	(\$24.6)	(\$42.2)	(\$59.8)	(\$59.9)

Note: () = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate increase; (-) = indeterminate decrease

Local Effect: Potential significant increase in revenues and expenditures in FY 2019, to the extent jurisdictions receive grants to expand drug court programs. Other provisions are expected to have a minimal impact on local fatality review teams, local health departments (LHDs), and local jails and detention centers, as discussed below.

Small Business Effect: Meaningful.

Analysis

Bill Summary: The bill, on an emergency basis, expresses the intent of the General Assembly that the \$10.0 million for the opioid crisis in the fiscal 2018 operating budget be used to implement the bill's provisions.

As of June 1, 2017, the bill does the following: (1) expresses the intent of the General Assembly that the Judiciary request an appropriation of at least \$2.0 million in additional funding in fiscal 2019 for grants to expand the scope of drug courts; (2) establishes that DHMH may take certain actions relating to a CDS registration; (3) authorizes local fatality review teams to review nonfatal overdoses; (4) requires DHMH to establish crisis treatment centers, a crisis hotline, and disseminate specified opioid use disorder information; (5) requires each health care facility and system to make the services of specified providers available to patients; (6) repeals certification requirements within the Overdose Response Program; (7) requires DHMH to establish guidelines for co-prescribing opioid overdose reversal drugs; (8) requires the Governor's proposed budget for fiscal 2019 through 2021 to include specified rate adjustments for community behavioral health providers; (9) requires hospitals to develop and report certain discharge protocols; and (10) requires the Department of Public Safety and Correctional Services (DPSCS) and local jails and detention centers to develop plans for substance use disorder treatment.

Beginning January 1, 2018, the bill also authorizes specified carriers to apply a prior authorization requirement for an opioid antagonist only under specified circumstances.

Most of these provisions are discussed in more detail below.

Drug Courts

The State Court Administrator must assess drug court programs in circuit courts, including juvenile courts, and the District Court to determine how to increase these programs in a manner sufficient to meet each county's needs. The State Court Administrator must disburse grants authorized by the \$2.0 million appropriation in the fiscal 2019 budget based on the population of each county.

Controlled Dangerous Substance Registrations

DHMH may deny, suspend, revoke, or refuse to renew a registration to manufacture, distribute, or dispense a CDS if the applicant or registrant has surrendered federal registration or has failed to meet the requirements for registration. The bill authorizes DHMH to limit an initial registration or the renewal of a registration to the particular CDS for which grounds for denial or refusal to renew exist.

Crisis Treatment Centers

The Behavioral Health Administration (BHA) within DHMH must establish crisis treatment centers, and at least one must be established by June 1, 2018. Clinical staff must be available 24 hours a day and 7 days a week to make assessments and level of care determinations and connect individuals experiencing a substance use disorder crisis with immediate care. BHA must establish the treatment centers in a manner that is consistent with the Behavioral Health Advisory Council's strategic plan, which is required to be submitted by December 31, 2017 (under Chapters 405 and 406 of 2016). BHA must submit a status report to the Joint Committee on Behavioral Health and Opioid Use Disorders on the establishment of the treatment centers by September 1, 2017, and each year thereafter until the required centers are established.

Health Crisis Hotline

DHMH must establish and operate a toll-free health crisis hotline that is available 24 hours a day and 7 days a week to assist callers by (1) conducting specified health screenings; (2) conducting risk assessments for callers experiencing an overdose or potentially committing suicide or homicide; (3) connecting callers to an emergency response system; (4) referring callers for ongoing care; and (5) following up with callers to determine if the callers' needs were met. DHMH must train staff for the hotline and disseminate information about the hotline to the public. Further, DHMH must maintain up-to-date and accurate information regarding (1) specified behavioral health programs, including private programs and programs administered by LHDs; (2) hospitals and other facilities that provide detoxification services; (3) the levels of care provided at these programs, hospitals, and other facilities; (4) whether these entities accept insurance; and (5) whether these entities offer services for pregnant women, specific genders, individuals with co-occurring disorders, parental support for children with behavioral health disorders, and grief support.

Opioid Use Disorder Information

DHMH must identify up-to-date, evidence-based, written information about opioid use disorder that (1) has been reviewed by medical experts and organizations specializing in the treatment of opioid use disorder; (2) is designed for use by health care providers and

individuals with opioid use disorder and their families; (3) is culturally and linguistically appropriate for potential recipients of the information; and (4) includes specified information. DHMH must provide this information to health care facilities and providers that treat opioid use disorder. These facilities and providers must make the information available to each patient who is treated for opioid use disorder.

Availability of Opioid Addiction Treatment Prescribers

For purposes of these provisions, “health care facility” means a hospital, a federally qualified health center, an outpatient mental health clinic, an outpatient or residential addiction treatment provider, and an LHD.

Also, for purposes of these provisions, “opioid addiction treatment medication” means a medication approved by the federal Food and Drug Administration for the treatment of opioid use disorders.

Each health care facility that is not part of a health care system and each health care system must make the services of health care providers who are trained and authorized under federal law to prescribe opioid addiction treatment medications, including buprenorphine, available to patients. A health care facility or system may directly employ, contract with, or refer a patient to a qualified health care provider or may deliver the services in person or via telehealth in order to meet the bill’s requirements.

Overdose Response Program

The bill makes several changes to the Overdose Response Program, including repealing the requirement that specified health care providers may only prescribe or dispense naloxone to a program certificate holder. The bill repeals existing certification requirements and instead specifies that an individual is not required to obtain specified training and education in order for a pharmacist to dispense naloxone to the individual.

