HB 116

Department of Legislative Services

Maryland General Assembly
2019 Session

FISCAL AND POLICY NOTE
First Reader

House Bill 116 (Delegate Barron, *et al.*)

Judiciary and Health and Government Operations

Public Health - Correctional Services - Opioid Use Disorder Examinations and Treatment

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This bill requires each State or local correctional facility to conduct an assessment of the mental health and substance use status of each inmate within 24 hours after incarceration, including pretrial, using guidelines and criteria approved by the Behavioral Health Administration (BHA) within the Maryland Department of Health (MDH) to determine if the medical diagnosis of an "opioid use disorder" is appropriate and if "medication-assisted treatment" (MAT) is appropriate. The State must fund the program of opioid use disorder screening, examination, and treatment of inmates, and the bill establishes requirements for screening and treatment. By November 1, 2020, and annually thereafter, the Maryland Commission on Correctional Standards must report to the General Assembly specified information regarding assessments, examinations, and treatment of inmates.

Fiscal Summary

State Effect: General fund expenditures increase by *at least* $20.3 million in FY 2020. Future years reflect annualization and ongoing costs. Revenues are not affected.

($ in millions)	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Revenues	$0	$0	$0	$0	$0
GF Expenditure	20.3	24.5	25.3	26.2	27.1
Net Effect	($20.3)	($24.5)	($25.3)	($26.2)	($27.1)

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

Local Effect: Local expenditures likely increase significantly. Local revenues are not affected. **The bill imposes a mandate on a unit of local government.**

Small Business Effect: None. Small businesses are not directly affected.

Analysis

Bill Summary:

Screening: If a required assessment indicates opioid use disorder, a physical examination of the inmate must be conducted by a health care practitioner. In addition, MAT must be available to an inmate for whom such treatment is determined to be appropriate.

MDH must (1) determine whether an inmate received medication or MAT for opioid use disorder immediately preceding or during the inmate's incarceration, including pretrial, and (2) continue the treatment within 24 hours after incarceration or transfer unless:

- the inmate voluntarily discontinues the treatment, verified through a written agreement that includes a signature; or
- a health care practitioner determines that the treatment is no longer medically appropriate.

Treatment: Each State and local correctional facility must:

- make MAT available within 24 hours after incarceration to any inmate, including inmates incarcerated pretrial, for whom such treatment is found to be appropriate, as specified;
- maintain or provide for the capacity to possess, dispense, and administer medication for use in opioid treatment therapy;
- provide behavioral health counseling for inmates diagnosed with opioid use disorder consistent with therapeutic standards for such therapies in a community setting;
- provide access to a health care practitioner licensed as a drug addiction treatment act-waiver practitioner under the federal Comprehensive Addiction and Recovery Act of 2016; and
- provide on-premises access to peer recovery specialists.

In addition, before the release of an inmate diagnosed with opioid use disorder, a State or local correctional facility must develop a plan of reentry that:

- includes information regarding postincarceration access to medication continuity, "peer recovery specialists," other supportive therapy, and enrollment in health insurance plans;
- includes any recommended referrals by a health care practitioner to medication continuity, peer recovery specialists, and other supportive therapy; and
- is reviewed and, if needed, revised by a health care practitioner and peer recovery specialist.

Peer support services training: A State or local correctional facility must pay the costs for an inmate diagnosed with opioid use disorder and eligible for work release or leave who is seeking peer recovery specialist certification from an entity approved by MDH, as specified. "Peer recovery specialist" means an individual in recovery for opioid use disorder who has been certified by an entity approved by MDH for the purpose of providing "peer support services." "Peer support services" means a set of nonclinical activities provided by individuals in recovery from mental disorders, substance-related disorders, or addictive disorders who use their personal, lived experiences and training to support other individuals with mental disorders, substance-related disorders, or addictive disorders.

Procedures and standards: The procedures and standards used to determine opioid use disorder and treatment of addicted inmates are subject to the guidelines and regulations adopted by MDH. The Maryland Commission on Correctional Standards and BHA must develop a timetable in accordance with medical best practices for inmates to receive assessments, examinations, or treatment under the bill.

Methadone detoxification: The bill repeals the requirement for an inmate in a State or local correctional facility to be placed on a properly supervised program of methadone detoxification under specified conditions.

