SB 1099

Department of Legislative Services

Maryland General Assembly
2024 Session

FISCAL AND POLICY NOTE
Enrolled - Revised

Senate Bill 1099 (Senator Smith, *et al.*)

Education, Energy, and the Environment Health and Government Operations

Emergency Services - Automated External Defibrillator and Naloxone Co-Location Initiative - Requirements for Public Buildings

This bill expands the purpose of the Public Access Automated External Defibrillator Program (AED program) to include an initiative to co-locate up to two doses of naloxone with each automated external defibrillator (AED) placed in a "public building." The Emergency Medical Services (EMS) Board must (1) develop and implement the initiative in collaboration with the Maryland Department of Health (MDH) and (2) adopt regulations jointly with MDH. The initiative must be funded using funds from the Opioid Restitution Fund (ORF) appropriated through the State budget.

Fiscal Summary

State Effect: Special fund expenditures from ORF increase by *at least* $74,100 in FY 2025 and future years for staff. Additional, more significant, costs incurred in FY 2025 through FY 2028 are not quantified. Nevertheless, as discussed below, ORF expenditures also increase for one-time information technology costs, to supply specified materials, and for the naloxone that needs to be co-located. Additional expenditures are also incurred in future years as naloxone is used or expires and is replaced. Revenues are not affected.

(in dollars)	FY 2025	FY 2026	FY 2027	FY 2028	FY 2029
Revenues	$0	$0	$0	$0	$0
SF Expenditure	74,100	87,800	91,700	95,700	99,900
Net Effect	($74,100)	($87,800)	($91,700)	($95,700)	($99,900)

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

Local Effect: The bill can be implemented within existing resources, as discussed below. Revenues are not affected.

Small Business Effect: None.

Analysis

Bill Summary: "Public building" means (1) a public mass transportation accommodation that is supported by public funds; (2) an improvement of a public area used for gathering or amusement, including a public park or recreation center; and (3) a facility that is supported by public funds and primarily used to provide secondary or higher education.

The purpose of the AED program is expanded to include the implementation of an initiative requiring the co-location of up to two doses of naloxone (a medication approved by the U.S. Food and Drug Administration (FDA) for the reversal of a known or suspected opioid overdose) with each AED in a public building under the program. In order to qualify for a valid certificate under the AED program, a registered facility that is a public building must (in addition to current law provisions) meet the bill's requirements to co-locate naloxone with each AED maintained in the facility.

The initiative must ensure that the doses of naloxone are maintained in a location that (1) is visible and in close physical proximity to the AED and (2) has a label that clearly indicates to the public the availability of naloxone.

The EMS Board and MDH must jointly adopt regulations that (1) establish guidelines for periodic inspections and maintenance of the naloxone placed in public buildings; (2) assist the administrators of each public building in carrying out the bill's provisions; and (3) establish initial prioritization of the public buildings eligible to receive funding under the bill with a goal of co-location of naloxone with each AED located in a public building by October 1, 2027.

The owner or operator of a public building is immune from civil liability for any act or omission in the provision and maintenance of naloxone, if the owner or operator has satisfied any requirements established for providing and maintaining naloxone pursuant to the initiative.

Likewise, an individual is immune from civil liability for any act or omission in providing assistance or medical aid to a victim at the scene of an emergency when administering naloxone in response to a known or suspected drug overdose, including an individual who administers naloxone made available pursuant to the initiative.

The purposes for which ORF may provide funds is expanded to include supporting the initiative to co-locate naloxone with AEDs placed in public buildings under the bill.

Current Law:

Maryland Public Access Automated External Defibrillator Program

"AED" means a medical heart monitor and defibrillator device that (1) is cleared for market by FDA; (2) recognizes the presence or absence of ventricular fibrillation or rapid ventricular tachycardia; (3) determines, without intervention by an operator, whether defibrillation should be performed, and on determination that defibrillation should be performed, automatically charges; and (4) requires operator intervention to deliver an electrical impulse or automatically continues with delivery of an electrical impulse.

The AED program permits an organization, business, association, or agency that meets specified requirements to make AEDs available to victims of sudden cardiac arrest. The Maryland Institute for Emergency Medical Services Systems (MIEMSS) oversees the program, including approving entities to participate and issuing registrations.

Under Maryland regulations (COMAR 30.06.02.01), to be eligible for registration or renewal of registration, each facility must designate an AED coordinator who must:

- complete cardiopulmonary resuscitation (CPR) and AED training and subsequent refresher training, in accordance with specified requirements;
- be responsible for implementing and administering the AED program at the facility; and
- ensure that monthly safety inspections of all supplemental and AED equipment are conducted.