Even so, DHMH may authorize private or public entities to conduct education and training on opioid overdose recognition and response that includes (1) education on recognizing the signs and symptoms of an opioid overdose; (2) training on responding to an opioid overdose, including the administration of naloxone; and (3) access to naloxone and the necessary supplies for the administration of the naloxone.

An authorized private or public entity must enter into a written agreement with a licensed health care provider with prescribing authority to establish protocols for the prescribing and dispensing of naloxone under the Overdose Response Program.

An individual may (1) receive a prescription for naloxone and the necessary supplies for its administration from any licensed health care provider with prescribing authority; (2) possess the prescribed naloxone and necessary supplies for its administration; and (3) in an emergency situation when medical services are not immediately available, administer naloxone to an individual experiencing or believed to be experiencing an opioid overdose.

A licensed health care provider with prescribing authority may prescribe and dispense naloxone to an individual who is believed to be at risk of experiencing an opioid overdose or is in a position to assist the individual at risk of experiencing an opioid overdose. Such a health care provider may also prescribe and dispense naloxone by issuing a standing order if the licensed health care provider (1) is employed by DHMH or an LHD or (2) has a written agreement with an authorized private or public entity. A licensed health care provider who issues a standing order may delegate the dispensing of naloxone to an employee or volunteer of an authorized private or public entity in accordance with a written agreement between the delegating licensed health care provider and the authorized private or public entity that employs the employee or volunteer. A licensed health care provider with dispensing authority may also dispense naloxone to any individual in accordance with a standing order that is issued by a licensed health care provider with prescribing authority as described above.

The bill applies existing exemptions from disciplinary action and immunity provisions to individuals who administer, prescribe, or dispense naloxone in accordance with the bill.

Co-prescribing of Opioid Overdose Reversal Drugs

The Secretary of Health and Mental Hygiene must establish guidelines for the co-prescribing of opioid overdose reversal drugs, as defined in the bill, that are applicable to all licensed health care providers in the State who are authorized to prescribe a monitored prescription drug. The guidelines must address the co-prescribing of opioid overdose reversal drugs for patients who are at an elevated risk of overdose and are (1) receiving opioid therapy for chronic pain; (2) receiving a prescription for benzodiazepines; or (3) being treated for opioid use disorders. The Secretary must establish the guidelines by December 1, 2017.

Behavioral Health Community Provider Reimbursement Rates

For purposes of these provisions, “community provider” means a community-based agency or program funded by BHA or the Medical Care Programs Administration to serve individuals with mental disorders, substance-related disorders, or a combination of these disorders.

The bill requires the Governor's proposed budget for fiscal 2019 and 2020 to include a 3.5% rate increase for community providers over the funding provided in the prior year's legislative appropriation for specified services; for fiscal 2021, if a required payment system has not been implemented, a 3.0% rate increase must be included in the Governor's proposed budget.

The bill expresses the intent of the General Assembly that a substantial portion of the rate adjustment be used to compensate direct care staff and licensed clinicians employed by community providers and to improve the quality of programming provided. Thus, the bill establishes that the increased funding provided under the bill may only be used to increase the rates paid to community providers (that are accredited by an approved accrediting body and licensed by the State) and to health care providers (who are acting within the scope of their licenses or certificates under the Health Occupations Article).

If community providers' services are provided through managed care organizations (MCOs), the MCOs must (1) for the first fiscal year the MCOs provide the services, pay the rate in effect during the prior fiscal year and (2) adjust the rate for community providers each fiscal year by at least the same amount as specified in the bill. However, the bill's provisions do not apply to reimbursement for any service provided by a community provider whose rates are regulated by the Health Services Cost Review Commission.

In addition, the bill establishes that the Governor's proposed budget for fiscal 2019 through 2021 for community providers must be presented in the same manner as provided for in the fiscal 2018 budget.

DHMH's BHA and Medical Care Programs Administration must jointly (1) conduct an independent cost-driven, rate-setting study to set community provider rates that includes a rate analysis and an impact study that considers the actual cost of providing community-based behavioral health services; (2) develop and implement a payment system incorporating the study's findings, including projected costs and recommendations on funding; and (3) consult with stakeholders, including providers and individuals receiving services, in conducting the study and developing the payment system.

By December 1, 2018, DHMH must submit an interim report on the delivery system through which community-based behavioral health services should be provided and any preliminary recommendations regarding the required payment system. DHMH must complete the required study by September 30, 2019. Further, DHMH must adopt regulations to implement the required payment system.

By December 1, 2019, and each year thereafter, DHMH must submit a report on the impact of the rate adjustment and the payment system on community providers, including the impact on (1) the wages, salaries, and benefits provided to direct care staff and licensed

clinicians employed by community providers; (2) the tenure and turnover of direct care staff and licensed clinicians employed by community providers; and (3) the ability of community providers to recruit qualified direct care staff and licensed clinicians. DHMH may require community providers to submit necessary information in order to complete the report.

Additionally, by December 1, 2019, DHMH must submit a report that (1) details outcome measures that reasonably can be collected for each treatment modality offered by community providers for which the rate would be adjusted under the bill and (2) includes specified recommendations on how reimbursement rates can be tied to outcomes.

Hospital Discharge Protocol

By January 1, 2018, hospitals must have a discharge protocol for an individual who was treated for a drug overdose or identified as having a substance use disorder. The protocol may include (1) coordination with peer review counselors to conduct a Screening, Brief Intervention, and Referral to Treatment and (2) prescribing naloxone for the patient.

