HB 1092

Department of Legislative Services

Maryland General Assembly
2018 Session

FISCAL AND POLICY NOTE
Enrolled - Revised

House Bill 1092 (Delegate Rosenberg, *et al.*)

Health and Government Operations and Appropriations — Finance

Behavioral Health Crisis Response Grant Program – Establishment

This bill establishes a Behavioral Health Crisis Response Grant Program in the Maryland Department of Health (MDH) to provide funds to local jurisdictions to establish and expand community behavioral health crisis response systems. The Governor must include the following appropriations in the State operating budget for the program: (1) $3.0 million for fiscal 2020; (2) $4.0 million for fiscal 2021; and (3) $5.0 million for fiscal 2022. **The bill takes effect July 1, 2018.**

Fiscal Summary

State Effect: General fund expenditures increase by $17,100 in FY 2019. General fund expenditures increase by $3.0 million in FY 2020, escalating to $5.0 million in FY 2022. Revenues are not affected. **This bill establishes mandated appropriations for FY 2020 through 2022.**

(in dollars)	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Revenues	$0	$0	$0	$0	$0
GF Expenditure	17,100	3,000,000	4,000,000	5,000,000	-
Net Effect	($17,100)	($3,000,000)	($4,000,000)	($5,000,000)	(-)

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

Local Effect: Potential significant increase in grant revenues and expenditures from FY 2020 through 2022.

Small Business Effect: Potential meaningful.

Analysis

Bill Summary: The program must award competitive grants to local behavioral health authorities to establish and expand behavioral health crisis response programs and services that (1) serve local behavioral health needs for children, adults, and older adults; (2) meet national standards; (3) integrate the delivery of mental health and substance use treatment; and (4) connect individuals to appropriate community-based care in a timely manner on discharge.

Distributed funds may be used to establish or expand specified programs and services, including mobile crisis teams, on-demand walk-in services, and crisis residential beds. Grant funds must be used to supplement, and not supplant, any other funding for behavioral health crisis response programs and services.

MDH must develop application procedures for the program, as well as a system of outcome measurement and specified guidelines regarding billing. Local behavioral health authorities may submit a proposal requesting program funding to MDH. MDH must prioritize proposals based on specified criteria, including those that make use of more than one funding source. Local behavioral health authorities that receive grant funding under the bill must report outcome measurement data, as determined by MDH.

By December 1, 2020, and annually thereafter, MDH must submit a report to the Governor and the General Assembly with specified information.

Current Law/Background: The Maryland Behavioral Health Crisis Response System (BHCRS) is required to (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, 24 hours a day and 7 days a week; (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 behavioral health services; and (3) respond quickly and effectively to community crisis situations.

In each jurisdiction, a crisis communication center provides a single point of entry to the system and coordination with the local core service agency (CSA) or local behavioral health authority, police, emergency medical service personnel, and behavioral health providers.

Crisis communication centers *may* provide programs that include the following:

- 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.

The Behavioral Health Administration (BHA) determines the implementation of BHCRS in collaboration with the local CSA or local behavioral health authority serving each jurisdiction. Additionally, BHCRS must conduct an annual survey of consumers and family members who have received services from the system. Annual data collection is also required 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.

Chapters 405 and 406 of 2016 required the Behavioral Health Advisory Council, in consultation with CSAs, community behavioral health providers, and interested stakeholders, to develop a strategic plan for ensuring that clinical crisis walk-in services and mobile crisis teams are available statewide and operating 24 hours a day and 7 days a

week. The council submitted the plan in November 2017. **Exhibit 1** outlines the council's eight recommendations.

Exhibit 1
Behavioral Health Advisory Council Strategic Plan: Recommendations

1. Establish a crisis walk-in and mobile crisis team program model for each jurisdiction or region.
2. A delegation from Maryland composed of various representatives should make a site visit to one or more of the comprehensive crisis services sites, in either San Antonio, Texas, or Shelby County, Tennessee.
3. The Behavioral Health Administration (BHA), with input from the Behavioral Health Advisory Council, local behavioral health authority directors, and other stakeholders should determine how the jurisdictions can be divided into regions for purposes of siting these services.
4. Each jurisdiction should develop an ongoing crisis services advisory group chaired by its local behavioral health authority director(s) and composed of stakeholder representatives, including law enforcement and local hospitals, to work on the development and implementation of its crisis plan.
5. BHA should explore the Medicaid 1915(b) and 1915(c) waivers for behavioral health crisis services as one source of a comprehensive funding strategy. Local government funding strategies and potential funding from community organizations such as hospitals and private insurance providers should also be developed.
6. BHA should develop a plan to work with the legislature regarding the necessary changes in regulation, statute, or interpretation regarding the location at which an individual must be psychiatrically evaluated when detained on an Emergency Evaluation Petition (EEP).
7. Require that each crisis walk-in center capture a set of outcome data that include, at a minimum, clinical outcomes, disposition, reduction in EEPs issued, diversion rate from emergency departments, diversion rate from hospitalization, and diversion rate from the criminal justice system.
8. Require accreditation of all crisis walk-in and mobile crisis team programs.

