HB 116

Department of Legislative Services

Maryland General Assembly
2019 Session

FISCAL AND POLICY NOTE
Enrolled

House Bill 116 (Delegate Barron, *et al.*)

Judiciary and Health and Government Operations — Finance

Public Health - Correctional Services - Opioid Use Disorder Examinations and Treatment

This bill establishes specified programs of "opioid use disorder" screening, evaluation, and treatment in local correctional facilities and in the Baltimore Pre-trial Complex. The program begins in four counties and phases in to include all counties and the Baltimore Pre-trial Complex. The State must fund the programs of opioid use disorder screening, examination, and treatment of inmates, and the bill establishes requirements for screening and treatment. By November 1, 2020, and annually thereafter, the Governor's Office of Crime Control and Prevention (GOCCP) must report specified data to the General Assembly data from local correctional facilities. **A pilot program at the Baltimore Pre-trial Complex terminates September 30, 2023.**

Fiscal Summary

State Effect: General fund expenditures increase by *at least* $2.0 million in FY 2020. Future years reflect annualization and ongoing costs, including increased payments to counties as the program expands. Federal fund revenues may increase beginning in FY 2021; to the extent they do, the need for general funds decreases.

($ in millions)	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
FF Revenue	$0	-	-	-	-
GF Expenditure	$2.0	$4.4	$4.9	$6.6	$8.3
Net Effect	($2.0)	($4.4)	($4.9)	($6.6)	($8.3)

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

Local Effect: Local expenditures increase significantly but are assumed to be fully reimbursed by the State.

Small Business Effect: None. Small businesses are not directly affected.

Analysis

Bill Summary:

Phase-in Schedule: By January 1, 2020, the bill's provisions apply to local detention centers in Howard, Montgomery, Prince George's, and St. Mary's counties, and by October 1, 2021, the bill's provisions apply to six additional counties. GOCCP, the Maryland Department of Health (MDH), and the Maryland Correctional Administrators Association (MCAA) must evaluate the implementation of the bill's requirements and determine a schedule to add additional counties; however, the provisions must apply to all local detention centers and the Baltimore Pre-trial Complex by January 2023.

Funding for the program at the Baltimore Pre-trial Complex must be as provided in the State budget. If the Baltimore Pre-trial Complex has not fully implemented the bill's provisions by January 2023, the Department of Public Safety and Correctional Services (DPSCS) must report to the Senate Finance Committee and the House Judiciary Committee on the status and timeline of implementation.

Baltimore Pre-trial Complex Pilot Program: Beginning January 1, 2020, DPSCS must establish a "medication-assisted treatment" (MAT) pilot program in the Baltimore Pre-trial Complex. DPSCS must, in consultation with its head of medical treatment services, determine whether the program is capable of being administered in existing structures of the Baltimore Pre-trial Complex. Funding for the pilot program must be as provided in the State budget. This provision terminates September 30, 2023.

Screening: Each local correctional facility must conduct an assessment of the mental health and substance use status of each inmate using evidence-based screenings and assessments to determine if the medical diagnosis of an opioid use disorder is appropriate and if MAT is appropriate. If a required assessment indicates opioid use disorder, an evaluation of the inmate must be conducted by a specified health care practitioner, and information must be provided to the inmate describing medications used in MAT. In addition, MAT must be available to an inmate for whom such treatment is determined to be appropriate, as specified.

Each local correctional facility must make available at least one formulation of each U.S. Food and Drug Administration (FDA)-approved full opioid agonist, partial opioid agonist, and long-acting opioid antagonist used for the treatment of opioid use disorders. If an inmate received medication or MAT for opioid use disorder immediately preceding or during the inmate's incarceration, a local correctional facility must continue the treatment after incarceration or transfer unless:

- the inmate voluntarily discontinues the treatment, verified through a written agreement that includes a signature; or
- a health care practitioner determines that the treatment is no longer medically appropriate.

Treatment: Each local correctional facility must:

- following an assessment using clinical guidelines for MAT, make medication available, as specified, or begin withdrawal management services prior to administration of medication;
- make available and administer medications for the treatment of opioid use disorder;
- provide behavioral health counseling for inmates diagnosed with opioid use disorder consistent with therapeutic standards for such therapies in a community setting;
- provide access to a health care practitioner who can provide access to all FDA-approved medications, as specified; and
- provide on-premises access to peer recovery specialists.

In addition, before the release of an inmate diagnosed with opioid use disorder, a local correctional facility must develop a plan of reentry that:

- includes information regarding post-incarceration access to medication continuity, "peer recovery specialists," other supportive therapy, and enrollment in health insurance plans;
- includes any recommended referrals by a health care practitioner to medication continuity, peer recovery specialists, and other supportive therapy; and
- is reviewed and, if needed, revised by a health care practitioner or peer recovery specialist.

