HB 273

Department of Legislative Services

Maryland General Assembly
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FISCAL AND POLICY NOTE

House Bill 273 (Delegate Rosenberg, *et al.*)
Health and Government Operations

Mental Health and Substance Use Disorder Safety Net Act of 2014

This bill requires the Department of Health and Mental Hygiene (DHMH), the Department of Public Safety and Correctional Services (DPSCS), and the Maryland State Department of Education (MSDE) to establish and implement various programs and provide various services to eliminate gaps in the State's mental health, substance use disorder, and behavioral health safety net. The bill also requires DHMH to develop a cost-based reimbursement methodology for community behavioral health providers, a data-sharing initiative between core service agencies (CSAs) and local detention centers, and various reports related to program implementation.

The bill takes effect July 1, 2014.

Fiscal Summary

State Effect: State expenditures increase significantly beginning in FY 2015 for DHMH, MSDE, and DPSCS to implement the bill's various programs and requirements. Exact costs to the State cannot be reliably estimated at this time, as discussed below. However, quantifiable costs likely approximate at least $44.5 million in general fund expenditures and $5.7 million in federal fund expenditures in the first year. Future year expenditures increase to reflect mandated appropriations (beginning in FY 2016) and other growth factors. **This bill establishes multiple mandated appropriations.**

Local Effect: Expenditures increase significantly (and by up to $137.0 million annually) beginning in FY 2015 for local boards of education to provide behavioral health services in each of the State's public schools. Expenditures also increase significantly for local health departments (LHDs) and, potentially, local detention centers to implement the bill's various programs and requirements. Exact costs to local governments cannot be reliably estimated at this time, as discussed below. **This bill imposes a mandate on a unit of local government.**

Small Business Effect: Potential meaningful for small mental health service providers that benefit from increased reimbursement under the bill.

Analysis

Bill Summary:

Prison In-Reach Program

The bill requires DPSCS, in collaboration with DHMH, to establish a Prison In-Reach Program to serve moderate- to high-risk offenders with histories of chronic mental illness and substance use who are returning to the community and who demonstrate an interest in continuing treatment. The bill specifies that the program must provide an in-reach team to (1) meet with an eligible individual at least three times during the four months prior to the individual's release to assess the community needs of the individual and establish linkages to community services; (2) provide services for at least six months post-release to provide continuity of care and ensure that a successful transition is made to publicly funded behavioral health services and other supports; and (3) monitor recidivism rates and other indicators of program success.

Public School Health Services

Each local board of education must provide behavioral health services in addition to other school health services. In addition, DHMH must report, by October 1, 2014, to the Governor and the General Assembly on a plan for statewide implementation of the pilot School Health Program operated in Baltimore City and Caroline County.

Evidence-based Early Identification of Substance Abuse

The Alcohol and Drug Abuse Administration (ADAA) within DHMH is required to implement an evidence-based program throughout the State to promote early identification of substance abuse. The program – which is required to provide for screening, brief intervention, and referral to treatment (SBIRT) – must be utilized for all age groups, with a priority on reaching adolescents and young adults.

Geriatric Behavioral Health Specialist Program

The Mental Hygiene Administration (MHA) within DHMH, in coordination with the Maryland Department of Aging (MDoA) and CSAs, must implement a geriatric behavioral health specialist program in each county that coordinates with local Maryland Access Point (MAP) offices. The bill specifies the purposes of the program to assist

older adults, caregivers, and aging network professionals in navigating behavioral health systems; facilitate access to the full array of geriatric services; and serve as a consultant, liaison, and referral source. DHMH is required to provide training and technical assistance and to measure program outcomes.

Mental Health First Aid Program

MHA is further required to implement a Mental Health First Aid program to improve mental health literacy. The program must use the Mental Health First Aid training curriculum and ensure the availability of training throughout the State.

Behavioral Health Integration in Pediatric Primary Care Program

DHMH and MSDE, in collaboration with schools of public health, medicine, and social work, must implement a Behavioral Health Integration in Pediatric Primary Care (B-HIPP) program. The bill specifies the purposes of the program and requires the program to provide phone consultation services for primary care providers with child mental health specialists; continuing education in mental health skills training for primary care providers; referral and resource networking to increase access to children's mental health services; and the collocation of social work interns in primary care practices to provide screening, brief intervention, referral, and consultation. The bill requires the Governor to include at least $2,000,000 annually in general fund support to implement the program.

