Part J
Health

Public Health – Generally

Medicaid

Budget Funding Increases and Rate Enhancements

The fiscal 2007 budget increases funding for Medicaid and the Maryland Children's Health Program by $221.9 million ($113.9 million of general funds) or 5.0 percent bringing total funding for the programs to $4.6 billion ($2.2 billion of general funds). The relatively modest growth in costs reflects the inclusion of $124 million in the fiscal 2006 budget to pay for services delivered during fiscal 2005.

Funds are provided in the budget to maintain 241 additional nursing home eligible individuals in the community ($4 million), extend coverage of primary care services to an additional 20,000 people ($18 million), and expand the Medicaid buy-in program for the working disabled ($11 million). About 1,550 people are expected to participate in the buy-in program during fiscal 2007, an increase of 1,080. The budget includes rate enhancements for many provider groups including physicians ($30 million), private duty nurses ($9 million), and personal care providers ($2 million). The physician rate increase represents the second year of a multi-year initiative to raise Medicaid rates to 100 percent of the Medicare rates.

The General Assembly sought to mitigate the impact of selected cost containment actions by restricting $10 million to allow for a 5 percent rather than a 4 percent rate increase for nursing homes and $0.8 million to provide a 3 percent rather than a 2 percent rate increase for medical day care providers.

Medicaid Advisory Committee

Senate Bill 771/House Bill 1330 ***(both passed)*** modify the membership of the Maryland Medicaid Advisory Committee and provide reimbursement for enrollee members under specified circumstances. The bills change the committee composition by specifying that (1) at least five

members be current or former enrollees or the parents or guardians of enrollees; and (2) at least five but not more than 10 members be advocates for Medicaid enrollees with special needs.

House Bill 1574 ***(passed)*** specifies that if the Department of Health and Mental Hygiene (DHMH) applies for a Medicaid waiver or modifies or amends an existing waiver, DHMH must submit the application or amendment to the Medicaid Advisory Committee for discussion at a Medicaid Advisory Committee Meeting. If DHMH submits a State Plan Amendment to the Medicaid State Plan or the Maryland Medical Assistance Program, DHMH must submit a copy of the amendment to the committee within five business days of submission.

Prescriptions

Senate Bill 624 ***(passed)*** specifies that a prescription may be written or oral under the Medicaid program, except for a drug that contains a substance listed on Schedule II or that is determined by the Secretary of Health and Mental Hygiene to present an emerging threat because of increased abuse or diversion. A pharmacist may not dispense a drug on an oral prescription unless the pharmacist promptly writes out and files the prescription.

Medicare Part D

Stopgap Program

House Bill 1467 ***(passed)*** establishes the Medicare Part D Stopgap Program in the Maryland Department of Aging (MDoA) to assist Medicare beneficiaries (including beneficiaries with disabilities and those who are at least 65 years old) in obtaining Medicare Part D prescription drug benefits. The Governor may provide $2 million to MDoA in the fiscal 2007 budget for distribution to local area agencies on aging for outreach, education, and counseling of individuals regarding Medicare Part D. Supplemental Budget No. 2 did in fact provide a $2 million appropriation. The bill requires the appropriation to be apportioned by jurisdiction based on the latest census of individuals who are eligible for Part D and the number of dually eligible individuals in the jurisdiction. It is the General Assembly’s intent for the Governor to work with the National Governor’s Association to seek federal reimbursement for State outreach and education on Medicare Part D. The bill terminates June 30, 2007.

Kidney Disease Program

House Bill 697 ***(passed)*** requires DHMH to require Kidney Disease Program recipients to apply for eligibility in the Maryland Medical Assistance Program, Medicare Part B Program, and the Medicare Part D prescription drug program within 60 days of notification to do so by DHMH. However, DHMH may not require program recipients to apply for eligibility in Medicare if DHMH determines the program recipient has comparable insurance coverage.

