MENTAL HEALTH ASSOCIATION OF MARYLAND

Heaver Plaza
1301 York Road, #505
Lutherville, MD 21093
phone 443.901.1550
fax 443.901.0038
www.mhamd.org

2017 LEGISLATIVE WRAP-UP

The 437th legislative session of the Maryland General Assembly drew to a close at midnight on April 10. Behavioral health issues received deserved attention this year as the legislature worked to tackle an ongoing behavioral health crisis that is devastating Maryland families. As chair of the Maryland Behavioral Health Coalition, MHAMD was front and center during these conversations, working with our Coalition partners to craft effective solutions to an alarming rise in suicides and opioid-related deaths. Additionally, the public policy team realized significant victories on a range of priority issues, advocating effectively to address unmet maternal mental health needs in our state and to pass legislation authorizing a program that will target services to hard-to-engage individuals with serious mental illness.

KEEP THE DOOR OPEN MARYLAND

MHAMD and the Maryland Behavioral Health Coalition once again called on the legislature to "Keep the Door Open" for the one in four Marylanders living with a mental health or substance use disorder. That call was answered this session, and not a moment too soon.

From 2010 to 2015, overdose deaths increased by a startling 216%, with final figures expected to show that some 2,000 people died from heroin overdoses last year alone. Opioid-related deaths are now the state's fourth leading cause of death, behind only heart disease, stroke and cancer. Maryland's suicide rate has also seen a marked increase. It is is now one of the leading causes of

death among residents aged 15 to 34, having risen nearly 20% since 2005. Demand for public behavioral health services has increased by 65% since 2008, yet despite this increase in need, mental health and substance use disorder treatment has actually decreased as a percentage of Maryland's healthcare budget year after year, to the point where only around six cents of every healthcare dollar is spent on behavioral health services.

Keep the Door Open Act | HOPE Act

The Keep the Door Open Act (SB 476 / HB 580) – the namesake legislation of the Coalition's multi-year advocacy campaign to properly resource Maryland's community behavioral health provider network – was reintroduced this session following a heartbreaking last day defeat in 2016. The bill increases yearly funding for the professionals serving over 180,000 Maryland children and adults living with behavioral health needs, ensuring that as the cost of healthcare goes up and the demand for services increases, these community providers can continue delivering high quality mental health and substance use disorder treatment.

The legislation received a major boost this year when it was included in the Heroin and Opioid Prevention Effort (HOPE) and Treatment Act of 2017 (SB 967 / HB 1329), a comprehensive measure designed to address Maryland's behavioral health crisis. MHAMD and its Coalition partners worked with legislators throughout the session to refine various provisions of the HOPE Act. In the end, the far-reaching, treatment-focused approach passed the Maryland General Assembly with near-unanimous support. Specific elements of the bill:

- Require specified increases in funding for community behavioral health services (**Keep the Door Open Act**). Payments to providers increase by 3.5% in each of the next two fiscal years, and by 3% the following year. The bill also requires that the Behavioral Health Administration and Medicaid, in consultation with stakeholders, conduct a rate-setting study for community behavioral health services and implement a payment system based on the findings. The study must be completed by September 30, 2019.

- Require the establishment of **behavioral health crisis treatment centers** consistent with forthcoming recommendations from the Maryland Behavioral Health Advisory Council. The recommendations are part of a strategic plan being developed as a result of Coalition priority legislation from last session (SB 551 / HB 682 (2016)). The HOPE Act requires that at least one crisis center be established by June 1, 2018.

- Makes expansion and promotion of the **statewide 24/7 crisis hotline** a statutory requirement. The bill requires that hotline staff be trained to screen callers for mental health and substance use disorder needs, conduct risk assessments for overdoses and suicides, and connect callers to appropriate behavioral health resources and supports.

- Require the collection and dissemination of up-to-date **resources and information** about opioid use disorder.

- Repeal a requirement that an individual be trained in overdose recognition and response before receiving the **overdose-reversal medication naloxone** from a pharmacist.

- Require hospitals to have **protocols for discharging patients** who were treated for a drug overdose or identified as having a substance use disorder. The protocols may include coordination with peer recovery counselors, connection to community-based treatment, a prescription for naloxone and more.