Defined terms: "Medication-assisted treatment" means the use of medication, in combination with counseling and behavioral health therapies, to provide a holistic approach to the treatment of opioid use disorder. "Opioid use disorder" means a medically diagnosed problematic pattern of opioid use that causes significant impairment or distress.

Current Law/Background: For information on the State's opioid crisis and funding for drug addiction treatment, refer to the **Appendix – Opioid Crisis.**

Methadone detoxification program: An inmate in a State or local correctional facility must be placed on a properly supervised program of methadone detoxification if a physician determines that the inmate is an addict, the treatment is prescribed by a physician, and the inmate consents in writing to the treatment. Methadone is a synthetic narcotic used to treat people addicted to heroin, morphine, and other opiates. Methadone, taken once daily, suppresses narcotic withdrawal.

Assessment before sentencing: Chapter 515 of 2016, the Justice Reinvestment Act, authorizes a court, before imposing a sentence for a violation of laws prohibiting the possession of a controlled dangerous substance or 10 grams or more of marijuana, to order MDH, or a certified and licensed designee, to conduct an assessment of the defendant for a substance use disorder and determine whether the defendant is in need of and may benefit from drug treatment. MDH or the designee must conduct an assessment and provide the results, as specified. The court must consider the results of an assessment when imposing

the defendant's sentence and, as specified, (1) must suspend the execution of the sentence, order probation, and require MDH to provide the medically appropriate level of treatment or (2) may impose a term of imprisonment and order the Division of Correction within the Department of Public Safety and Correctional Services (DPSCS) or a local correctional facility to facilitate the medically appropriate level of treatment.

State Expenditures: General fund expenditures for DPSCS increase by *at least* $20.3 million in fiscal 2020. MDH also incurs costs, but a reliable estimate of any increase in general fund expenditures for MDH cannot be made at this time.

Under the bill, the State must fund the program of opioid use disorder screening, examination, and treatment of inmates; however, it is unclear which State agency must provide the funding for the program. Based on the experience in Rhode Island, discussed in more detail below, the costs for additional personnel and medication for such a program could likely increase general fund expenditures by millions of dollars each year. The potential fiscal effects of the bill on DPSCS and MDH are discussed below.

Department of Public Safety and Correctional Services

General fund expenditures for DPSCS increase by *at least* $20.3 million in fiscal 2020, which accounts for the bill's October 1, 2019 effective date. This estimate reflects the cost of hiring 214 full-time employees and 120 contractual employees. It includes salaries, fringe benefits, one-time start-up costs, and ongoing operating expenses. DPSCS estimates that 20% of the offenders in State correctional facilities have an opioid use disorder. Based on the assumption that 20% of the population within DPSCS facilities qualifies for MAT, the estimate reflects the cost of hiring:

- 10 counselor supervisors, 68 counselors, 7 office secretaries, and 38 correctional officers to create new substance use disorder counseling services, as required by the bill, at the eight correctional facilities that do not currently have substance use counseling services available;
- 90 peer recovery specialists, as DPSCS does not currently employ any peer recovery specialists;
- 1 administrator for the Maryland Commission on Correctional Standards to handle the bill's data collection, analysis, and reporting requirements; and
- approximately 120 contractual employees for the establishment of 19 ambulatory Opioid Therapy Programs (OTP).

Regular Positions	214
Contractual Positions	120
Salaries and Fringe Benefits	$10,343,539
Contractual Services	8,410,928
Operating Expenses	1,548,257
Minimum FY 2020 DPSCS Expenditures	**$20,302,724**

Future year expenditures reflect full salaries with annual increases and employee turnover and ongoing operating expenses.

This estimate does not reflect any current or future federal or State grant funds related to the opioid crisis that could be used in place of general funds to meet the bill's requirements.

In addition, the estimate does not include:

- any medication costs;
- 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; or
- any additional costs incurred by MDH (discussed below).

Currently, all offenders newly admitted pretrial to a DPSCS facility receive an initial medical and mental health screening conducted by a registered nurse or higher level health care staff. This process is completed upon arrival to the facility, prior to custody exchange from law enforcement, to ensure that the offender is medically and mentally stable to complete the booking process. This current assessment meets the standards established by the National Commission on Correctional Health Care (NCCHC). While the bill requires that an assessment must meet guidelines and criteria approved by BHA, DPSCS advises that any assessment conducted through the department's OTP must be approved by NCCHC, since NCCHC is the accrediting body for the department's OTP.

