Maryland General Assembly
Joint Committee on Behavioral Health and Opioid Use Disorders
2016 Interim
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THE MARYLAND GENERAL ASSEMBLY
ANNAPOLIS, MARYLAND 21401

JOINT COMMITTEE ON BEHAVIORAL HEALTH AND OPIOID USE DISORDERS

December 7, 2016

The Honorable Thomas V. Mike Miller, Jr., Co-Chairman
The Honorable Michael E. Busch, Co-Chairman
The Honorable Members of the Legislative Policy Committee

Ladies and Gentlemen:

The Joint Committee on Behavioral Health and Opioid Use Disorders was established by Chapter 464 of 2015. The purposes of the joint committee are to review the final report of the Governor's Heroin and Opioid Emergency Task Force; review and monitor the activities of the Governor's Inter-Agency Heroin and Opioid Coordinating Council; monitor the effectiveness of the State's Overdose Prevention Plan, local overdose prevention plans, and strategic planning practices to reduce prescription drug abuse in the State; and enhance overdose response laws, regulations, training, and local overdose fatality review teams. The joint committee is required to identify areas of concern and, as appropriate, recommend corrective measures to the Governor and General Assembly. The joint committee met twice during the 2016 interim and is pleased to present its 2016 annual report.

The joint committee held its first briefing on August 24, 2016. The joint committee heard presentations from the Department of Health and Mental Hygiene (DHMH) on the implementation planning for the certification of recovery residences; DHMH on the status of the Mental Institutions for Mental Disease (IMD) Waiver; and DHMH and the Department of Public Safety and Correctional Services (DPSCS) on DHMH's removal of Suboxone film from the Maryland Medicaid Pharmacy Preferred Drug List.

Dr. Barbara J. Bazron, Executive Director of the Behavioral Health Administration (BHA) within DHMH, and Ms. Marian V. Bland, Deputy Director of the clinical services division of BHA, provided a presentation to the joint committee on recovery residences. The average number of people in a recovery residence is from 4 to 10, with an average length of stay of 90 days. In order to implement recently enacted legislation, DHMH will chose a credentialing entity that will be either BHA, a core service agency, a local addictions agency, or a combination of the three.

All recovery residences are State-funded, and the only limitation on residents is that there must be a minimum of four. There is no legal requirement for notifying a community that a recovery residence is to be opened, but there is a good neighbor policy to notify the neighborhood and inform neighbors of their grievance policy.

The IMD exclusion prohibits states from receiving federal matching dollars for services provided by IMDs for individuals between 21 and 64 years old. An IMD is a facility with more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases and chemical dependency disorders.

Ms. Shannon M. McMahon, Deputy Secretary for Health Care Financing in DHMH, provided a presentation to the joint committee on the status of the federal IMD waiver. Deputy Secretary McMahon noted that there have been some recent exceptions from the prohibition of Medicaid payment for IMD services. In June 2016, DHMH submitted a request to the federal government to cover IMD services for substance use disorder treatment through its Section 1115 waiver renewal. The request asks for federal matching funds for the American Society of Addiction Medicine deemed, clinically managed, medium and high intensity residential services as well as inpatient withdrawal. Although DHMH is in the early stages of conversations, Deputy Secretary McMahon is confident that the 1115 waiver renewal will include the requested coverage.

DHMH's removal of Suboxone film from the Medicaid pharmacy preferred drug list was controversial among providers who argued that such removal disrupts the clinical care of patients. A reason stated for the removal of the film from the list was the smuggling of the product into prisons. The joint committee was briefed on the issue by Deputy Secretary McMahon, Dr. Lisa A. Burgess, Chief Medical Officer of Health Care Financing in DHMH, Secretary of Public Safety and Correctional Services Stephen T. Moyer, Mr. Steven F. Geppi, Director of Investigation, Intelligence, and Fugitive Apprehension in DPSCS, and Dr. Sharon L. Baucom, Chief Medical Director of DPSCS.

The joint committee heard a presentation that described the Pharmacy and Therapeutics Committee and the process it used in removing Suboxone film from the preferred drug list. Three options were considered for Suboxone coverage with the committee unanimously recommending that Zubsolv tablets be the preferred method of providing Suboxone rather than the film. Suboxone film is still available through a prior authorization process. According to DHMH, provider outreach regarding the change was provided through provider alerts, faxes, and letters. Effective July 1, 2016, Zubsolv singular tablets became preferred, and Suboxone singular film became nonpreferred on the Medicaid fee-for-service preferred drug list.

DPSCS also provided information to the joint committee on the removal of Suboxone film from the Medicaid preferred drug list. According to DPSCS, the films are being smuggled into DPSCS facilities at an alarming rate, and films are the most prevalent form of contraband because

they are easily concealed. In calendar 2014, 2,875 strips were recovered, and in calendar 2015, 3,689 strips were recovered. According to DPSCS, on the black market, a strip is worth $5, and in prison, a strip is worth $100. Selling of the film has led to assaults in facilities.

