Department of Legislative Services

Maryland General Assembly
2019 Session

FISCAL AND POLICY NOTE
First Reader

House Bill 139 (Delegate Pena-Melnyk, *et al.*)
Health and Government Operations

Public Health – Overdose and Infectious Disease Prevention Site Program

This bill authorizes a community-based organization (CBO) to establish an Overdose and Infectious Disease Prevention Site Program. 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. However, a CBO must first receive approval from the Maryland Department of Health (MDH), in consultation with the local health department (LHD). MDH may not approve more than six programs, and to the extent practicable, should distribute programs evenly among urban, suburban, and rural areas of the State with each area receiving no more than two programs. **The bill takes effect July 1, 2019, and terminates June 30, 2023.**

Fiscal Summary

State Effect: The bill's requirements can likely be handled within 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 a hospital, clinic, substance abuse treatment center, medical office, federally qualified health center, mental health facility, LHD, and faith-based organization.

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 access or 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, overdoses experienced and reversed on-site, individuals who received overdose care, individuals referred to other services, and any other information deemed necessary by the department for assessing the impact of the program.

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: Approximately 100 supervised injection facilities (SIFs), sites where drug users can inject preobtained illicit drugs in the presence of medical staff, have been opened in 11 countries (primarily in Europe, Canada, and Australia) as part of various strategies to reduce the harms associated with opioid use. For information on the State's growing opioid crisis, please refer to the **Appendix – Opioid Crisis**.

A 2017 publication by The Lankenau Institute for Medical Research, which compiled a review of the evidence for SIFs, found no evidence that SIFs have any effect on crime rates; however, there was evidence of a reduction in (1) overdose deaths; (2) injections done in public; (3) blood-borne disease infections; (4) discarded injection equipment; and, (5) perceived neighborhood disorder. Additionally, the study identified a potential cost savings in health services.

There are currently no SIFs in the United States, although legislation passed in California (later vetoed by Governor Jerry Brown) to authorize SIFs. Additionally, the King County, Washington Health Department and County Board of Supervisors voted to open a SIF in Seattle although there is no authorization under Washington State law. Similarly, the Denver, Colorado City Council recently approved a pilot program to allow for a SIF in the city, but must await approval from the Colorado legislature before proceeding.

In an August 2018 *New York Times* op-ed, Deputy Attorney General Rod Rosenstein, reminded states considering SIFs that they are illegal and indicated that those states should expect the U.S. Department of Justice to meet the opening of any SIF with swift and aggressive action.

State Expenditures: MDH, in consultation with the LHD, must approve (or deny) applications from CBOs and provide written justification for the decision. The bill limits the number of programs that may be approved to six. The bill establishes no enforcement or ongoing requirements for MDH or LHDs. However, MDH advises that site inspections should be conducted as a matter of best practice. Although MDH advises that one full-time contractual and one part-time (50%) contractual position are 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 before authorizing no more than six programs, 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. However, the Maryland Association of County Health Officers (MACHO) anticipates any fiscal impact to be minimal as it does not expect any LHD to establish a program within the next few years. DLS notes that LHDs are *not* mandated to establish a program under the bill. Any expenditures may be offset by billing insurance companies for certain services, donations, grants, or other financial assistance.

Historically, MACHO has also advised that it may also cost LHDs approximately $1,500 to $2,000 annually to review CBO applications and reports. As the number of applications that MACHO anticipates is low, any fiscal impact is likely minimal. 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: Similar legislation has been considered in recent legislative sessions. HB 326 of 2018 received a hearing in the House Health and Government Operations Committee, but no further action was taken. Its cross file, SB 288, received an unfavorable report from the Senate Finance Committee. HB 519 of 2017 received a hearing in the House Health and Government Operations Committee, but no further action was taken. HB 1212 of 2016 received an unfavorable report from the House Health and Government Operations Committee.

Cross File: SB 135 (Senator Feldman, *et al.*) - Finance.

Information Source(s): Maryland Department of Health; Maryland Insurance Administration; Maryland Association of County Health Officers. The Lankenau Institute for Medical Research; *The Seattle Times*; *The Colorado Sun*; *The Washington Post*; *The New York Times*; Department of Legislative Services

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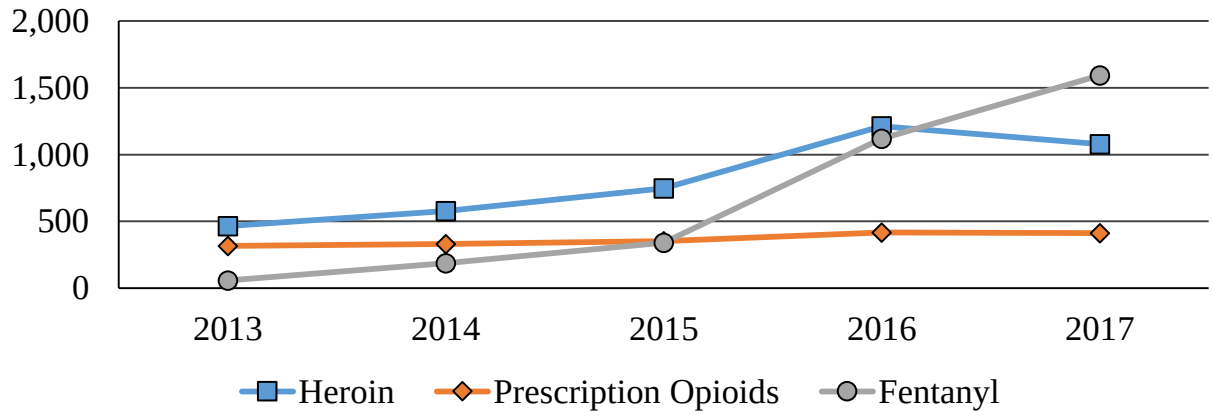
Appendix – Opioid Crisis

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.