Beginning in 2018, a hospital must submit the protocol to the Maryland Hospital Association (MHA). MHA must submit a report with the protocols to specified committees of the General Assembly by December 1, 2018. MHA must also conduct a study that identifies opportunities to support a comprehensive treatment continuum for individuals with substance use disorders in hospitals in the State (including withdrawal management) and includes an assessment of the barriers to providing such care. MHA must submit a report with its findings and recommendations to specified committees of the General Assembly by December 1, 2017.

Prior Authorization for Opioid Antagonists (Effective January 1, 2018)

The bill authorizes insurers, nonprofit health service plans, and health maintenance organizations (collectively known as carriers) that provide coverage for prescription drugs, including coverage through a pharmacy benefits manager (PBM), to apply a prior authorization requirement for an “opioid antagonist” on the carrier’s formulary *only if* coverage is provided for at least one formulation of the opioid antagonist without a prior authorization requirement.

This provision of the bill takes effect January 1, 2018, and applies to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after that date.

Substance Use Disorder Treatment Plans for State Prisons and Local Jails and Detention Centers

The bill requires DPSCS and each local jail and detention center, in collaboration with DHMH and stakeholders, to develop a plan to increase substance use disorder treatment in State prisons and local jails and detention centers, including medication-assisted treatment (MAT). Each local jail and detention center must submit a plan to DPSCS by November 1, 2017, and DPSCS must submit all the plans and any recommendations in a report to the General Assembly by December 1, 2017.

Additional Reporting Requirements

By January 1, 2018, DHMH, in consultation with the Governor's Office of Crime Control and Prevention and interested stakeholders, must submit a report to specified committees of the General Assembly on new, innovative, evidence-based programs and methods to better manage the State's substance abuse and opioid crisis.

The bill expresses the intent of the General Assembly that DHMH use the \$10.0 million in general funds that is included in the fiscal 2018 operating budget for the opioid crisis fund to prioritize the funding of services established under the bill. Accordingly, by January 1, 2018, DHMH must submit a report on how the funds were used and the criteria for the use of the funds. These provisions related to the funding are designated as emergency provisions, which take effect on the date the bill is enacted.

Current Law:

Drug Courts

Maryland's first two drug courts were established in Baltimore City in 1994. A drug court is a specialized docket that handles drug and dependency-related cases through judicial intervention, intensive monitoring, and continuous substance abuse treatment. These programs are used for offenders who are charged with less serious drug crimes and who do not have a history of violence. The drug court program provides options other than commitment or incarceration. Participants are generally assigned to one of two tracks: probation or diversion from prosecution in exchange for a plea of guilty; or admission of a delinquent act. Terms of program participation require intensive supervision and alcohol and other drug treatment.

Controlled Dangerous Substance Registrations

A person must be registered by DHMH in order to manufacture, distribute, or dispense a CDS in the State. DHMH may deny, suspend, revoke, or refuse to renew a registration if

DHMH finds that the applicant or registrant has (1) materially falsified an application; (2) been convicted of a crime under any federal or state law relating to CDS; (3) had federal registration suspended or revoked and may no longer manufacture, distribute, or dispense a CDS; or (4) otherwise violated State law relating to CDS. DHMH may limit revocation or suspension of a registration to the particular CDS for which grounds for revocation or suspension exist.

Local Fatality Review Teams

A “local team” means the multidisciplinary and multiagency drug overdose fatality review team established for a county. The purpose of each team is to prevent drug overdose deaths by promoting cooperation and coordination among agencies that investigate drug overdose deaths, understanding the causes of such deaths, developing plans and changes within agencies, and advising DHMH on changes to prevent drug overdose deaths. To achieve this purpose, each team must review drug overdose death cases, among other activities.

Behavioral Health Crisis Centers

The Maryland Behavioral Health Crisis Response System (BHCRS) is required to (1) operate a statewide network utilizing existing resources and coordinating interjurisdictional services to develop efficient and effective crisis response systems to serve all individuals in the State 24 hours a day and 7 days a week; (2) provide skilled clinical intervention to help prevent suicides, homicides, unnecessary hospitalizations, and arrests or detention, and to reduce dangerous or threatening situations involving individuals in need of behavioral health services; and (3) respond quickly and effectively to community crisis situations.

In each jurisdiction, a crisis communication center provides a single point of entry to the system and coordination with the local core service agency (CSA) or local behavioral health authority, police, emergency medical service personnel, and behavioral health providers.

Crisis communication centers *may* provide programs that include the following:

- a clinical crisis telephone line for suicide prevention and crisis intervention;
- a hotline for behavioral health information, referral, and assistance;
- clinical crisis walk-in services, including triage for initial assessment, crisis stabilization until additional services are available, linkage to treatment services and family and peer support groups, and linkage to other health and human services programs;

- critical incident stress management teams providing disaster behavioral health services, critical incident stress management, and an on-call system for these services;
- crisis residential beds to serve as an alternative to hospitalization;
- a community crisis bed and hospital bed registry, including a daily tally of empty beds;
- transportation coordination, ensuring transportation of patients to urgent appointments or to emergency psychiatric facilities;
- mobile crisis teams operating 24 hours a day and 7 days a week to provide assessments, crisis intervention, stabilization, follow-up, and referral to urgent care, and to arrange appointments for individuals to obtain behavioral health services;
- 23-hour holding beds;
- emergency psychiatric services;
- urgent care capacity;
- expanded capacity for assertive community treatment;
- crisis intervention teams with capacity to respond in each jurisdiction 24 hours a day and 7 days a week; and
- individualized family intervention teams.

BHA determines the implementation of BHCRS in collaboration with the local CSA or local behavioral health authority serving each jurisdiction. Additionally, BHCRS must conduct an annual survey of consumers and family members who have received services from the system. Annual data collection is also required on the number of behavioral health calls received by police, attempted and completed suicides, unnecessary hospitalizations, hospital diversions, arrests and detentions of individuals with behavioral health diagnoses, and diversion of arrests and detentions of individuals with behavioral health diagnoses.