Source: Behavioral Health Advisory Council

Additionally, Chapters 571 and 572 of 2017 (also known as the Heroin and Opioid Prevention Effort and Treatment Act) require MDH to establish crisis treatment centers, with at least one established by June 1, 2018. Clinical staff must be available 24 hours a day and 7 days a week to make assessments and level of care determinations and connect individuals experiencing a substance use disorder crisis with immediate care. BHA must establish the treatment centers in a manner that is consistent with the Behavioral Health Advisory Council's strategic plan.

Chapters 571 and 572 also require MDH to establish and operate a toll-free health crisis hotline that is available 24 hours a day and 7 days a week to assist callers by (1) conducting specified health screenings; (2) conducting risk assessments for callers experiencing an overdose or potentially committing suicide or homicide; (3) connecting callers to an emergency response system; (4) referring callers for ongoing care; and (5) following up with callers to determine if the callers' needs were met.

In November 2017, BHA submitted a status report to the Joint Committee on Behavioral Health and Opioid Use Disorders on the establishment of required crisis treatment centers. According to this report, the pilot crisis center will be in Baltimore City, and until the site is renovated, the Tuerk House (also in Baltimore City) will serve as a temporary location.

The fiscal 2018 operating budget included $10.0 million to implement Chapters 571 and 572 of 2017, including requirements relating to crisis services. In July 2017, $22.0 million was appropriated for fiscal 2018, including $10.0 million in federal funding, to be used for prevention, treatment, and enforcement activities relating to the opioid epidemic. Of this, $2.0 million is to establish the 24-hour crisis center in Baltimore City and $143,000 to improve the statewide crisis hotline. The fiscal 2019 budget does not include funding for the expansion of crisis services in the State.

State Expenditures: The bill establishes mandated appropriations for the grant program, increasing each year over a three-year period. Therefore, general fund expenditures for MDH increase by $3.0 million in fiscal 2020; $4.0 million in fiscal 2021; and $5.0 million in fiscal 2022.

MDH advises that it must hire one full-time administrator in fiscal 2020 to oversee the grant application process and to develop outcome measurement standards and billing guidelines in accordance with the bill's requirements.

The Department of Legislative Services agrees that additional staff are needed to administer the grant program. However, this analysis assumes that grants must be awarded in fiscal 2020; thus, additional staff are likely needed in fiscal 2019 to develop applications, outcome measurement standards, and required guidelines. Further, such responsibilities likely warrant a part-time (50%), rather than full-time, position. This analysis also assumes that additional staff are no longer required after fiscal 2022 (the last year in which the bill establishes a mandated appropriation for the grant program and in which grants are likely distributed).

Therefore, general fund expenditures for MDH increase by $17,077 in fiscal 2019. This estimate reflects the cost of hiring one part-time (50%) contractual administrator to oversee the grant program, with a start date of January 1, 2019. It includes a salary, fringe benefits, one-time start-up costs, and ongoing operating expenses.

Contractual Position	0.5
Salary and Fringe Benefits	$12,031
Operating Expenses	5,046
Total FY 2019 State Expenditures	**$17,077**

This estimate does not include any health insurance costs that could be incurred for specified contractual employees under the State's implementation of the federal Patient Protection and Affordable Care Act.

Future year expenditures reflect a full salary with annual increases and employee turnover, ongoing operating expenses, the awarding of grants from fiscal 2020 through 2022, and termination of the contractual position after fiscal 2022.

This analysis assumes that, from fiscal 2020 through 2022, appropriated funds are used for grants *and* the cost of program administration. Thus, in fiscal 2020, total general fund expenditures increase by $3.0 million, with $2,977,105 awarded for grants and $22,895 used to cover the costs of the part-time contractual administrator. Again, this analysis assumes that the contractual position is no longer required after fiscal 2022, as this is the last year in which the bill establishes a mandated appropriation for the grant program and in which grants are likely to be distributed. To the extent additional funding is provided to the grant program beyond fiscal 2022, staff may need to be retained and expenditures may continue to increase.

Local Fiscal Effect: Revenues and expenditures increase significantly for local behavioral health authorities that receive grants under the bill from fiscal 2020 through 2022. The extent of any increase depends on specific proposals approved in each jurisdiction and corresponding grant awards. If funding for the grant program is maintained beyond fiscal 2022, revenues and expenditures for local behavioral health authorities likewise continue.

Small Business Effect: Small businesses that provide crisis treatment services (such as community behavioral health providers) may benefit, from fiscal 2020 through 2022, from increased funding for such services from local behavioral health authorities. If funding for the grant program is maintained beyond fiscal 2022, small businesses may continue to benefit.

Additional Information

Prior Introductions: None.

Cross File: SB 703 (Senator Klausmeier) - Finance.

Information Source(s): Department of Budget and Management; Maryland Department of Health; Maryland Association of County Health Officers; Department of Legislative Services

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