- Require an assessment to determine how to **expand drug court programs**. Drug courts are specialized dockets that handle criminal cases involving individuals with substance use disorders through judicial intervention, intensive monitoring and continuous substance use treatment. The bill also states the intent of the General Assembly that $2 million in additional funding be awarded next year to expand the programs.

- Require a report from the Department of Health and Mental Hygiene (DHMH) by December 1, 2019 on potential **outcomes measures** for behavioral health providers and recommendations for how reimbursement can be tied to outcomes.

- Require development of a plan for **increasing substance use disorder treatment in jails and prisons.**

The legislation also includes a section stating the intent of the General Assembly that $10 million in supplemental funding issued by Governor Hogan for an Opioid Crisis Fund be used to implement the HOPE Act provisions.

FISCAL YEAR 2018 BUDGET

Budget negotiations were notable this year for their absence of contention. Entering session facing a $400 million revenue shortfall, the legislature gave final approval to the $43.5 billion state budget a full two weeks before the General Assembly adjourned. After adjusting for fiscal 2017 targeted reversions and deficiencies and fiscal 2018 contingent reductions, the fiscal 2018 allowance for the Behavioral Health Administration increases by $116.5 million (6.3%) over the 2017 working appropriation. The majority of this increase is in fee-for-service community behavioral health expenditures, including a 2% provider rate increase.

Governor Hogan issued an additional $10 million in supplemental funding to the Inter-Agency Heroin and Opioid Coordinating Council to “develop a broad range of evidence-based strategies aimed at preventing and treating the opioid crisis, provide grants to other state agencies and local governments, pursue enforcement strategies against drug traffickers, and prepare education and outreach efforts.” As noted above, the legislature has stated its intent that this funding be used to implement the various provisions of the HOPE Act.

Collaborative Care and Other Budget Narrative

MHAMD continued working this year to improve mental health outcomes in primary care settings by advocating for the implementation of the Collaborative Care model within the Medicaid managed care organizations (MCOs). For nearly 20 years, Maryland's Medicaid waiver has required the delivery of primary mental health treatment within the MCOs and includes reimbursement for these services within MCO capitation rates.

Collaborative Care is an integrated care approach for treating common mental health conditions through team-based care management, telepsychiatric consultation and routine monitoring of outcomes. The majority of individuals receive their mental health care from their primary care provider. Unfortunately, the mental health treatment in these settings is often sub-optimal, with individuals poorly diagnosed and treated, or not identified at all. The intervention has repeatedly shown improved clinical outcomes, patient satisfaction and cost savings, largely from a reduction in hospital costs.

Although DHMH recently identified Collaborative Care as the evidence-based practice with the strongest demonstrated results in integrating mental health treatment with primary care, and recommended the development of a limited pilot program, no funding was included in the fiscal 2018 budget. Accordingly, the budget committees requested that DHMH develop a framework for a pilot Collaborative Care program with a view for implementation in the fiscal 2019 budget. The department is expected to issue a summary of its efforts by October 1, 2017.

Additional budget narrative requires DHMH and other departments to report on the following:

- Feasibility, costs and benefits of merging the core service agencies (CSAs) with the local addictions authorities (LAAs)
- Adequacy of Medicaid reimbursement rates for substance use disorder treatment services
- Behavioral health provider accreditation process
- Efforts to connect individuals transitioning from the criminal justice system to health care
- Integration of behavioral and somatic health services
- Reclassification of employees at institutions with forensic patients
- Opiate dependence treatment medications, particularly related to the utilization of those medications in state correctional facilities
- Agency coordination in determining appropriate community or out-of-home placements for children with mental illness, developmental disabilities, or complex medical needs

MATERNAL MENTAL HEALTH

Two years after leading the effort to establish the Task Force to Study Maternal Mental Health, and just months after the Task Force issued its final report and recommendations, MHAMD advocated successfully to enact legislation implementing several of those recommendations.