Reimbursement Methodology

DHMH is required to develop a cost-based reimbursement methodology for the reimbursement of community behavioral health providers. The methodology must adjust annually for inflation; apply specified rate-setting and adjustment methodologies; and include accreditation costs, program start-up costs, and long-term capital needs. In addition, DHMH must implement a plan to provide funding support for community behavioral health providers to invest in electronic medical records technology.

Data-sharing Initiatives

MHA must require each CSA to enter into memoranda of understanding with local detention centers to establish a data-sharing initiative, which must (1) promote continuity of treatment for individuals with serious mental illness who have received services in the public mental health system and have become involved in the criminal justice system; (2) implement electronic submission by local detention centers of specified information related to arrestees to the public mental health system's administrative services organization; (3) require the administrative services organization to cross reference the

information received from the detention center in order to identify, to the jurisdiction's CSA, residents within the jurisdiction who are public mental health system enrollees with a serious mental illness; and (4) provide a mechanism for a CSA to, with the arrestee's consent, share treatment information with the detention center health care provider and make necessary linkages to the community service provider network to ensure that treatment information is available to appropriate detention center staff.

Report on Evidence-based Treatment Practices

By July 1 of each year, the Director of Mental Hygiene must report to the Governor and the General Assembly on the progress of MHA in implementing evidence-based practices for the treatment of mental illness and substance use disorders in children, adults, and older adults in primary care and specialty care settings. The report must include a county-by-county update on progress in taking each evidence-based practice to scale, an estimate of the cost to achieve implementation of evidence-based practices throughout the State, and outcomes resulting from the implementation of evidence-based practices.

Funding Support for Housing and Residential Care and Recovery Support Services

For fiscal 2016 through 2025, the Governor must increase general funds for housing assistance for individuals with a primary diagnosis of serious mental illness by at least $1.0 million *per year* over the fiscal 2015 funding level, or until the funding equals $25.0 million annually. Once the funding level reaches $25.0 million, the Governor must include at least the same level of funding in each subsequent budget.

Similarly, for fiscal 2016 through 2025, the Governor must increase general funds for providing residential levels of care and recovery support services for children, youth, adults, and older adults by at least $1.0 million *per year* over the fiscal 2015 funding level, or until the funding equals $24.5 million annually. Once the funding level reaches $24.5 million, the Governor must include at least the same level of funding in each subsequent budget.

Additional Funding Provisions

The Governor must also include enough general funds in the budget each fiscal year to implement the Maryland Mental Health Crisis Response System. In addition, the bill repeals the existing limit of $250,000 on annual general fund expenditures.

The bill expresses the General Assembly's intent that the bill's provisions be funded using general funds resulting from cost savings associated with implementation of the Patient Protection and Affordable Care Act (ACA), the reallocation of cost savings resulting from hospital diversion efforts, other efforts to promote efficiency in health care

spending, and any savings achieved through the programs and initiatives established in the bill.

The bill also requires DHMH to examine potential funding sources for mental health services, including a tax on health insurers and the use of interest on the reserve funds of nonprofit health insurers to pay for health care provided by the State system for privately insured individuals. DHMH must report, by December 1, 2015, to the Governor and the General Assembly on the examination.

Repeal of Contingency Funding Provisions

The bill repeals a provision of Chapter 371 of 2002, which made the establishment of the Maryland Mental Health Crisis Response System contingent on the receipt of federal funding or funding from another private or public source. The bill also repeals a provision of Chapter 82 of 2005, which made the suspension of an incarcerated individual's Maryland Medical Assistance Program (Medicaid) benefits contingent on DHMH's receipt of funding for the development of a computerized eligibility system for Medicaid and the implementation of the system.

Expanded Primary Care Provider Responsibilities under Medicaid

Within the Medicaid program, each managed care organization (MCO) must require primary care providers who serve individuals with mental illness to implement collaborative care within primary care for common mental health and substance use disorders using a collaborative care model that includes (1) care management; (2) clinical monitoring using a validated tool; and (3) behavioral health consultation.