Chapters 405 and 406 of 2016 required the Behavioral Health Advisory Council, in consultation with CSAs, community behavioral health providers, and interested stakeholders, to develop a strategic plan for ensuring that clinical crisis walk-in services and mobile crisis teams are available statewide and operating 24 hours a day and 7 days a week. The council was required to submit an update on the development of the strategic plan by December 31, 2016. The council must submit the strategic plan in its 2017 annual report, which is required by December 31, 2017.

Buprenorphine Prescription

Buprenorphine is used in MAT to help people reduce or quit their use of heroin or other opiates. Buprenorphine was the first medication to treat opioid addiction that is permitted to be prescribed or dispensed in physicians' offices.

Under the federal Controlled Substances Act, a qualifying practitioner may apply for a waiver from the annual registration requirement for dispensing or prescribing Schedule III, IV, or V narcotic drugs for maintenance or detoxification treatment, including buprenorphine, if the practitioner submits a notice to the U.S. Secretary of Health and Human Services of the practitioner's intent to dispense such drugs. A waiver may be obtained for the treatment of up to 30 patients at one time. However, one year after the practitioner submits the initial notice, the physician may submit a second notice of the need and intent to treat up to 100 patients.

Through new regulations, effective August 8, 2016, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) increased the maximum number of patients a qualifying practitioner may treat at one time from 100 patients to 275, subject to renewal every three years. According to SAMHSA, licensed physicians who have had a waiver to treat 100 patients for at least one year are eligible for the increased limit if they (1) hold additional specified credentials; (2) practice in a qualifying practice setting; (3) have not had their Medicare enrollment and billing privileges revoked; and (4) have not violated the federal Controlled Substances Act. Additionally, practitioners with a current waiver to treat up to 100 patients but who are not otherwise eligible to apply for a waiver for the increased limit may request a temporary increase for up to 275 patients to address emergency situations, which is valid for up to six months. To the extent possible, SAMHSA will consult with appropriate governmental authorities to determine if the emergency situation justifies the increase. An "emergency situation" is one where an existing substance use disorder system is overwhelmed or unable to meet the existing need for MAT as a direct consequence of a clear precipitating event, which must have an abrupt onset (*e.g.*, practitioner incapacity, natural or human-caused disaster, or a drug use outbreak).

Comprehensive Addiction and Recovery Act

President Barack Obama signed the Comprehensive Addiction and Recovery Act (CARA) on July 22, 2016. The law authorizes over \$181 million each year in new funding. Among other provisions, CARA:

- authorizes grants to federally qualified health centers, opioid treatment programs, and practitioners who offer office-based MAT to expand access to naloxone through co-prescribing;
- reauthorizes funding for the National All Schedules Prescription Electronic Reporting Act for states to improve or maintain a prescription drug monitoring program;
- directs the U.S. Secretary of Health and Human Services to develop recommendations regarding education programs for opioid prescribers;

- authorizes grants to states to expand evidence-based MAT in areas with high rates of opioid and heroin use;
- authorizes grants to state substance abuse agencies to carry out pilot programs for nonresidential treatment of pregnant and postpartum women; and
- authorizes grants to states to implement integrated opioid abuse response initiatives, including expanding availability of MAT and behavioral therapy for opioid addiction.

Section 303 of CARA expands office-based treatment by allowing nurse practitioners and physician assistants to prescribe buprenorphine for opioid addiction for five years (until October 1, 2021). Physician assistants and nurse practitioners must complete 24 hours of training to be eligible for a waiver to prescribe buprenorphine and must be supervised by or work with a qualifying physician if required by state law. Section 303 also specifies the training components for qualifying physicians. Additionally, office-based treatment practitioners must have the capacity (including necessary training) to either provide directly, or by referral, all drugs approved by the U.S. Food and Drug Administration for the treatment of opioid use disorders, including for maintenance, detoxification, overdose reversal, and relapse prevention.

Overdose Response Program

Chapter 299 of 2013 established the Overdose Response Program within DHMH to authorize certain individuals (through the issuance of a certificate) to administer naloxone to an individual experiencing, or believed to be experiencing, opioid overdose to help prevent a fatality when medical services are not immediately available. Chapter 356 of 2015 expanded the program to authorize standing orders for naloxone and provided additional legal protections for prescribers and those administering naloxone.

To qualify for a certificate to administer naloxone, an individual must (1) be 18 or older; (2) have, or reasonably expect to have, the ability to assist an individual who is experiencing an opioid overdose; and (3) successfully complete an educational training program offered by a private or public entity authorized by DHMH.

An educational training program must be conducted by a licensed physician, an advanced practice nurse, a pharmacist, or an employee or volunteer of a private or public entity who is supervised in accordance with a specified written agreement. Educational training must include (1) the recognition of opioid overdose symptoms; (2) the proper administration of naloxone; (3) the importance of contacting emergency medical services; (4) the care of an individual after the administration of naloxone; and (5) any other topics required by DHMH.

If an individual completes the training program and otherwise qualifies, an authorized private or public entity must issue a serialized certificate to the individual. A replacement certificate may be issued to replace a lost, destroyed, or mutilated certificate. Each certificate is valid for two years and may be renewed if the individual completes a refresher training program or demonstrates proficiency to the entity issuing the certificate.

Under the Overdose Response Program, a licensed physician or advanced practice nurse with prescribing authority may prescribe and dispense naloxone to a certificate holder. A registered nurse may dispense naloxone to a certificate holder in an LHD if the registered nurse complies with specified requirements.

