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2020 LEGISLATIVE SUMMARY

Amid concerns over spread of the novel coronavirus, the 441st legislative session of the Maryland General Assembly ended on Wednesday, March 18 – nearly three weeks earlier than planned. It is believed to be the first time the session has been cut short since the Civil War. While the last few days of session were marked by a frenzied effort to finalize priority legislation and advance emergency bills to mitigate the impact of the COVID-19 public health emergency, the work done by MHAMD and our coalition partners during the first two months laid the groundwork for another positive campaign. As outlined below, MHAMD and partners worked effectively during the abbreviated session to protect critical funding for community mental health and substance use disorder treatment and ensure passage of a number of critical behavioral health policy reforms.

KEEP THE DOOR OPEN MARYLAND

MHAMD and the Maryland Behavioral Health Coalition rallied again this year around an ambitious agenda aimed at increasing access to mental health and substance use treatment and prevention services for Marylanders of all ages. Building on a successful 2019 campaign that resulted in statutory funding increases for community providers and several important behavioral health service expansions, the Coalition once again asked legislators to 'Keep the Door Open' for the one in four Marylanders with behavioral health needs.

The Maryland General Assembly has taken several important steps in recent years to address a continuing behavioral health crisis. We are making progress, but we are not out of the woods yet. Overdose deaths increased in 2018 for the eighth year in a row, reaching an all-time high of 2,406. And while these deaths decreased by four percent during the first nine months of 2019, a total of 1,774 Marylanders still lost their lives to overdose during that time. Maryland suicides

are increasing dramatically, and demand for mental health and substance use treatment has risen steadily since 2008, with nearly 300,000 Maryland children and adults currently using and depending on the state's public behavioral health system.

Funding for Community Behavioral Health Services

Despite a continuing increase in demand and rising health care costs, funding for community behavioral health services has not kept pace with the need. In recent years, thanks to an outpouring of support from people across the state, MHAMD and its partners on the Maryland Behavioral Health Coalition have been successful in securing long-overdue multiyear funding increases for community mental health and substance use treatment.

However, the Fiscal Year 2021 budget introduced in early January did not fund community behavioral health services to the extent required by either the minimum wage bill of 2019 *or* the bipartisan HOPE Act of 2017. Instead the proposal would have cut mandatory increases in half, underfunding mental health and substance use treatment by nearly $25 million. Restoring this funding was a top priority this session for MHAMD and the Coalition.

The budget cut was front and center in February at the *Keep the Door Open Rally in Annapolis*, where hundreds of consumers, family members, providers, advocates, legislators and more unified in support of the Behavioral Health Coalition's 2020 legislative agenda. The event was covered by a variety of traditional media outlets and generated widespread social media activity. The Coalition rounded out the effort with testimony at every possible hearing, direct advocacy to legislators and a strong social media messaging campaign.

In the end, the General Assembly passed a bipartisan budget that fully funds all prior behavioral health budget commitments, increasing funding for community mental health and substance use treatment by nearly $50 million over the next year, as required by the HOPE Act and the minimum wage bill.

School Behavioral Health Supports

Chaired by MHAMD, the Maryland Children's Behavioral Health Coalition (CBHC) has worked over two years to inform the work of the (Kirwan) Commission on Innovation and Excellence in Education. The Commission was charged with setting new education funding formulas and developing recommendations to transform the state's public education system.

CBHC presented the Commission with a comprehensive set of strategies for enhancing school-based behavioral health services, which have been shown to improve student health and education outcomes. Recommendations included increased training for school personnel, the scaling of school behavioral health services in all jurisdictions, partnerships with community

behavioral health providers, systematic screening and identification of student needs, and a statewide system of accountability and outcome measurement.

The landmark Blueprint for Maryland's Future (HB 1300 (passed)) fully incorporates every CBHC recommendation, a pivotal accomplishment for a coalition formed just three years ago. The bill dedicates staff at the Maryland State Department of Education to coordinate with school behavioral health services coordinators, requires training of school personnel in all schools to recognize student behavioral health concerns and protocols to support students in need of behavioral health services, and requires each local school system to develop and implement systematic screening to identify students with behavioral health needs.

