HB 576

Department of Legislative Services

Maryland General Assembly
2024 Session

FISCAL AND POLICY NOTE
Enrolled - Revised

House Bill 576 (The Speaker, *et al.*) (By Request - Administration)
Health and Government Operations Finance

Mental Health - Assisted Outpatient Treatment Programs

This Administration bill requires that an Assisted Outpatient Treatment Program be established *in* each county by July 1, 2026. A county may establish its own program and must notify the Maryland Department of Health (MDH) by January 1, 2025, as to whether the county intends to do so. In any county that does not opt to establish its own program, MDH must establish a program in the county. The bill generally sets standards and procedures for "assisted outpatient treatment" (AOT) programs, petitions, treatment plans, rights of respondents, hearings, criteria for orders, court orders, and order modifications. MDH must establish clinical and operational standards for AOT programs and care coordination teams. By December 1 each year, the Behavioral Health Administration (BHA) must submit a specified report on each AOT program. **The bill generally takes effect July 1, 2025, and terminates June 30, 2030; the provision regarding required notification about intent to establish an AOT program takes effect July 1, 2024.**

Fiscal Summary

State Effect: General fund expenditures increase by $3.0 million in FY 2025, reflecting contingent funds in the FY 2025 budget. In FY 2026, general fund expenditures increase by *at least* $291,700 for MDH staff as well as one-time programming for the Judiciary; future years reflect inflation. Other costs cannot be quantified, but general fund expenditures also increase from FY 2026 through 2030, likely significantly, to the extent MDH must establish AOT programs in counties that opt not to do so, and for the Office of the Public Defender (OPD) to pay expert fees and hire staff (whose costs may be ongoing). Medicaid expenditures (50% general funds/50% federal funds) and corresponding federal fund revenues may also increase from FY 2026 through FY 2030, as discussed below.

(in dollars)	FY 2025	FY 2026	FY 2027	FY 2028	FY 2029
FF Revenue	$0	-	-	-	-
GF Expenditure	$3,000,000	$291,700	$152,100	$158,800	$165,800
FF Expenditure	$0	-	-	-	-
Net Effect	($3,000,000)	($-)	($-)	($-)	($-)

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

Local Effect: Local expenditures and revenues increase from FY 2026 through 2030, potentially significantly, to the extent that a county chooses to establish an AOT program as authorized under the bill. Circuit court caseloads may increase minimally, albeit temporarily, to the extent that petitions for AOT are filed.

Small Business Effect: The Administration has determined that this bill has minimal or no impact on small business (attached). The Department of Legislative Services (DLS) disagrees with this assessment as discussed below. (The attached assessment does not reflect amendments to the bill.)

Analysis

Bill Summary: An AOT program established by a county must be approved and overseen by the local behavioral health authority (LBHA) or core service agency (CSA). A county may partner with another county to establish an AOT program. Otherwise, an AOT program must be established by MDH.

Petitions

"AOT" means a specific regimen of outpatient treatment for a "serious and persistent mental illness" to which an individual is ordered by the court to adhere. The director of a specified mental health program or any individual who is at least age 18 and has a legitimate interest in the welfare of the respondent may petition a circuit court as specified for AOT. A petition for AOT must be in writing, signed by the petitioner, and state (1) the petitioner's name, address, and relationship to the respondent; (2) the name and any known address of the respondent; (3) that the petitioner has reason to believe the respondent meets the criteria for AOT; and (4) the specific factual allegations for each criterion supporting the petitioner's belief.

The AOT petition must be (1) filed in the circuit court for the county where the respondent resides or the last known residence of the respondent; (2) under seal and may not be published on Maryland Judiciary Case Search; and (3) accompanied by an affidavit of a psychiatrist stating that the psychiatrist is willing and able to testify at the hearing on the petition and has examined the respondent within 30 days prior to the filing of the petition and concluded the respondent meets specified criteria.

