Department of Legislative Services

Maryland General Assembly
2018 Session

FISCAL AND POLICY NOTE
First Reader

House Bill 326 (Delegate Morhaim, *et al.*)
Health and Government Operations

Public Health - Overdose and Infectious Disease Prevention Supervised Drug Consumption Facility Program

This bill authorizes a community-based organization (CBO) to establish an Overdose and Infectious Disease Prevention Supervised Drug Consumption Facility Program in one or more jurisdictions. A program must, among other requirements, provide a supervised location where drug users can consume preobtained drugs, as well as receive other services, education, and referrals. A CBO must receive approval from the Maryland Department of Health (MDH), in consultation with the local health department (LHD).

Fiscal Summary

State Effect: The bill's requirements can likely be handled with existing budgeted resources, as discussed below. Revenues are not affected.

Local Effect: Potential significant operational and fiscal impact for some LHDs, as discussed below.

Small Business Effect: Potential meaningful.

Analysis

Bill Summary: "Community-based organization" means a public or private organization that is representative of a community or significant segments of a community and that provides educational, health, or social services to individuals in the community. The definition includes hospitals, clinics, substance abuse treatment centers, medical offices, federally qualified health centers, mental health facilities, and LHDs.

A CBO may apply to MDH at any time, regardless of previous applications, for approval. MDH, in consultation with the LHD, must make a decision regarding approval within 45 days of receiving an application and provide a written explanation of its decision to the CBO.

A program must, among other requirements, (1) provide secure sterile needle exchange; (2) answer questions about safe injection practices; (3) administer first aid, if needed, monitor for potential overdose, and administer rescue medications; (4) provide referrals to other health care services; (5) educate participants on the risks of contracting HIV and viral hepatitis; (6) provide overdose prevention education and access to or referrals to obtain naloxone; and (7) provide adequate security and training for staff, as specified. A program may, with permission, bill a participant's health insurance, accept specified outside financial assistance, apply for grants, coordinate with any opioid-associated substance abuse prevention and outreach program or CBO, and use a mobile facility.

A program may not be located in an area zoned for residential uses.

A program must annually collect and report a range of data about its operations, including information relating to the number of participants served, hypodermic needles and syringes distributed, and overdoses experienced and reversed on site.

Program participants, staff members, and program property owners who act in accordance with the bill's provisions are not subject to arrest, prosecution, or any civil or administrative penalty (including action by a professional licensing board), nor are they subject to the seizure or forfeiture of any real or personal property used in connection with a program in accordance with State or local law. However, these individuals are not immune from criminal prosecution for any activities not authorized or approved by the program.

Current Law: Chapter 348 of 2016 authorizes a LHD or CBO, with the approval of MDH and the appropriate local health officer, to establish an opioid-associated disease prevention and outreach program. A LHD or CBO must apply to MDH and a local health officer for authorization to operate a program. MDH and the local health officer must jointly authorize the program.

An opioid-associated disease prevention and outreach program must:

- provide security of program locations and equipment;
- allow participants to obtain and return hypodermic needles and syringes at any program location, if more than one location is available;
- have appropriate staff expertise in working with individuals who inject drugs;
- include adequate staff training;

- disseminate other means for curtailing the spread of HIV and viral hepatitis;
- link individuals to additional services, including substance-related disorder counseling, treatment, and recovery services; testing for specified diseases; reproductive health education and services; wound care; and overdose response program services;
- educate participants on the dangers of contracting HIV and viral hepatitis;
- provide overdose prevention education and access to naloxone or a referral to obtain naloxone;
- establish procedures for identifying program participants in accordance with specified confidentiality provisions;
- establish methods for identifying and authorizing staff members and volunteers who have access to hypodermic needles, syringes, and program records;
- develop a plan for data collection and program evaluation; and
- collect and report specified information to MDH at least annually.

Background: According to a 2011 study published in *The Lancet*, internationally, more than 65 supervised injecting facilities (SIFs), sites where drug users can inject preobtained illicit drugs, have been opened as part of various strategies to reduce the harms associated with drug use. The study, which reviewed the reduction in overdose mortality after the opening of a SIF in Vancouver, found that SIFs are an effective intervention to reduce community overdose mortality and should be considered for assessment, particularly in communities with high levels of injection drug use.

For information on the State's growing opioid crisis, please refer to the **Appendix – Opioid Crisis**.

State Expenditures: MDH, in consultation with the LHD, must approve (or deny) applications from CBOs and provide written justification for the decision. The bill establishes no enforcement or ongoing requirements for MDH or the LHD. However, MDH advises that site inspections should be conducted as a matter of best practice. Although MDH advises that one full-time employee is needed to implement the bill, the Department of Legislative Services (DLS) disagrees. Assuming that a small number of CBOs are likely to apply, and that MDH must consult with the LHD to review applications, DLS advises that MDH can likely implement the bill's requirements with existing resources and staffing levels. To the extent that a significant number of CBOs apply, MDH may need additional staff to review applications and possibly conduct site visits.

