Part J
Health

Public Health – Generally

Medical Assistance

Medical Assistance for Adults

Approximately 10.4 percent (559,325) of all Maryland residents are uninsured. Of the uninsured in Maryland, 49 percent are age 19 to 39, and 30 percent are age 40 to 64. Maryland ranks forty-first among the 50 states in Medicaid coverage for adults. Approximately 185,000 adults are currently covered by the Medicaid program, 76 percent of whom are blind, aged, or disabled. ***House Bill 762 (passed)*** requires the Department of Health and Mental Hygiene (DHMH) to conduct a comprehensive review of certain health care services currently offered to adults under the Medicaid program and to identify mechanisms through which the programs and services can be consolidated. The bill requires DHMH to use the information obtained from the comprehensive review to seek approval of a waiver from the Centers for Medicare and Medicaid Services (CMS) in order to access federal matching funds to implement the Primary Adult Care Network (network). If the waiver is approved, the network will provide a health care benefit package offering primary and preventive care to indigent and medically indigent adults.

Medicaid Home- and Community-based Waivers

Medicaid home- and community-based waivers allow individuals to receive long-term care services in the community rather than in an institutional setting. ***House Bill 478 (passed)*** prohibits DHMH from denying an individual access to a home- and community-based services waiver due to a lack of funding for the waiver services if (1) the individual is living in a nursing home at the time of the waiver services application; (2) the nursing home services for the individual were paid by the Medicaid program for at least 30 consecutive days immediately prior to the application; (3) the individual meets all eligibility criteria for participation in the home- and community-based services waiver; and (4) the home- and community-based services provided to the individual would qualify for federal matching funds in the Medicaid program.

Maryland Children's Health Program

***House Bill 935* (passed)**, the Budget Reconciliation and Financing Act, repeals the Maryland Children's Health Program Private Option Program. The 200 children enrolled in the employer-sponsored program will instead enroll with a managed care organization. In addition, the bill implements actions taken in the budget by requiring, for fiscal 2004 only, that enrollees with incomes between 185 percent and 200 percent of poverty must pay a family contribution equal to 2 percent of the annual income for a family of two at 185 percent of poverty.

Prescription Drugs

Maryland Pharmacy Assistance Program

The Maryland Pharmacy Assistance Program (MPAP) provides prescription benefits for low-income individuals who make less than $10,417 per year and have assets that are not more than 1.5 times the amount of assets allowed by Medicaid. MPAP provides coverage for all prescription drugs covered in the Medicaid program. Enrollees must pay a $5 copayment for each prescription. In 2002, DHMH received waiver approval from CMS to include MPAP under the Medicaid program in order to receive matching federal funds.

The waiver also permits Qualified Medicare Beneficiaries (QMBs) to enroll in MPAP. QMBs are individuals with incomes below 100 percent of the federal poverty guidelines (FPG). ***House Bill 17* (passed)** changes asset and income requirements for MPAP to permit married QMBs up to 100 percent FPG to enroll in MPAP and provide them with prescription drug coverage. Currently, married QMBs earning more than 92 percent FPG may not enroll in MPAP. The bill will enable approximately 200 additional individuals to enroll in MPAP.

***House Bill 950* (passed)** changes the copayment requirement in MPAP from $5.00 per prescription to $2.50 per generic drug or brand name drug on a preferred drug list and $7.50 for a brand name drug not on a preferred drug list.

Senior Prescription Drug Program

The Short-Term Prescription Drug Subsidy Plan provides drug coverage to all Medicare-eligible residents over 65 and individuals who have annual household incomes at or below 300 percent of FPG. Enrollment is limited to 30,000 enrollees. Enrollees pay a $10 monthly premium and have copayments ranging from $10 to $35, based on the type of drug prescribed. There is a $1,000 annual benefit limit for each enrollee. The plan was scheduled by law to terminate on June 30, 2003. As of that date, plan enrollees would be transferred to the new Senior Prescription Drug Program. Created by Chapter 153 of 2002, the Senior Prescription Drug Program offers the same benefits as the plan but is funded by CareFirst BlueCross BlueShield, which must deposit in the program's account an amount sufficient to fund the program.

However, ***Senate Bill 450*/*House Bill 211* (Chs. 3 and 4)** repeal the enrollment cap of 30,000 enrollees in the Short-Term Prescription Drug Subsidy Plan and permit the plan to enroll

the maximum number of individuals eligible for enrollment, subject to available funds. According to CareFirst, there were 29,623 enrollees as of January 26, 2003. As of April 1, 2003, $9.8 million remained available for new enrollees. With enrollment nearing the 30,000 cap, the bills permit CareFirst to immediately enroll more individuals and spend down the fund balance.

Medbank

The Medbank program assists low-income individuals who lack prescription drug coverage by accessing medically necessary prescription drugs through patient assistance programs sponsored by pharmaceutical drug manufacturers. ***Senate Bill 334*/*House Bill 143* *(both passed)*** extend the June 30, 2003, termination date for the Maryland Medbank Program to June 30, 2006, and transfer the Medbank program from the Maryland Health Care Foundation to Medbank of Maryland, Inc.

The Budget Reconciliation and Financing Act, ***House Bill 935* *(passed)***, alters the allowable uses of the fund for fiscal 2004 through 2006 from the HealthChoice program to the Medbank program. Allocations to Medbank are capped at $1.2 million in fiscal 2004, $1 million in fiscal 2005, and $0.5 million in fiscal 2006. An additional $800,000 was provided for Medbank in fiscal 2004 through a supplemental appropriation.

Maryland Pharmacy Access Hotline

Senate Bill 676*/*House Bill 363* *(both passed) require DHMH to use existing resources to establish a toll-free Maryland Pharmacy Access Hotline that operates during regular business hours. DHMH must distribute to all Medicaid program recipients information about the hotline, which must clearly state (1) the toll-free telephone number of the hotline; and (2) that the Medicaid recipient should call the number if the recipient is having problems getting necessary medicines. DHMH must notify all health care providers who participate in the Medicaid program about the hotline.