The bill also establishes a Maryland Consortium on Coordinated Community Supports to develop and fund community-partnered school behavioral health programs across the state. The Consortium will develop a statewide framework for the programs, provide grants to support service delivery, work with the Maryland Department of Health to determine reimbursement options for uninsured students and for services not covered by commercial insurance, and develop a list of evidence-based programs for addressing students' behavioral health needs in the classroom. Funding for the services begins at $25 million in FY22, increasing to $125 million in FY26 and each year thereafter.

Behavioral Health Parity and Network Adequacy

Under federal and state parity laws, Marylanders are entitled to receive mental health and substance use disorder benefits at the same level as other medical benefits. But many Marylanders still face barriers in accessing behavioral health services that are not imposed for medical and surgical benefits.

➢ Parity Compliance Reporting

Over the past several years, the Maryland Insurance Administration (MIA) has identified significant behavioral health provider network and credentialing violations that limit access to treatment. These violations have resulted in numerous enforcement orders involving most commercial insurance carriers in the state. Nevertheless, the barriers persist.

As introduced, SB 334 | HB 455 (passed) would have required carriers to submit annual parity compliance reports modeled on the U.S. Department of Labor's Parity Act Self-Compliance Tool. Behavioral Health Coalition representatives participated throughout session in negotiations with legislators, insurers and the MIA, resulting in passage of a heavily amended bill. And while MHAMD and partners believe the final product does not go far enough to ensure carriers are in compliance with the parity law, it should produce information and data that will prove useful in our continuing enforcement efforts. Key provisions include:

- Carriers will submit compliance and data reports in March 2022 and March 2024
- Compliance reports will include identification of nonquantitative treatment limitations (NQTLs) applied to behavioral health and medical benefits, and a comparative analysis of those NQTLs as written and in operation
- Data reports will include information on denial of claims and prior authorization requests for behavioral health benefits
- A summary of carrier compliance and data reports will be publicly available online
- MIA is required to consider any identified parity violation a "serious violation with a significantly deleterious effect on the public," which should increase penalties on noncompliant carriers
- MIA will use a regulatory process to develop a standardized reporting tool to collect the information outlined in the bill
- MIA must submit an interim report to the General Assembly by December 2023 and a final report by December 2025

➢ Consumer Payment Protections for Out of Network Care

The General Assembly and the MIA have taken important steps in recent years to address network adequacy concerns and improve access to treatment for individuals with mental health and substance use disorders, but these efforts have yet to ensure that Marylanders with commercial insurance can access in-network behavioral health care when needed. An independent national report published in late 2019 showed that Marylanders are 10 times more likely to go out-of-network for behavioral health care compared to primary care – a rate that is fourth worst in the nation. Regulations enacted in 2018 require that Maryland insurers meet strict wait time and distance standard for behavioral health appointments, yet recent filings indicate that only 2 of 16 carriers provided urgent mental health and substance use disorder care within the required 72 hours and only 1 of 6 carrier networks provided non-urgent care within the required 10 days.

These network adequacy failures limit access to care and result in higher out-of-pocket costs that can make treatment unaffordable, even for those with insurance. Maryland law requires carriers to approve the delivery of behavioral health services through a non-network provider if there is no in-network provider that can deliver the service without unreasonable delay or travel. But because the provider is allowed to bill the patient for any charges not reimbursed by the plan, carriers are in effect shifting the cost of covered mental health and substance use treatment onto the consumer when they have inadequate provider networks.

SB 484 | HB 1165 (failed) was introduced to prevent this 'balance billing' of commercially-insured Marylanders who are forced to go out-of-network for mental health and substance use treatment. It would have required insurers to provide coverage for out-of-network care at "no greater cost" than for services received in-network. The bill stalled after carriers argued it

would undermine efforts to recruit providers to their networks, but supportive legislators have indicated that network adequacy concerns will be discussed as part of an interim process.