A licensed physician or advanced practice nurse with prescribing authority may prescribe and dispense naloxone to a certificate holder by issuing a standing order if the physician or nurse is employed by DHMH or an LHD or supervises or conducts an educational training program under the Overdose Response Program. These physicians and nurses may also delegate dispensing authority to a licensed registered nurse who meets specified requirements or to an employee or volunteer of a private or public entity who is authorized to conduct an educational training program under the Overdose Response Program.

Any licensed health care provider who has dispensing authority may also dispense naloxone to a certificate holder in accordance with a physician's standing order. Licensed health care providers may also prescribe naloxone to a patient who is believed to be at risk of experiencing an opioid overdose or in a position to assist an individual who is at risk of experiencing an opioid overdose. A patient who receives a naloxone prescription does not need to hold a certificate from the Overdose Response Program.

Behavioral Health Community Provider Reimbursements

The fiscal 2018 operating budget includes a 2.0% rate increase for community behavioral health providers (totaling \$16.2 million) and a supplemental general fund appropriation of \$8.0 million for Medicaid community behavioral health provider reimbursements for fiscal 2017.

In its December 2015 final report, the Governor's Heroin and Opioid Emergency Task Force recommended that DHMH review Medicaid reimbursement rates for substance use disorder treatment every three years, in order to increase the workforce and expand access to care by attracting more practitioners to the field. Additionally, as part of its "Keep the Door Open" campaign, the Community Behavioral Health Association has also stated that indexing the reimbursement rate for behavioral health providers to the cost of inflation for medical care will expand access to care.

Health Benefit Plans

Maryland's mental health parity law (§ 15-802 of the Insurance Article) prohibits discrimination against an individual with a mental illness, emotional disorder, or substance use disorder by failing to provide benefits for the diagnosis and treatment of these illnesses under the same terms and conditions that apply for the diagnosis and treatment of physical illnesses.

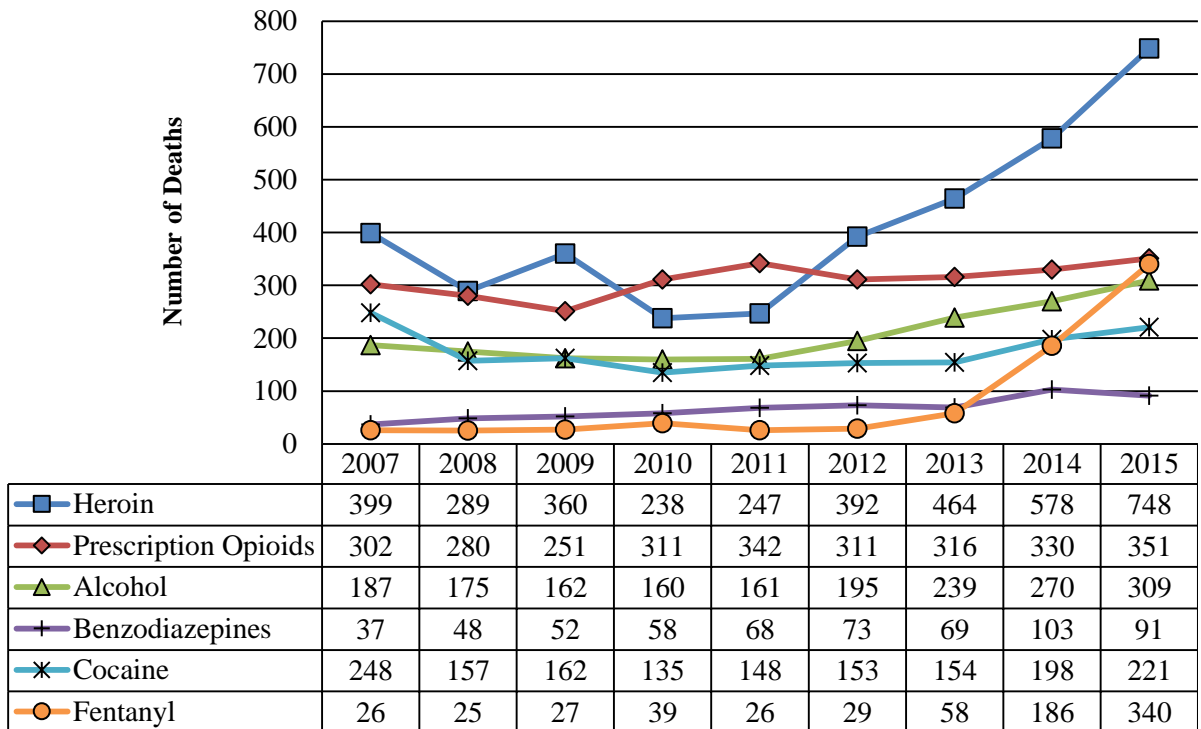
The federal Mental Health Parity and Addiction Equity Act (MHPAEA) requires group health plans of large employers, as well as qualified health plans sold in health insurance exchanges and in the small group and individual markets as of January 1, 2014, to equalize health benefits for addiction and mental health care and medical and surgical services in many fundamental ways. MHPAEA prohibits group health plans from imposing separate or more restrictive financial requirements or treatment limitations on mental health and substance use disorder benefits than those imposed on other general medical benefits. MHPAEA also imposes nondiscrimination standards on medical necessity determinations.