Mental Health

Reimbursement for Outpatient Mental Health Treatment

An individual with dual eligibility has both Medicare and Medicaid coverage. When such an individual receives outpatient mental health treatment, Medicare and Medicaid only reimburse 62.5 percent of the total bill. ***Senate Bill 209*/*House Bill 675* *(both passed)*** require Medicaid to reimburse an outpatient mental health care provider the entire amount of the Medicaid program fee for outpatient mental health treatment provided to a dually eligible individual, including any amount ordinarily withheld as a psychiatric exclusion and any copayment not covered under Medicare. Medicaid expenditures could increase by $1.68 million ($937,800 general funds, $787,800 federal funds) in fiscal 2004. The bill specifies that it is the intent of the General Assembly that the Mental Hygiene Administration of DHMH is to fund the provisions through existing resources by reprioritizing existing grant funds.

Early Childhood Mental Health Services

***House Bill 360* (passed)** codifies an Early Childhood Mental Health Services Pilot Program in Baltimore City and the Eastern Shore, contingent upon the State receiving federal or other sources of funds before July 1, 2003. The bill expires December 31, 2007. The pilot program must provide mental health screening and consultation services for children under age six who are in early childhood programs or in licensed or registered child care facilities and to licensed or registered child care providers.

Petitions for Emergency Evaluation

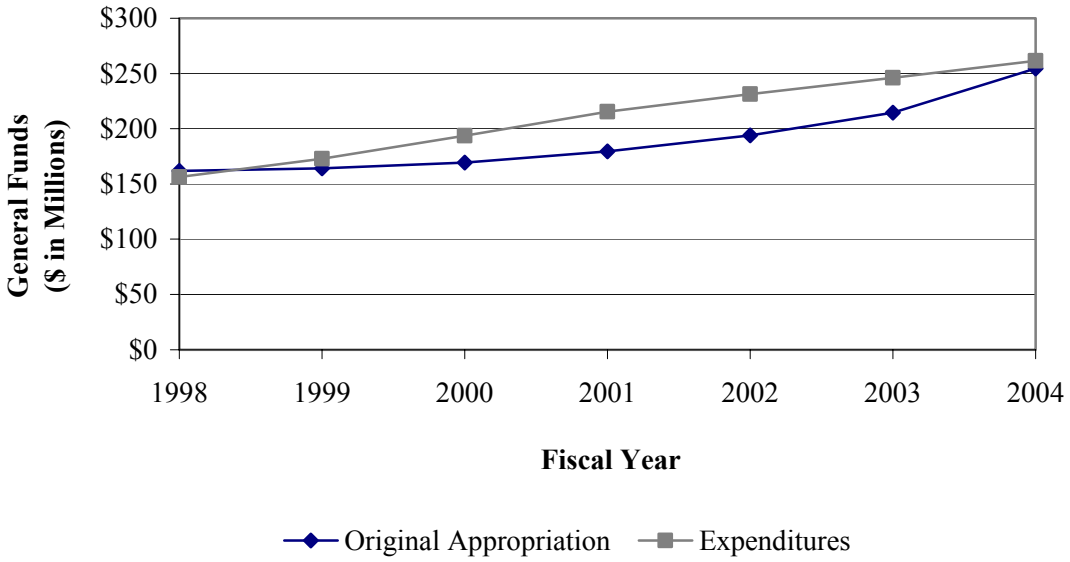
***Senate Bill 273*/*House Bill 668* (both passed)** alter the standard for a petition for emergency evaluation of an individual with a mental disorder to bring the standard in line with the standard for involuntary commitment. The bills replace the current standard requiring a petitioner to believe there is a clear and imminent danger of an individual doing bodily harm to the individual or another with the new standard requiring the petitioner to believe the individual presents a danger to the life or safety of the individual or others. The bills broaden the information on which a health professional or a peace officer can base the petition by adding any information that is pertinent to the factors giving rise to the petition.

Mental Health Funding

For the past three sessions, much of the discussion surrounding community mental health services funded through the Mental Hygiene Administration focused on the significant deficit in that program. The legislature has provided one-time funding to address these deficits: proceeds from a Tax Amnesty Program in 2001; and higher than anticipated disproportionate share payments in 2002. However, these one-time solutions did not resolve the structural deficit.

The Fiscal 2004 Budget for the Mental Hygiene Administration included a $120 million increase for community mental health services ($60 million in both general and federal funds). Half of these funds were introduced as a fiscal 2003 deficiency, the remainder applied to fiscal 2004. Based on the Department of Legislative Services' estimates of funding requirements, there are still potentially significant shortfalls in fiscal 2003 (as much as $20 million). However, as shown in **Exhibit J-1**, the fiscal 2004 appropriation did come close to addressing the structural deficit.

Exhibit J-1
The Community Services Structural Deficit
Fiscal 1998 through 2004



Note: Fiscal 2002 through 2004 expenditures are DLS estimates.

Source: Department of Legislative Services

Developmental Disabilities Administration Funding

The Developmental Disabilities Administration is responsible for the statewide system of services provided to individuals with a mental or physical impairment manifested before age 22 resulting in substantial functional limitations in major life activities and that are likely to continue indefinitely. The budget for the Developmental Disabilities Administration will grow by $32 million in fiscal 2004. The increase is the result of several recent initiatives intended to increase access to and quality of community services.

The first initiative, the Waiting List Initiative, was scheduled to conclude after fiscal 2003. The Governor provided $15.3 million for the expansion of community services, including transitioning youth and emergency placements, an amount sufficient to extend the initiative through fiscal 2004. The General Assembly reduced funds for expansion by $4.3 million, leaving funding sufficient to expand services to an estimated 1,000 individuals in fiscal 2004.

Fiscal 2004 also marked the second year of an initiative to increase wages for community direct service workers. Concern that direct care workers employed by community providers

were not being compensated at the rate of employees in State residential centers led to legislation, enacted in 2001, to eliminate the wage disparity over a five-year period. The General Assembly reduced funding for the initiative by 10 percent, from $16.1 million to $14.6 million. Language in the Budget Reconciliation and Financing Act of 2003 requires the difference to be made up in the next fiscal year.

The remainder of the increase provides funds for the annualization of fiscal 2003 community placements and deinstitutionalization.