Procedures and standards: The procedures and standards used to determine substance use disorder diagnosis and treatment of inmates are subject to the guidelines and regulations adopted by MDH. DPSCS and the Behavioral Health Administration within MDH, in consultation with MCAA, must develop a timetable in accordance with medical best practices for inmates to receive assessments, evaluation, or treatment under the bill.

Methadone detoxification: The bill alters the requirement for an inmate in a State or local correctional facility to be placed on a properly supervised program of methadone detoxification to include a person with opioid use disorder, under specified conditions.

Defined terms: "Medication-assisted treatment" means the use of medication, in combination with counseling and behavioral health therapies, to provide a holistic

approach to the treatment of opioid use disorder. "Opioid use disorder" means a medically diagnosed problematic pattern of opioid use that causes significant impairment or distress.

Funding: As provided in the State budget, the State must fund the program of opioid use disorder screening, evaluation, and treatment of inmates. However, by December 1, 2019, GOCCP, DPSCS, and MDH must apply for federal funding to support implementation of the bill's provisions beyond fiscal 2020 and must report to the General Assembly on the efforts to secure funding.

The bill must not be construed to supersede any federal law or existing agreement between a court or agency of the federal, State, or local government.

Current Law/Background: For information on the State's opioid crisis and funding for drug addiction treatment, refer to the **Appendix – Opioid Crisis.**

Methadone detoxification program: An inmate in a State or local correctional facility must be placed on a properly supervised program of methadone detoxification if a physician determines that the inmate is an addict, the treatment is prescribed by a physician, and the inmate consents in writing to the treatment. Methadone is a synthetic narcotic used to treat people addicted to heroin, morphine, and other opiates. Methadone, taken once daily, suppresses narcotic withdrawal.

Assessment before sentencing: Chapter 515 of 2016, the Justice Reinvestment Act, authorizes a court, before imposing a sentence for a violation of laws prohibiting the possession of a controlled dangerous substance or 10 grams or more of marijuana, to order MDH, or a certified and licensed designee, to conduct an assessment of the defendant for a substance use disorder and determine whether the defendant is in need of and may benefit from drug treatment. MDH or the designee must conduct an assessment and provide the results, as specified. The court must consider the results of an assessment when imposing the defendant's sentence and, as specified, (1) must suspend the execution of the sentence, order probation, and require MDH to provide the medically appropriate level of treatment or (2) may impose a term of imprisonment and order the Division of Correction within DPSCS or a local correctional facility to facilitate the medically appropriate level of treatment.

State Fiscal Effect: General fund expenditures increase by *at least* $2.0 million in fiscal 2020; by fiscal 2024, costs are estimated to be *at least* $8.3 million.

Department of Public Safety and Correctional Services

General fund expenditures for DPSCS increase by *at least* $1.4 million in fiscal 2020, which accounts for the bill's October 1, 2019 effective date. This estimate

reflects the cost of hiring 15 full-time employees. It includes salaries, fringe benefits, one-time start-up costs, and ongoing operating expenses. The information and assumptions used in calculating this estimate are stated below:

- by January 1, 2020, DPSCS must establish a MAT pilot program that uses at least one formulation of each FDA-approved full opioid agonist, partial opioid agonist, and long-acting opioid antagonist for the treatment of opioid use disorders in the Baltimore Pre-trial Complex;
- in order to implement the pilot program, DPSCS needs to hire nine peer recovery specialists and six correctional officers within the Baltimore Pre-trial Complex, reflecting, in part, the security needs of the complex as a correctional facility with inmates housed in multiple facilities within the complex;
- based on information provided by DPSCS, 100 inmates on a daily basis are anticipated to participate in the DPSCS pilot program;
- contractual services related to the medical contract increase for medical staff; and
- medication costs average $80,426 annually per 100 inmate participants.

Positions	15
Salaries and Fringe Benefits	$596,964
Contractual Services	714,688
Medication Costs	40,213
Equipment/Operating Expenses	80,381
Minimum FY 2020 DPSCS Expenditures	**$1,432,246**

Future year expenditures reflect full salaries with annual increases and employee turnover and ongoing operating expenses. In addition, future year estimates assume that 100 inmates continue to participate in the program at the complex, even though the bill contemplates an expansion of the program as of January 2023.

In addition, the estimate does not include:

- any publication costs for MAT information;
- any capital costs necessary to provide additional treatment rooms within the Baltimore Pre-trial Complex; or
- costs to renegotiate the medical contract to accommodate the bill.