One in seven women will experience depression during pregnancy or in the first 12 months after delivery, and more than 400,000 infants are born every year to mothers who are depressed, making perinatal depression the most underdiagnosed and untreated obstetric complication in the United States. This and other perinatal mood and anxiety disorders (PMADs) can have very serious adverse effects on the health and functioning of the mother, her infant and her family, and although PMADs are treatable once recognized, 50 percent of all mothers who experience these disorders are never identified. The provisions of SB 600 / HB 775 address this unmet need, taking a critical step toward the development of a comprehensive and robust maternal mental health system of care in Maryland.

The legislation requires the Department of Health and Mental Hygiene to (1) develop accredited continuing medical education programs for providers to improve early identification of postpartum depression and other PMADs; (2) work to expand the Behavioral Health Integration in Pediatric Primary Care (BHIPP) consultation program to assist providers in addressing the emotional and mental health needs of pregnant and postpartum patients; and (3) identify up-to-date, evidence-based information about PMADs, which must be provided to health care facilities and providers, and posted on the Department's website. These provisions will begin to address a frustration among providers about the lack of available training, resources and tools specific to PMADs, and they will ensure that mothers and their families have the information necessary to recognize signs and symptoms when they occur.

OUTPATIENT CIVIL COMMITMENT

The debate over how best to serve a small population of hard-to-engage individuals with serious mental illness has raged for decades. Passionate proponents and opponents of outpatient civil commitment have invariably praised or condemned numerous proposals over the years. This year, however, advocates on both sides of the issue worked together to enact SB 1042 / HB 1383, authorizing the development of an outpatient civil commitment pilot program designed to improve services for individuals with serious mental illness who have not been well-served by the public behavioral health system.

MHAMD and partners have worked for over a year to develop the pilot, which will serve Baltimore City residents with a mental illness who are currently committed involuntarily to an inpatient psychiatric hospital and (1) have been civilly committed at least one other time over the previous twelve months; (2) have a demonstrated history of declining available community treatment; and (3) are unlikely to seek and / or participate in community treatment upon discharge. Using $2.8 million in federal funding from the Substance Abuse and Mental Health Services Administration (SAMHSA), eligible individuals referred to the program will receive a comprehensive range of evidence-based and client-centered behavioral health and social services in the community, either through voluntary engagement with the pilot or involuntarily as a condition of release. Robust evaluation and data collection components will provide a thorough review of program effectiveness, a better understanding of why individuals fail to engage or discontinue community care, and the differences in outcomes between those who participate voluntarily or involuntarily.

After nearly 30 years of disagreement, stakeholders on all sides are working together to move the ball forward on outpatient civil commitment in a thoughtful, data-driven way. MHAMD is proud to be a part of this effort.

OTHER LEGISLATION

Healthcare Reform and Insurance

Many Marylanders who have health insurance nonetheless face barriers when attempting to access mental health and substance use disorder crisis services through their insurance companies. In fact, many crisis service providers do not accept commercially-insured individuals because of difficulties in securing reimbursement for the delivery of those services, leaving many with no choice but to seek treatment in costlier, less appropriate emergency departments. In response, the Behavioral Health Coalition unified behind HB 1288, which would have required the Maryland Insurance Administration (MIA) to convene a workgroup to address barriers to the provision and coverage of behavioral health crisis services. Unfortunately, the legislation stalled following insurer opposition and MIA testimony indicating that the challenges identified in the bill are already being addressed by a separate process examining carrier compliance with the federal Mental Health Parity and Addiction Equity Act (MHPAEA). MHAMD will raise these issues again during a stakeholder feedback component of that process this summer.

A January 2017 report from the Department of Legislative Services noted that Maryland has observed a significant increase in healthcare coverage under the federal Patient Protection and Affordable Care Act (ACA) through the expansion of Medicaid (291,000 individuals) and the establishment of the Maryland Health Benefit Exchange (142,872 individuals). Uncertainty at the federal level about the future of the ACA led to the passage of SB 571, establishing the Maryland Health Insurance Coverage Protection Commission. The Commission must monitor and assess the impact of potential and actual federal changes to the ACA, Medicaid, Medicare and more, and provide recommendations for state and local action to protect access to affordable health coverage. The bill was amended at the request of MHAMD and others to add a behavioral health representative to the Commission membership.