Treatment Plans

After a petition is filed, but by the date of the psychiatrist's testimony, a "care coordination team" (a multidisciplinary team under the oversight of an LBHA, CSA, or MDH that consists of, at a minimum, a psychiatrist, case manager, certified peer recovery specialist,

other treating providers as clinically appropriate, and any other individuals required by MDH regulations) must develop a "treatment plan" and provide a copy to the respondent, the respondent's attorney and, if applicable and known, the respondent's guardian and health care agent. "Treatment plan" means a plan developed by a care coordination team that incorporates all outpatient treatment services that are determined to be essential and available for the maintenance of an individual's health and safety and that include, at a minimum, (1) services of a treating psychiatrist; (2) case management; (3) services of a certified peer recovery specialist; and (4) if clinically appropriate, assertive community treatment services.

In developing a treatment plan, a care coordination team must (1) give the respondent, the respondent's guardian or health care agent, and any individual designated by the respondent, a reasonable opportunity to participate and (2) honor any directions included in a respondent's mental health advance directive (if available). A treatment plan developed by the care coordination team must be recovery-oriented and consistent with evidence-based and evolving best practices in the treatment of serious and persistent mental illness. The care coordination team must provide a copy of the treatment plan (and the providers included in the treatment plan) to the respondent, the county attorney, and OPD. The respondent must have an opportunity to voluntarily agree to the treatment plan. If the respondent voluntarily agrees to the treatment plan, the care coordination team must notify the court that the parties are dismissing the case, as specified, and file a stipulated agreement that includes the treatment plan.

The care coordination team must assist in connecting the respondent to services that would help the respondent be successful in adhering to a treatment plan, including (if needed) transportation, housing, accessibility services, and other services that would address the health-related social needs of the respondent. If the treatment plan or providers change before the specified hearing is conducted, the care coordination team must promptly notify the respondent, the respondent's attorney, the county attorney, and if applicable and known, the respondent's guardian and health care agent.

Hearings and Respondent Rights

On receipt of a complete petition for AOT, the court must schedule a hearing only if the respondent has not agreed to enter voluntary treatment and notify (1) the respondent; (2) the mental health division in OPD; (3) as applicable, the LBHA, CSA, or MDH; (4) the county attorney; and (5) if applicable and known, the respondent's guardian and health care agent.

All rules of civil procedure and any right normally afforded to an individual in a civil or criminal matter must apply to cases that proceed following a petition for AOT. Further, the bill may not be construed to abridge or modify any civil right of the respondent, including

(1) any civil service ranking or appointment; (2) the right to apply for voluntary admission to a facility; and (3) any right relating to a license, permit, certification, privilege, or benefit under any law. Participation in AOT may not be used against a respondent in a subsequent legal matter that carries negative collateral consequences, and an order for AOT may not be the basis for the involuntary admission of the respondent to a facility or used as evidence of incompetency of the respondent.

A respondent is entitled to be represented by counsel at all stages of the proceedings; if the respondent is unable to afford an attorney or is unable to obtain an attorney due to the respondent's mental illness, representation must be provided by OPD or an OPD panel attorney. The respondent may not be required to give testimony at a hearing and must be given the opportunity to present evidence, call witnesses, and cross-examine adverse witnesses at the hearing.

At the hearing, the petitioner must present testimonial evidence of both a psychiatrist whose most recent examination of the respondent is within the 30 days prior to the date of the petition as well as a psychiatrist to explain the treatment plan who (1) may or may not be the same as the examining psychiatrist; (2) has met with or made a good faith effort to meet with the respondent; (3) is familiar with the relevant history to the extent practicable; and (4) has examined the treatment plan.