Current Law/Background:

Mental Hygiene Administration and Core Service Agencies

MHA, within DHMH, is the State's lead agency for providing publicly funded mental health services and ensuring that residents receive appropriate treatment. The administration provides services in the community through CSAs designated by each county government. Additionally, the administration provides services through five psychiatric hospitals and two residential treatment centers for youth.

CSAs are the local mental health authorities responsible for planning, managing, and monitoring public mental health services at the local level. CSAs operate under DHMH as agents of county government.

Maryland Mental Health Crisis Response System

Chapter 371 of 2002 established the Maryland Mental Health Crisis Response System within MHA. The system operates a statewide network by coordinating inter-jurisdictional services to develop crisis response systems to serve the entire State. Local crisis response systems provide suicide prevention and crisis intervention hotlines, mental health information and referrals, coordination of disaster mental health teams, a community crisis bed and hospital bed registry, and linkages to social services telephone systems. Currently, there are crisis teams in Baltimore City and Anne Arundel, Baltimore, Harford, Howard, Montgomery, Prince George's, and Worcester counties.

Mental Health and Criminal Justice

Chapter 82 of 2005 required DHMH, the Department of Human Resources, and DPSCS to convene a workgroup to make recommendations on actions to break the cycle of rearrest and reincarceration for individuals with mental illnesses. Chapter 82 also required suspension, rather than termination, of Medicaid benefits for incarcerated individuals to facilitate reenrollment and continuity of care on release. (Because this process was found to be ineffective for individuals whose incarceration extends past the Medicaid redetermination period, DHMH and DPSCS have since developed an expedited eligibility process for the Primary Adult Care program to facilitate continuity of care.) Chapter 628 of 2006 extended the workgroup's reporting deadline and expanded the scope of its required report. Subsequently, the workgroup made a number of recommendations to address rearrest and reincarceration of individuals with mental illnesses in Maryland, and Chapter 595 of 2007 implemented several of the workgroup's recommendations. Specifically, Chapter 595 required DPSCS to provide specified inmates access to a 30-day supply of medication for a mental illness and required MHA to (1) compensate case managers or other appropriate community mental health providers for conducting initial assessments of inmates who are identified by DPSCS as having a serious mental illness and are expected to be released in three months; (2) develop a plan to divert individuals with serious mental illnesses from the criminal justice system to inpatient or outpatient to mental health services; and (3) with each CSA, develop a plan to enter into an agreement with local detention centers to establish a data-sharing initiative.

According to the December 2011 Mental Health and Criminal Justice Progress Report of the workgroup's successor, the Maryland Mental Health and Criminal Justice Partnership (MHCJP), staffing limitations and other difficulties associated with implementing electronic sharing of information have resulted in a limited number of individuals having Medicaid benefits granted at the time of release or expedited appointments with community mental health providers.

Behavioral Health Integration in Pediatric Primary Care Program

In January 2013, DHMH, MSDE, the Johns Hopkins Bloomberg School of Public Health, the University of Maryland School of Medicine, and the Salisbury University Department of Social Work announced the launch of B-HIPP to support the efforts of pediatric primary care providers to assess and manage mental health concerns in their patients and connect their patients to mental health services. The program is supported by funding from DHMH and MSDE, and assistance is provided without charge or regard to a patient's insurance status. The program offers phone consultations for primary care providers with child mental health specialists, opportunities for mental health skills training for primary care providers, referral and resource networking, and a pilot program for social work collocation in pediatric primary care practices.

Maryland Access Point

MAP is a statewide resource for information and assistance about long-term services and supports, particularly for older adults and individuals with disabilities. The seven common care options from MAP are in-home care, community health and social services, nursing homes, residential facilities, medical services, caregiver resources, and care and coordination and other services. MAP operates a website and local service sites in 10 counties and is a gateway, guide, and a single-entry point to service providers in local areas.

Screening, Brief Intervention, and Referral to Treatment

SBIRT is a service grant program of the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services. SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. The purpose of the federal program is to implement screening, brief intervention, and referral to treatment services for adults in primary care and community health settings for substance misuse and substance use disorders.