The ability of Medicaid behavioral health providers to treat patients remotely via telehealth, when necessary, is paramount. Incentives enacted by DHMH have failed to bring clinicians to underserved areas of the state, and large swaths of some of Maryland's most populous jurisdictions have been federally designated as mental health professional shortage areas. MHAMD supported SB 570 / HB 658 to remove restrictions that are limiting access to telehealth services, exacerbating the workforce shortage. The bills were not passed, but in a joint letter to the Secretary of DHMH, the chairs of the Senate Finance Committee and the House Health and Government Operations Committee requested a commitment to expand the telehealth program. In his response, the Secretary indicated a willingness to expand the program in several areas, and MHAMD expects to advocate for a greater expansion with the publication of forthcoming regulations addressing the types of professionals authorized to provide telehealth services.

Medication assisted treatment in conjunction with counseling is one of the most effective treatments for opioid use disorders. For those who may benefit from these medications, a prior authorization requirement imposed by their health insurer may literally be the difference between life and death. These requirements unnecessarily delay entry into treatment, potentially leading to continued drug use and possible overdose death. MHAMD supported the passage of HB 887, prohibiting prior authorizations for these medications.

Older Adults

MHAMD supported legislation this year to enhance the safety of vulnerable adults and to assist the state in serving the older adult population, which is anticipated to rise to 25% of the population by 2030. SB 47 (passed) will improve reporting of and response to abuse of vulnerable adults in long-term care facilities by strengthening confidentiality requirements and ensuring that reports are received by the most appropriate programs and agencies. HB 147 (passed) establishes the Healthy Aging Program within the Maryland Department of Aging (MDOA) to promote and advance healthy aging and living. By expanding the statutory scope of MDOA authority, the bill will assist in securing federal grants for these purposes.

Children and Youth

The legislature considered a wide range of education measures this year, and MHAMD supported a number of bills designed to improve access to mental health and substance use disorder services in schools, ensure the safety of children with behavioral health needs, and give parents of children with disabilities more input into their child's development and education.

HB 786 (passed) requires the identification of best practices for enhancing school-based mental health and substance use disorder treatment and prohibits insurers from denying coverage for those services solely on the basis that the service is provided in a public school or through a school-based health center. SB 786 (passed) requires an examination of school policies and practices related to restraint and seclusion. It also includes annual reporting requirements on the use of those interventions. SB 710 and HB 174 (both passed) require an individualized education program (IEP) team to obtain written parental consent before making certain changes to a child's IEP. Additional legislation (SB 1) will require each county school board to report on the number of K-12 students who receive certain academic and behavioral supports.

About 75% of Maryland children being treated for attention-deficit/hyperactivity disorder (ADHD) receive medicine, but less than half of those receive any form of therapy or psychological services. HB 184 (passed) requires DHMH to identify and post on its website up-to-date ADHD information and resources. MHAMD supported the bill to increase awareness among parents and the public about the range of available treatment options. Innovation in the field is occurring at a rapid pace, with neuroplasticity-based brain health technologies holding enormous promise for children with ADHD and other mental health and learning disorders. As treatment options continue to evolve, it is essential that parents have access to the most up-to-date information available.

Nationally, 65-70% of children in the juvenile justice system have a diagnosable mental health disorder. Whenever possible, children should be diverted away from the juvenile justice system and towards community-based programs, including behavioral health treatment as needed. MHAMD supported SB 35 (passed), which will help to ensure successful diversions by allowing children the time necessary to complete such a program.

Behavioral Health and Disability

There is no shortage of studies and scholarly articles detailing the overrepresentation of mental illness and addiction among the homeless population. Failure to address the treatment and rehabilitation needs of individuals with behavioral health disorders has contributed to a large increase in the number of people who are especially vulnerable to displacement and homelessness. MHAMD supported SB 531 / HB 269 (passed), which establishes a program in the Department of Human Resources to assist families and individuals who are experiencing, or who are in imminent danger of, a housing crisis in obtaining and maintaining permanent housing. By coupling stable housing with aftercare and service coordination for some of our most vulnerable citizens, this legislation will improve health outcomes, reduce costs, and provide many with opportunities to live safe, productive and fulfilling lives.