Department of Legislative Services

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FISCAL AND POLICY NOTE
Revised

House Bill 367 (Delegate Rosenberg, *et al.*)
Health and Government Operations Finance

Public Health - Maryland Behavioral Health Crisis Response System

This bill alters the name of the Mental Health Crisis Response System (MHCRS) to be the Behavioral Health Crisis Response System (BHCRS) and expands the content and scope of authorized services, as specified in the bill. The Behavioral Health Administration (BHA) must collect specified data related to individuals with behavioral health diagnoses. The bill repeals the requirement that the State may not spend more than $250,000 in general funds in each fiscal year to implement MHCRS. The bill also repeals the requirement that MHCRS is contingent on the receipt of federal funding or funding from any other source.

Fiscal Summary

State Effect: General fund expenditures may increase, potentially significantly, due to the bill's expansion of authorized BHCRS services, as discussed below. Federal fund revenues and expenditures for Medicaid enrollees likely increase, as discussed below.

Local Effect: Local core service agencies (CSAs) may receive additional funding to implement new services and expand existing services, as discussed below.

Small Business Effect: None.

Analysis

Bill Summary/Current Law:

Purpose of Crisis Response System

MHCRS is established under the Health-General Article in BHA. The crisis response system must (1) operate a statewide network utilizing existing resources and coordinating interjurisdictional services to develop efficient and effective crisis response systems to

serve all individuals in the State; (2) provide skilled clinical intervention to help prevent suicides, homicides, unnecessary hospitalizations, and arrests or detention, and to reduce dangerous or threatening situations involving individuals in need of mental health services; and (3) respond quickly and effectively to community crisis situations.

BHCRS is also established in BHA and with the same purpose, except that it must reduce dangerous or threatening situations involving individuals in need of behavioral health services (not just mental health services).

Crisis Communication Center Services

MHCRS must include, in each jurisdiction, a crisis communication center to provide a single point of entry to the system, coordination with the local CSA, police, emergency medical service personnel, and mental health providers. The bill maintains this requirement for BHCRS but expands coordination to include behavioral health providers.

MHCRS crisis communication center services may, but need not, include:

- a hotline for suicide prevention and crisis intervention;
- a telephone service for mental health information, referral, and assistance;
- triage for initial assessment and referral;
- referral to treatment, family and peer support groups, and other services as needed;
- follow-up for up to one month;
- coordination of disaster mental health teams, critical incident stress management, and maintenance of an on-call system for these services;
- a community crisis bed and hospital bed registry, including a daily tally of empty beds;
- transportation coordination, ensuring transportation of patients to urgent appointments or to emergency psychiatric facilities; and
- linkage to 911 emergency systems and other telephone systems providing public or social services.

MHCRS must include emergency services, including:

- mobile crisis teams to provide assessments, crisis intervention, treatment, follow-up, and referral to urgent care, and to arrange appointments for individuals to obtain public mental health services;
- urgent care; and
- emergency psychiatric services.

MHCRS must also include follow-up services, including:

- mobile treatment teams to provide outreach services on location;
- individualized family intervention teams; and
- residential crisis services.

In contrast, the bill authorizes, but does not require, BHCRS crisis communication centers to have the following programs:

- a clinical crisis telephone line for suicide prevention and crisis intervention;
- a hotline for behavioral health information, referral, and assistance;
- clinical crisis walk-in services, including triage for initial assessment, crisis stabilization until additional services are available, linkage to treatment services and family and peer support groups, and linkage to other health and human services programs;
- critical incident stress management teams providing disaster behavioral health services, critical incident stress management, and an on-call system for these services;
- crisis residential beds to serve as an alternative to hospitalization;
- a community crisis bed and hospital bed registry, including a daily tally of empty beds;
- transportation coordination, ensuring transportation of patients to urgent appointments or to emergency psychiatric facilities;
- mobile crisis teams operating 24 hours a day and 7 days a week to provide assessments, crisis intervention, stabilization, follow-up, and referral to urgent care, and to arrange appointments for individuals to obtain behavioral health services;
- 23-hour holding beds;
- emergency psychiatric services;
- urgent care capacity;
- expanded capacity for assertive community treatment;
- crisis intervention teams with capacity to respond in each jurisdiction 24 hours a day and 7 days a week; and
- individualized family intervention teams.

BHA Responsibilities

Under current law, BHA must conduct an annual survey of consumers and family members who have received services from the crisis response system. The bill institutes an additional requirement for annual data collection on the number of behavioral health calls received by police, attempted and completed suicides, unnecessary hospitalizations,

hospital diversions, arrests and detentions of individuals with behavioral health diagnoses, and diversion of arrests and detentions of individuals with behavioral health diagnoses.

Additional Provisions

Under current law, CSAs determine the implementation of MHCRS services. The bill requires BHA, in collaboration with CSAs, to implement BHCRS services.

Current law requires BHA to implement MHCRS in collaboration with CSAs on a regional or jurisdictional basis as federal or other funding becomes available. The bill maintains this requirement for BHCRS.