Background: In February 2015, the Governor issued two executive orders establishing the Governor's Inter-Agency Heroin and Opioid Coordinating Council and the Heroin and Opioid Emergency Task Force to establish a coordinated statewide and multijurisdictional effort to prevent, treat, and significantly reduce heroin and opioid abuse. Additionally, Chapter 464 of 2015 established the Joint Committee on Behavioral Health and Opioid Use Disorders. The joint committee is required to monitor the activities of the coordinating council and the effectiveness of the State Overdose Prevention Plan; local overdose prevention plans and fatality review teams; strategic planning practices to reduce prescription drug abuse; and efforts to enhance overdose response laws, regulations, and training. In January 2017, the Governor issued another executive order establishing an Opioid Operational Command Center within the coordinating council to facilitate coordination and sharing of data among State and local agencies. On March 1, 2017, the Governor declared a state of emergency in response to the opioid epidemic in the State and announced a supplemental budget of \$50.0 million in new funding over a five-year period to support Maryland's prevention, recovery, and enforcement efforts. On March 31, 2017, the Governor issued an executive order extending the declared state of emergency an additional 30 days (until April 30, 2017).

According to DHMH's 2016 report, *Drug and Alcohol-Related Intoxication Deaths in Maryland*, drug- and alcohol-related intoxication deaths in Maryland increased for the fifth year in a row, totaling 1,259 deaths in 2015 – a 21% increase since 2014 and an all-time high. Of all intoxication deaths, 1,089 deaths (86%) were opioid related, including deaths related to heroin, prescription opioids, and nonpharmaceutical fentanyl. Opioid-related deaths increased by 23% between 2014 and 2015 and have more than doubled since 2010. Heroin- and fentanyl-related deaths have risen particularly sharply.

The number of heroin-related deaths increased by 29% between 2014 and 2015 and has more than tripled between 2010 and 2015. The number of fentanyl-related deaths increased by 83% between 2014 and 2015 and has increased nearly twelvefold since 2012. **Exhibit 1** shows trends in drug- and alcohol-related intoxication deaths in Maryland from 2007 through 2015.

Exhibit 1
Total Number of Drug- and Alcohol-related Intoxication Deaths
By Selected Substances in Maryland
2007-2015



Source: Department of Health and Mental Hygiene

Preliminary data from DHMH indicates that the number of intoxication deaths increased at an even steeper rate in 2016, with 1,468 deaths from January through September 2016 compared to 904 deaths during the same period in 2015 (a 62% increase). Additionally, for January through September 2016, the number of heroin-related deaths increased 72% and the number of fentanyl-related deaths increased nearly fourfold compared to the same period in 2015.

Naloxone (also known as Narcan®) is an opioid antagonist long used in emergency medicine to rapidly reverse opioid-related sedation and respiratory depression. Medicaid

covers naloxone prescriptions; in 2016, Medicaid enrollees filled 4,631 naloxone prescriptions. DHMH advises that, in response to the increasing number of opioid-related deaths in the State and amongst Medicaid enrollees, DHMH and its eight Medicaid MCOs have collaborated on policy changes and recommendations to promote changes in prescribing practices based on guidance from the U.S. Centers for Disease Control and Prevention. DHMH and those MCOs have advised providers that naloxone should be prescribed to patients who meet certain risk factors, namely (1) a history of substance use disorder; (2) high-dose or cumulative prescriptions that result in over 50 morphine milligram equivalents; (3) prescriptions for both opioids and benzodiazepine or non-benzodiazepine sedative hypnotics; or (4) other factors such as friends or family that use drugs.

State Fiscal Effect: The fiscal 2018 operating budget includes \$10.0 million for DHMH to provide grants to State agencies, local governments, and private community-based programs for specified services to combat the heroin epidemic, including crisis services, expansion of drug court programs, marketing the behavioral health crisis hotline, and education and outreach efforts. Funding decisions must be made as specified in this bill or its cross file (Senate Bill 967). If these bills are not enacted, funding decisions must be made by the Inter-Agency Heroin and Opioid Coordinating Council.

Although the bill generally takes effect June 1, 2017, this analysis assumes that implementation of the bill's requirements, other than DHMH's required report on the use of specified funds, prior authorization requirements for opioid antagonists, funding for the expansion of the drug court programs, and the required reimbursement rate for behavioral health community providers, does not begin until fiscal 2018.

Judiciary

The Judiciary advises that there are currently 35 drug court programs in the circuit courts and District Court. Assessing the needs of each jurisdiction requires an examination of several factors, including caseload data, substance use trends, available treatment programs, local jail and detention center booking information, and violation statistics for each jurisdiction. The Judiciary was unable to estimate the cost of such an assessment; however, the Department of Legislative Services (DLS) advises that the assessment can likely be absorbed within existing budgeted resources. To the extent the assessment requires additional resources and extended collaboration with other agencies, expenditures may increase minimally.

The bill expresses the intent of the General Assembly that the Administrative Office of the Courts request an appropriation of at least \$2.0 million in additional funding in the State budget in fiscal 2019 to award grants to expand the scope of drug courts. This analysis assumes such a request is made and additional funds are received in fiscal 2019. Thus,

general fund expenditures for the Judiciary increase by at least \$2.0 million in fiscal 2019. DLS notes that additional funding may be required in the out-years to maintain the expanded scope of drug courts; any such impact has not been factored into this analysis.

Crisis Hotline, Crisis Treatment Centers, and Opioid Information for Health Care Providers

DHMH advises that, although it currently funds a crisis hotline for mental health and substance use services and is already in the process of reworking the hotline, the bill expands the scope of the hotline to include screenings for mental health and substance use needs, cognitive or intellectual functioning, infectious disease, and acute somatic conditions. This requires more extensive screening than is currently conducted and requires additional staffing, supervision, and training. DHMH advises that, in order to expand the hotline to include such screenings, general fund expenditures increase by \$142,340 each year beginning in fiscal 2018. DLS advises that DHMH did not provide a more specific explanation as to why this cost is relatively low compared to the additional functionality noted above.