Immigrant Health Care

House Bill 89 ***(passed)*** requires the Governor to include in the budget bill for fiscal 2008 at least $3 million in general funds for an immigrant health initiative to provide health care

services for all legal immigrant children under the age of 18 and pregnant women who meet program eligibility standards and arrived in the United States on or after August 22, 1996. By January 1, 2007, DHMH must report to the Governor and the General Assembly on the immigrant health initiative established under Senate Bill 110 (fiscal 2007 budget bill) and funded at $3 million. The report must include (1) a description of the immigrant health initiative; (2) the number of individuals served under the initiative; (3) the types of health care services provided; (4) how the services compare to those provided under the Medicaid program prior to 2005; and (5) if inequities are identified, recommendations for methods to provide health care services equal to those provided under Medicaid. It is the intent of the General Assembly that if funds are available, $7 million be provided to the immigrant health program in fiscal 2008.

Stem Cell Research

Senate Bill 144 ***(Ch. 19)*** creates a Maryland Stem Cell Research Fund administered by the Maryland Technology Development Corporation (TEDCO) to promote State-funded stem cell research and cures through grants and loans to public and private entities in Maryland. Annually, beginning in fiscal 2008, the Governor may include in the budget bill an appropriation to the stem cell research fund. The fund supports research using adult stem cells or any unused material from infertility treatments. An independent scientific peer review committee composed of scientifically recognized experts in the field of stem cell research will evaluate, rank, and rate stem cell research proposals. An independent Stem Cell Research Commission that functions within TEDCO will make recommendations for the award of grants and loans from funds based solely on the rankings and ratings of the committee. An applicant for State-funded stem cell research must obtain institutional review board approval before receiving funding. The fiscal 2007 budget allocates $15 million for a new Stem Cell Research Fund to be administered by TEDCO, which is contingent on the passage of ***Senate Bill 144***. For a further discussion of ***Senate Bill 144***, see the subpart "Economic and Community Development" within Part H – Business and Economic Issues of this *90 Day Report*.

Mental Health

Senate Bill 748 ***(passed)*** requires DHMH to apply to the Centers for Medicare and Medicaid Services (CMS) for a psychiatric residential treatment demonstration waiver if CMS announces that it is accepting such applications. The application must provide for services for at least 150 individuals or for the maximum number of individuals CMS allows, if the maximum allowed is fewer than 150 individuals. During the waiver application process, DHMH must conduct an analysis of the short-term and long-term costs and benefits of implementing the waiver. DHMH must report to the General Assembly every six months on the application until the waiver is approved or denied. If CMS approves the waiver, DHMH must report to the General Assembly on its decision regarding whether it will implement the waiver. The report must include a summary of the cost and benefits analysis. If DHMH implements the waiver, expenditures could increase by $10.9 million in fiscal 2008 and future years.

Senate Bill 418 ***(Ch. 50)***/***House Bill 203*** ***(passed)*** expands the membership of the Joint Committee on Access to Mental Health Services from 8 to 10 members by adding a member of the Senate Judicial Proceedings Committee and a member of the House Judiciary Committee.

Mental Health Studies

House Bill 98 ***(passed)*** requires DHMH's Mental Hygiene Administration (MHA) to study and determine the appropriate utilization level of children's psychiatric rehabilitation program services. MHA also must study the impact of the shift from fee-for-service payments to case rates on consumer outcomes; recalculate the case rate based on the appropriate utilization level and determine whether consumers can be classified by level of care to establish multiple tiers of case rates. The bill establishes a report deadline of January 1, 2007.

House Bill 771 ***(passed)*** requires DHMH to conduct a study of the adequacy of rates paid to therapeutic behavioral services providers. Among other things, the study must assess the impact of the current rates on participation of existing and potential therapeutic behavioral services providers in Medicaid, the ability of providers to recruit and retain staff, the ability of DHMH to promptly refer a child for receipt of therapeutic behavioral services, and the ability of providers to deliver the requisite number of therapeutic behavioral services hours. The bill establishes a report deadline of January 1, 2007.

Senate Bill 960/***House Bill 1594*** ***(both passed)*** extends to October 1, 2006, the final report deadline for a workgroup addressing the rearrest and reincarceration of individuals with mental illnesses and details what should be included in that final report including the number of individuals with a mental illness who are receiving services; a determination of whether current services are adequate to meet the needs of mentally ill inmates; and a summary of currently available effective pilot programs.