Consent to Health Care Treatment for a Child

***Senate Bill 31* (passed)** allows a relative of a child providing "informal kinship care" to consent to health care on behalf of the child. The relative must verify the informal kinship care relationship through a sworn affidavit filed with the Department of Human Resources' Social Services Administration. The relative may apply for medical and public assistance entitlements eligible to the child. An affidavit does not abrogate the parent's or guardian's right to consent to health care on behalf of the child in a future health care decision.

Informed Consent for HIV Testing

Often when exposure to HIV/AIDS occurs between a patient and a health care provider, the patient is unable to give consent to HIV testing because the patient is critically ill or dies before being able to give consent. ***House Bill 343* (passed)** requires a hospital to order an HIV test, under specified circumstances, if there has been an exposure between a patient and a health care provider or between a patient and a first responder before the patient is admitted to a hospital.

Specifically, a hospital is required to order an HIV test if (1) informed or substitute consent of the patient was sought and the patient was unavailable or unable to consent; (2) the "exposed" health care provider promptly notified the hospital of the incident or the first responder promptly notified the jurisdiction's medical director and the medical director promptly notified the hospital where the patient is admitted; (3) the health care provider or first responder gave informed consent and submitted a blood sample; and (4) the hospital determined that testing the patient for HIV would be helpful in managing the provider's or responder's risk of disease and health outcome. A hospital must notify the patient of the test results and, if the results are positive, provide or arrange for counseling and treatment recommendations for the health care provider or first responder and patient. The hospital may not document the test in either the patient's, the provider's, or the responder's medical records. Instead, the hospital must keep a confidential record or incident report of these tests. Hospitals must pay for the HIV testing costs.

Alcohol and Drug Abuse

The Alcohol and Drug Abuse Administration (ADAA) of DHMH currently provides grant funding directly to local health departments for third-party substance abuse prevention and treatment programs. Local health departments are authorized by ADAA to take a percentage of

the grant to cover the administrative costs of supervising third-party grantees. In addition, it can take up to 4 to 12 weeks in some jurisdictions to release funds to the programs.

House Bill 465 ***(passed)*** allows the Baltimore City Health Department to designate a nonprofit or quasi-governmental entity to receive funds from ADAA to plan, manage, monitor, and disburse funds to substance abuse prevention and treatment programs. ADAA must disburse funds budgeted to the health department for these services directly to the designees.

Vital Record Fees

House Bill 935, the Budget Reconciliation and Financing Act, adds $6 to current fees charged for copies and searches of vital records and expands the records for which a fee can be charged. Together these actions will generate $4.35 million that accrues to the general fund. Maryland's current fees rank in the bottom quintile nationwide, and the scope of records for which fees are charged is also limited relative to other states.

Certificate of Birth Resulting in Stillbirth

Parents of stillborn children born after a 20-week gestation period receive a certificate of fetal death. ***House Bill 272*** ***(passed)*** requires the Secretary of Health and Mental Hygiene to establish procedures to issue a certificate of birth resulting in stillbirth. DHMH must make available a certificate to the parent or parents of a stillborn child for whom a fetal death was registered. A reference to the stillborn child's first name may not be put on the certificate if the parent or parents do not wish to provide one. DHMH must establish procedures for issuing a certificate to the parent or parents of a stillborn child who received a certificate of fetal death prior to June 1, 2003.

Food Products

During the legislative session of 2002, the Governor vetoed legislation that would have allowed the Secretary of Health and Mental Hygiene to establish a sell-by period for Grade A milk products of up to 17 days. In his veto message, the Governor stated that the milk product sell-by period should not be extended for up to three days "until we are absolutely certain that there is no possibility of adverse health impacts." The International Dairy Foods Association reports that advancements in milk processing and packaging have extended the shelf life of milk to 18 to 21 days. ***House Bill 357*** ***(passed)*** requires the Secretary of Health and Mental Hygiene to adopt regulations that establish the sell-by period for Grade A milk products before they are purchased by or delivered to the consumer.

Breast-feeding

Within the past eight years, 31 states have enacted a variety of breast-feeding legislation: 17 states allow mothers to breast-feed in any public or private location; 13 states exempt breast-feeding from public indecency laws; 9 states have laws related to breast-feeding in the workplace; 5 states exempt breast-feeding mothers from jury duty; and 4 states have

implemented or encouraged the development of a breast-feeding awareness education campaign. ***Senate Bill 223*** ***(passed)*** grants a mother the right to breast-feed her child in any public or private location in which the mother and child are authorized to be and forbids a person from restricting or limiting the right of a mother to breast-feed her child.

Health Care Disparities

According to the Institute of Medicine's report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, racial and ethnic minorities tend to receive a lower quality of health care than nonminorities, even when access-related factors, such as patients' insurance status and income, are controlled. ***House Bill 883*** ***(passed)*** specifies that it is the intent of the General Assembly to encourage courses or seminars that address the identification and elimination of health care services disparities of minority populations as part of (1) curriculum courses or seminars offered or required by institutions of higher education; (2) continuing education requirements for health care providers; and (3) continuing education programs offered by hospitals for hospital staff and health care practitioners. The bill also requires DHMH, in consultation with the Maryland Health Care Foundation, to develop and implement a plan to reduce health care disparities based on gender, race, ethnicity, and poverty.

Miscellaneous Program Changes

Maternal Mortality Review Program

Chapter 74 of 2000 established the Maternal Mortality Review Program to review maternal deaths and to develop strategies for the prevention of maternal deaths. ***Senate Bill 688***/***House Bill 981*** ***(both passed)*** repeal the September 30, 2003, termination date for the Maternal Mortality Review Program within DHMH and direct the future work of the program.

Lead Poisoning Tests for Children

The Governor's Initiative on Lead Poisoning Prevention reported in August 2002 that there is not a process within the pubic schools or local health departments to react to results from children's lead poisoning test results. In response, ***House Bill 819*** ***(passed)*** modifies the requirements for reporting lead poisoning test results when a child enters a public prekindergarten program, kindergarten program, or first grade. To make follow-up with untested children easier, the bill requires each program or school to supply contact information to the local health department for each child for whom certified documentation of a lead poisoning test is not provided. Documentation must be provided on forms developed by DHMH.

