

Department of Legislative Services
Maryland General Assembly
2021 Session

FISCAL AND POLICY NOTE
First Reader

Senate Bill 279

Finance

(Senators Hettleman and Feldman)

Public Health – Overdose and Infectious Disease Prevention Services Program

This bill authorizes a “community-based organization” (CBO) to establish an Overdose and Infectious Disease Prevention Services Program. A program must, among other requirements, provide a supervised location where drug users can consume pre-obtained drugs, as well as receive other services, education, and referrals. However, a CBO must first receive approval from the Maryland Department of Health (MDH), in consultation with the local health department (LHD). MDH may not approve more than six programs and, to the extent practicable, should distribute programs evenly among urban, suburban, and rural areas of the State with each area receiving no more than two programs. Each program must operate at a single location in an area with a high incidence of drug use. **The bill takes effect July 1, 2021, and terminates June 30, 2025.**

Fiscal Summary

State Effect: The bill’s requirements can likely be handled within existing budgeted resources, as discussed below. Revenues are not affected.

Local Effect: Potential significant operational and fiscal impact for some LHDs, as discussed below.

Small Business Effect: Potential meaningful.

Analysis

Bill Summary: “Community-based organization” means a public or private organization that is representative of a community or significant segments of a community and that provides educational, health, or social services to individuals in the community. The definition includes a hospital, clinic, substance abuse treatment center, medical office,

federally qualified health center, mental health facility, the LHD, and faith-based organization.

MDH, in consultation with the LHD, must make a decision regarding approval within 45 days of receiving an application and provide a written explanation of its decision to the CBO.

A program must, among other requirements, (1) provide secure sterile needle exchange; (2) answer questions about safe injection practices; (3) administer first aid, if needed, monitor for potential overdose, and administer rescue medications; (4) provide access or referrals to other health care services; (5) educate participants on the risks of contracting HIV and viral hepatitis; (6) provide overdose prevention education and access to or referrals to obtain naloxone; and (7) provide adequate security and training for staff, as specified. A program may, with permission, bill a participant's health insurance, accept specified outside financial assistance, apply for grants, coordinate with any opioid-associated substance abuse prevention and outreach program or CBO, and use a mobile facility.

A program may not be located in an area zoned for residential uses.

A program must annually collect and report a range of data about its operations, including information relating to the number of participants served, hypodermic needles and syringes distributed, overdoses experienced and reversed on-site, individuals who received overdose care, individuals referred to other services, and any other information deemed necessary by the department for assessing the impact of the program.

Program participants, staff members, and program property owners who act in accordance with the bill's provisions are not subject to arrest, prosecution, or any civil or administrative penalty (including action by a professional licensing board), nor are they subject to the seizure or forfeiture of any real or personal property used in connection with a program in accordance with State or local law. However, these individuals are not immune from criminal prosecution for any activities not authorized or approved by the program.

Current Law: Chapter 348 of 2016 authorizes an LHD or CBO, with the approval of MDH and the appropriate local health officer, to establish an opioid-associated disease prevention and outreach program. An LHD or CBO must apply to MDH and a local health officer for authorization to operate a program and receive their joint approval. An opioid-associated disease prevention and outreach program must:

- secure program locations and equipment;
- allow participants to obtain and return hypodermic needles and syringes at any program location, if more than one location is available;

- have appropriate staff expertise in working with individuals who inject drugs;
- include adequate staff training;
- disseminate other means for curtailing the spread of HIV and viral hepatitis;
- link individuals to additional services, including substance-related disorder counseling, treatment, and recovery services; testing for specified diseases; reproductive health education and services; wound care; and overdose response program services;
- educate participants on the dangers of contracting HIV and viral hepatitis;
- provide overdose prevention education and access to naloxone or a referral to obtain naloxone;
- establish procedures for identifying program participants in accordance with specified confidentiality provisions;
- establish methods for identifying and authorizing staff members and volunteers who have access to hypodermic needles, syringes, and program records;
- develop a plan for data collection and program evaluation; and
- collect and report specified information to MDH at least annually.

