mhamd
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

2014 Preliminary End of Session Wrap-Up

The 434th legislative session of the Maryland General Assembly drew to a close at midnight on April 7. The elimination of a structural deficit in 2013 gave hope that the legislature may opt in 2014 to address some longstanding unmet need in the mental health and substance use disorder systems. However, a series of unexpected revenue shortfalls, stemming partly from a harsh winter, created budget unpredictability making it difficult to garner financial support for new service initiatives. Nevertheless, the MHAMD public policy team navigated a compressed procedural calendar in an election year to raise awareness around key issues, lay the groundwork for future efforts, mitigate potentially harmful legislation, and advocate generally to reduce stigma and increase access to needed services.

Budget

Outgoing Governor Martin O'Malley introduced his final budget proposal in early January. The Fiscal Year 2015 proposal included the first ever Behavioral Health Administration (BHA) budget, continuing the process of integrating mental health and substance use disorder services in Maryland. BHA reflects a merger of the Mental Hygiene Administration (MHA) and the Alcohol and Drug Abuse Administration (ADAA). The FY15 BHA allowance included additional community mental health funding to cover anticipated costs for the Affordable Care Act (ACA) Medicaid expansion population and a 4% rate increase for community mental health providers effective January 1, 2015. The proposal also made a potentially significant change by transferring funding for Medicaid-eligible mental health services from MHA to the Medicaid Administration.

The Department of Legislative Services (DLS) analyzed the budget proposal and made several recommendations. The legislature rejected a DLS recommendation to begin the proposed provider rate increase in July 2014, rather than January 2015. Such a move would have effectively cut the adjustment from 4% to 2%. The legislature did adopt DLS language restricting the use of Medicaid behavioral health funding to that purpose. This language is important given the funding transfer referenced above. Concern about the transfer was addressed again in language asking the Department of Health and Mental Hygiene (DHMH) to clarify the clinical and financial management responsibilities of BHA and Medicaid in the new integrated service delivery system, and also to identify opportunities for stakeholders to be part of the transition process. Additional budget language requires reports on treatment and service options for court-involved individuals with mental illness, intellectual disabilities, and substance use disorders (SUDs); mental health anti-stigma education practices; treatment capacity/options for youth with heroin-related SUDs; budget and eligibility issues at the Maryland Health Benefit Exchange; and financial management issues at the Maryland Department of Aging.

Unfortunately, calls from MHAMD and its Behavioral Health Coalition partners for supplemental funding to address two critical unmet service needs went unanswered. This is covered in greater detail below.

THE MENTAL HEALTH AND SUBSTANCE USE DISORDER SAFETY NET ACT OF 2014

For the second straight year, the Coalition rallied around the **Mental Health and Substance Use Disorder Safety Net Act** (SB 262 / HB 273), a policy platform covering a wide range of longstanding unmet need in the public behavioral health system that will remain unaddressed through implementation of federal health care reform. Dozens of witnesses testified in each chamber in support of the various bill provisions, speaking passionately about everything from services for children and older adults to housing and reentry needs to mental health literacy. Although the Senate and House committees each conveyed general support for the issues raised, a large fiscal note and a tight budget prevented any legislative movement on the bill.

In the absence of legislative action, MHAMD and its Coalition partners urged the Governor to allocate funding through a supplemental budget appropriation for two key Safety Net provisions. The advocacy campaign called for (1) an additional $1 million to fund mobile crisis response services in jurisdictions that currently lack these services altogether or have inadequate capacity, and (2) $1.2 million to continue the Behavioral Health Integration in Pediatric Primary Care program (B-HIPP), which is improving early identification of mental illness in children and youth. Unfortunately, the Governor included no additional funding for these initiatives in his supplemental appropriation. However, language added to the budget expresses legislative intent that B-HIPP be supported in FY15 through any savings realized from lower than budgeted expenditures on Residential Treatment Center services.

Moving into the interim, MHAMD will join with its Coalition partners to debrief and assess the activity and results from the session and formulate a strategy moving forward. Efforts likely will include a focus on garnering commitments from gubernatorial and legislative candidates to support and implement key Safety Net Act provisions. Another strategy may be to separate certain aspects of the bill into more economically feasible standalone bills, much like legislation this year to improve school-based mental health services. See below for more information on this bill.

INVOLUNTARY MENTAL HEALTH TREATMENT

A triumvirate of bills was introduced during the 2014 session to mandate involuntary treatment in the community (SB 831 / HB 767 (failed)), loosen the standards for committing someone involuntarily to a psychiatric facility (SB 67 / HB 606 (failed)), and make it easier to medicate individuals against their will once they've been committed (SB 620 / HB 592 (passed)). Taken together, these three bills constitute a substantial step backward in our collective response to mental illness, moving us toward increased institutionalization of people with mental illness and

involuntary administration of psychiatric medications, despite growing concern about the long-term effects of medication and the limited effectiveness of this approach.

In response to the bills authorizing involuntary outpatient commitment, legislation was introduced at the request of MHAMD and others to provide an alternative, non-coercive approach to engage the same hard-to-reach target population. SB 882 / HB 1267 (passed) was heavily amended, but in the end it served as an alternative to forced treatment legislation by instead establishing a process to develop a program that best serves individuals with mental illness who are at high risk for disruptions in the continuity of care.

Efforts to expand the use of forced medication in facilities proved successful, however, thanks partly to strong support from DHMH. Voicing concern over the lack of transparency in outcomes for those who have been forcibly medicated, MHAMD offered an amendment to monitor services provided to and outcomes for individuals involuntarily hospitalized. Although the amendment was rejected, its introduction laid the groundwork for future discussions about transparency in service outcomes.