Task Forces/Councils

Hepatitis C is an inflammation of the liver caused by a virus. The Centers for Disease Control and Prevention (CDC) report that there are an estimated 3.9 million people in the United States who are currently infected with the Hepatitis C virus. ***Senate Bill 519***/***House Bill 386*** ***(both passed)*** create a State Advisory Council on Hepatitis C to review and recommend changes

to DHMH's existing "Maryland Hepatitis C Prevention Plan." The advisory council is also charged with soliciting grants from federal, local, private, or other resources to implement the plan. The advisory council will sunset on September 30, 2005.

The Council on Management and Productivity was asked by the Glendening Administration in the fall of 2001 to assess DHMH's organizational capacity in meeting its current mandates and planning for the future. The council, after meeting with members of the Administration, legislators, health professionals, vendors, and others, assembled a list of organizational options and recommended that more specific options for organization be made. ***House Bill 761*** ***(passed)*** establishes a 21-member Task Force to Study the Reorganization of DHMH to identify ways to improve the delivery of health and mental health services to residents of the State and study the effects of moving specified programs out of DHMH. The task force must report its findings to the General Assembly by December 1, 2004.

House Bill 433 ***(passed)*** creates the Task Force on the Needs of Persons with Co-Occurring Mental Health and Substance Abuse Disorders. The task force is charged with identifying and recommending creative ways to provide and deliver comprehensive, integrated, cost-effective services to individuals with co-occurring disorders.

Senate Bill 153 ***(passed)*** creates the Task Force to Study Health Regulations for Bed and Breakfast Operators. The task force shall (1) study the health regulations that govern bed and breakfast operators; (2) study the advantages and disadvantages of requiring a commercial or stainless steel kitchen when serving a hot meal; (3) compare State health regulations with health regulations in other states that govern bed and breakfast operators; and (4) make recommendations regarding the need for a commercial or stainless steel kitchen when serving a hot breakfast and the need for a change in current regulation of bed and breakfast operators. The task force must report its findings by December 30, 2003.

Health Occupations

Board of Physician Quality Assurance

During the interim of 2001, the Department of Legislative Services (DLS) conducted a full evaluation of the State Board of Physician Quality Assurance (BPQA) in accordance with the Maryland Program Evaluation Act (Sunset Law). The sunset evaluation called for major changes to the statutes that govern the licensure of physicians in the State. The DLS recommendations included lowering the standard by which factual findings are reached in a disciplinary case; contracting with an entity or entities for peer review services rather than using the Medical and Chirurgical Faculty of the State of Maryland (MedChi); changing the composition of the board; and revising the use of corrective action agreements. Most of the DLS recommendations were incorporated into Senate Bill 613 and House Bill 846 of 2002. However, both bills failed, ultimately due to a disagreement regarding the proper standard of proof.

Before this impasse was surmounted, ***Senate Bill 774*** ***(failed)*** was introduced to go into effect contingent upon the failure of ***Senate Bill 500*** ***(passed)*** which reflects the DLS

recommendations from the sunset evaluation. Since BPQA was scheduled to terminate on July 1, 2003, ***Senate Bill 774*** was designed to ensure that a physician licensing scheme would be in place in Maryland. However, a compromise was eventually reached with regard to the standard of proof for the discipline of physicians and select other health professionals. In addition to changing the name of the board from the State Board of Physician Quality Assurance to the State Board of Physicians, the major components of ***Senate Bill 500*** are as follows:

Evidentiary Standards for Disciplinary Hearings

- ***Clear and Convincing:*** The evidentiary standard for disciplinary hearings for (1) a failure to meet the appropriate standard of care for the delivery of quality medical and surgical care; (2) a failure to meet appropriate standards for the delivery of respiratory care; and (3) a failure to meet appropriate standards for the delivery of quality radiation oncology/therapy technology care, medical radiation technology care, or nuclear medicine technology care remains clear and convincing.

- ***Preponderance of the Evidence:*** The evidentiary standard for disciplinary hearings for all other violations is by a preponderance of the evidence.

Peer Review/Physician Rehabilitation

- The bill repeals the requirement that the board use MedChi to provide physician rehabilitation and peer review services and instead authorizes the board to contract with a nonprofit entity or entities to provide these services.

- The bill includes the criteria for peer reviewers and the authority to grant extensions or make new contracts for failure to timely review.

- The entity or entities must use two peer reviewers, and in the event of a lack of agreement, the board must use a third peer reviewer to render a final decision.

Board Membership and Composition

- On July 31, 2003, the term of office of each member of the board will expire and the Governor, with the advice of the Secretary of Health and Mental Hygiene and the advice and consent of the Senate, must appoint a new State Board of Physicians.

- Board membership is increased from 15 to 21 members by adding more consumer members and specified providers.

Voting

- The vote required to initiate or dismiss a charge against a licensee is changed to a majority of its quorum from an affirmative vote of the full-authorized membership of the board.

Public Individual Profiles

- The board must maintain a public profile on each licensee that includes information regarding (1) the number of final medical malpractice court judgments against the licensee within the most recent ten-year period; and (2) the number of medical malpractice settlements, if numbering three or more, with a settlement amount of $150,000 or greater within the most recent five-year period.

Reports

- The board must report to the Governor and specified committees by January 1, 2004, on investigative caseloads of board investigators.

- The board also must report, with the Department of Health and Mental Hygiene, to specified committees by December 1 of 2003, 2004, and 2005 on the implementation of the bill's changes to the licensure and regulation of physicians and other allied health professionals.

Office-based, Medication-assisted Opioid Addiction Therapy

A new prescription medication, buprenorphine, can be used to treat addiction to opioids, such as prescription painkillers and heroin. Unlike other medications available to treat addiction, buprenorphine can be prescribed by physicians in their own offices. The federal Drug Abuse Treatment Act of 2000 permits qualified physicians to provide this medication in an office setting after obtaining a waiver from the provisions of the federal Controlled Substances Act from the Substance Abuse and Mental Health Services Administration. Twenty-two Maryland physicians have obtained a waiver. In order to qualify for a waiver, a licensed physician must meet one or more of a list of criteria, including "has such other training or experience as the State medical licensing board … considers to demonstrate the ability of the physician to treat and manage opiate-dependent patients." ***Senate Bill 224 (passed)*** requires BPQA to establish or designate a program to facilitate the attainment of this waiver.