For information on the State's growing opioid crisis, please refer to the **Appendix – Opioid Crisis**.

State Expenditures: MDH, in consultation with the LHD, must approve (or deny) applications from CBOs and provide written justification for the decision. The bill limits the number of programs that may be approved to six and establishes no enforcement or ongoing requirements for MDH or LHDs. However, MDH advises that site inspections should be conducted as a matter of best practice. Although MDH advises that one full-time nursing program consultant/administrator is needed to implement the bill, the Department of Legislative Services (DLS) disagrees. Assuming a small number of CBOs apply, and that MDH must consult with the LHD to review applications before authorizing no more than six programs, DLS advises that MDH can likely implement the bill's requirements with existing resources and staffing levels. To the extent that a significant number of CBOs apply, MDH may need additional staff to review applications and possibly conduct site visits; however, the authorization for a program terminates after four years.

Local Fiscal Effect: Expenditures increase significantly (through fiscal 2025) for any LHD that chooses to implement a program as authorized under the bill. It is unknown how much such a program will cost, and there would likely be significant variations among programs depending on the size, number of health care professionals, hours, variety of services, and population served. MDH advises, for comparison, that implementing an opioid-associated disease prevention and outreach program for an average-sized LHD costs approximately \$400,000. Thus, establishing a program under the bill likely costs at least \$400,000. However, the Maryland Association of County Health Officers (MACHO)

advises that no LHD plans to set up such a facility or program at this time. DLS notes that LHDs are *not* mandated to establish a program under the bill. Any expenditures may be offset by billing insurance companies for certain services, donations, grants, or other financial assistance.

Historically, MACHO has also advised that it may also cost LHDs approximately \$1,500 to \$2,000 annually to review CBO applications and reports. A specific process may need to be established to allow for the proper consideration of program applications from LHDs, which qualify as CBOs under the bill but are also involved in the application review and approval process.

Small Business Effect: To the extent that a CBO is a small business and successfully applies to establish a program under the bill, expenditures increase significantly, as discussed under the local fiscal effect. Expenditures may be offset by billing insurance companies for certain services, donations, grants, or other financial assistance.

Additional Information

Prior Introductions: SB 990 of 2020 received a hearing in the Senate Finance Committee, but no further action was taken. Its cross file, HB 464, received a hearing in the House Health and Government Operations Committee, but no further action was taken. SB 135 of 2019 received a hearing in the Senate Finance Committee but was withdrawn. Its cross file, HB 139, received a hearing in the House Health and Government Operations Committee but was withdrawn. In addition, similar bills were introduced in the 2016 through 2018 sessions.

Designated Cross File: HB 396 (Delegate Pena-Melnyk) - Health and Government Operations.