Substance Abuse

House Bill 1118 ***(passed)*** specifies that the Community Health Resources Commission, when developing regulations that establish the criteria for awarding grants, must give priority to a community health resource (CHR) center that provides a clinical home for individuals who access hospital emergency departments for substance abuse services. Currently, priority is given to a CHR that provides a clinical home for individuals who access hospital emergency departments only for mental health services.

Funding, Monitoring, and Evaluation

House Bill 1604 ***(Ch. 107)*** permits DHMH, for fiscal 2007 only, to assess an administrative charge on the Maryland Health Care Commission (MHCC) and the Health Services Cost Review Commission (HSCRC) for costs or services provided to the commissions by the Executive Branch. This charge cannot exceed 18 percent of commission salaries and must be based on the indirect costs or services benefiting the commissions, less overhead costs paid directly by the commissions. DHMH general fund expenditures would decrease by $1,185,000, this decline is offset by a corresponding increase in special fund expenditures.

House Bill 1701 ***(passed)*** specifies that any rebates received by DHMH under the Maryland AIDS Drug Assistance Program (MADAP) must be distributed to a special fund to be used only to fund MADAP. MADAP assists persons diagnosed with HIV/AIDS who meet certain income eligibility criteria with their HIV/AIDS-related drug costs. MADAP drug rebates are anticipated to be just over $11.3 million in fiscal 2007.

Senate Bill 1065 ***(passed)*** specifies that in fiscal 2007 only, up to $5 million may be transferred from the Revenue Stabilization Account by budget amendment to DHMH for the purpose of providing a special fund operating grant appropriation to Prince George's Hospital Center. The fiscal 2007 budget for DHMH contains $5 million to expend as a grant to Prince George's Hospital Center. This appropriation is contingent upon the prior receipt of $15 million by the Hospital Center from Prince George's County.

Senate Bill 117 ***(Ch. 70)*** codifies the existing Office of the Inspector General (OIG) within DHMH and authorizes the inspector general, collaborating with a DHMH program, to take necessary steps to reduce fraud, waste, and abuse. The bill also requires DHMH to establish a task force to examine consolidating departmental authority over fraud, waste, and abuse by reviewing State laws governing DHMH and DHMH-issued regulations to eliminate overlapping and duplicate administrative authority as a result of establishing OIG. By December 1, 2006, the task force must issue a report of its findings and recommendations to specified legislative committees.

Prescription Drugs

Senate Bill 61 ***(Ch. 22)***/***House Bill 822*** ***(passed)*** repeal the June 30, 2006, termination date for the Maryland Medbank Program. Administered by Medbank of Maryland, Inc. (a private entity), the 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. Since its inception, Medbank has provided $90 million in free medicine to about 32,000 patients.

Senate Bill 1059/***House Bill 1689*** ***(both passed)*** establish a prescription drug repository program regulated by the Board of Pharmacy. The purpose of the program is to accept donated prescription drugs for the purpose of dispensing the drugs to eligible individuals. The program may only accept and dispense drugs in their original unopened, sealed, and tamper-evident unit dose packaging, and with an expiration date at least 90 days from the date the drug is donated. Any person, including an individual, drug manufacturer, or health care facility, may donate prescription drugs. Drugs may only be donated at a drop-off site designated by the Board of Pharmacy.

Senate Bill 333/***House Bill 1287*** ***(both passed)*** require DHMH, in consultation with a newly established Advisory Board on Prescription Drug Monitoring, to establish a prescription drug monitoring program (PDMP) that electronically collects and stores data concerning "monitored prescription drugs (*i.e.,* drugs containing a substance listed in Schedule II, III, or IV)." Implementation of the program is contingent on the advisory board's obtaining federal,

private, or State funds. Data may be shared with federal, State, or local law enforcement agencies or a licensure entity as needed.

Trauma Center Services

House Bill 1164 ***(passed)*** expands the types of trauma centers eligible for reimbursement under the Maryland Trauma Physician Services Fund, expands the types of trauma physicians who are eligible for reimbursement from the fund, and changes reimbursement rates for Level II and Level III trauma centers. Trauma fund special fund expenditures for these purposes could increase by at least $6 million in fiscal 2007. In addition, the bill authorizes grants totaling $3 million to Level II and Level III trauma centers for equipment primarily used for trauma.