Criteria for Ordering Assisted Outpatient Treatment

The court may order the respondent to receive AOT on a finding of clear and convincing evidence that:

- the respondent is at least age 18;
- the respondent has a "serious and persistent mental illness" meaning a mental illness that is severe in degree and persistent in duration, that causes a substantially diminished level of functioning in the primary aspects of daily living and an inability to meet the ordinary demands of life, and that may lead to an inability to maintain independent functioning in the community without intensive treatment and support;
- the respondent has demonstrated a lack of adherence with treatment for the serious and persistent mental illness that has (1) been a significant factor in necessitating either hospital inpatient admission to a psychiatric hospital for at least 48 hours or receipt of services in a correctional facility, at least twice within the immediately preceding 36 months or (2) resulted in an act of serious violent behavior toward self or others, or patterns or threats of, or attempts at, serious physical harm to self or others, at least once within the immediately preceding 36 months;
- the respondent is in need of AOT in order to prevent a relapse or deterioration that would create a substantial risk of serious harm to self or others;

- the respondent is unlikely to adequately adhere to outpatient treatment on a voluntary basis, as specified; and
- AOT is the least restrictive alternative appropriate to maintain the health and safety of the respondent, as specified.

The court must hear all relevant evidence and (using a clear and convincing evidence standard) either (1) deny the petition if the court finds that the respondent does not meet specified criteria for AOT or (2) order the respondent to comply with AOT for up to one year if the court finds that the respondent meets specified criteria.

Orders for Assisted Outpatient Treatment

The court's order for AOT must incorporate a treatment plan that is limited in scope to those elements included in the treatment plan presented to the court and to those elements the court finds by clear and convincing evidence to be essential to the maintenance of the respondent's health or safety.

Order Modifications: At any time during an order for AOT, a petitioner, a care coordination team member, or a respondent may move that the court stay, vacate, or modify the order. "Material change" means an addition or a deletion of a category of services to or from the treatment plan.

Within 30 days of receiving a motion (and any timely responses to the motion) for a material change, the court must issue a ruling on the motion (and any timely responses to the motion), unless the respondent informs the court that the respondent agrees to the proposed material change (in which case the court may incorporate the material change). Otherwise, the respondent need not comply with the material change unless explicitly authorized in advance by the court's initial order or incorporated into the treatment plan following a finding by clear and convincing evidence that the change is essential to the respondent's health or safety. However, nonmaterial changes to the treatment plan require the respondent's compliance without further court action. The bill may not be construed to require a psychiatrist to delay changes to the respondent's treatment plan as circumstances may immediately require, but the care coordination team must notify the respondent, the respondent's attorney, and if applicable and known, the respondent's guardian and health care agent.

Failure to Comply with Assisted Outpatient Treatment: If a petition for emergency evaluation of the respondent is filed or the respondent is the subject of other court involvement, the petitioner (to the extent practicable) must notify the respondent's care coordination team. If the care coordination team knows that a petition for emergency evaluation was filed for the respondent, a team member must notify the court in writing of the reasons for and finding of the evaluation. In response to such a notice or at any time

during an AOT order, the court may convene the parties on its own motion for a conference to review the respondent's progress. Failure to comply with an AOT order is not grounds for a finding of contempt or for involuntary admission.

Orders to Continue Assisted Outpatient Treatment: At least 30 days before an AOT order expires, the respondent's care coordination team must provide the respondent with a plan for continued treatment, if considered necessary.

Annual Reports

BHA must issue an annual report of information on each AOT program established under the bill that includes (1) the number of individuals ordered to receive AOT in the prior 12 months; (2) any effect AOT had on incidences of hospitalizations, arrests, and incarceration among individuals ordered to receive AOT, as specified; (3) specified program statistics for the immediately preceding 12-month period; (4) any information MDH has about system-wide impacts of AOT orders, as specified; and (5) information about the costs incurred by MDH, BHA, and any county that establishes an AOT program under the bill, as specified. Each county must provide information to BHA that is determined to be necessary for BHA to complete the required report. The report must be submitted to the General Assembly by December 1 of each year.