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

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rh/jc

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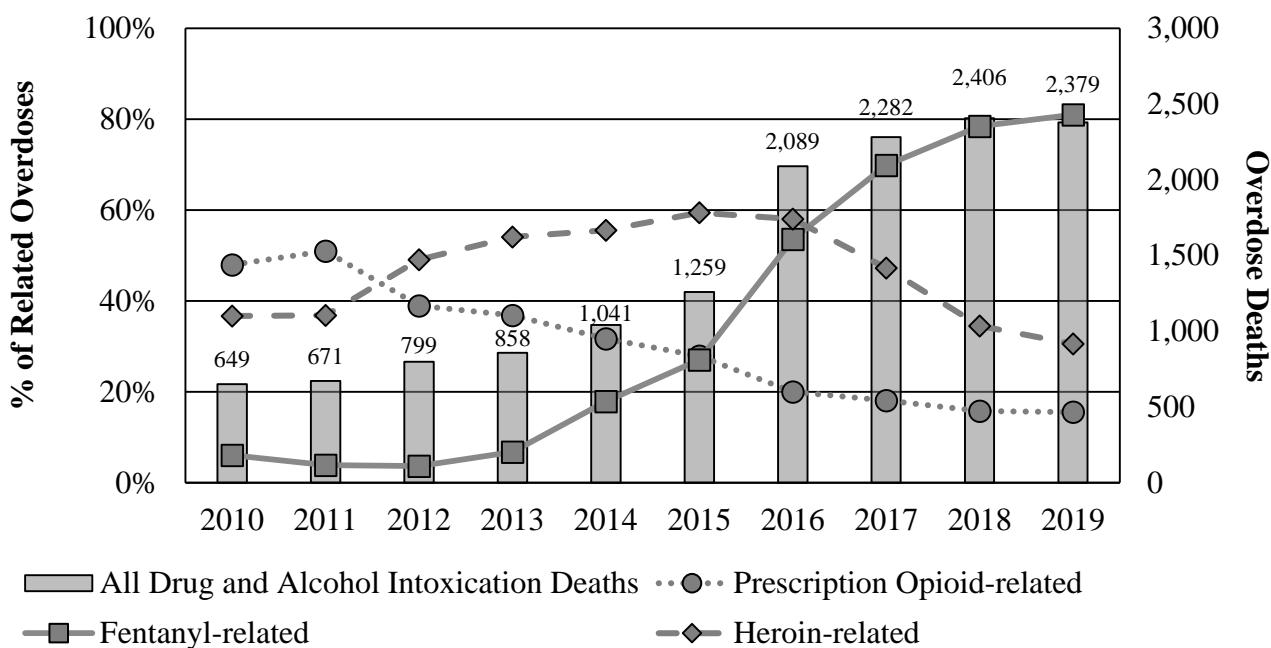
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Appendix – Opioid Crisis

Opioid Overdose Deaths

Maryland ranks among the top three states for the highest rates of opioid-related overdose deaths. In 2018, the State experienced the deadliest year on record for overdose deaths, due almost exclusively to the continued presence of fentanyl. **Exhibit 1** shows the total overdose deaths in the State since 2010 and the prevalence of prescription opioids, fentanyl, and heroin in contributing to overdose deaths.

Exhibit 1
Overdose Deaths and Substance Prevalence
Calendar 2010-2019



Source: Maryland Department of Health

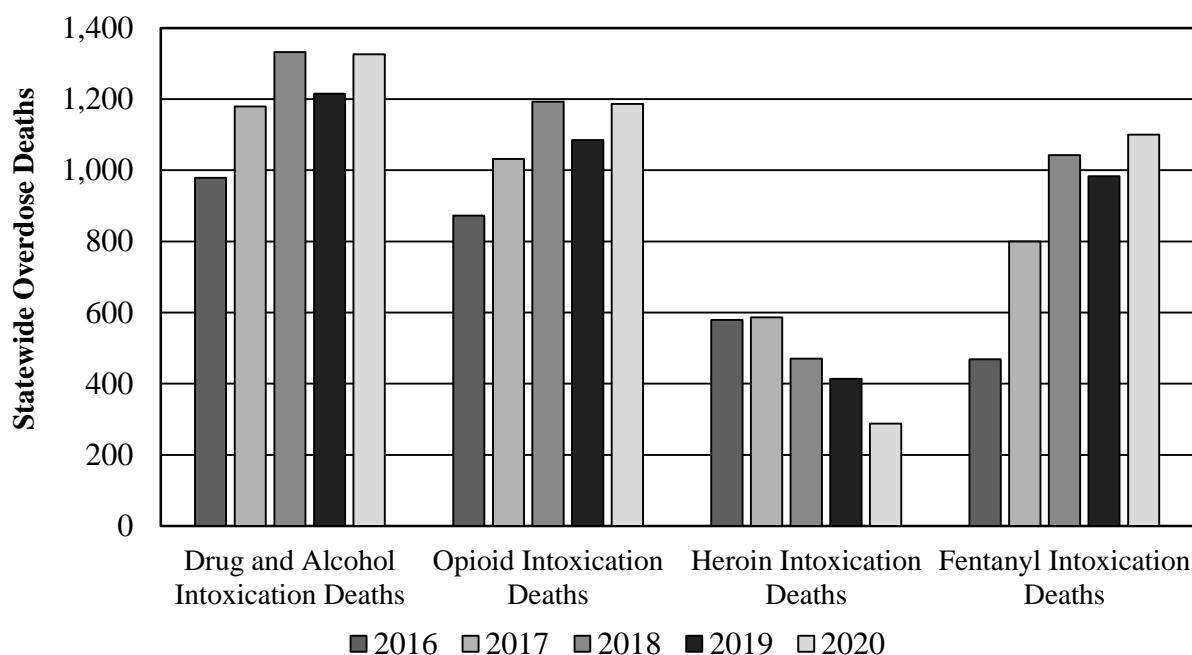
The COVID-19 Pandemic and the Opioid Epidemic