Pilot School Health Program

Pilot school health programs were established in Baltimore City and Caroline County to improve health services for school-age children in two areas with underserved portions of the population. The programs became permanent in 1997. The specified purposes and objectives of the program in Baltimore City are to encourage and promote appropriate and cost-effective use of health care services; reduce unnecessary use of hospital emergency room services; demonstrate the efficacy of involving parents, students, and community organizations in school health programs; and assess whether school health

programs could be used as a basis for advising other family members of the student of other sources of primary care. The specified purposes and objectives of the program in Caroline County are to concentrate on the early identification, health counseling, and referral for mental health problems to prevent suicides; assess whether school health programs could be used as a basis for advising other family members of the student of other sources of primary care; and provide specified health and referral services for students, including counseling.

Reach-In Program and the Second Chance Grant

DPSCS administers a "Reach-In" program, which is the same as the prior "In-Reach" program, in conjunction with DHMH. The program is funded by the Second Chance Grant. The program targets moderate- to high-risk offenders with a history of chronic mental illness and substance abuse who are returning to Baltimore City, which accounted for 60% of the prison population in January 2013. Reach-In services are provided four months pre-release and six months post-release by a case management/peer support team. The Reach-In program is currently administered in the Patuxent Institution and the Correctional Mental Health Center – Jessup (CMHC-J).

State/Local Fiscal Effect:

General and federal fund expenditures increase significantly beginning in fiscal 2015 to implement the bill. The programmatic descriptions below identify at least $44.5 million in new general fund expenditures and $5.7 million in new federal fund expenditures for that year. These costs are assumed to be ongoing and increase in future years according to various growth factors. Beginning in fiscal 2016, the bill requires additional mandated general fund appropriations for specified housing and residential services; costs for those services must increase by at least $1.0 million each year over a 10-year period for *each* service. The bill also requires the Governor to appropriate at least $2.0 million in general funds annually for B-HIPP and fully fund the Mental Health Crisis Response System, estimated to cost as much as $37.4 million per year but at least $28.6 million (rather than limit general fund spending on that program to $250,000 annually); however, this estimate assumes full funding for those programs beginning in fiscal 2015.

The estimate does not account for additional costs associated with certain requirements established by the bill – for example, those associated with medical technology and rate setting – which could be significant. Likewise, despite the expression of legislative intent, the estimate does not account for reallocation of cost savings resulting from various efforts to promote efficiency.

At the local level, expenditures increase significantly for local boards of education beginning in fiscal 2015, as discussed below. Other costs at the local level are likely incurred for local detention centers (for data sharing) and LHDs.

Each of the bill's provisions that has a fiscal impact is described below.

Prison In-Reach Program

The bill requires DPSCS, in collaboration with DHMH, to establish a Prison In-Reach program to serve moderate- to high-risk offenders with histories of chronic mental illness and substance use who are returning to the community and who demonstrate an interest in continuing treatment. As discussed earlier, DPSCS is already implementing a Prison Reach-In program at the Patuxent Institution and CMHC-J. This program is funded by the federal Second Chance Grant. However, the bill expands the scope of this program to inmates housed in other facilities. Therefore, DPSCS may need to hire four additional social workers to expand the program, at a cost of $200,000 annually in additional general fund expenditures. DHMH advises that it has been awarded, or expects to be awarded, a total of $1.6 million in federal grant funding that the department intends to dedicate to Prison In-Reach services under the bill. Thus, federal fund expenditures increase by approximately $1.6 million to implement the program.

DPSCS further advises that, in order to adequately monitor and provide services for at least six months after inmates are released, it likely needs to hire additional agents to maintain manageable caseloads. Each additional agent costs $68,768, which includes salary, benefits, and equipment. The estimated cost for supervising an offender for one year is approximately $1,595.

Public School Health Services

Each local board of education is required, under the bill, to offer behavioral health services along with other school health services. There are several possible options to fulfill this requirement.

One option is for each of the 1,454 public school in the State to hire, on average, one full-time employee dedicated to the provision of behavioral health services. Based on the average State salary (approximately $94,000) for therapists, guidance counselors, and school psychologists, MSDE advises that this approach to implementation would increase expenditures by almost $137.0 million annually for local boards of education statewide.

However, other approaches could be used. For example, since 1987, Baltimore City Public School System has implemented an expanded school mental health (ESMH)

program that is considered to be a successful model. The program was originally implemented because children who needed services were not keeping appointments at mental health clinics; by bringing the services to the schools, children had the opportunity to receive the care they needed. ESMH is funded by the collaborative efforts of the Baltimore Mental Health Systems, Inc., the Baltimore City Public School System, and the Foundation Community. The basic premise is that supplemental funding pays for those outreach services, while fee-for-service pays for those services for which a mental health clinician can bill.