Crisis Response Services and Overdose Prevention

An inability to access quality mental health and substance use disorder services in the community is forcing more Marylanders into costly emergency departments or discouraging them from seeking treatment at all. This crisis in access is tied to an exponential increase in the number of Marylanders lost to suicide, unintentional overdose and other preventable deaths. Accordingly, MHAMD and the Maryland Behavioral Health Coalition worked this session to expand access to crisis response services and harm reduction interventions.

➢ Designated Emergency Facilities

Maryland law requires individuals subject to an emergency petition be taken to a designated emergency facility (DEF). The statute has always been interpreted as requiring DEFs to be hospitals with emergency departments, though hospitals are rarely the most appropriate place to deescalate a behavioral health crisis. They can be loud and chaotic, priorities are triaged, and staff are pulled in many directions. Settings like this may actually serve to exacerbate a crisis.

Behavioral health crisis response centers, on the other hand, are developed and designed specifically to address the unique needs of individuals experiencing a mental health or substance use crisis. They provide services and supports necessary to stabilize the immediate crisis and linkages to community resources that can help maintain that stability.

SB 441 | HB 332 (passed) will allow the Maryland Department of Health to include behavioral health crisis response centers on its list of DEFs, addressing a statutory barrier that has prevented the routine diversion of individuals in crisis from emergency departments to more appropriate community-based alternatives. The bill requires annual departmental reporting on the identification of new DEFs and a stakeholder protocol development process to ensure prospective DEFs have the appropriate safeguards and supports in place.

➢ Crisis Intervention Teams (CIT) Center of Excellence

CIT is a law enforcement-led, team-based intervention to divert individuals experiencing behavioral health crises away from the criminal justice system and into treatment. It results in less lethal interactions, better outcomes and increased safety for all involved. Since 2013, a subcommittee of the MHAMD-chaired Maryland Behavioral Health and Criminal Justice Partnership (BHCJP) has been working with the Behavioral Health Administration and a range of other stakeholders to standardize the model and expand it in jurisdictions across the state.

Tremendous progress has been made. While CIT coverage was sparse in 2013, there is now at least some CIT presence in most areas of the state. But the work is far from complete, and extra resources are needed to achieve the ultimate goal of around-the-clock CIT coverage in every law enforcement agency and jurisdiction throughout Maryland. SB 305 | HB 607 (passed) establishes a CIT Center of Excellence in the Governor's Office of Crime Control and Prevention to assist local jurisdictions in developing, evaluating and improving their CIT programs.

➢ Overdose Prevention Services

The public health and safety threat from drug and alcohol related intoxication continues to grow. Americans are now more likely to die from opioid overdoses than car crashes. As noted above, Maryland has made progress in recent years to address this epidemic, but we are still in the middle of a crisis that is devastating families across the state.

Overdose and infectious disease prevention sites (OPS) are facilities where people can use previously purchased drugs under trained supervision. Providing sterile needles, health care services, and referrals to drug treatment, these sites aim to reduce the harms associated with drug use. Studies have demonstrated the positive impact of this particular intervention, with evidence showing that OPS facilities reduce opioid- and overdose-related deaths, reduce public drug use, serve as an access point to behavioral health care and other social services, and reduce hospital admissions and associated costs.

SB 990 | HB 464 (failed) would have allowed community-based organizations to establish OPS facilities at up to six locations around the state. The bill was modeled after programs already operating in 60 cities in 12 countries around the world. Unfortunately, even after several emotional hearings where there was no opposition and encouraging words of support from legislative leadership, the bill did not receive a vote in the House or Senate.

➢ Good Samaritan Law

In another effort to stem the tide of overdose deaths, MHAMD and partners supported efforts to expand legal protections afforded under Maryland's Good Samaritan statute. Current law encourages people who witness an overdose to call 911 by providing immunity from *prosecution* for several minor drug and alcohol offenses. However, callers may still be *arrested and charged* with one of those offenses. This greatly limits the effectiveness of the Good Samaritan law. Fear of arrest remains a key concern for individuals in the community, even when they know the arrest will not lead to prosecution.

SB 849 | HB 738 (failed) sought to further encourage individuals to make a life-saving 911 call by extending the Good Samaritan immunity to "arrest and charge," but the bill did not receive a vote in the House or Senate.