As part of the initial screening completed during the booking process, offenders are questioned regarding current medication therapy and participation in a methadone program. Offenders responding affirmatively to methadone as a medication or as a participant in a community-based OTP are referred to medical prior to completion of the booking process. Inmates who identify on suboxone or buprenophine variations are managed using methadone. OTP includes maintenance treatment and short-term detoxification. Offenders who cannot be clinically maintained within the facility are transferred to an appropriate hospital or alternate care facility.

Within 12 hours of notification that an inmate is to be released or transferred, the inmate's medical records are reviewed by nursing staff at the intake facility, and a transfer screening

form is completed. Once completed, the transfer screening accompanies the offender to the next facility. Offenders who are on MAT with methadone and who are being released to the community receive a continuity of care form advising on the treatment received while in the DPSCS facility and the need to continue with OTP in the community. If the offender is sentenced, the offender undergoes a detoxification process as written by a clinician and upon completion of detoxification, is transferred to a maintaining facility.

Currently, the average total cost per inmate in a State correctional facility, including overhead, is estimated at $3,800 per month. Excluding overhead, the average cost of housing a new State inmate (including health care costs) is about $895 per month. Excluding all health care (which is a fixed cost under the current contract), the average variable costs total $199 per month.

Maryland Department of Health:

MDH advises that no database currently exists to track medications prescribed for opioid use disorder. Thus, MDH needs to establish a registry to track whether an inmate received medication or MAT for opioid use disorder immediately preceding or during the inmate's incarceration, and to continue the treatment within 24 hours after incarceration or transfer as required by the bill. In addition, MDH needs personnel to maintain and monitor the registry. MDH could also incur costs to approve guidelines and criteria for State and local correctional facilities to conduct assessments of the mental health and substance use status of each inmate. Accordingly, general fund expenditures for MDH increase.

MDH did not provide an estimate regarding the costs for establishing the database or the number of personnel needed; however, MDH advises that the costs of maintaining and monitoring the registry could potentially be offset by savings associated with reducing opioid overdose among inmates following release. MDH notes, for example, that Rhode Island experienced a 61% reduction in opioid-related overdose fatalities among inmates following release from incarceration after the state initiated a statewide initiative to provide all three Federal Drug Administration-approved medications for opioid addiction throughout the state correctional system. The Rhode Island program costs approximately $2 million annually to treat approximately 350 patients per month, with all inmates located in a single state facility.

Local Expenditures: Local government expenditures increase, likely significantly, to meet the bill's requirements relating to assessments, treatment, medications, and data collection and reporting. The following information was gleaned from counties contacted for information regarding the potential effects of the bill:

- Charles County advises that the sheriff's office was unable to provide a fiscal estimate; however, the county notes that the bill's requirements likely increase the workload and work hours for the medical contractor who provides medical services to the county detention center. Any additional work and hours for the medical contractor increases the county's expenditures.
- Frederick County advises that local expenditures increase for the county to provide any medications required under the bill, to hire necessary medical staff to perform the required assessments, to comply with the 24-hour requirement, and to provide any medications. The county estimates that the additional expenditures exceed $800,000. The county also notes that, although the bill requires that a plan of reentry is reviewed and, if needed, revised by a health care practitioner and peer recovery specialist, a peer recovery specialist would likely not pass the required background check to work within the county detention facility.
- Anne Arundel County advises that the monthly medication costs for MAT averages between $16 per day to $1,400 per month, not including the cost of medical staff.
- Montgomery County reports the need for a community service aide to handle coordination of care upon the scheduled release of inmates, at a cost of approximately $85,000 annually.
- Somerset County was unable to quantify the potential costs resulting from the bill; however, the county advises that the required assessments likely increase local expenditures.

Additional Information

Prior Introductions: None.

Cross File: SB 846 (Senator West) - Finance.