Developmental Disabilities

Senate Bill 734**/*****House Bill 831*** ***(both passed)*** changes the name of the Mortality Review Committee to the Mortality and Quality Review Committee within DHMH. The bills also require the committee, in addition to current duties, to review aggregate incident data regarding facilities or programs that are licensed or operated by the Developmental Disabilities Administration (DDA) or operating by waiver. Aggregate incident data means information or statistics maintained by the Office of Health Care Quality (OHCQ) on the reported incidents of Level III serious injuries at health care facilities. The committee must make recommendations to the Secretary of Health and Mental Hygiene and the Secretary of Disabilities to prevent avoidable injuries and avoidable deaths, and improve quality of care.

OHCQ must provide aggregate incident data to the extent practicable to the committee once every three months. The committee must review the data and make findings and recommendations to the department on system quality assurance needs. The bills terminate September 30, 2009.

Disease Prevention and Public Health Education

House Bill 342 ***(passed)*** requires DHMH, as funds are available, to conduct a needs assessment to determine the incidence of Hepatitis C in Maryland as well as undertake other activities related to prevention of Hepatitis C infections. The bill also establishes a reporting requirement and repeals the State Advisory Council on Organ and Tissue Donation Awareness. The Secretary of DHMH is required to contract with a qualified, independent, nonprofit third party to promote public education and awareness about organ, tissue, and eye donations.

House Bill 507 ***(passed)*** creates a Folic Acid Supplement Distribution Program within DHMH to reduce the number of cases of neural tube defects and other birth defects in Maryland children. Subject to funding availability, the program will distribute a folic acid supplement to "women of childbearing age" (15-45) who have family incomes at or below 185 percent of the federal poverty level. The program also must provide counseling and written information regarding the proper use of the supplement and any other necessary health information.

House Bill 1676 ***(passed)*** authorizes blood lead testing to be conducted using a venous blood test or two capillary blood tests. If the capillary blood test method is used, an individual first must have a sample of capillary blood drawn and tested. A second sample of capillary blood must be drawn and tested within 84 days after the first sample is drawn. If the result of one capillary blood test would require action related to reducing the lead risk in housing to be taken and the other sample would not, an individual's elevated blood lead level must be confirmed by a venous blood test. Currently, the only blood test that can be administered is the whole venous blood test that is only performed at a laboratory and not in a doctor's office or other community setting.

Senate Bill 824*/*House Bill 681 ***(both passed)*** establish the Maryland Commission for Men's Health within DHMH. The commission is to develop strategies and programs, including community outreach and public-private partnerships, to raise public awareness of men's health issues.

House Bill 851 ***(passed)*** requires DHMH, consulting with the Office of Minority Health and Health Care Disparities and stakeholders, to report on adult sickle cell anemia in Maryland to specified legislative committees by December 1, 2006. The report must include recommendations on (1) improving the quality of care delivered to diagnosed adults; (2) reducing the mortality rate of diagnosed adults; (3) assisting health care institutions with clinics for adults with sickle cell anemia; (4) the amount of general funds required to address the previous recommendations; and (5) any available funding sources.

Senate Bill 197 ***(passed)*** requires DHMH, in consultation with obstetricians, the Maryland Hospital Association, and interested groups, to develop umbilical cord blood donation educational materials. Each obstetrician and hospital that provides obstetrical services must distribute the educational materials to pregnant patients. Chapters 450 and 451 of 2004 require hospitals to allow pregnant patients to arrange for the donation of the umbilical cord blood from their newborn child to a certified public cord blood bank, unless it is medically inadvisable.

Advance Directives and Medical Records

Senate Bill 236 ***(passed)*** creates a voluntary Advance Directive Registry within DHMH. The bill requires that the registry be a secure, electronic database to which authorized access is available 24 hours per day, seven days per week. DHMH must specify in regulation the persons who are authorized to access the registry, including (1) the registrant or the registrant's designee; and (2) representatives of a health care facility in which a registrant is receiving health care. The Maryland Department of Transportation is required to provide for a method that allows an applicant for a driver's license or identification card to indicate that the individual has an advance directive registered with DHMH.