Likewise, a facility must ensure that all expected AED operators have completed CPR and AED training and subsequent refresher training, as specified. AEDs must be placed in locations that are visible and readily accessible to any person willing to operate the AED in the event of a suspected cardiac arrest. A facility at which an AED is operated must have a telephone or communication service available at all times for the notification of a public safety answering point; it must also submit data or other information concerning the AED program as requested by MIEMSS.

Overdose Response Program

MDH's Overdose Response Program (ORP) allows for FDA-approved opioid overdose reversal drugs to be offered to specified individuals – free of charge – by multiple providers, programs, and entities. Subject to the limitations of the State budget, MDH must purchase and provide FDA-approved opioid overdose reversal drugs, at no cost, to the entities who may provide the reversal drugs only if MDH provides them. MDH 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 FDA-approved opioid overdose reversal drugs; and (3) access to opioid overdose reversal drugs and the necessary supplies for the administration of the opioid overdose reversal drug. Individuals are not required to obtain the specified training and education on opioid overdose recognition and response from a private or public entity before a pharmacist may dispense an FDA-approved opioid overdose reversal drug.

Standing Orders for Opioid Overdose Reversal Drugs

A licensed health care provider with prescribing authority may prescribe and dispense an FDA-approved opioid overdose reversal drug 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. A health care provider may also prescribe and dispense an FDA-approved opioid overdose reversal drug by issuing a standing order if the licensed health care provider (1) is employed by MDH or a local health department 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 an FDA-approved opioid overdose reversal drug 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 an FDA-approved opioid overdose reversal drug to any individual in accordance with a standing order that is issued by a licensed health care provider with prescribing authority as described above. A pharmacist may also dispense an FDA-approved opioid overdose reversal drug in accordance with a therapy management contract under the Health Occupations Article.

Maryland has a statewide standing order for opioid overdose reversal drugs that authorizes any Maryland-licensed pharmacist to dispense unlimited prescriptions and refills of naloxone and devices for its administration to any individual, as specified. A pharmacist must provide consultation with the individual regarding the naloxone dosage that is most appropriate, select and dispense two doses of naloxone, and provide directions for use. The standing order is set to expire June 30, 2024, at which time a new order will be issued. If a patient cannot afford naloxone or related copayments, or does not wish to use insurance coverage, pharmacists are instructed to refer them to ORP where they can obtain a naloxone kit free of charge.

Opioid Restitution Fund

Chapter 537 of 2019 established ORF, a special fund to retain any revenues received by the State relating to specified opioid judgments or settlements, which may be used only for opioid-related programs and services. Chapter 270 of 2022 specifies that ORF may be used for programs, services, supports, and resources for evidence-based substance use disorder (SUD) prevention, treatment, recovery, or harm reduction that have the purpose of currently authorized outcomes and activities. ORF may also be used for:

- evidence-informed SUD prevention, treatment recovery, or harm reduction pilot programs or demonstration studies that are not evidence based if the advisory council determines that emerging evidence supports funding or that there is a reasonable basis for funding with the expectation of creating an evidence-based program and approves the use of money for the pilot program or demonstration study; and
- evaluations of the effectiveness and outcomes reporting for SUD abatement infrastructure, programs, services, supports, and resources for which the fund is used.

In fiscal 2023, ORF revenues totaled $57.9 million, and expenditures (largely in the form of grants) totaled $26.9 million. The fiscal 2025 budget includes $81 million in grants from opioid settlement funds to local government and community organizations for opioid abatement efforts.

State Expenditures:

Administrative Costs

As noted above, MIEMSS is responsible for administering the AED program. Under the bill, MIEMSS (jointly with MDH) must establish guidelines for periodic inspections of the co-located naloxone and assist public building administrators in carrying out the bill. The initiative must be funded using funds from ORF appropriated through the State budget. As such, this analysis assumes that most of the responsibilities for implementation will be undertaken by MIEMSS with support from MDH but paid for using ORF special funds. MIEMSS advises it requires two full-time staff (one program manager and one administrative officer) to implement the bill. The Department of Legislative Services agrees that additional personnel are likely necessary and advises that one full-time program manager should be sufficient for implementation in light of the requirement that MIEMSS collaborate with MDH to develop and implement the program.

Thus, special fund expenditures from ORF increase by at least $74,108 in fiscal 2025, which accounts for the bill's October 1, 2024 effective date. This estimate reflects the cost

of hiring one program manager to establish inspection guidelines and assist public building administrators in carrying out the bill's requirements. It includes a salary, fringe benefits, one-time start-up costs, and ongoing operating expenses.