Dentists and Dental Hygienists

Supervised Practice in a Private Dental Office

A dental hygienist may practice only under the supervision of a licensed dentist who is on premises and available for consultation while the hygienist is working. However, when a dental hygienist performs procedures in a federal, State, or local government-owned and operated

dental facility or a State or county public health department, the hygienist may practice under the general supervision of a dentist, where the dentist may or may not be present. ***Senate Bill 225*/*House Bill 230* *(both passed)*** allow an active licensed dental hygienist with at least 1,500 hours of clinical practice in direct patient care to provide services in a "private dental office" without the supervising dentist on the premises under certain conditions.

Volunteer Licenses

Senate Bill 341* *(passed) creates a volunteer dentist license and a volunteer dental hygienist license. To qualify for the volunteer licenses, an applicant must (1) meet the board's requirements for a general license to practice dentistry or a general license to practice dental hygiene; (2) hold an active license to practice dentistry or dental hygiene in another state or the District of Columbia; (3) meet certain practice restrictions; and (4) meet specified examination requirements. Under these circumstances, an applicant for a volunteer license may not be required to pay a fee.

Examination Requirements for Licensure

***Senate Bill 414* /*House Bill 334* (*both passed*)** allows an applicant for a dental license who is licensed in another state and has passed a regional dental board examination to receive a license in Maryland if the applicant also passes a comprehensive examination on applied clinical diagnosis and treatment planning and passes a law examination. A dentist licensed in another state who has not passed a regional dental board examination must be granted a license in Maryland if (1) for the preceding five years the dentist was practicing dentistry; and (2) the applicant passes a comprehensive examination on applied clinical diagnosis and treatment planning and a law examination given by or designated by the board.

State Board of Examiners for Audiologists, Hearing Aid Dispensers, and Speech-Language Pathologists

Senate Bill 588* *(passed) reduces the membership of the State Board of Examiners for Audiologists, Hearing Aid Dispensers, and Speech-Language Pathologists from 13 to 11 by removing the two physician members. No other health occupation board, with the exception of BPQA, has physician board members.

State Board of Social Work Examiners

Senate Bill 268*/*House Bill 310* *(both passed) reflects most of the DLS recommendations contained within the sunset evaluation of the board. The board is extended until July 1, 2014, and the bill requires another sunset evaluation on or before July 1, 2013.

State Board of Pharmacy

House Bill 684* *(passed) requires a pharmacist or a pharmacist's designee to inform consumers, to the best of the pharmacist's or the pharmacist designee's knowledge, of the

availability of a generically equivalent drug and the approximate cost difference as compared to the brand name drug.

State Board of Examiners in Optometry

***Senate Bill 387* (passed)** requires the Department of Health and Mental Hygiene to adopt regulations that govern the selling and dispensing of plano (colored) and zero-powered contact lenses. However, this requirement does not infringe upon the right of the State Board of Examiners in Optometry to regulate an optometrist who knowingly sells or dispenses contact lenses or replacement contact lenses without a valid and unexpired prescription.

State Board of Electrologists

***Senate Bill 269*/*House Bill 376* (both passed)** repeals the autonomous State Board of Electrologists and creates the Electrology Practice Committee under the regulatory purview of the State Board of Nursing. It specifies application procedures, licensure requirements, committee duties and responsibilities, and regulatory powers of the board. The bill takes effect July 1, 2003, and transfers all functions, powers, duties, equipment, revenues, assets, liabilities, fund balances, and records of the State Board of Electrologists to the Electrology Practice Committee within the State Board of Nursing.

Health Care Facilities Regulation

Maryland Trauma Physician Services Fund

In recent years, trauma centers both in Maryland and across the country have faced growing financial difficulties and a declining willingness among physicians to participate in the trauma system. Nationally, centers in such states as Pennsylvania, Nevada, and Oregon have been forced to temporarily close or downgrade their status due to staffing shortages, concerns about physician reimbursement, and rising medical malpractice insurance premiums. In Maryland, Washington County Hospital in Hagerstown was forced to suspend its trauma program in June 2002 due to the insufficient availability of trauma physicians to provide the required 24-hour staffing. Although the program reopened in October 2002, it was forced to downgrade from a Level II to a Level III trauma center. In recent months, Peninsula Regional Medical Center in Salisbury has expressed concerns about its ability to continue as a trauma center after July 1, 2003, due to similar staffing problems. Closures and downgraded status compromise access to trauma care services, resulting in diversions to other trauma centers and delays in care to patients that may make the difference between life and death.

Multiple factors threaten Maryland's trauma system, most significantly:

- financial burdens on trauma physicians (i.e., uncompensated care, insufficient reimbursement under Medicaid and managed care, and lost revenues);

- the challenge of maintaining physician commitment to trauma services;

- increasing medical malpractice insurance premiums; and

- the proportion of trauma costs captured in hospital rates.

To address the trauma physician funding issues, ***Senate Bill 479*** ***(passed)*** establishes the Maryland Trauma Physician Services Fund. The purpose is to subsidize the documented costs of:

- uncompensated care incurred by a trauma physician in providing trauma care to a trauma patient on the State Trauma Registry;

- undercompensated care incurred by a trauma physician in providing trauma care to an enrollee of the Maryland Medicaid program who is a trauma patient on the State Trauma Registry;

- a trauma center to maintain trauma physicians on call as required by the Maryland Institute of Emergency Medical Services Systems; and

- the Maryland Health Care Commission and the Health Services Cost Review Commission to administer the fund and audit reimbursement requests to assure appropriate payments are made from the fund.

The bill establishes a $2.50 annual surcharge on motor vehicle registrations to provide revenues for the fund; the surcharge is expected to raise between $10 and $12 million in fiscal 2004.

Nursing Homes and Electronic Monitoring – Vera's Law

Family members of nursing home residents have been advocating for several years to expand nursing homes residents' rights to include monitoring their care with electronic surveillance equipment. While electronic monitoring is allowed by law, the question has been whether to mandate that nursing homes allow electronic monitoring of patients. ***House Bill 149*** ***(passed)*** requires the Department of Health and Mental Hygiene (DHMH) to develop guidelines for a nursing home that elects to use electronic monitoring with the consent of a resident or the resident's legal representative. DHMH must report on the guidelines by December 1, 2003, to the Senate Finance Committee and the House Health and Government Operations Committee.