Senate Bill 369 ***(passed)*** changes the suggested forms to be used for living wills or advance directives. The bill provides a model advance directive form, divided into three parts. The first part specifies the selection of a health care agent, allowing primary and back-up agent designations. The second part specifies treatment preferences in the case of a terminal condition,

persistent vegetative state, or end-stage condition. The third part specifies required signatures and witnesses for the advance directive. The model form allows an individual to authorize a health care agent to visit the individual in the hospital or other health care facility and to ride with an individual in an ambulance. The bill also includes a model form regarding organ donation, donation of body, and disposition of body and funeral arrangements.

House Bill 1389 ***(passed)*** allows a health care provider to charge a fee in the amount currently specified in statute, for the retrieval, copying, preparation, mailing, and actual cost of postage and handling of a medical record that must be disclosed without the authorization of the person in interest in response to an investigation. A government unit or agency may not be charged by the health care provider for any of these costs if the government unit or agency makes this request as part of an investigation.

Health Care Providers

House Bill 1455 ***(passed)*** requires the Family Health Administration, in consultation with the Office of Minority Health and Health Disparities to provide technical assistance to qualified community-based entities for a pilot program that addresses (1) cultural competency training of health care providers, with an emphasis on community-based providers; and (2) health outcomes and community-based models for targeting health outcomes as determined by tracking indicators relating to the specific health care needs of the population in a specified area.

Senate Bill 754/***House Bill 1476*** ***(both passed)*** require DHMH to provide voluntary withholding of any applicable federal and State income taxes for self-employed providers of health care services as attendants, personal care aides, personal care providers, and respite care workers to recipients participating in the home- and community-based services waiver for the Older Adults Program or the Medicaid program. A more detailed discussion of this bill can be found under Part B – Income Tax of this *90 Day Report*.

Senate Bill 447 ***(passed)*** requires DHMH, beginning in fiscal 2008 and subject to available funding, to annually adjust the fees paid to a community developmental disabilities services provider and a community mental health services provider for approved services rendered to an eligible individual. The fees must be adjusted using the update factor recommended by the Community Services Reimbursement Rate Commission but may not exceed 5 percent.

Agriculture

House Bill 239 ***(passed)*** requires the Secretary of Health and Mental Hygiene to designate an agricultural ombudsman to serve as the primary DHMH contact for individuals involved in agriculture. The ombudsman also must provide information regarding DHMH regulations of on-farm food processing, on-farm food preparation, and other on-farm activities.

Senate Bill 1049/***House Bill 1717*** ***(both passed)*** allow an "on-farm home processing facility" to obtain an on-farm food processing plant license for a fee established in DHMH regulation. Such a facility may manufacture or process only foods that are provided for in

regulations. An on-farm home processing facility is a home or domestic kitchen on an individual's farm that manufactures and processes foods for commercial sale. It is the intent of the General Assembly that the fee for this license be set at $30 to commence with the 2006 growing season.

Health Occupations

Shortages in the Health Care Workforce

In recognition of the current shortages of health care practitioners in the State, ***House Bill 1127*** ***(passed)*** creates a statewide commission within the Department of Health and Mental Hygiene to study this issue. The commission is charged with determining the current extent of the health care workforce shortage in the State and examining what is needed to enhance institutional capacity, enhance educational programs, and identify methods to recruit and retain health professionals.

Specifically addressing the shortage of nurses, ***Senate Bill 230***/***House Bill 322*** ***(both passed)*** establish a fund in the Maryland Higher Education Commission that would facilitate an increase in the number of bedside nurses in hospitals in the State. The fund consists of money generated by an increase in hospital rates, as approved by the Health Services Cost Review Commission, specifically for this purpose. Additionally, the bill requires guidelines established for the administration of the fund to provide that a portion of the grants be used to attract and retain minorities to nursing and nurse faculty careers in the State. The fiscal 2007 budget appropriates $5.6 million to the fund.

Nurses, Nursing Assistants, Medication Technicians, and Electrologists

Requiring Criminal History Records Checks

Of the 8,000 individuals that the Board of Nursing licenses or certifies each month, the board estimates that 10 percent of these individuals have a criminal background. ***Senate Bill 769***/***House Bill 1318*** ***(both passed)*** include as part of the license and certification application that registered nurses, licensed practical nurses, selected nursing assistants, and electrologists submit to a criminal history records check. For current licensees, criminal history records checks will be phased in beginning in January 2008 with an additional check conducted every 10 years thereafter. The board may take disciplinary action against a licensee or certificate holder for failing to submit to a criminal history records check.