Position	1.0
Salary and Fringe Benefits	$66,852
Operating Expenses	7,256
FY 2025 Personnel Expenditures	**$74,108**

Future year expenditures reflect a full salary with annual increases and employee turnover as well as annual increases in ongoing operating expenses. To the extent that additional staff is necessary, special fund expenditures may increase further.

Special fund expenditures from ORF increase by an additional indeterminate amount in fiscal 2025 only for MIEMSS to update its AED program tracking system to add the new requirement to co-locate up to two doses of naloxone with each AED in a public building.

MDH can likely provide support to MIEMSS and expertise as to protocols and procedures related to naloxone using existing budgeted resources.

Any operational impact on State agencies for conducting periodic inspections under the bill cannot be reliably estimated as MIEMSS and MDH must establish guidelines through regulations. Nevertheless, this analysis assumes that the impact of periodic inspections is absorbable within existing budgeted resources for each entity.

Costs to Co-locate Naloxone with AEDs in Public Buildings

As the initiative must be funded using available funds from ORF, this analysis assumes that all costs related to co-locating naloxone in public buildings statewide (local- and State-owned or operated public buildings) are paid for using ORF funds. MIEMSS advises that, in order to ensure consistency in storage and packaging of naloxone at AED sites, MIEMSS intends to supply sites with these materials at an estimated cost of $25 per AED site. MDH has previously advised that the most commonly requested and provided form of naloxone within ORP is Narcan nasal spray (4 milligrams). A two-dose kit of Narcan is approximately $45 with a shelf life of three years. Thus, this analysis assumes a cost of $45 for two-doses of naloxone, which is incurred at least every three years (as the naloxone expires) or sooner as naloxone is used and needs to be replaced.

Thus, ORF expenditures increase by $70 ($25 for storage and packaging and $45 for a two-dose naloxone pack) for each AED located in a public building to supply naloxone and storage and packaging materials in fiscal 2025 through 2028 (based on regulations establishing initial prioritization of co-location of naloxone with each AED located in a

public building by October 1, 2027); expenditures increase by $45 per AED in future years as naloxone is used or expires and is replaced.

MIEMSS advises that, in 2023, there were 15,528 AEDs in 9,226 locations across the State. However, the proportion of these AEDs that are located in "public buildings" as defined by the bill is unknown. MIEMSS further advises that, while some entities (*e.g.*, restaurants and schools) are required to have AEDs, the vast majority of entities that participate do so voluntarily. *For illustrative purposes only,* if the bill applies to 40% of AEDs statewide (local- and State-owned or -operated public buildings), ORF expenditures increase by $434,784 spread across fiscal 2025 through 2028 to provide initial doses of naloxone and the specified storage and packaging materials. At a minimum, additional costs are incurred in fiscal 2028 through 2030 to replace expired naloxone – at $45 per two-dose pack (or sooner as naloxone is used and needs to be replaced).

Some agencies advise that MDH already provides naloxone for their facilities through ORP (paid for by MDH general funds). To the extent naloxone is already provided, additional ORF expenditures for this purpose may be reduced; conversely, to the extent that an agency accepts naloxone under the bill (rather than requesting through ORP) general fund expenditures may decrease. However, overall State finances are not materially affected by which program provides naloxone.

Additionally, each public secondary school must have an AED on site and each public school must store naloxone. Thus, each secondary public school has an AED, and all public schools have naloxone. However, current naloxone supplies are not co-located with the AED. This analysis assumes that each secondary public school likely must obtain additional naloxone to co-locate with the AED and that the costs to obtain the additional naloxone are paid for using funds from ORF as discussed above.

Local Expenditures: Similar to the above effect for State agencies, any operational effect on local jurisdictions due to conducting periodic inspections is assumed to be absorbable within existing budgeted resources.

Additional Information

Recent Prior Introductions: Similar legislation has not been introduced within the last three years.

Designated Cross File: None.

Information Source(s): Maryland Institute for Emergency Medical Services Systems; Baltimore, Carroll, Harford, and Queen Anne's counties; Maryland Association of Counties; Maryland Municipal League; Maryland State Department of Education; Maryland School for the Deaf; Baltimore City Community College; University System of Maryland; Morgan State University; St. Mary's College of Maryland; Department of Natural Resources; Maryland Department of Transportation; Baltimore City Public Schools; Anne Arundel County Public Schools; Prince George's County Public Schools; Department of Legislative Services

Fiscal Note History: First Reader - February 29, 2024
km/jc Third Reader - April 1, 2024
Revised - Amendment(s) - April 1, 2024
Enrolled - April 22, 2024
Revised - Amendment(s) - April 22, 2024
Revised - Budget Information - April 22, 2024

Analysis by: Amber R. Gundlach

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