Several researchers and scholars suggest that increased social isolation, potential job loss, and other hardships caused by the COVID-19 pandemic could exacerbate the current opioid crisis. Providers have expressed concerns that social distancing measures in place

to stop the spread of COVID-19 have added challenges in providing substance use disorder (SUD) treatment. While the full impact of COVID-19 on the opioid crisis in Maryland is still unknown, recent trends and early research are concerning.

Preliminary data for 2020 suggests that the COVID-19 pandemic has contributed to increases in intoxication fatalities related to nearly all major drug categories in Maryland with the exception of heroin-related deaths, which continued to decline. Data published by the Opioid Operational Command Center (OOCC) indicates that the total number of overdose deaths in Maryland for the first six months of 2020 were on par with the number of deaths at the same point in 2018, eroding strides made to address the opioid crisis in 2019. **Exhibit 2** shows the total overdose deaths and overdose deaths involving opioids, heroin, and fentanyl for the first six months of calendar 2016 through 2020.

Exhibit 2
Overdose Deaths, First Six Months
Calendar 2016-2020



Source: Maryland Department of Health

Conversely, the State saw significantly fewer hospital emergency department (ED) visits during the first six months of 2020, with a 36.29% decline in visits for nonfatal opioid overdoses as compared to the first half of 2019. Historically, the number of ED visits for

nonfatal opioid overdoses has a positive correlation with the number of opioid intoxication deaths, leading to further speculation that the inverse correlation shown between opioid overdose deaths and ED visits may be the result of fear of visiting the ED due to the COVID-19 pandemic.

Maryland Actions to Address the Opioid Crisis

Legislative Response: The General Assembly has passed numerous acts to address the State's opioid crisis, including prevention, treatment, overdose response, and prescribing guidelines.

- Chapters 571 and 572 of 2017 require the Governor's proposed budget for fiscal 2019 through 2021 to include specified rate adjustments for community behavioral health providers; require development of a plan to increase provision of treatment; expand access to naloxone; require the Maryland Department of Health (MDH) to distribute evidence-based information about opioid use disorders to health care facilities and providers that provide treatment; and prohibit health insurance carriers from applying a prior authorization requirement for certain SUD treatment drugs.
- Chapters 573 and 574 of 2017 expand drug education in public schools to include heroin and opioid addiction prevention; require local boards of education to establish a policy requiring each public school to store naloxone and other overdose-reversing medication to be used in an emergency; and require institutions of higher education that receive State funding to establish a policy that addresses heroin and opioid addiction and prevention.
- Chapter 570 of 2017 requires a health care provider to prescribe the lowest effective dose of an opioid and a quantity that is no greater than that needed for the expected duration of pain severe enough to require an opioid that is a controlled dangerous substance, with specified exceptions.
- Chapter 149 of 2018 authorizes an emergency medical services provider or law enforcement officer to report an actual or suspected overdose to an appropriate information technology platform.
- Chapter 211 of 2018 requires MDH to identify a method for establishing a tip line for a person to report a licensed prescriber whom the person suspects is overprescribing certain medications.