Nursing Home Third Party Liability Reviews and Audits

Senate Bill 550/***House Bill 553*** ***(both passed)*** require DHMH to conduct a third party liability review of the credit balances of each nursing home that receives payment from the Medical Assistance program (Medicaid). The audits ensure that third party payors, such as health insurance and Medicare, cover the appropriate share of a resident's care so that these fees are not inappropriately charged to Medicaid. Nursing homes will be allowed to appeal audit findings when certain conditions are met.

Medicaid Payment for Reserved Beds in Nursing Facilities

Chapters 382 and 383 of 1999 changed the nursing home reimbursement formula in Medicaid to exclude payment for nursing services if a nursing home patient is absent from the nursing home due to hospitalization for an acute condition. The provisions terminated June 30, 2002. As a result of Chapters 382 and 383 of 1999, DHMH adjusted the Medicaid rate formula under the nursing services cost center to increase payments for nursing services based on the savings it experienced from not having to pay for nursing services when a patient was absent from the nursing home. Even though the law was abrogated June 30, 2002, DHMH has continued to use the adjusted rate formula.

House Bill 1009 ***(passed)*** codifies the existing policy for Medicaid reimbursement to nursing homes for a patient who has been hospitalized for an acute condition but who is expected to return to the nursing home. Medicaid must continue to pay the nursing home for the patient's care but may not include payment for nursing services. The bill's provisions apply retroactively and affect payments made by DHMH to a nursing facility for a reserved bed on or after July 1, 2002.

Hospice Care Certificates of Need

Senate Bill 732 ***(passed)*** alters the certificate of need and licensing requirements for general hospice care programs. The jurisdictions in which a purchaser of a hospice program may provide home-based hospice services will be restricted to those jurisdictions in which the seller of the hospice program is licensed to provide home-based hospice services. Additionally, the Maryland Health Care Commission is prohibited from issuing a certificate of need that authorizes a hospice program to provide home-based hospice services on a statewide basis. Additionally, a hospice program is prohibited from providing home-based hospice services in a jurisdiction unless the hospice program, or an entity acquired by the hospice program, provided home-based hospice services to a patient in the jurisdiction during the 12-month period ending December 31, 2001. An exception to the preceding prohibition allows a hospice program to follow a patient from a hospital or other health facility, with which the hospice program has contracted to provide hospice care services.

The commission must conduct a study to clarify, and if necessary update, the existing status of certificates of need or determinations for hospice services in Maryland. The results of the study must be reported to the Senate Finance Committee and the House Health and Government Operations Committee by January 1, 2004.

Assisted Living Facilities – Third Party Accreditation Programs

DHMH licenses assisted living programs and inspects assisted living program facilities. DHMH delegates certain assisted living program and facility monitoring and inspection responsibilities to the Department of Aging and the Department of Human Resources, according to an interagency agreement. There are more than 2,000 assisted living facilities in Maryland, approximately half of which are licensed.

In an attempt to address some of the regulatory burden associated with assisted living facilities, ***Senate Bill 553/House Bill 824 (both passed)*** authorize DHMH to accept third-party accreditation reports as sufficient to meet the standards for renewing a license to operate an assisted living facility. DHMH and the assisted living industry must review its payment rates, study the cost of providing services, and consider reimbursement options, including an annual rate-setting formula based on the actual cost for assisted living services. DHMH must submit a report on its findings to the General Assembly by January 1, 2004. Additionally, DHMH must evaluate assisted living services in Maryland, in consultation with assisted living consumers and providers, and submit a report to the Senate Finance Committee and the House Health and Governmental Operations Committee by January 1, 2004.

Health Insurance

Nonprofit Health Service Plan Reform

On November 20, 2001, CareFirst BlueCross BlueShield, the State's largest nonprofit health service plan, announced its intention to convert to a for-profit company and subsequently be acquired by WellPoint Health Networks, Inc. Under State law, a nonprofit health service plan cannot convert to a for-profit entity unless the conversion is deemed to be in the public interest. The application was filed with the Maryland Insurance Administration on January 11, 2002. Maryland Insurance Commissioner Steven B. Larsen announced on March 5, 2003, that he had denied the CareFirst BlueCross BlueShield application to convert to a for-profit company and be acquired by WellPoint Health Networks, Inc. because the proposed transaction was not in the public interest due to several disqualifying factors.

CareFirst, as a nonprofit health service plan, receives favorable tax status from the State in exchange for providing community benefits. Over the past few years, CareFirst has exited from several health insurance markets, particularly those with medically fragile individuals such as those enrolled in the Medicare+Choice program and the Medicaid HealthChoice managed care program. In response to these actions and to focus CareFirst on its nonprofit mission, the General Assembly introduced two emergency bills, ***Senate Bill 772/House Bill 1179 (both passed)***, that specify a nonprofit health service plan's nonprofit mission as well as certain other criteria a nonprofit health service plan must meet in order to maintain favorable tax treatment, including: (1) requiring a nonprofit health service plan to commit to a nonprofit corporate structure and meet other requirements in order to receive and maintain a certificate of authority to sell insurance products in the State; (2) requiring a nonprofit health service plan to meet certain public purpose requirements in order to maintain its 2 percent premium tax exemption; (3) permitting a nonprofit health service plan to finance capital improvement projects through the Maryland Health and Higher Educational Facilities Authority and the Maryland Economic Development Corporation; (4) specifying the composition, goals, functions, and compensation of board members; (5) requiring compensation of officers, directors, and employees to be fair and reasonable; (6) directing the Insurance Commissioner to prohibit payment of compensation determined excessive; (7) altering the definition of an unsound or unsafe business practice and authorizing the Attorney General to take action against an unsound or unsafe business practice; and (8) creating a Joint Nonprofit Health Service Plan Oversight Committee within the General

Assembly to examine and evaluate the ability of nonprofit health service plans that carry the BlueCross BlueShield trademark to meet certain community health care needs.