OTHER LEGISLATION

Behavioral Health Integration

After many years of deliberation, Maryland is finally at the point of implementing collaborative efforts to integrate and improve the delivery of behavioral health care to the public. A request for proposals for a new administrative services organization (ASO) to oversee both mental health and addiction treatment in a combined behavioral health carve-out was issued in February, and the new system is expected to be up and running on January 1, 2015. Nevertheless, certain parties opposed to the direction in which the state is moving continued their efforts to reverse course. MHAMD successfully thwarted several attempts during the 2014 session to delay or weaken the planned behavioral health carve-out. Additionally, MHAMD worked with DHMH and other stakeholders to craft amendments to HB 1510 (passed), an important and significant piece of legislation formalizing the merger of MHA and ADAA.

Healthcare Reform and Insurance

The healthcare landscape in Maryland continues to evolve rapidly, and MHAMD remains vigilant in its efforts to ensure a consistent level of consumer involvement in all reform discussions and at all stages of change. HB 1235 (passed) establishes an advisory body to make recommendations for implementation of a Community Integrated Medical Home Program (CIMHP). The CIMHP aims to better target resources to those most in need, and coordinate care across patient-centered medical homes and community-based services and supports. MHAMD joined others in successfully advocating for language to ensure consumer representation on the advisory body.

MHAMD also supported legislation to eliminate barriers to appropriate treatment, expand treatment options, and improve access to care. Step therapy is a policy used by insurers to require their members exhaust the least expensive treatment before approving a more costly one. SB 622 / HB 1233 (passed) regulates this procedure by preventing insurers from forcing patients who are already being effectively treated on a medication to undergo the step therapy process. This is particularly important for individuals who are successfully managing their mental illness where a change in medication could prove incredibly detrimental to their continued wellness.

SB 198 / HB 802 (passed) will address serious access-to-care issues by expanding coverage to all Medicaid recipients for health care services delivered via telemedicine. The Medicaid population expansion accompanying implementation of the ACA will only exacerbate the difficulties many face when seeking access to a mental health provider. Increased use of telemedicine offers an opportunity to address chronic provider shortages throughout Maryland.

Stigma and fear of repercussions from family members prevent many from seeking timely treatment for a mental illness or a substance use disorder. This is particularly true for those in abusive relationships where distribution of an insurance document to the policy holder could further endanger the individual seeking help. MHAMD supported SB 790 (passed) to require development of a standard form enabling consumers to request that a health insurance carrier keep all documentation confidential if they feel such communication could endanger them.

Children and Adolescents

A key provision of the Safety Net Act described above is the requirement that school mental health services be available in all public schools. Seeking other methods of furthering that goal, MHAMD joined with partners to request the introduction of SB 679 / HB 639 (failed). The bill sought to create a task force that would study and make recommendations to expand and improve the delivery of community-partnered school mental health programs in Maryland. These cross-system partnerships between families, schools, and community mental health providers ensure a rapid and cost-effective response to early signs of mental illness. While the bill did not pass, a letter from the Chairman of the House Health and Government Operations Committee to the Secretary of DHMH requested that the issues raised be examined in correlation with another process being established to evaluate the expansion and use of school-based health centers. MHAMD will seek to remain actively involved as these conversations proceed.

Older Adults

Access to medication is critical to disease management, wellness and recovery. Sixty-five percent of Medicare beneficiaries have multiple chronic health conditions, including a high prevalence of depression. Many older adults in Maryland are on fixed incomes and have difficulty paying for needed medications. MHAMD supported HB 106 (passed), to continue the Senior Prescription Drug Assistance Program, which is currently assisting over 27,000 individuals with prescription drug costs.

Mental Health and Disability

Conditions at the former Crownsville Hospital Center were deplorable. Many individuals who died on the campus were buried in the hospital cemetery under stone markers showing only numbers, not names. These markers have not been maintained and there is no way for family members to access the cemetery. MHAMD supported SB 577 / HB 404 (passed), requiring the State to maintain the property, to ensure a dignified final resting place for the estimated 3,000 people buried there.

There is no shortage of studies and scholarly articles detailing the overrepresentation of mental illness among the homeless population. Failure to address the treatment and rehabilitation needs of individuals with mental illness has contributed to a large increase in the number of people who are especially vulnerable to displacement and homelessness. MHAMD supported legislation creating an interagency council (SB 796 (passed)) and a joint legislative committee (SB 795 / HB 813 (passed)) to collaborate on efforts to eliminate homelessness and identify supportive services for special populations such as veterans, youth, and individuals with mental illness.

MHAMD supported SB 257 (passed) to establish a task force to study and report on barriers and obstacles to pharmacy services facing patients leaving hospitals. Inability to quickly fill a prescription for a psychiatric or substance use medication could result in a lack of resolve to deal with the underlying behavioral health issue and a hasty return to the emergency department. MHAMD advocated successfully to add a behavioral health representative to the task force membership and the bill passed unanimously in both chambers.

Criminal Justice

As chair of the Mental Health and Criminal Justice Partnership (MHCJP), MHAMD supports all efforts to prevent recidivism and promote the successful reentry of ex-offenders. After a conference committee was unable to settle differences late last session, the Maryland Second Chance Act (SB 1056 / HB 1166 (failed)) was introduced again this year to allow individuals to request that records related to certain nonviolent misdemeanors be shielded from public view three years after completion of their sentence. Shielding nonviolent convictions after a defined period of time increases employment opportunities for ex-offenders, thereby lowering recidivism and increasing public safety. The Act passed both the House and Senate again this year in different forms. Unfortunately, a conference committee was never appointed, differences were never addressed, and the bill died on the last day of session.