- Chapters 215 and 216 of 2018 require a health care provider to advise a patient of the benefits and risks associated with a prescribed opioid or co-prescribed benzodiazepine.
- Chapters 439 and 440 of 2018 require a general hospice care program to establish a written policy for the collection and disposal of unused prescription medication and require a program employee to collect and dispose of a patient's unused medication on the death of the patient or the termination of a prescription.
- Chapter 532 of 2019 establishes programs for opioid use disorder screening, evaluation, and treatment (specifically medication-assisted treatment) in local correctional facilities and in the Baltimore Pretrial Complex.
- Chapter 537 of 2019 establishes the Opioid Restitution Fund, a special fund that will retain any revenues received by the State relating to specified opioid judgments or settlements. The fund may be used only for specified opioid-related programs and services.
- Chapters 172 and 173 of 2020 authorize MDH to include comprehensive crisis response centers, crisis stabilization centers, crisis treatment centers, and outpatient mental health clinics in the list of emergency facilities published annually related to emergency mental health evaluations. MDH must give the list to each local behavioral health authority. Crisis centers support individuals with a variety of behavioral health diagnoses including opioid use disorder.
- Chapter 547 of 2020 establishes a Crisis Intervention Team Center of Excellence in the Governor's Office of Crime Prevention, Youth, and Victim Services to provide technical support to local governments, law enforcement, public safety agencies, behavioral health agencies, and crisis service providers; and develop and implement a "crisis intervention model program." Crisis intervention programs support individuals with a variety of behavioral health diagnoses, including opioid use disorder.
- Chapters 211 and 212 of 2020 require health insurance carriers to submit two specified reports to the Insurance Commissioner to demonstrate compliance with the federal Mental Health Parity and Addiction Equity Act, which requires carriers to equalize health benefits for addiction and mental health care and medical and surgical services in many fundamental ways.

Executive Branch Response: Governor Lawrence J. Hogan, Jr.'s Administration has continued efforts to respond to the opioid epidemic through the creation of OOCC. OOCC

awards grants to assist in combating the opioid crisis and coordinates and provides funding to local Opioid Intervention Teams, which are multiagency bodies in each of the 24 jurisdictions that address the opioid crisis on the local level.

Opioid Response During the COVID-19 Pandemic: In June 2020, OOCC, in consultation with MDH and other State agencies, developed and released Maryland's COVID-19 Inter-Agency Overdose Action Plan to lay out a comprehensive strategy for coordinating response efforts.

Legal Actions Related to the Opioid Crisis: In October 2020, the U.S. Department of Justice announced a global resolution of its criminal and civil investigations into the opioid manufacturer Purdue Pharma with an agreement that Purdue (1) plead guilty to a three-count felony information related to conspiracy charges; (2) pay a criminal fine of \$3.5 billion; (3) pay an additional \$2.0 billion in criminal forfeitures; (4) pay a civil settlement of \$2.8 billion to resolve civil liability under the False Claims Act; and (5) emerge from bankruptcy as a public benefit company. This resolution is subject to approval by the bankruptcy court for the Southern District of New York. Additionally, the resolution does not include the criminal release of any individuals and does not resolve any claims that states may have against Purdue Pharma.

Funding to Address the Opioid Crisis: The fiscal 2021 budget has more than \$825 million targeted toward addressing the opioid crisis in Maryland. Approximately \$708 million is budgeted in MDH, the vast majority of which is for SUD treatment in Medicaid (\$608.5 million). Outside of Medicaid, MDH has \$99.7 million budgeted for other treatment and prevention programs. Included within this total is federal funding available through the State Opioid Response (SOR) grant. On September 4, 2020, MDH announced a \$50.7 million award in the second round of SOR funding, portions of which will be expended in fiscal 2021 and 2022. The fiscal 2021 budget also contains \$4.0 million for the Behavioral Health Crisis Response Grant Program as mandated by the General Assembly, which will increase to \$5.0 million in fiscal 2022. Outside of funding and programming through MDH, the State has \$10.8 million in general funds for OOCC, \$5.0 million of which will be competitively awarded in fiscal 2021. Additional fiscal 2021 funding includes \$4.2 million in Department of Public Safety and Correctional Services support for medication-assisted treatment in State correctional facilities, and \$3.5 million between the Governor's Office of Crime Prevention, Youth, and Victim Services and the Department of State Police for various enforcement and treatment efforts.