Current Law:

Emergency Evaluations

Under the Health-General Article, specified health professionals, a health officer (or designee), a peace officer, or any other interested party may petition for an emergency evaluation of an individual if the petitioner has reason to believe that the individual (1) has a mental disorder and (2) presents a danger to the life or safety of the individual or of others. A peace officer may petition for an emergency evaluation only if the peace officer has personally observed the individual or the individual's behavior, whereas specified health professionals and health officers (or designees) who petition for an emergency evaluation must have examined the individual.

When the petitioner is a specified health professional or health officer (or designee), the petition must be given to a peace officer. On receipt of a valid petition for an emergency evaluation, a peace officer must take the individual to the nearest emergency facility and must notify the facility in advance, to the extent practicable. The peace officer may stay for the duration of the evaluation on request of the evaluating physician if the individual exhibits violent behavior.

Involuntary Admissions

Under the Health-General Article, an application for involuntary admission of an individual to a facility or Veterans' Administration hospital may be made by any person who has a legitimate interest in the welfare of the individual. In addition to other requirements, the application must (1) state the relationship of the applicant to the individual for whom admission is sought; (2) be signed by the applicant; and (3) be accompanied by the certificates of one physician and one psychologist, two physicians, or one physician and one psychiatric nurse practitioner.

Additionally, within 12 hours of receiving notification from the health care practitioner who has certified an individual for involuntary admission, MDH must receive and evaluate the individual for involuntary admission if certain requirements are met, including that the health care practitioner is unable to place the individual in a facility not operated by MDH.

A facility or Veterans' Administration hospital may not admit an individual under involuntary admission unless (1) the individual has a mental disorder; (2) the individual needs inpatient care or treatment; (3) the individual presents a danger to the life or safety of the individual or of others; (4) the individual is unable or unwilling to be admitted voluntarily; and (5) there is no available, less restrictive form of intervention that is consistent with the welfare and safety of the individual.

Specified health professionals and other interested parties may petition for an emergency evaluation of an individual, which may result in the involuntary admission of the individual to a mental disorder treatment facility, if the petitioner has reason to believe that the individual (1) has a mental disorder and (2) presents a danger to the life or safety of the individual or of others. Petitions for an emergency evaluation must contain specified additional information. If an emergency evaluee meets the requirements for an involuntary admission and is unable or unwilling to agree to a voluntary admission, the examining physician must take the steps needed for involuntary admission of the emergency evaluee to an appropriate facility, which may be a general hospital with a licensed inpatient psychiatric unit. If the examining physician is unable to have the emergency evaluee admitted to a facility, the physician must notify MDH, which must provide for the admission of an emergency evaluee to an appropriate facility within six hours of receiving notification.

In practice, there is no level of priority that admits emergency evaluees within six hours. There is additionally no penalty provision or compulsion mechanism in statute for failure to admit patients within six hours. BHA considers certifications for involuntary civil commitments and inmate civil certifications fourth priority after (1) conditionally released patients returning voluntarily or pursuant to a hospital warrant and mandatory releases from the Department of Public Safety and Correctional Services who meet involuntary

admission criteria; (2) patients committed as Not Criminally Responsible or Incompetent to Stand Trial and dangerous; and (3) patients referred to MDH for examination regarding competency to stand trial or a juvenile court order for examination or depositions. Often civil certifications and inmate certifications expire while an individual waits; thus, individuals may be re-certified multiple times before admission occurs.

At any time, a court may order an emergency evaluation of an individual who has been arrested, if the court finds probable cause to believe that the individual has a mental disorder and the individual presents a danger to the life or safety of the individual or of others.

Within 12 hours after initial confinement to a facility, the facility must provide the individual with a form, provided by BHA, which explains the individual's rights, including the right to consult with a lawyer. An individual who is proposed for involuntary admission must be afforded a hearing to determine whether the individual should be involuntarily admitted or released, which must be conducted within 10 days of initial confinement. The hearing officer must consider all the evidence and testimony of record and order the release of the individual from the facility unless the record demonstrates by clear and convincing evidence that, at the time of the hearing, each of the following elements exists: (1) the individual has a mental disorder; (2) the individual needs inpatient care or treatment; (3) the individual presents a danger to the life or safety of the individual or of others; (4) the individual is unable or unwilling to be voluntarily admitted to the facility; and (5) there is no available less restrictive form of intervention that is consistent with the welfare and safety of the individual. Additional findings must be made if the individual to be admitted is at least age 65.