With the expansion of Medicaid in the State and the new changes in health insurance brought on by ACA, the Baltimore City model may be more tenable for use statewide. ACA requires group health plans and insurers that offer mental health and substance use disorder benefits to provide coverage that is comparable to coverage for general medical and surgical care. This addresses concerns of parity between mental and general medical care. Further, ACA eliminates lifetime caps for essential benefits, which could help foster a school-based fee-for-service program.

Following a Baltimore City model significantly decreases costs of implementation compared to an approach that hires a full-time staff member at each school. The Department of Legislative Services (DLS) advises that it is unclear to what extent schools can integrate the provision of behavioral health services into existing school health programs. However, DLS concurs that significant additional staff is likely needed. Thus, while exact costs to local boards of education cannot be reliably estimated at this time, DLS advises that they are expected to be significant.

LHD expenditures also increase, perhaps significantly, to the extent that they assist local boards of education in ensuring that adequate behavioral health services are provided. The Maryland Association of County Health Officers (MACHO) advises that small LHDs need one additional full-time employee, medium-sized LHDs need two additional full-time employees, and large LHDs need three full-time employees to monitor and implement this and other programs required in the bill. MACHO estimates that the fiscal 2015 costs for LHDs are approximately $2.9 million, growing to $3.6 million in fiscal 2016.

In addition to in-school providers, DHMH's Health Systems and Infrastructure Administration advises that, in order to include behavioral health services within School Health Services and to develop a plan to expand the School Based Health Clinics statewide, the administration's Office of School Health must hire three additional full-time staff – a program administrator, an epidemiologist, and a program manager – at a cost of more than $239,000 in fiscal 2015. MSDE likewise advises it needs additional staff – one education program specialist and one administrative support staff – at a cost of more than $120,000 in fiscal 2015.

Evidence-based Early Identification of Substance Abuse

DHMH is required to implement an evidence-based program throughout the State to promote early identification of substance abuse and provide for screening, brief intervention, and referral to treatment. MHA advises that, on an annual basis, State expenditures increase by $10.5 million (including $6.4 million in general funds and $4.1 million in federal funds), which primarily reflects increased reimbursements to providers for evidence-based services but also includes the cost of hiring additional permanent staff to implement each of the program's components.

In addition, ADAA estimates that, based on a review of similar programs, general fund expenditures increase by $2.0 million for statewide implementation, with more than $100,000 annually to provide training for the program.

Geriatric Behavioral Health Specialist Program

MHA is required, in coordination with MDoA and CSAs, to implement a geriatric behavioral health specialist program in each county that coordinates with local MAP offices. Accordingly, MHA advises that general fund expenditures increase by approximately $1.1 million to hire 11.4 full-time nursing program administrators to assist older adults, caregivers, and aging network professionals in navigating behavioral health systems; facilitate access to the full array of geriatric services; and serve as consultants, liaisons, and referral sources. DHMH may incur additional costs related to training, technical assistance, and measurement of program outcomes to the extent that such costs are not absorbable.

Local health department expenditures also increase to the extent that they assist in implementing the program.

Mental Health First Aid Program

MHA must implement a Mental Health First Aid program to improve mental health literacy. Based on a review of similar training programs, MHA advised, in fiscal 2013, that general fund expenditures would increase by approximately $500,000 annually to provide the required training.

Behavioral Health Integration in Pediatric Primary Care Program

The bill requires DHMH and MSDE – in collaboration with schools of public health, medicine, and social work – to implement a B-HIPP program to provide phone consultation services for primary care providers with child mental health specialists; continuing education in mental health skills training for primary care providers; referral

and resource networking to increase access to children's mental health services; and collocation of social work interns in primary care practices to provide screening, brief intervention, referral, and consultation. As noted above, the launch of such a program was announced in January 2013. The bill requires the Governor to include at least $2.0 million annually in general fund support to implement the program. Thus, DLS advises that general fund expenditures increase by that amount annually beginning in fiscal 2015, although the mandate begins in fiscal 2106.