FISCAL YEAR 2021 BUDGET

The legislature gave bipartisan approval to the $47.9 billion state budget on the final day of the shortened session. As noted above, the FY21 appropriation increases funding for community behavioral health by nearly $50 million in total dollars (state and federal match). The budget also includes specific language and narrative requiring a variety of agency reports and taking other actions of note to the behavioral health community:

- Behavioral Health Administration report on **quality and performance measures in the public behavioral health system** *(Due 10/1/2020)*
- Behavioral Health Administration report on causes for the increase in **psychiatric rehabilitation program (PRP) expenditures** *(Due 12/1/2020)*
- Medicaid Administration report on potential expansion of the **Baltimore City Capitation Project** *(Due 11/15/2020)*
- Department of Aging report on administration of the **public guardianship program** for older Marylanders *(Due 10/1/2020)*
- Department of Aging reports on **waitlists at each Area Agency on Aging** and on how those waitlists will be managed *(Due 9/1/2020 and 1/15/2021)*
- Department of Health report on the **ASO transition**, including the status of estimated payments to providers and client access issues *(Due 7/1/2020)*
- Department of Health report on new **Assertive Community Treatment (ACT) fidelity measurement standards** *(Due 9/1/2020)*
- Department of Human Services plan for improving the provision of appropriate physical and mental health **services for children in out-of-home placements** *(Due 10/1/2020)*
- Joint report from the Departments of Human Services and Health on **psychiatric bed capacity for youth and a plan to improve youth psychiatric crisis response** to prevent hospitalization (Due 12/1/2020)
- Joint report from the departments of Human Services, Health, and Juvenile Services on **emergency room visits, hospital stays, and out-of-state placements for youth** with psychiatric and medical conditions *(Due 9/1/2020)*

Further, the budget provides that over $7 million in funding for the Department of Public Safety and Correctional Services may only be used to create a **Medication Assisted Treatment (MAT)** program in the Baltimore Pretrial Complex or for MAT programs in local detention centers as required by HB 116 of 2019.

CHILDREN, YOUTH AND YOUNG ADULTS

Maryland has witnessed an increase in the number of children and adolescents experiencing lengthy stays in hospital emergency departments awaiting transfer to more appropriate behavioral health care facilities. The Maryland Health Care Commission reports that only five

acute care general hospitals in the state provide inpatient psychiatric services for children aged 13 to 17, and only two provide that level of care for children aged 0 to 12.

Accordingly, the Children's Behavioral Health Coalition prioritized legislation this year to increase options for children experiencing a behavioral health crisis. SB 624 | HB 1140 (failed) would have required development of a comprehensive mobile response and stabilization system (MRSS) for children and their families. MRSS is an upstream intervention used primarily to divert youth from higher intensity services such as inpatient and residential care. The model is designed to assist a child in crisis by connecting families to behavioral health providers in the community that are trained to respond to acute needs.

The bill passed the Senate but fell victim to the abbreviated session and did not make it through the House. However, we anticipate a letter from legislative leadership to the Maryland Department of Health requesting a review of various MRSS models, potential cost savings and funding options.

Homeless youth are at greater risk of substance misuse, criminal involvement, incarceration, trauma, depression, suicide, poverty and unemployment. SB 207 | HB 206 (passed) removes a barrier that limits these children from accessing appropriate safe shelter and support services. The bill allows unaccompanied minors to consent to such services if the provider reasonably believes the minor understands the nature of the services and that they are necessary to ensure the child's safety and well-being.

About 50% of children are exposed to a traumatic event, and as many as 67% of trauma survivors experience lasting psychosocial impairment. Trauma can affect a child's brain and delay certain development, making it harder for the child to concentrate and study. HB 277 (passed) requires the Maryland State Department of Education to develop guidelines to help schools implement comprehensive trauma-informed policies.