DHMH advises that it does not currently fund any crisis treatment centers and that, in order to meet the bill's requirements, these centers must be built from the ground up. DHMH advises that, in addition to "facilities costs" of \$1.4 million for substance use disorder services and another \$0.4 million for mental health services, each crisis treatment center must include, at a minimum: 1 psychiatrist, 10 social workers, 5 clinical directors, and 10 peer support specialists – at more than \$2.2 million. Thus, DHMH estimates the total cost for *one* crisis treatment center at \$4,070,000 annually. DHMH advises that in order to establish one crisis treatment center by June 1, 2018, general fund expenditures increase by \$1,017,500 in fiscal 2018, which reflects the center being open in advance of the deadline and three months of operating costs for the one center. Thus, general fund expenditures increase by \$1,017,500 in fiscal 2018 and by at least \$4,070,000 annually thereafter to continue to operate the one center. Beyond this initial center, the bill does not specify a number of treatment centers required to be established. Therefore, to the extent DHMH chooses to establish additional centers, general fund expenditures for DHMH increase significantly beyond the estimate in this analysis as soon as fiscal 2018. For example, if five such centers are established, general fund expenditures increase by \$20,250,000.

DHMH's estimates for the cost to establish crisis treatment centers under the bill are based on costs for a crisis treatment center that is currently being developed by Montgomery County to treat those experiencing a *substance use* crisis. Although "facilities costs" for that center are estimated at \$1.4 million, DHMH advises that the estimate does not include costs for mental health services, which must be included in any crisis treatment center developed under the bill. Thus, costs to establish a crisis treatment center in accordance

with the bill's requirements are significantly higher than the estimated costs for the Montgomery County center.

DLS additionally notes that the bill requires the crisis treatment centers to be established in accordance with the strategic plan submitted by the Behavioral Health Advisory Council, which is due by December 31, 2017. Depending on the services included in that plan, costs for each crisis treatment center may vary.

Finally, the bill requires DHMH to identify and disseminate specified information on opioid use disorders to health care facilities and health care providers that provide treatment for opioid use disorders. DHMH advises that the American Society of Addiction Medicine publishes a brochure that has the requisite information and likely meets the bill's criteria. DHMH anticipates annually mailing 50,000 copies of this brochure to health care providers and facilities at \$4 per mailing. Thus, general fund expenditures for DHMH increase by at least \$200,000 annually beginning in fiscal 2018 for DHMH to provide the requisite information. Costs may be higher depending on how many health care facilities and providers must receive the information.

Availability of Opioid Addiction Treatment Prescribers

To the extent the bill results in additional prescriptions for opioid addiction treatment medications that are covered by Medicaid, expenditures (60% federal funds, 40% general funds) increase by an indeterminate amount. Federal matching revenues increase correspondingly.

DLS notes that the bill includes hospitals in the definition of "health care facility." Some State hospitals may not treat substance use as part of their routine or authorized functions. Specifically, the State's two chronic disease hospitals (Western Maryland Hospital Center and Deer's Head Hospital Center) provide chronic care and treatment to patients in need of acute rehabilitation (at a level greater than that available at a nursing home), long-term nursing care, and inpatient and outpatient renal dialysis services. Thus, the bill's requirements may fall outside the scope of certain facilities.

Behavioral Health Community Provider Reimbursement Rates

General fund expenditures for DHMH increase by \$18,192,478 in fiscal 2019 for DHMH to provide the bill's required rate of reimbursement and to ensure completion of the bill's reporting requirements and rate-setting study.

Rate Adjustment: General fund expenditures for DHMH increase by \$18,066,483 in fiscal 2019 to provide a 3.5% rate increase for behavioral health community providers. This analysis is based on an estimated \$1,045,563,557 in total budgeted costs and

\$443,869,464 in general fund expenditures for community behavioral health providers' reimbursable services in fiscal 2018. Federal fund revenues and expenditures increase by \$18,528,242 due to the Medicaid match.

Future year expenditures reflect a lower federal matching rate and assume a 3.5% rate increase in fiscal 2020. This analysis also assumes that DHMH does not implement a new payment system before fiscal 2021 and, thus, assumes a 3.0% rate increase in fiscal 2021. Future year expenditures also reflect the compounding effect of increasing reimbursement each year. Therefore, in fiscal 2021, general fund expenditures are estimated to increase by \$55,306,794 and federal fund revenues and expenditures increase by \$52,764,485. General fund and federal fund expenditures continue at this level in fiscal 2022 and subsequent years. This analysis does not take into account any increase in utilization or enrollment, which may further increase costs. Costs also vary depending on if or when DHMH implements a payment system in accordance with the bill.

Rate-setting Study and Reporting Requirements: DHMH advises that it can handle the bill's required interim report on the payment system with existing resources. However, DHMH advises that, in fiscal 2019, \$100,000 in contractual services is required to complete the required rate-setting study and an additional \$100,000 in separate contractual services is also required to complete the required report on outcome measures, for a total of \$200,000 in contractual services in fiscal 2019. Further, \$100,000 in annual contractual services is required beginning in fiscal 2020 to complete the required annual report on the impact of rate adjustments and the payment system on community providers. As Medicaid contracts these services, such services are eligible for a federal matching rate. Thus, Medicaid expenditures (60% federal funds, 40% general funds) increase by \$200,000 in fiscal 2019 and by \$100,000 annually thereafter for the required contracts. Federal matching revenues increase correspondingly.