Outpatient Civil Commitment Pilot Program

Pursuant to authorizing legislation, BHA established an outpatient civil commitment (OCC) pilot program to allow for the release of an individual who is involuntarily admitted for inpatient treatment on condition of the individual's admission into the pilot program. The OCC pilot program, limited to Baltimore City residents (initially funded by federal grants, and subsequently with general funds **at least** through **fiscal 2023**) was established under Maryland regulations (COMAR 10.63.07.03). To be *involuntarily* admitted into the OCC pilot program, an individual must meet specified criteria:

- have a mental disorder;
- be at least 18 years old;
- be a Baltimore City resident;
- have had at least two involuntary inpatient facility admissions within the preceding 12 months, including the most recent admission, before submitting an application;

- have a demonstrated history of refusing community treatment that has been a significant factor in contributing to the current involuntary inpatient admission;
- have a treatment history and behavior that indicates the need for outpatient treatment to prevent deterioration after discharge and is substantially likely to result in the individual becoming a danger to self or others in the community in the foreseeable future;
- have been offered, and refused, the opportunity to accept voluntary outpatient admission into the pilot program on discharge from the inpatient facility;
- be substantially likely to benefit from outpatient treatment;
- not be a danger to self or others if released into the pilot program; and
- be someone for whom treatment in the program is the appropriate least restrictive alternative.

To be *voluntarily* admitted into the pilot program, an individual must (1) meet the criteria for involuntary admission, with the exception that the individual has been offered, and refused, voluntary outpatient admission; (2) participate in a settlement conference with an administrative law judge, the legal service provider, and a representative of the inpatient facility; and (3) enter into a settlement agreement whereby the individual agrees to adhere to program recommendations including a treatment plan or support services, or both, as needed by the individual.

Background: AOT is a form of civil commitment that authorizes the judicial system to commit eligible individuals with severe psychiatric disorders to mental health intervention in the community. AOT is authorized by statute in 47 states and the District of Columbia, while 3 states (Connecticut, Maryland, and Massachusetts) do not authorize AOT. Criteria for AOT varies, with about half the states having identical criteria for both inpatient and outpatient commitment, while the other half have criteria that are distinct from inpatient criteria in some way.

State Fiscal Effect: As discussed further below, general fund expenditures increase by $3.0 million in fiscal 2025, despite the bill's general fiscal 2026 effective date. Otherwise, readily quantifiable general fund expenditures increase in fiscal 2026 – by $133,209 for the Judiciary and by $158,489 for MDH. However, general fund expenditures increase further for MDH, including potentially for Medicaid (with corresponding federal fund revenues and expenditures), and for OPD, as discussed below.

Judiciary

The Judiciary advises that the bill's implementation requires programming changes for the judicial information system, which affects the circuit courts (as well as the District Court). Thus, general fund Judiciary expenditures increase by at least $133,209. These one-time

costs are assumed to be incurred in fiscal 2026, as the programming changes can still be completed before any AOT programs are implemented.

Maryland Department of Health

The fiscal 2025 budget includes $3.0 million in general funds for BHA, contingent upon the enactment of legislation establishing AOT programs. As the bill satisfies the contingency, the appropriation is effectuated. Nevertheless, in fiscal 2025, there are no anticipated expenses for BHA related to the bill's implementation (as the bill largely takes effect in fiscal 2026). Thus, this analysis assumes that BHA uses the budgeted funds for any *preliminary* expenses related to establishing AOT programs that can be incurred or encumbered prior to the AOT program provisions in the bill taking effect. To the extent that less than $3.0 million in expenses for AOT programs can be incurred or encumbered in fiscal 2025, this analysis further assumes the available monies are redirected to other behavioral health-related purposes – which is not precluded in the contingent language in the budget bill.