Setting Standards for Nursing Assistants and Medication Technicians

Senate Bill 449/***House Bill 1080*** ***(both passed)*** gives the Board of Nursing the authority to set standards for certified nursing assistants and certified medication technicians. The bill also makes changes to the authority of the board's rehabilitation committee, the requirements of multi-licensing privileges, license renewal procedures, and the authority of the board to send an advisory letter to a licensee.

Electrologists

Senate Bill 405 ***(Ch. 49)***/***House Bill 1149*** ***(passed)*** codifies the existing practice of licensed electrologists renewing their licenses annually with the Board of Nursing, instead of every two years as statute requires. The bill specifies that if a licensee fails to provide satisfactory evidence of complying with continuing education requirements, the board must place the licensee on inactive status. The bill adds additional grounds in which the board may take disciplinary action against a licensee.

Physician Assistants

Practicing in Accordance with a Pending Delegation Agreement

Senate Bill 818 ***(passed)*** authorizes physician assistants to practice in accordance with a delegation agreement that is pending before the Physician Assistant Advisory Committee or the State Board of Physicians if:

- the supervising physician has been previously approved for supervision of the same scope of practice in the same practice setting; and
- the physician assistant has been previously approved for the same scope of practice in a different practice setting.

The bill also repeals the current requirement that a diagnostic order issued by a physician assistant be counter-signed by a physician.

Regulation of Newly Designated Health Care Practitioners

Pharmacy Technicians

Senate Bill 371/***House Bill 492*** ***(both passed)*** require an individual to be registered with the Board of Pharmacy prior to practicing as a pharmacy technician and performing specified delegated pharmacy acts. A licensed pharmacist may delegate pharmacy acts if the pharmacy acts:

- are directly supervised by a licensed pharmacist;
- are not required to be performed by a licensed pharmacist;
- are within the scope of the delegating licensed pharmacist's education, training, experience, and area of practice; and
- are appropriate to the education, training, and experience of the individual to whom the acts are being delegated.

Polysomnographic Technologists

House Bill 957 ***(passed)*** requires the Board of Physicians to license and otherwise regulate the practice of polysomnography (the collection of physiologic variables during sleep). The bill authorizes a licensed polysomnographic technologist to:

- monitor and record data during sleep under the supervision of a licensed physician; or
- use data collected while an individual is sleeping for the purpose of assisting a licensed physician in the diagnosis and treatment of sleep and wake disorders.

Waiver of Education Requirements for Pediatric Dental Specialists

In 2003, the General Assembly passed House Bill 237 that authorized the Board of Dental Examiners to waive certain educational requirements and issue temporary licenses to applicants who contracted with federally qualified or Maryland qualified heath centers to provide pediatric dental services. The program was designed to provide access to pediatric dental services in areas where no services were available and is scheduled to terminate on September 30, 2006. ***House Bill 1560*** ***(passed)*** repeals the termination provision.

Responding to Catastrophic Health Emergencies

Senate Bill 32 ***(passed)*** requires the Secretary of Health and Mental Hygiene to coordinate with health occupations boards to develop a process to license, certify, or credential both licensed and out-of-state health care practitioners who may be needed to respond to a catastrophic health emergency. The bill also includes this process as a training program that may be instituted by the Governor in the event of an emergency.

Miscellaneous

Legislation was introduced on behalf of nursing home administrators, professional counselors and therapists, pharmacists, dentists, dieticians, emergency medical service providers, and social workers. ***House Bill 690*** ***(passed)*** requires the Board of Examiners of Nursing Home Administrators to convene a workgroup to study the current standards for licensure of these individuals and the effectiveness of the board. ***House Bill 955*** ***(passed)*** authorizes the Board of Professional Counselors and Therapists to waive certification requirements for an applicant who is certified or otherwise authorized to practice in another state. The requirements of the other state must meet or exceed the requirements of Maryland. ***House Bill 1569*** ***(passed)*** requires the Board of Pharmacy to revoke the license of a licensee convicted of knowingly selling or delivering a specified substance that is different from what was ordered or called for in a prescription.