DHMH advises that, given the scope of the annual reporting requirement, it must hire one full-time, grade 18 policy analyst to develop forms for data collection, provide training and technical assistance to behavioral health providers on completing the forms, and track and review forms for completion. Extensive follow-up with providers is likely necessary in order to gather all required data.

In order to ensure data analysis is completed in time for the December 1, 2019 report, DLS advises that, although costs for contractual data analysis services for the annual report begin in fiscal 2020, DHMH must hire staff in fiscal 2019 to allow sufficient time to develop any required forms, conduct training or outreach, and begin the data collection process and follow up with providers as necessary.

Therefore, general fund expenditures increase by \$45,995 in fiscal 2019 for DHMH to hire one full-time policy analyst to coordinate data collection for the required annual report.

This estimate reflects a start date of January 1, 2019. It includes a salary, fringe benefits, one-time start-up costs, and ongoing operating expenses.

Position	1
Salary and Fringe Benefits	\$41,042
Operating Expenses	<u>4,953</u>
FY 2019 DHMH Administrative Expenditures	\$45,995

Future year expenditures reflect a full salary with annual increases and employee turnover and ongoing operating expenses. This analysis assumes certain of these costs continue at least through fiscal 2021, and likely continue in the out-years as the bill maintains an annual reporting requirement.

Prior Authorization Requirement for Opioid Antagonists

Special fund revenues for MIA increase minimally in fiscal 2018 from the \$125 rate and form filing fee. Review of filings can likely be handled with existing MIA resources. The bill does not materially affect expenditures for the State Employee and Retiree Health and Welfare Benefits Program (State Plan), which is largely self-insured for its medical contracts and, as such, with the exception of the one fully insured integrated health model medical plan (Kaiser), is not subject to this mandate. However, the Department of Budget and Management advises that prescription drug coverage provided through the State Plan's PBM, Express Scripts (which is not subject to this mandate), does not currently require prior authorization for opioid antagonists.

Other Provisions

The bill's changes relating to CDS registrations and local fatality review teams are not expected to materially affect State operations or finances. DHMH can develop the required co-prescribing guidelines with existing resources.

DHMH advises that, as it does not directly train individuals or issue certificates under the Overdose Response Program, the bill's repeal of certification requirements and related changes do not materially affect DHMH operations or finances. DHMH further advises that, although BHA provides funding to LHDs for program administration, including naloxone distribution, funding levels for LHDs are not expected to change under the bill – the bill's changes allow LHDs to redistribute funds that are otherwise used for certification to other purposes, including increased purchase of naloxone.

Medicaid covers naloxone prescriptions; in 2016, Medicaid enrollees filled 4,631 naloxone prescriptions. Thus, Medicaid expenditures (60% federal funds, 40% general funds) likely increase beginning in fiscal 2018, to the extent the bill's provisions relating to the Overdose

Response Program, co-prescribing guidelines, and hospital discharge protocols result in *additional* prescriptions for naloxone (or other opioid antagonists) covered by Medicaid. Federal fund revenues increase by a corresponding amount.

DHMH can also likely submit the required report on new programs and methods to better manage the State's substance abuse and opioid crisis, and the report on the use of specified funds, with existing resources. Staff may need to be temporarily diverted from other tasks in order to meet the January 1, 2018 deadline for these reports.

Finally, DPSCS advises that it can handle the bill's reporting requirement on plans to expand substance use disorder treatment in State prisons and local jails and detention centers with existing resources.

Local Fiscal Effect: To the extent circuit courts receive grants from the Judiciary to expand drug court programs, revenues and expenditures may increase significantly in fiscal 2019. As noted above, additional funding may be required in the out-years to maintain the expanded scope of drug courts; however, any such impact has not been factored into this analysis.

DHMH advises that the bill's changes relating to local fatality review teams may have an operational impact on local agencies that choose to increase the number of cases reviewed. However, local fatality review teams still retain flexibility to adjust their caseloads based on capacity. The Maryland Association of County Health Officers advises that, to the extent local fatality review teams choose to review additional cases, expenditures may increase.

As noted previously, BHA provides funding to LHDs for Overdose Response Program administration, including issuance of certificates and naloxone. However, funding levels are not expected to change as a result of the bill; LHDs may choose to redistribute funds toward other services or priorities, including increased purchase of naloxone. Any revised training as a result of the bill (such as training for other programs on stocking and providing naloxone) can be handled with existing staff. DHMH additionally advises that LHDs may realize improved efficiencies under the bill from no longer having to issue and renew program certificates.

Finally, local jails and detention centers can develop the required plans to expand substance use disorder treatment with existing resources. The Maryland Correctional Administrators Association, as well some local jurisdictions, note that expanding such programs may result in significant staffing and medication costs. However, the extent of such an increase depends on the individual plans developed by each local jurisdiction and if, or when, such plans are implemented.

Small Business Effect: Small business community providers that receive annual rate adjustments under the bill benefit. Providers must also submit required information to DHMH, which may be burdensome for smaller providers with limited resources. Small business entities that provide Overdose Response Program training and certification may continue to provide training, but likely on a more limited basis, as the certification requirement is repealed.

Additional Information

Prior Introductions: None.

Cross File: HB 1329 (Delegate Bromwell, *et al.*) - Health and Government Operations.

Information Source(s): Baltimore, Montgomery, and St. Mary's counties; Governor's Office of Crime Control and Prevention; Department of Health and Mental Hygiene; Maryland Insurance Administration; Maryland Association of Counties; Maryland Association of County Health Officers; Maryland Health Benefit Exchange; Department of Public Safety and Correctional Services; Maryland Higher Education Commission; Maryland State Department of Education; Department of Budget and Management; Maryland Correctional Administrators Association; Substance Abuse and Mental Health Services Administration; Department of Legislative Services

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