The bills also ratify the Insurance Commissioner's ruling that the conversion of CareFirst to a for-profit entity is not in the public interest and that it is in the interest of Maryland citizens to protect and preserve CareFirst in its nonprofit form. A nonprofit health service plan that has filed an application for conversion and acquisition may not file again for a period of five years.

Disability Benefits

House Bill 499 ***(passed)*** requires the Maryland Insurance Commissioner to adopt regulations governing the processing of claims by an insurer that issues or delivers individual or group policies that include a disability benefit. The regulations must establish and maintain reasonable procedures for disability claim filings, including notification of an adverse benefit determination and the opportunity for an appeal. This bill will allow the Insurance Commissioner to enforce new federal Department of Labor regulations in Maryland's group market and also extend those regulations to the individual market.

Small Group Market Reform

The Comprehensive Standard Health Benefit Plan (CSHBP) was established in 1994 as a result of health care reforms adopted by the General Assembly to provide better access to coverage in the small group market at an affordable price. CSHBP is a standard health benefit package that carriers must sell to small businesses (50 or fewer employees). To enhance benefits, a carrier may offer riders to the standard plan. CSHBP includes guaranteed issuance and renewal, adjusted community rating with rate bands, and a prohibition on preexisting condition limitations. In order to maintain affordability, the average CSHBP premium rate must remain below 12 percent of Maryland's average annual wage.

Senate Bill 477 ***(passed)*** attempts to maintain affordability by clarifying that a carrier must, when offering CSHBP to small businesses (1) clearly distinguish the standard plan from other offerings of the carrier; (2) indicate the standard plan is the only plan required by State law; and (3) specify that all enhancements to the standard plan are not required by State law. In addition, the bill reduces the premium rate affordability cap for the standard plan from 12 to 10 percent of the average annual wage in Maryland.

The bill also requires the Maryland Health Care Commission (MHCC) to report to the General Assembly by December 1, 2003, on (1) the methodology used by MHCC in developing CSHBP; and (2) the feasibility of creating a basic plan in addition to the standard plan in the small group market. Other bills would have allowed preexisting conditions to be considered, expanded cost-sharing options, and authorized a basic health care plan reimbursement arrangement in addition to the standard benefit plan in the small group market.

Health Maintenance Organizations

***Senate Bill 687*/*House Bill 974* (both passed)** require an HMO to permit an enrollee to select a certified nurse practitioner as the enrollee's primary care provider if (1) the certified nurse practitioner provides services at the same location as the certified nurse practitioner's collaborating physician; and (2) the collaborating physician provides the continuing medical management required. An enrollee who selects a certified nurse practitioner as a primary care provider must receive the name and contact information of the collaborating physician. The bill's provisions may not be construed to require that an HMO include certified nurse practitioners on the HMO's provider panel as primary care providers.

Similar legislation has been before the General Assembly since 1997, when the Maryland Insurance Administration indicated that, in order for plans to recognize nurse practitioners as primary care providers, the HMO law needed to be amended to include nurse practitioners.

Task Force to Study Access to Mental Health Services

***House Bill 25*/*Senate Bill 252* (both passed)** create a 17-member Task Force on Access to Mental Health Services to study and make recommendations on various aspects of mental health coverage in the State, including the differences in mental health services coverage among the public mental health system, commercial insurers, and commercial HMOs. A 1999 Surgeon General report on mental health found that although 84 percent of Americans have some type of health insurance coverage, the mental health services available through the coverage vary widely.

Definition of Covered Service

***House Bill 656* (passed)** changes the definition of "covered service" for HMOs. A covered service is defined as a health care service included in the HMO's benefit package and rendered to an enrollee by (1) a provider under contract with the HMO, when the service is obtained in accordance with the terms of the enrollee's benefit contract; or (2) a noncontracting provider when the service is obtained in accordance with the terms of the enrollee's benefit contract, obtained pursuant to a verbal or written referral, or preauthorized or otherwise approved by the HMO or a provider that contracts with the HMO.

The bill also clarifies that for trauma care rendered to a trauma patient in a trauma center by a trauma physician, an HMO may not require a referral or preauthorization for a service to be covered. Prior to 2001, covered services included the preauthorization and referral requirements that this bill reinstates. Several bills have been passed by the General Assembly in the past few years that require HMOs to reimburse noncontracting trauma physicians at certain rates. In addition to specifying reimbursement rates for trauma physicians, Chapter 423 of 2001 changed the definition of covered services by repealing the referral or preauthorization requirements necessary for HMO reimbursement in order to clarify that services rendered by a trauma physician in a trauma center are deemed covered services, even if no referral or preauthorization was given. Due to the exigent nature of trauma services, preauthorization or referrals are not practical.

The unintended consequence of this repeal was to prohibit health care providers from balance-billing HMO enrollees who received services without a referral or preauthorization. By clarifying when a service is considered a covered service, a provider and enrollee will know when balance billing is permitted.

Repeal of the 2 Percent Premium Tax Exemption on HMOs

House Bill 753 ***(passed)*** imposes the 2 percent insurance premium tax on HMOs and managed care organizations (MCOs) that is currently imposed on all gross direct insurance premiums derived from business in Maryland. All health insurers, other than nonprofit health service plans, fraternal benefit societies, and HMOs currently are subject to the premium tax. Although an MCO is not considered an insurer, the gross receipts received by an MCO as a result of capitation payments made by the Department of Health and Mental Hygiene will be subject to the premium tax. Applying the 2 percent premium tax to these organizations could increase revenues by at least $48.9 million in fiscal 2004. A more detailed discussion of this bill can be found under Part A – Budget and State Aid of this *90 Day Report*.

Maryland Health Insurance Program and the Senior Prescription Drug Program

In 2002 the General Assembly created two programs to assist certain individuals obtain health insurance coverage or prescription drug coverage. The Maryland Health Insurance Program (MHIP) is an independent unit of the Maryland Insurance Administration whose purpose is to decrease uncompensated care costs by providing access to affordable, comprehensive health benefits for medically-uninsurable residents by July 1, 2003. The Senior Prescription Drug Program (SPDP) provides Medicare beneficiaries who lack prescription drug coverage with access to affordable, medically necessary prescription drugs until such time as an outpatient prescription drug benefit is provided through the federal Medicare program.

