Public Comment: Lessons from Illinois – Support for SB 549

TO: Chair Beidle and members of the Senate Finance Committee

FROM: [Your Name], Concerned Aunt and Federal Taxpayer

HEARING DATE: March 10, 2026

BILL: SB 549 – Mental Health – Treatment Plans for Individuals in Facilities – Participation of Family Members or Other Individuals (The H.E.R. Continuity of Care Act)

POSITION: SUPPORT (FAV)

The Illinois Benchmark: Unbroken Continuity of Care

In my home state of Illinois, true continuity of care is achieved because the legal and medical framework provides a clear pathway for families to remain engaged when a loved one is in a psychiatric crisis.

Maintaining the Bridge to Home: Illinois recognizes that a facility is only a temporary stop, and the family is the long-term care provider. Through statutes like the Mental Health Treatment Preference Declaration Act (755 ILCS 43/), Illinois legally mandates that an authorized surrogate has the exact same right as the patient to receive information regarding proposed treatments and to review medical records. Patients are actively informed of their right to have family involved in their treatment plans, preventing the clinical isolation that Maryland currently permits.

Honoring Directives: When a family proactively establishes legal directives—such as Mental Health Advance Directives—those documents are respected. Under the Health Care Surrogate Act (755 ILCS 40/), once a physician documents a lack of capacity, facilities are legally mandated to turn to the designated advocate or family hierarchy to authorize stabilization. This allows for private decision-making without judicial involvement, ensuring the continuity of care is never broken by administrative negligence. A family standing in a facility with legally binding documents is treated as an asset, not a liability.

Fiscal Responsibility and Accountability: Illinois treats a psychiatric readmission not as an inevitability, but as a preventable failure of the facility. Through programs that track Potentially Preventable Readmissions (PPR), Illinois actively penalizes hospitals that allow excessive behavioral health readmissions within a 30-to-60-day window. Their proactive approach to family integration ensures that state and federal Medicaid dollars are spent on effective, continuous treatment rather than the waste of repeated, preventable readmissions.

The Federal Stake: Protecting Medicaid Resources

When a state's operational loopholes force a medical crisis, it strains the federal budget. As a federal taxpayer, I have a direct interest in how Maryland manages its healthcare laws. When Maryland facilities block family advocacy, it severs the continuity of care and places an undue burden on our shared national resources:

* Medicaid Waste: Maryland is currently wasting $127 million annually in Medicaid funds due to preventable psychiatric readmissions. We are paying for a "revolving door" because Maryland facilities are cutting the safety net that families are trying to provide.

* The Cost of Exclusion: A single "serial cycle" of readmission costs over $35,000. Clinical data proves that half of that cost—$17,500—is 100% preventable simply by allowing family advocacy to occur. Maryland is currently paying $35,000 per serial cycle to fund a revolving door that benchmark states like Illinois are actively refusing to pay for. Preventing stabilization drives up the national cost of healthcare and increases the burden on federal systems.

Bridging the Gap: How SB 549 Resolves the Concern

SB 549 is the bridge Maryland desperately needs. It mirrors the effectiveness we see in states like Illinois by ensuring the patient's support system is not legally severed at the hospital doors.

By mandating that facilities inform individuals of their rights in plain language and actively honor legally executed documents, SB 549 ensures that a patient's transition from inpatient crisis to outpatient stability is supported by the people who know them best. True continuity of care is impossible when the most consistent caregivers are locked out of the treatment planning process.

We have a responsibility to ensure our laws are not straining the system through unnecessary barriers. We are not asking the state to take over; we are asking the state to stop cutting the safety net that families have legally and proactively put in place. Saving lives is budget-neutral.

I urge a FAVORABLE report on SB 549 to bring Maryland in line with successful models, ensuring that healing, equity, representation, and continuity of care applies to the mental health community.

Sincerely,

Parchenney N. Donley

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