Local Fiscal Effect: Expenditures increase significantly for any LHD that chooses to implement a program as authorized under the bill. It is unknown how much such a program will cost, and there would likely be significant variations among programs depending on the size, number of health care professionals, hours, variety of services, and population

served. MDH advises, for comparison, that implementing an opioid-associated disease prevention and outreach program for an average-sized LHD costs approximately $400,000. Thus, establishing a program under the bill likely costs at least $400,000. DLS notes that LHDs are *not* mandated to establish a program under the bill. These expenditures may be offset by billing insurance companies for certain services, donations, grants, or other financial assistance. MDH also notes that some opioid-associated disease prevention and outreach programs will be operational by fall 2018; to the extent such programs choose to expand services to include those specified under the bill, costs may be significantly lower.

The Maryland Association of County Health Officers (MACHO) advises that it may also cost LHDs approximately $1,500 to $2,000 annually to review CBO applications and reports. Depending on the number of programs that apply, some LHDs may be able to absorb these costs with existing resources. MACHO additionally notes that it is unclear if LHDs have any ongoing enforcement or monitoring role in overseeing these programs. Further, MACHO notes that a specific process may need to be established to allow for the proper consideration of program applications from LHDs (who qualify as CBOs under the bill but are also involved in the application review and approval process).

Small Business Effect: To the extent that a CBO is a small business and successfully applies to establish a program under the bill, expenditures increase significantly, as discussed under the local fiscal effect. Expenditures may be offset by billing insurance companies for certain services, donations, grants, or other financial assistance.

Additional Information

Prior Introductions: HB 519 of 2017, a similar bill, received a hearing in the House Health and Government Operations Committee, but no further action was taken. HB 1212 of 2016, another similar bill, was heard by the House Health and Government Operations Committee and was subsequently withdrawn.

Cross File: SB 288 (Senator Feldman, *et al.*) - Finance.

Information Source(s): Maryland Department of Health; Maryland Association of County Health Officers; *The Lancet*; Department of Legislative Services

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md/jc

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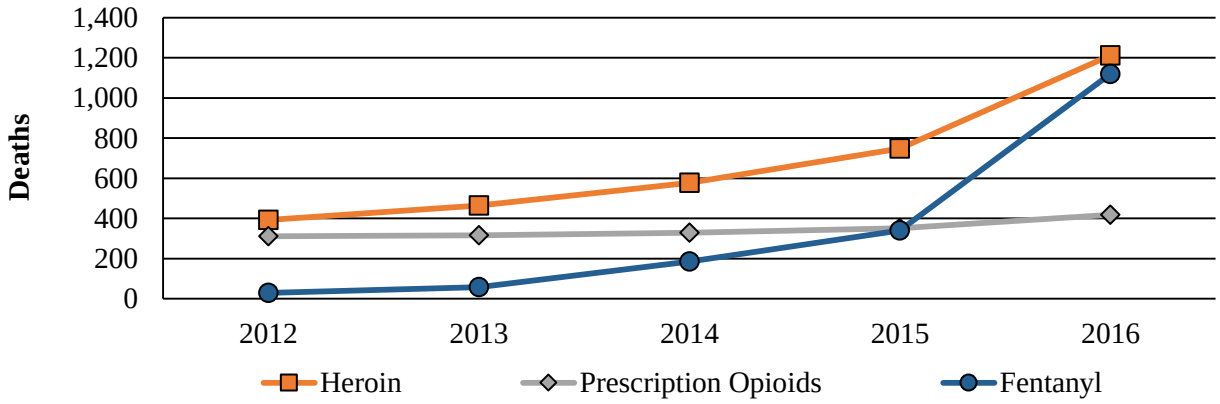
Appendix – Opioid Crisis

Opioid Overdose Deaths

The rate of opioid-related deaths continues to rise at an alarming rate. As seen in **Exhibit 1**, between 2015 and 2016, prescription opioid-related deaths in Maryland increased by 19% (from 351 to 418), heroin-related deaths increased by 62% (from 748 to 1,212), and fentanyl-related deaths increased by 229% (from 340 to 1,119). Between January and June 2017, there were 799 deaths related to fentanyl, a 70% increase over the same time period for 2016, and 46 deaths related to carfentanil, a drug used as an elephant tranquilizer, a substance which first appeared as a cause of death in April 2017.

Exhibit 1
Total Number of Drug-related Intoxication Deaths
By Selected Substances in Maryland
2012-2016



Source: Maryland Department of Health

Federal Actions to Address the Opioid Crisis

In 2016, the Comprehensive Addiction and Recovery Act authorized over $181 million annually, and the 21st Century Cures Act (CURES Act) authorized up to $970 million to be distributed through the State Targeted Response to the Opioid Crisis Grants. The grants are to be used by states to increase access to treatment and reduce unmet treatment needs and opioid-related overdose deaths. In 2017, Maryland received a two-year, $20 million grant for the prevention and treatment of opioid abuse. In March 2017, President Donald J. Trump signed an executive order establishing the President's Commission on Combating Drug Addiction and the Opioid Crisis. The commission issued a final report in November 2017, with 56 recommendations, including a recommendation

for federal block grant funding for state activities relating to opioids and substance use disorders. The full report can be found here: https://www.whitehouse.gov/ondcp/presidents-commission

Maryland Actions to Address the Opioid Crisis

The General Assembly passed several comprehensive acts during the 2017 session to address the State's opioid crisis, which addressed prevention, treatment, overdose response, and prescribing guidelines.