Information Source(s): Anne Arundel, Charles, Frederick, Montgomery, and Somerset counties; Maryland Department of Health; Department of Public Safety and Correctional Services; Governor's Office of Crime Control and Prevention; Department of Legislative Services

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Analysis by: Shirleen M. E. Pilgrim

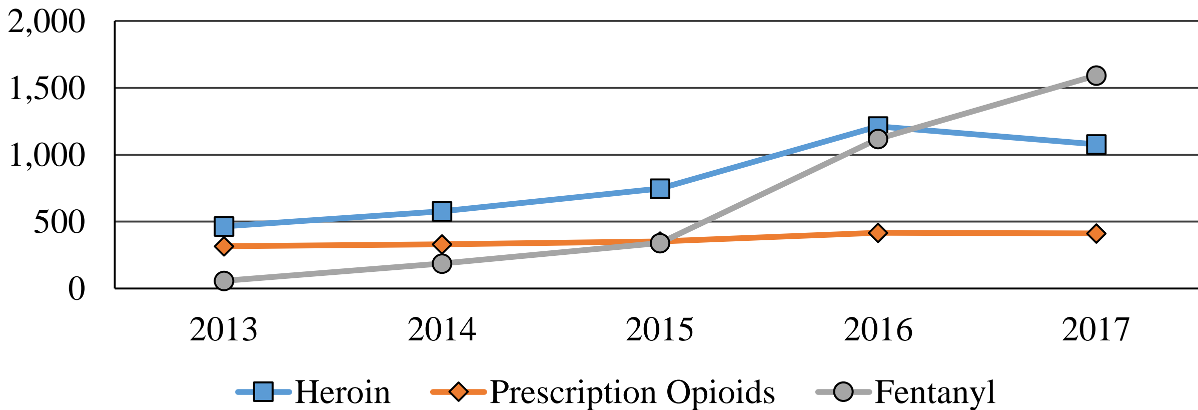
Direct Inquiries to:
(410) 946-5510
(301) 970-5510

Appendix – Opioid Crisis

Opioid Overdose Deaths

While heroin and prescription opioid deaths have begun to taper off, fentanyl deaths have continued to rise at a high rate. As seen in **Exhibit 1**, between 2016 and 2017, prescription opioid-related deaths in Maryland decreased negligibly by 1% (from 418 to 413) while heroin-related deaths decreased by 11% (from 1,212 to 1,078). However, fentanyl-related deaths increased by 42% (from 1,119 to 1,594). Between January and June 2018, there were 1,038 deaths related to fentanyl, a 30% increase over the same time period for 2017.

Exhibit 1
Total Number of Drug-related Intoxication Deaths
By Selected Substances in Maryland
2013-2017



Source: Maryland Department of Health

Federal Actions to Address the Opioid Crisis

In 2016, the Comprehensive Addiction and Recovery Act authorized over $181 million annually, and the 21st Century Cures Act (CURES Act) authorized up to $970 million to be distributed through the State Targeted Response to the Opioid Crisis Grants. The grants are to be used by states to increase access to treatment and reduce unmet treatment needs and opioid-related overdose deaths. In 2017, Maryland received a two-year, $20 million grant for the prevention and treatment of opioid abuse. In March 2017, President Donald J. Trump signed an executive order establishing the President's Commission on Combating Drug Addiction and the Opioid Crisis. The commission issued

a final report in November 2017, with 56 recommendations, including a recommendation for federal block grant funding for state activities relating to opioids and substance use disorders.

In 2018, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act was passed. The legislation expands existing programs and creates new programs to prevent substance use disorders and overdoses, including reauthorization of the Office of National Drug Control Policy, new Centers for Disease Control and Prevention grants for states and localities to improve prescription drug monitoring programs, and funding to encourage research into nonaddictive painkillers. Additionally, the legislation partially lifts the restriction that blocks states from spending federal Medicaid dollars on residential addiction treatment centers by allowing payments for residential services for up to 30 days while also allowing Medicare to cover medication-assisted treatment (MAT) in certain settings for the treatment of substance use disorder.

Maryland Actions to Address the Opioid Crisis

The General Assembly passed several comprehensive acts during the 2017 session to address the State's opioid crisis, which addressed prevention, treatment, overdose response, and prescribing guidelines.