Further, this analysis does not account for any costs associated with continuing to treat participants after their release from a facility. It is unclear how this provision would be implemented.

Currently, all offenders newly admitted pretrial to the Baltimore Pre-trial Complex receive an initial medical and mental health screening conducted by a registered nurse or higher level health care staff. This process is completed upon arrival to the facility, prior to custody exchange from law enforcement, to ensure that the offender is medically and mentally stable to complete the booking process. This current assessment meets the standards established by the National Commission on Correctional Health Care.

As part of the initial screening completed during the booking process, offenders are questioned regarding current medication therapy and participation in a methadone program. Offenders responding affirmatively to methadone as a medication or as a participant in a community-based Opioid Therapy Program (OTP) are referred to medical prior to completion of the booking process. Inmates who identify on suboxone or buprenophine variations are managed using methadone. OTP includes maintenance treatment and short-term detoxification. Offenders who cannot be clinically maintained within the facility are transferred to an appropriate hospital or alternate care facility.

Within 12 hours of notification that an inmate is to be released or transferred, the inmate's medical records are reviewed by nursing staff at the intake facility, and a transfer screening form is completed. Once completed, the transfer screening accompanies the offender to the next facility. Offenders who are on MAT with methadone and who are being released to the community receive a continuity of care form advising on the treatment received while in the DPSCS facility and the need to continue with OTP in the community. If the offender is sentenced, the offender undergoes a detoxification process as written by a clinician and upon completion of detoxification, is transferred to a maintaining facility.

Currently, the average total cost per inmate in a State correctional facility, including overhead, is estimated at $3,800 per month. Excluding overhead, the average cost of housing a new State inmate (including health care costs) is about $895 per month. Excluding all health care (which is a fixed cost under the current contract), the average variable costs total $199 per month.

State Payments to Counties

Under the bill, the State must fund the program of opioid use disorder screening, evaluation, and treatment of inmates. Based on information regarding anticipated costs to Howard, Montgomery, Prince George's, and St. Mary's counties, payments to counties average approximately $250,000 per county annually. Reimbursement costs could be much greater as local program costs are not capped. **Exhibit 1** shows anticipated payments to counties as counties are phased in under the bill.

Exhibit 1
State Payments to Counties
Fiscal 2020-2024

	2020	2021	2022	2023	2024
4 counties (1/2020)	$500,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000
6 counties added (10/2021)		1,125,000	1,500,000	1,500,000	1,500,000
13 counties added (1/2023)				1,625,000	3,250,000
Total	**$500,000**	**$2,125,000**	**$2,500,000**	**$4,125,000**	**$5,750,000**

Source: Department of Legislative Services

Governor's Office of Crime Control and Prevention

General fund expenditures for GOCCP increase by *at least* $57,818 in fiscal 2020, which accounts for the bill's October 1, 2019 effective date. This estimate reflects the cost of hiring at least one program administrator to (1) work with other entities to evaluate the implementation of the bill, as specified; (2) work with DPSCS and MDH to apply for federal funding to support implementation of the bill; and (3) gather and report extensive information from local correctional facilities to the General Assembly. It includes a salary, fringe benefits, one-time start-up costs, and ongoing operating expenses.

Position	1
Salary and Fringe Benefits	$52,459
Operating Expenses	5,359
Minimum FY 2020 GOCCP Expenditures	**$57,818**

Future year expenditures reflect a full salary with annual increases and employee turnover and ongoing operating expenses.

Potential State and Federal Funding to Cover these Costs

The fiscal 2020 budget includes State and anticipated federal funds for MAT programs and other substance use treatment services; however, it is unclear at this time to what extent existing funding in the State budget can be used to support the costs identified above. To the extent any existing funds can be used to support these costs, the need for additional general funds decreases.

In addition, the bill requires DPSCS, GOCCP, and MDH to apply for federal funding to support implementation of the bill beyond fiscal 2020. To the extent that the State is able

to secure federal funding for these purposes, the need for general funds decreases beginning in fiscal 2021.

Local Fiscal Effect: Local government expenditures increase, likely significantly, to meet the bill's requirements relating to assessments, treatment, medications, and data collection and reporting. Based on information regarding anticipated costs to Howard, Montgomery, Prince George's, and St. Mary's counties, expenditures average approximately $250,000 per county annually.

However, the bill requires *the State* to fund the program of opioid use disorder screening, evaluation, and treatment of inmates; therefore, it is assumed that local correctional facilities are reimbursed for any expenses incurred.

Additional Information

Prior Introductions: None.

Cross File: SB 846 (Senator West) - Finance.