MDH advises that it requires one health policy analyst and one half-time epidemiologist to provide training, technical assistance, and oversight for the implementation of AOT programs across the State. Thus, general fund expenditures increase by $158,489 in fiscal 2026, which accounts for the delayed effective date of July 1, 2025, for the bill's AOT program provisions. As all such programs must be fully in place by July 1, 2026, programs must be developed in fiscal 2026. The estimate reflects the cost of hiring (1) one health policy analyst to establish clinical and operational standards for AOT programs and care coordination teams and provide training, technical assistance, and oversight for the implementation of AOT programs and (2) one half-time epidemiologist to compile data and issue the annual report on AOT programs. It includes salaries, fringe benefits, one-time start-up costs, and ongoing operating expenses.

Positions	1.5
Salaries and Fringe Benefits	$143,960
Operating Expenses	14,529
Total FY 2026 MDH Administrative Expenditures	**$158,489**

Future year expenditures reflect full salaries with annual increases and employee turnover as well as annual increases in ongoing operating expenses. Even though the bill terminates at the end of fiscal 2030, this estimate assumes permanent staff are hired for the AOT programs. Accordingly, expenditures are maintained in fiscal 2031 and beyond, and the staff are redirected to other duties within MDH.

General fund expenditures increase further beginning in fiscal 2026 (by a potentially significant and indeterminate amount) to the extent that MDH must take responsibility for

establishing AOT programs in counties that do not opt to do so themselves. The Maryland Association of County Health Officers (MACHO) estimates that, for a medium-sized county, it would cost $250,000 annually to operate an AOT program, while for a larger county, it would cost between $3.0 million and $5.0 million annually to operate an AOT program. Such costs for the State terminate after fiscal 2030; nevertheless, given the temporary nature of the program, DLS advises counties may be more likely to opt out of establishing their own programs in favor of having the State do so.

California, Florida, New York, and North Carolina have reported reductions in state expenditures (including for state hospital admissions) following the implementation of AOT programs. Thus, AOT may result in fewer State hospital admissions. However, given the current shortage of psychiatric hospital placements and the continued existence of waiting lists for admission, it is likely that State hospital resources are redirected to other patients.

Medicaid expenditures (50% general funds, 50% federal funds) and corresponding federal fund revenues increase beginning as early as fiscal 2026 and continuing through fiscal 2030 to the extent that Medicaid recipients receive additional outpatient treatment services through AOT programs under the bill.

Office of the Public Defender

Under the bill, OPD must provide representation in AOT proceedings to any individuals who qualify for its services. OPD advises it would need significant resources, including 20 attorneys, 10 social workers, 10 peer specialists, 7 secretaries, 5 paralegals, and 1 mental health treatment trainer at an estimated cost of $5.2 million in the first full fiscal year of implementation and would incur expert fees (including psychiatrists and investigators) at a cost of approximately $600,000 annually. OPD further advises that other additional costs would be incurred to obtain medical records and obtain additional office space in some, if not all, jurisdictions across the State.

According to its 2023 annual report, OPD's mental health division handled 877 cases per each of its 11 mental health attorneys (a total of 9,651 cases) during fiscal 2023, which is in line with the appropriate annual mental health attorney case load standards of 883 cases per attorney. Also in its 2023 annual report, OPD reports that the recommended attorney to core staff ratios are as follows: (1) a secretary for every 3 attorneys; (2) a social worker for every 8 attorneys; and (3) a paralegal for every 11 attorneys.