Reimbursement Methodology and Medical Technology

Staffing needs for the Community Services Reimbursement Rate Commission (CSRRC) may increase under the bill to the extent that the commission's expanded rate-setting responsibilities are not absorbable. Since there are nearly 1,000 community behavioral health providers under MHA alone, CSRRC may be unable to handle its expanded duties with existing budgeted resources. However, exact costs to CSRRC cannot be reliably estimated at this time.

DHMH is also required to implement a plan to provide funding support for community behavioral health providers to invest in electronic medical records technology. It is unclear to what extent DHMH must actually provide funding; nor is it clear what funding source is likely to be used. However, the department advises that one-time start-up costs for implementing electronic health records range from $15,000 to $70,000 (per provider) and that ongoing costs range from $4,000 to $8,000 (per provider), depending on what type of system is used. A federal program offers incentives for the adoption of electronic health records, and physicians and hospitals can receive $21,250 in the first year of participation and $8,500 for subsequent years of participation up to five years. However, community behavioral health providers are not currently eligible for this program.

Data-sharing Initiatives

MHA must require each CSA to enter into memoranda of understanding with local detention centers to establish a data-sharing initiative. MHA is expected to reimburse each CSA for its costs under this provision; thus, general fund expenditures increase by approximately $187,000. Costs for local detention centers under this provision are estimated by DHMH to approximate $736,000; however, DLS advises that existing infrastructure available to local detention centers is unknown and that their expenditures cannot be reliably estimated at this time.

Expanded Primary Care Provider Responsibilities

Medicaid expenditures increase (50% federal funds, 50% general funds) to increase capitation rates to MCOs beginning in fiscal 2015. A reliable estimate cannot be provided at this time.

Funding Support for Housing and Residential Care and Recovery Support Services

General fund expenditures for housing assistance increase by at least $1.0 million per year beginning in fiscal 2016 until the funding equals $25.0 million annually. MHA advises that these expenditures consist largely of reimbursements to CSAs that provide housing assistance.

Similarly, general fund expenditures for residential services increase by at least $1.0 million per year beginning in fiscal 2016 until the funding equals $24.5 annually. MHA advises that these expenditures consist largely of reimbursements to providers for rehabilitative treatment.

Additional Funding Provisions

The Governor is required to include enough general funds in the budget each fiscal year to implement the Maryland Mental Health Crisis Response System. (The bill also repeals the existing limit of $250,000 on annual general fund expenditures.) Accordingly, MHA advises that general fund expenditures increase significantly to fully fund the provision of specified community response crisis services ($28.6 million annually), specified longer-term crisis services ($1.6 million annually), enhancements to the existing crisis and referral hotline ($350,000 annually), and additional essential components ($6.7 million annually).

Thus, DLS advises that funding for the program must increase to at least $28.6 million annually – and possibly as much as $37.4 million annually. This funding is mandated beginning in fiscal 2016, although DLS assumes the funding may be provided in the fiscal 2015 budget.

Because DHMH and DPSCS have developed an expedited eligibility process for the Primary Adult Care program to facilitate continuity of care for incarcerated individuals, the fiscal impact of the bill's repeal of a provision of law relating to the suspension of an incarcerated individual's Medicaid benefits cannot be reliably estimated at this time.

DLS notes that the bill expresses the General Assembly's intent that its provisions be funded using general funds resulting from cost savings associated with implementation of ACA, the reallocation of cost savings resulting from hospital diversion efforts, other

efforts to promote efficiency in health care spending, and any savings achieved through the programs and initiatives established in the bill. However, the extent to which any such savings offset the costs of implementing the bill is unknown. Furthermore, DLS notes that any such savings largely do not directly result from the present bill.

It is assumed that DHMH can use existing budgeted resources to satisfy the bill's various reporting requirements.

Additional Information

Prior Introductions: SB 822 of 2013 received a hearing in the Senate Finance Committee, but no further action was taken. Its cross file, HB 1245, received a hearing in the House Health and Government Operations Committee, but no further action was taken.

Cross File: SB 262 (Senator Madaleno, *et al.*) - Finance.

Information Source(s): Baltimore City, Department of Budget and Management, Maryland State Department of Education, Department of Health and Mental Hygiene, Maryland Association of Counties, Maryland Association of County Health Officers, Montgomery and Prince George's counties, Maryland Department of Aging, Department of Public Safety and Correctional Services, University System of Maryland, Department of Legislative Services

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