Information Source(s): Anne Arundel, Charles, Frederick, Howard, Montgomery, Prince George's, Somerset, and St. Mary's counties; Maryland Department of Health; Department of Public Safety and Correctional Services; Governor's Office of Crime Control and Prevention; Department of Legislative Services

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Analysis by: Shirleen M. E. Pilgrim

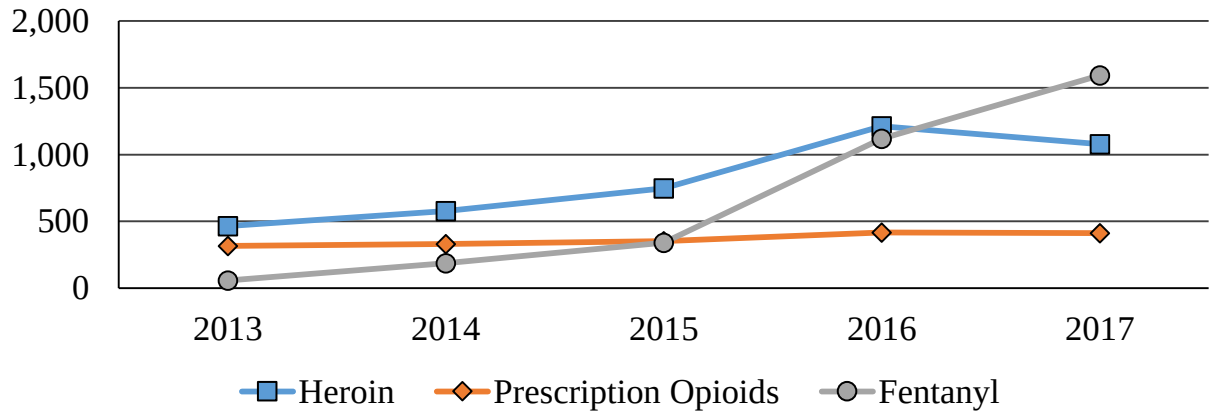
Direct Inquiries to:
(410) 946-5510
(301) 970-5510

Appendix – Opioid Crisis

Opioid Overdose Deaths

While heroin and prescription opioid deaths have begun to taper off, fentanyl deaths have continued to rise at a high rate. As seen in **Exhibit 1**, between 2016 and 2017, prescription opioid-related deaths in Maryland decreased negligibly by 1% (from 418 to 413) while heroin-related deaths decreased by 11% (from 1,212 to 1,078). However, fentanyl-related deaths increased by 42% (from 1,119 to 1,594). Between January and June 2018, there were 1,038 deaths related to fentanyl, a 30% increase over the same time period for 2017.

Exhibit 1
Total Number of Drug-related Intoxication Deaths
By Selected Substances in Maryland
2013-2017



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.

In 2018, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act was passed. The legislation expands existing programs and creates new programs to prevent substance use disorders and overdoses, including reauthorization of the Office of National Drug Control Policy, new Centers for Disease Control and Prevention grants for states and localities to improve prescription drug monitoring programs, and funding to encourage research into nonaddictive painkillers. Additionally, the legislation partially lifts the restriction that blocks states from spending federal Medicaid dollars on residential addiction treatment centers by allowing payments for residential services for up to 30 days while also allowing Medicare to cover medication-assisted treatment (MAT) in certain settings for the treatment of substance use disorder.

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; (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 to have a protocol for discharging a patient who was treated for an 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 MAT, in prisons and jails; (7) authorization of the provision of naloxone through a standing order and 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 requiring preauthorization for a prescription drug used for treatment of an opioid use disorder 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 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 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.

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 data sharing relevant to the heroin and opioid epidemic; (3) develop a memorandum of understanding among State and local agencies regarding sharing and collection of health and public safety information and data relating to the 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.

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 MAT; expand law enforcement diversion programs; and improve the State's crisis hotline.

In 2018, the General Assembly expanded upon the comprehensive legislation of the prior year. Chapter 149 of 2018 authorizes an emergency medical services provider or law enforcement officer to report an actual or suspected overdose to an appropriate information technology platform. Chapter 211 of 2018 requires MDH to identify a method for establishing a tip line for a person to report a licensed prescriber who the person suspects is overprescribing certain medications. Chapters 215 and 216 of 2018 require a health care provider to advise a patient of the benefits and risks associated with a prescribed opioid or co-prescribed benzodiazepine. Chapters 439 and 440 of 2018 require a general hospice care program to establish a written policy for the collection and disposal of unused prescription medication and require a program employee to collect and dispose of a patient's unused medication on the death of the patient or the termination of a prescription.