House Bill 803 ***(Ch. 1)*** makes several procedural changes to MHIP and SPDP in order to facilitate administration of the two programs. It repeals the provision requiring the Health Services Cost Review Commission (HSCRC) to determine and collect funds necessary to operate and administer MHIP. Instead, HSCRC only must calculate the hospital assessment that produces the amount of funds necessary to operate and administer MHIP. The Act clarifies that the MHIP board must collect the assessment.

The Act permits the MHIP board to allow the fund administrator to collect premiums from both MHIP and SPDP enrollees, deposit premiums in a separate account, titled in the name of the State of Maryland, and pay claims for the enrollees from the account. If monthly premiums collected by the administrator exceed monthly claims, the administrator must deposit the remaining balance, including interest, for that month into the MHIP fund by the fifteenth of the following month. The MHIP board, if it determines that a standard risk rate would create market dislocation, may adjust the premium rate based on member age. Currently, the premium rate may vary only on the basis of family composition.

The Act also clarifies that the amount CareFirst must deposit in the fund for SPDP may not exceed the value of its premium tax exemption for the previous calendar year.

Health Insurance Coverage Availability Act of 2003

In order to assist Bethlehem Steel retirees who lost health coverage due to the company's bankruptcy filing and subsequent acquisition, ***House Bill 1100*** ***(Ch. 2)*** makes several changes to MHIP and requires health insurance carriers who offer Medigap policies to offer them to certain eligible individuals. In February 2003, International Steel Group, Inc. announced its intention to purchase Bethlehem Steel which had previously filed for bankruptcy protection in 2001. Subsequent to the acquisition announcement, Bethlehem Steel announced that it planned to end health and life insurance benefits for retirees and dependents on March 31. This decision impacts over 19,000 Baltimore area retirees and their dependents.

The Act facilitates coverage for Bethlehem Steel retirees in two ways. It assists retirees who are eligible for Medicare by requiring a carrier that issues Medigap policies in the State to issue any Medigap policy the carrier sells to an individual eligible for Medicare if (1) the individual is enrolled under an employee welfare benefit plan that provides health benefits; (2) the employee welfare benefit plan in which the individual is enrolled terminates; (3) solely because of eligibility for Medicare, the individual is not eligible for credit for health insurance costs under the federal Internal Revenue Code (IRC) and enrollment in MHIP; and (4) the individual applies for the Medigap policy no later than 63 days after the employee welfare benefit plan terminates. Up to 4,000 Bethlehem Steel retirees and their dependents will be eligible for insurance coverage through MHIP. The Act also adds two members of the health insurance industry to the MHIP board and directs the Maryland Insurance Administration to request approval from the federal government for MHIP to be designated as the "alternate mechanism" under the Health Insurance Portability and Accountability Act.

The Act also permits retirees under 65 who are not yet eligible for Medicare to enroll in MHIP. To do this, the Act expands the definition of "medically uninsurable individual" for the purposes of MHIP eligibility to include a person who is eligible for the tax credit for health insurance costs under the federal IRC. The Federal Trade Adjustment Assistance Reform Act of 2002 allows certain individuals who are age 55 or older and receiving a pension benefit paid in whole or part by the Public Benefit and Guaranty Corporation to receive a tax credit for health insurance costs. The tax credit is equal to 65 percent of the amount paid by an eligible individual for coverage of the individual and certain family members under qualified health insurance coverage.

Medicare Supplement Contracts

House Bill 498 ***(Ch. 41)*** requires a health insurer, nonprofit health service plan, or fraternal benefit society (carrier) that offers a Medicare supplement policy Plan C or a Medicare supplement policy Plan I to an individual under age 65 but eligible for Medicare due to a disability to make the plans available to the individual if the individual submits an application during the six-month period following the individual's enrollment in Medicare Part B. Medical

supplement policies, also called Medigap policies, pay most, if not all, Medicare coinsurance amounts and may provide coverage for Medicare's deductibles. Carriers may only offer ten standardized plans, Plans A through J, so that consumers may easily compare prices and coverage levels. Some of the standard plans pay for services not covered by Medicare such as outpatient prescription drugs, preventive screening, and emergency medical care while traveling outside the United States.

Currently, there are few carriers in the Maryland market that offer a Medicare supplement policy Plan C, and only one carrier offers a Medicare supplement policy Plan I. Carriers have expressed concerns that the continuous open enrollment period encourages individuals to wait until they need medical care to purchase coverage. The Act's provisions attempt to make it more attractive to carriers to offer the Medicare supplement plans if the offerings are limited to the six-month period following the applicant's enrollment in Medicare Part B.

Provider Reimbursements

House Bill 894 ***(passed)*** requires that if an insurance policy, contract, or certificate awarded by an insurer or a nonprofit health service plan provides for reimbursement of a service that is within the lawful scope of practice of a licensed clinical professional counselor, licensed clinical marriage and family therapist, or licensed clinical alcohol and drug counselor, the insured or any other covered person is entitled to reimbursement for the service. Current law has been interpreted by some carriers to mean services provided by licensed clinical counselors and therapists are not covered unless a policy expressly includes these types of providers. The bill's provisions clarify current law by specifying that required coverage and reimbursement relate to a particular service rather than the type of provider offering the service.

House Bill 335 ***(passed)*** permits a program operating under a Community Access Program grant from the federal Department of Health and Human Services (DHHS) to establish a pilot program to coordinate health care provider reimbursements in order to test innovations in health care services payment. The federal Community Access Program (CAP) was created in 2000 to provide grants that would help grantees in 22 states build integrated health care systems among local partner organizations, all of which were committed to expanding health services to uninsured individuals.

Allegany Community Access Program (ACAP) (part of Western Maryland Health System) is a community-based initiative funded with a CAP grant from DHHS and supported by community partners, health care providers, and other sources. ACAP facilitates collaboration among health and human service providers to increase access to quality health care for uninsured adults. Currently, ACAP provides access to health care for individuals who earn up to 200 percent federal property level guidelines using various funding sources and programs. ACAP is seeking to develop a health care coverage product designed for employed individuals who do not qualify for other assistance programs but who cannot afford health insurance coverage. The program will target small businesses that are unable to provide health insurance coverage through commercial sources. The bill permits ACAP to implement the program and not be subject to Maryland insurance law.