Chapters 571 and 572 of 2017, the Heroin and Opioid Prevention Effort and Treatment Act, among other things, require (1) the Behavioral Health Administration to establish crisis treatment centers that provide individuals in a substance use disorder crisis with access to clinical staff, requiring at least one center be established by June 1, 2018; (2) the Maryland Department of Health (MDH) to establish and operate a toll-free health crisis hotline; (3) certain health care facilities and systems to make available to patients the services of health care providers who are trained and authorized under federal law to prescribe opioid addiction treatment medications, including buprenorphine; (4) each hospital, by January 1, 2018, to have a protocol for discharging a patient who was treated for a drug overdose or identified as having a substance use disorder; (5) the Governor's proposed budget for fiscal 2019 through 2021 to include specified rate adjustments for community behavioral health providers; (6) the Department of Public Safety and Correctional Services and MDH to develop a plan to increase the provision of substance use disorder treatment, including medication assisted treatment, in prisons and jails; (7) the authorization of the provision of naloxone through a standing order and that MDH establish guidelines to co-prescribe naloxone to high-risk individuals; and (8) the expansion of private insurance coverage for opioid use disorders by prohibiting certain carriers from applying a pre-authorization requirement for a prescription drug when used for treatment of an opioid use disorder and that contains methadone, buprenorphine, or naltrexone.

Chapters 573 and 574 of 2017, the Heroin and Opioid Education and Community Action Act (Start Talking Maryland Act), require (1) the State Board of Education to expand an existing program in public schools to encompass drug addiction and prevention education that specifically includes instruction related to heroin and opioid addiction and prevention and information relating to the lethal effect of fentanyl; (2) each local board of education to establish a policy requiring each public school to obtain and store naloxone and other overdose-reversing medication to be used in an emergency situation; (3) each local board of education or local health department to hire a sufficient number of community action officials or develop and implement a program that provides community relations and education functions that coordinate forums and conduct public relations efforts; and (4) specified institutions of higher education in Maryland to establish a policy that

addresses heroin and opioid addiction and prevention, including awareness training for incoming students, obtaining and storing naloxone, and campus police training.

Chapter 570 of 2017 requires a health care provider, on treatment for pain and based on the provider's clinical judgment, to prescribe the lowest effective dose of an opioid and a quantity that is no greater than that needed for the expected duration of pain severe enough to require an opioid that is a controlled dangerous substance (CDS). The Act establishes that the quantity limitations do not apply to opioids prescribed to treat a substance-related disorder; pain associated with a cancer diagnosis; pain experienced while the patient is receiving end-of-life, hospice, or palliative care services; or chronic pain. A violation of the Act is grounds for disciplinary action by the appropriate health occupations board.

In January 2017, Governor Lawrence J. Hogan issued an executive order establishing an Opioid Operational Command Center (OOCC) to facilitate collaboration between State and local public health, human services, education, and public safety entities to combat the heroin and opioid crisis. OOCC will (1) develop operational strategies to continue implementing the recommendations of the Governor's Heroin and Opioid Emergency Task Force; (2) collect, analyze, and facilitate the sharing of data relevant to the epidemic from State and local sources; (3) develop a memorandum of understanding among State and local agencies that provides for the sharing and collection of health and public safety information and data relating to the heroin and opioid epidemic; (4) assist and support local agencies in the creation of opioid intervention teams; and (5) coordinate the training of and provide resources for State and local agencies addressing the threat to the public health, security, and economic well-being of the State.

In March 2017, Maryland became the first state to declare a state of emergency for the opioid crisis, activating the Governor's emergency management authority and enabling increased and more rapid coordination between the State and local jurisdictions. In conjunction with the declaration, Governor Hogan included a supplemental budget appropriation of $10 million, part of a $50 million, five-year commitment to address the State's heroin and opioid epidemic.

In July 2017, $22 million was appropriated for fiscal 2018, including $10 million in CURES Act funding, to be used for prevention, treatment, and enforcement activities. Prevention efforts include distribution of opioid intervention teams for each jurisdiction, a public awareness campaign, funding to train community teams on overdose response and linking to treatment, a pilot program to create school-based teams for early identification of the problems related to substance use disorders, and distribution of opioid information to health care facilities and providers that offer treatment. Enforcement initiatives include funding to disrupt drug trafficking organizations for the heroin coordinator program and to increase MDH's regulatory oversight of CDS. Treatment funding will be used to expand treatment beds and implement a tracking system to identify available beds; improve access to naloxone; establish a 24-hour crisis center in Baltimore City; expand use of peer

recovery support specialists; expand Screening, Brief Intervention, and Referral to Treatment to hospitals and parole, probation, and correctional facilities; increase access to medication-assisted treatment; expand law enforcement diversion programs; and improve the State's crisis hotline.