For purposes of nonprofit hospitals' annual community benefit reports, the bill also alters the definition of "community benefit" to include financial or in-kind support of BHCRS.

Background: According to the U.S. Substance Abuse and Mental Health Services Administration, "crisis services" are designed to stabilize individuals in psychological distress and allow them to receive the appropriate course of treatment; they are intended to reach people in their communities. The "continuum of services" includes telephone hotlines, peer crisis services, crisis intervention teams, mobile crisis services, crisis stabilization beds, and short-term residential services. Crisis services may serve as an alternative to costly inpatient hospitalization.

In Maryland, BHA (as part of the Department of Health and Mental Hygiene) has provided $16.3 million in funding to CSAs for crisis response services and crisis intervention teams in both fiscal 2014 and 2015. The services vary by jurisdiction, depending on local need (as determined by CSAs). CSAs in highly populated jurisdictions generally provide a wider array of, and more robust, services as compared to more rural jurisdictions. For example, the Montgomery County CSA provides a suicide prevention hotline, crisis residential beds, emergency psychiatric services, mobile crisis teams, urgent care, crisis intervention teams, and critical incident response services, all available 24 hours a day and 7 days a week. In contrast, the Mid-Shore CSA (representing Caroline, Dorchester, Kent, Queen Anne's, and Talbot counties) only provides crisis residential beds, mobile crisis teams, and urgent care, all on a more limited basis (although it does provide a suicide prevention hotline available 24 hours a day and 7 days a week). Funding was expanded in fiscal 2014 to allow various CSAs to expand their services, so that currently most jurisdictions have more robust mobile crisis services and have begun developing crisis intervention teams.

State Fiscal Effect: The bill expands the scope and content of services CSAs *could* implement; however, BHA would need to allocate funding for these additional services. Actual costs vary depending on the level of additional services, if any, implemented in each

jurisdiction (as determined by BHA and each CSA). BHA advises that implementation of additional BHCRS components would be based on available funds.

For illustrative purposes only, if all of the enhanced services specified in the bill are fully implemented in all local jurisdictions, general fund expenditures would increase by as much as $15,205,875 in fiscal 2016, which reflects the bill's October 1, 2015 effective date, and by about $20,274,500 annually thereafter. This estimate is based on BHA's cost projection for a statewide "crisis services continuum" and includes cost projections for providing in each jurisdiction: (1) a clinical crisis line; (2) a hotline for behavioral health information; (3) a mobile crisis team; (4) crisis residential beds; (5) emergency psychiatric services; (6) critical incident stress management teams; (7) crisis intervention teams; (8) 23-hour holding beds; (9) urgent care; and (10) crisis stabilization and case management. Costs for each of these services vary by jurisdiction, depending on the extent of existing services and the population levels and needs of each jurisdiction. (For example, the cost to provide mobile crisis teams may exceed $600,000 in Baltimore City, but be only $100,000 in Washington County.)

The estimate does not include cost projections for services providing hospital diversion, pre- and post-booking diversion, or court-based diversion. Costs for these services may total more than $11 million. Although such services may be considered part of a "crisis services continuum," these services are not specifically authorized in the bill.

Additionally, BHA advises that the bill's data collection requirement may present operational challenges and may require additional resources since the data must come from both behavioral health and law enforcement entities; complications may also arise due to federal privacy restrictions (BHA cannot always match data with entities outside of BHA or submit identifying information).

Federal fund revenues and expenditures likely increase by a minimal amount (along with general fund expenditures), to the extent individuals served by BHCRS are Medicaid enrollees. BHA advises that it cannot reliably estimate potential revenues from Medicaid reimbursements, though it expects a minimal effect, if any. Since BHCRS services are frequently provided under emergency, possibly life-threatening situations, BHA assumes it must provide funds for these services at the outset. However, retroactive reimbursement is still a possibility for services provided to these individuals.

The Health Services Cost Review Commission, which oversees nonprofit hospitals' annual community benefit reporting, advises that the altered definition of "community benefit" under the bill is consistent with current law and so does not have a fiscal or operational impact.

Local Fiscal Effect: CSAs may implement new services and expand existing services to the extent of funding as provided by BHA. The Health-General Article prohibits the Secretary of Health and Mental Hygiene from requiring a CSA to provide services the department does not provide funding for; this analysis assumes local governments continue to contribute funding for their CSAs either to the same services or for other enhanced services. Nevertheless, the bill, by making more existing services optional, *could* result in a reduction in certain services in some CSAs.

The Maryland Association of County Health Officers (MACHO) advises that costs may increase for local health departments to implement BHCRS programs depending on whether the local health departments provide additional services as authorized under the bill; however, MACHO was unable to estimate which departments might provide these additional services.

Additional Information

Prior Introductions: None.

Cross File: SB 469 (Senator Madaleno, *et al.*) - Finance.

Information Source(s): Department of Human Resources; Department of Health and Mental Hygiene; Maryland Association of Counties; Maryland Association of County Health Officers; Department of State Police; U.S. Substance Abuse and Mental Health Services Administration; Department of Legislative Services

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