There was a five-month transition period for providers and patients to adjust to the change from Suboxone film to Zubsolv tablets. The committee that made the decision to change from Suboxone film to Zubsolv tablets worked from financial information, clinical information, and knowledge of the smuggling issue. Concerns were expressed that if most prior authorization requests are being granted, then the smuggling issue is not going to be resolved. DHMH stated that it is too early in the process to know the effect on the smuggling issue.

The joint committee held its second briefing on November 2, 2016. The joint committee heard presentations from DHMH and the Governor's Office of Crime Control and Prevention (GOCCP) on the Governor's Inter-Agency Heroin and Opioid Coordinating Council; DHMH on a report on the feasibility and desirability of analyzing Prescription Drug Monitoring Program (PDMP) data, as required by Chapter 147 of 2016; DHMH on an update on their opioid treatment program work plan; DHMH and DPSCS on an additional update on the removal of Suboxone film from the Medicaid preferred drug list; and the Maryland Hospital Association (MHA) on MHA's behavioral health environmental scan.

Secretary Van T. Mitchell, DHMH, and Mr. V. Glenn Fueston, Executive Director, GOCCP, discussed the status of the Governor's Inter-Agency Heroin and Opioid Coordinating Council. Secretary Mitchell is recommending that the executive director chair the council and would like to see greater collaboration between health programs and law enforcement. Mr. Fueston has assigned staff to each of the 33 recommendations of the task force that advised the council and will require performance measures on each of the council's recommendations.

The joint committee asked Secretary Mitchell for an update on the statewide needle exchange program that was enacted this year. DHMH is in the process of working with local health departments that want to move forward with a program. In addition, regulations have been drafted and are being reviewed by DHMH. According to Secretary Mitchell, there is interest among local health departments in establishing programs, and local health officers are glad to have that additional tool to combat substance abuse.

Dr. Bazron, and Ms. Kate Jackson, Manager, PDMP, reported on the feasibility and desirability of analyzing prescription drug monitoring program data. Dr. Bazron reported that the provider community wants to use PDMP data to improve quality of care and would like to use the data to enhance clinical outcomes. She also stated that Maryland is far ahead of most other states regarding implementing a PDMP. Ms. Jackson relayed that the predictive risk model is designed so that providers do not see criminal history of a patient. In addition, DHMH has a training video about the PDMP, and provides information on the Chesapeake Regional Information System for Our Patients (CRISP) policies and on how to navigate in CRISP.

Dr. Bazron and Ms. Kathleen Rebbert-Franklin, Deputy Director, Office of Population Based Behavioral Health, DHMH, provided an update on the DHMH opioid treatment program work plan. Dr. Bazron ended the presentation by stating that DHMH will be submitting a final report to the Senate Finance Committee and the House Health and Governmental Operations Committee by January 1, 2017.

Deputy Secretary McMahon, Dr. Burgess, Secretary Moyer, and Mr. Gary McLhinney, Director of Professional Standards, DPSCS, provided a further update on the removal of Suboxone film from the Medicaid preferred drug list. DPSCS has seen a 67% decline in recovery of Suboxone films since removing Suboxone film from the Medicaid preferred drug list in July 2016, and are continuing to monitor the numbers. Suboxone film is still an issue because prisoners use it to get high "behind the fence," and when an individual has contraband behind the fence, this gives the prisoner power and creates problems for inmates and staff. All of the recent Eastern Shore Correctional Institution indictments involved Suboxone film.

Mr. Steven C. Snelgrove, President, Howard County General Hospital, Chair of MHA's Behavioral Health Task Force, and Ms. Nicole Dempsey Stallings, Vice President for Policy and Data Analytics, MHA, reported on MHA's behavioral health environmental scan. The purpose of the scan is to reduce behavioral health readmissions. Although behavioral health readmissions are not the biggest threat to the State's Medicare waiver, such readmissions are significant enough for MHA to form a task force. Ms. Stallings reported that the scan is just a starting point, MHA is aware that more stakeholder input is needed, and that MHA would like to work closely with community health providers and local health improvement coalitions in the future.

The joint committee held two very informative and comprehensive briefings during the 2016 interim. We wish to thank the committee members for their participation, the many individuals who briefed the committee, and committee staff for their support.

Sincerely,

Kathy Klausmeier

Senator Katherine Klausmeier
Senate Chair

Peter A. Hammen

Delegate Peter A. Hammen
House Chair

KK:PAH/ERH:DAS/kmc

cc: Mr. Ryan Bishop
Mr. Warren G. Deschenaux
Ms. Carol L. Swan