DLS agrees that additional staff is likely necessary but advises that the number of AOT petitions that will be filed under the bill cannot be reliably determined. Additionally, the ability to file an AOT petition may reduce other types of mental health cases for which OPD also provides representation (*e.g.,* involuntary commitment cases). Nevertheless,

general fund expenditures increase to hire one mental health attorney for every 877 AOT petitions, a secretary for every 2,631 AOT petitions, a social worker for every 7,016 AOT petitions, and a paralegal for every 9,647 AOT petitions. General fund expenditures increase further to pay costs associated with experts, estimated to be 10 hours per AOT case at $200 an hour. The cost for each such additional position for the first full fiscal year (which could be as early as fiscal 2026) would be approximately (1) $129,392 for one mental health attorney; (2) $68,160 for one secretary; (3) $94,226 for one social worker; and (4) $74,377 for one paralegal. *For illustrative purposes only*, if the bill results in 1,500 new cases for AOT clients, general fund expenditures increase by as much as $3,356,943 in fiscal 2026 and increase to as much as $3,471,822 by fiscal 2029 for OPD to hire two mental health attorneys and one secretary and pay as much as $3.0 million in expert fees annually.

As for MDH, to the extent additional positions are hired, DLS assumes they would be permanent and expenditures would be maintained after the bill's termination date. However, the additional costs for expert fees terminate when the bill does.

Local Fiscal Effect: MACHO advises that it is unclear whether a CSA or LBHA would operate such a program or only oversee such a program but advises the respective agency could not both operate and oversee. As discussed above, MACHO estimates that the cost of establishing an AOT program varies significantly (with estimates as low as $250,000 annually for medium jurisdictions and up to $5.0 million annually for large jurisdictions). However, many of the services provided by an AOT program are billable services for which a county can receive reimbursement revenues.

Thus, local expenditures increase (including for a CSA or LBHA) to the extent that a county exercises the bill's authority to establish an AOT program. Local revenues increase as local jurisdictions provide billable services, bill for them, and receive reimbursement revenues. However, local expenditures are incurred for a mental health provider to appear for and/or testify at an AOT hearing – a nonbillable service for which a local jurisdiction is not reimbursed. Any such expenditures and revenues are only incurred (or realized) through fiscal 2030, after which the bill terminates.

Any increase in circuit court caseloads from AOT petitions is assumed to be minimal and absorbable within existing budgeted resources; further, any such increase is only temporary under the bill.

Small Business Effect: Small business behavioral health care providers may treat additional individuals who are ordered to participate in outpatient treatment under the bill. The magnitude of any such impact is dependent upon the number of individuals ordered to AOT but is potentially meaningful – and temporary.

Additional Comments: To the extent that AOT programs are used to provide outpatient services to respondents, overall service costs (including hospitalization and incarceration costs) for individuals with serious and persistent mental illness may be reduced during the period the bill is in effect.

Additional Information

Recent Prior Introductions: Similar legislation has been introduced within the last three years. See SB 480 and HB 823 of 2023, and SB 807 and HB 1017 of 2022.

Designated Cross File: SB 453 (The President, *et al.*) (By Request - Administration) - Finance.

Information Source(s): Maryland Association of County Health Officers; Baltimore, Carroll, Harford, Queen Anne's, and St. Mary's counties; Maryland Association of Counties; Judiciary (Administrative Office of the Courts); Office of the Public Defender; Maryland Department of Health; Department of Juvenile Services; Department of Public Safety and Correctional Services; Department of State Police; Department of Legislative Services

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ANALYSIS OF ECONOMIC IMPACT ON SMALL BUSINESSES

TITLE OF BILL: **Mental Health - Assisted Outpatient Treatment Programs**

BILL NUMBER: **HB 576**

PREPARED BY: **June Chung**

PART A. ECONOMIC IMPACT RATING

This agency estimates that the proposed bill:

X WILL HAVE MINIMAL OR NO ECONOMIC IMPACT ON MARYLAND SMALL BUSINESS

OR

___ WILL HAVE MEANINGFUL ECONOMIC IMPACT ON MARYLAND SMALL BUSINESSES

PART B. ECONOMIC IMPACT ANALYSIS