Chapters 571 and 572 of 2017, the Heroin and Opioid Prevention Effort and Treatment Act, among other things, require (1) the Behavioral Health Administration to establish crisis treatment centers that provide individuals in a substance use disorder crisis with access to clinical staff; (2) the Maryland Department of Health (MDH) to establish and operate a toll-free health crisis hotline; (3) certain health care facilities and systems to make available to patients the services of health care providers who are trained and authorized under federal law to prescribe opioid addiction treatment medications, including buprenorphine; (4) each hospital to have a protocol for discharging a patient who was treated for an overdose or identified as having a substance use disorder; (5) the Governor's proposed budget for fiscal 2019 through 2021 to include specified rate adjustments for community behavioral health providers; (6) the Department of Public Safety and Correctional Services and MDH to develop a plan to increase the provision of substance use disorder treatment, including MAT, in prisons and jails; (7) authorization of the provision of naloxone through a standing order and guidelines to co-prescribe naloxone to high-risk individuals; and (8) the expansion of private insurance coverage for opioid use disorders by prohibiting certain carriers from requiring preauthorization for a prescription drug used for treatment of an opioid use disorder that contains methadone, buprenorphine, or naltrexone.

Chapters 573 and 574 of 2017, the Heroin and Opioid Education and Community Action Act (Start Talking Maryland Act), require (1) the State Board of Education to expand an existing program in public schools to encompass drug addiction and prevention education that includes instruction related to heroin and opioid addiction and prevention and information relating to the lethal effect of fentanyl; (2) each local board of education to establish a policy requiring each public school to obtain and store naloxone and other overdose-reversing medication to be used in an emergency situation; (3) each local board of education or local health department to hire a sufficient number of community action officials or develop and implement a program that provides community relations and education functions that coordinate forums and conduct public relations efforts; and (4) specified institutions of higher education in Maryland to establish a policy that addresses heroin and opioid addiction and prevention, including awareness training for incoming students, obtaining and storing naloxone, and campus police training.

Chapter 570 of 2017 requires a health care provider, on treatment for pain and based on the provider's clinical judgment, 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 (CDS). The quantity limitations do not apply to opioids prescribed to treat a substance-related disorder; pain associated with a cancer diagnosis; pain experienced while the patient is receiving end-of-life, hospice, or palliative care services; or chronic pain.

In January 2017, Governor Lawrence J. Hogan issued an executive order establishing an Opioid Operational Command Center (OOCC) to facilitate collaboration between State and local public health, human services, education, and public safety entities to combat the heroin and opioid crisis. OOCC will (1) develop operational strategies to continue implementing the recommendations of the Governor's Heroin and Opioid Emergency Task Force; (2) collect, analyze, and facilitate data sharing relevant to the heroin and opioid epidemic; (3) develop a memorandum of understanding among State and local agencies regarding sharing and collection of health and public safety information and data relating to the epidemic; (4) assist and support local agencies in the creation of opioid intervention teams; and (5) coordinate the training of and provide resources for State and local agencies addressing the threat to the public health, security, and economic well-being of the State.

In March 2017, Maryland became the first state to declare a state of emergency for the opioid crisis, activating the Governor's emergency management authority and enabling increased and more rapid coordination between the State and local jurisdictions. In conjunction with the declaration, Governor Hogan included a supplemental budget appropriation of $10 million, part of a $50 million, five-year commitment.

In July 2017, $22 million was appropriated for fiscal 2018, including $10 million in CURES Act funding, to be used for prevention, treatment, and enforcement activities. Prevention efforts include distribution of opioid intervention teams for each jurisdiction, a

public awareness campaign, funding to train community teams on overdose response and linking to treatment, a pilot program to create school-based teams for early identification of the problems related to substance use disorders, and distribution of opioid information to health care facilities and providers that offer treatment. Enforcement initiatives include funding to disrupt drug trafficking organizations for the heroin coordinator program and to increase MDH's regulatory oversight of CDS. Treatment funding will be used to expand treatment beds and implement a tracking system to identify available beds; improve access to naloxone; establish a 24-hour crisis center in Baltimore City; expand use of peer recovery support specialists; expand Screening, Brief Intervention, and Referral to Treatment to hospitals and parole, probation, and correctional facilities; increase access to MAT; expand law enforcement diversion programs; and improve the State's crisis hotline.

In 2018, the General Assembly expanded upon the comprehensive legislation of the prior year. 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 who 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.