MHAMD also supported unsuccessful bills that would have created a task force to study access to mental health care in higher education (SB 1015 | HB 1504), expanded reporting of sexual abuse and harassment at residential treatment centers (SB 818), required the state to maintain an updated list of services available for children with mental health disorders (SB 453 | HB 374), and increased funding for youth services bureaus (SB 490 | HB 709). The condensed session did not allow time to finalize these efforts.

OLDER ADULTS

As chair of the Maryland Coalition on Mental Health and Aging, MHAMD worked actively this session to improve the system of care for older adults with behavioral health needs and their caregivers. The organization supported legislative efforts to address a growing population of

Marylanders living with progressive dementia, and to ensure access to services and supports that meet the specific trauma and long-term care needs of older Marylanders.

It can be difficult to find assisted living placements for older adults with behavioral health needs. This has created a growing and concerning trend whereby older Marylanders with dementia, mental illness and substance use disorders are disproportionately placed in unlicensed programs that provide substandard care in substandard conditions. SB 966 (passed) prohibits a person from referring another person to an unlicensed assisted living facility and from making referrals only to facilities with which they have a financial relationship.

MHAMD also supported efforts to create a task force on home- and community-based waiver services (SB 642 | HB 1163), establish a commission to ensure the trauma-informed delivery of state services (SB 918), and increase public outreach and education on Alzheimer's disease and other types of dementia (SB 725 | HB 456). While these bills appeared on a path to passage, they too fell victim to the truncated session.

WORKFORCE AND TECHNOLOGY

A persistent workforce shortage is exacerbating the increased demand for behavioral health services and challenging Maryland's ability to effectively address the unmet need. As such, MHAMD supported legislation this year to reduce staffing shortages at state facilities and to eliminate service restrictions that prevent the broad delivery of care to those in need.

State psychiatric facilities treat individuals with serious mental illnesses who require an intensive array of specialized treatment services. These are challenging work environments that require a particular set of skills and qualifications. But high demands and low wages force many qualified and dedicated staff to seek employment elsewhere, which can disrupt treatment plans, compromise staff and patient safety, and hinder recovery and discharge. SB 693 (passed) increases salaries for staff at state psychiatric facilities, which should help to recruit and retain qualified personnel.

SB 502 (passed) eliminates barriers to the use of telehealth by requiring Medicaid to cover mental health services delivered by telehealth to patients in their home settings, and by expanding the definition of telehealth similarly for purposes of commercial insurance coverage. The bill also requires the Maryland Department of Health to study whether substance use disorder services may be appropriately provided through telehealth to a patient in their home.

OTHER LEGISLATION

The federal Affordable Care Act requires hospitals to complete needs assessments to prioritize the health needs of local communities and direct spending of community benefit dollars

accordingly. However, community benefit reports in Maryland lack specificity, making it impossible to determine whether actual spending is driven by the unmet needs identified in the assessments. SB 774 | HB 1169 (passed) repeals current community benefit reporting requirements and establishes a workgroup at the Health Services Cost Review Commission (HSCRC) to make improvements that maximize transparency and clarity in the reporting process. MHAMD and partners were successful in amending the bill to ensure attention to community behavioral health needs during the workgroup process.

On average, over 500 Marylanders die every year from suicide. SB 810 (passed) authorizes the State Highway Administration to post suicide prevention information on electronic signs along any highway within a five-mile radius of a high suicide risk zone. The bill provides a new option for getting valuable preventive information to individuals at risk for suicide at a time when they may need it the most.

Maryland's Maternal Mortality Review Committee reviews maternal death cases and makes findings and recommendations to prevent other maternal deaths. At least twice a year, a group of stakeholders must be convened to review these findings and provide feedback. HB 286 (passed) requires that those stakeholders reflect the racial and ethnic diversity of women most impacted by maternal deaths in Maryland.

A lack of knowledge about available behavioral health resources in the community – among health care providers and the public at large – is a major factor in the overutilization of hospital emergency departments and acute care inpatient settings for mental health and substance use treatment. HB 1121 (passed) seeks to address this by establishing a statewide registry and referral system through which health care providers can identify and access available inpatient and outpatient mental health and substance use services for patients in a seamless manner. The bill makes development and implementation of the registry subject to availability of funds.