In a number of different bills, the Board of Dental Examiners, the Board of Dietetic Practice, the Board of Social Work Examiners, and the Emergency Medical Services Board made various changes to their respective regulatory statutes. These changes include updating education and other licensure and certification requirements and repealing obsolete provisions.

Failure to Extend the Sunset Termination Date of the Board of Physicians

During the 2005 interim, the Department of Legislative Services (DLS) conducted a full evaluation of the Board of Physicians in accordance with the Maryland Program Evaluation Act (Sunset Law). ***Senate Bill 398***/***House Bill 121*** ***(both failed)*** incorporated the majority of the DLS recommendations. The board is set to terminate July 1, 2007.

Health Care Facilities and Regulation

Facilities Regulation

Senate Bill 102 ***(passed)*** modifies the licensure process for a variety of health care facilities that currently may be deemed as having met State licensure requirements by obtaining accreditation through a recognized independent accreditation organization. The bill repeals existing accreditation provisions for hospitals, health maintenance organizations, ambulatory care facilities, assisted living facilities, laboratories, home health agencies, comprehensive rehabilitation facilities, and residential treatment centers. Instead, these facilities are subjected to a uniform accreditation regulatory system. All accreditation organizations must obtain Department of Health and Mental Hygiene (DHMH) approval to accredit these facilities. The bill also specifies situations under which the DHMH may inspect an accredited health care facility. Health care facilities that are found to have deficiencies must correct them within 30 days or face specified penalties. If DHMH determines that an approved accreditation organization has failed to meet its obligations, DHMH may withdraw approval as well as the deemed status (which provides an exemption from regular surveys conducted by the department) given to a health care facility by the accreditation organization.

Regulating Assisted Living Programs

Two bills addressed the prevalence of unlicensed assisted living programs in Maryland. Currently, there are approximately 1,580 licensed assisted living programs in Maryland and approximately 570 known unlicensed programs. DHMH's Office of Health Care Quality is aware of these unlicensed programs because of complaints received. The office works with these providers to try to bring them into compliance with State laws and regulations; however, local State's Attorneys often are hesitant to prosecute an unlicensed program because prior to the 2006 session it was only a misdemeanor offense to operate without a license.

House Bill 1322 ***(passed)*** specifies the term of an assisted living program license and clarifies that a person must be licensed to conduct, operate, or maintain such a program in Maryland. The bill increases the regulatory requirements for the operation of assisted living programs by requiring applicants to submit specific information to DHMH. The Secretary must review licensing applications and either unconditionally approve, conditionally approve, or deny an application. In addition, a type of program licensed by the Department of Human Resources is exempted from DHMH's licensing requirements for assisted living programs.

House Bill 1036 ***(passed)*** establishes that knowingly and willfully operating, maintaining, or owning an unlicensed assisted living program is a felony and sets related criminal penalties. The bill establishes civil money penalties for false representation and creates a continuing, nonlapsing Health Care Quality Account for Assisted Living Programs in DHMH. Similar to an account for nursing homes, the account is funded with civil penalties paid by programs and other penalties assessed by the Office of Health Care Quality. Civil money penalties that are currently paid into DHMH's Health Care Quality Account are transferred into the account for assisted living programs. Account funds must be used for training, grant awards, demonstration projects, or other purposes designed to improve the quality of care.

Two bills this session require certain assisted living facilities to have an emergency electrical power generator on-site. ***Senate Bill 385***/***House Bill 204*** ***(both passed)*** both require an assisted living program facility that serves 50 or more individuals to have an emergency electrical power generator on the premises. The emergency generator must provide lighting in specified areas of an assisted living facility, including areas of common refuge, emergency telephone use, elevators, and other areas where electrical operation is necessary during an emergency. Facilities are exempted from the law if it can transfer residents to an adjacent building equipped with a generator. DHMH may also grant a waiver from these requirements to an assisted living facility that experiences an undue financial burden complying with the bills' provisions. The bill does not take effect until October 1, 2009.

Certificate of Need Process

As a result of a task force convened by the Maryland Health Care Commission, ***Senate Bill 832***/***House Bill 1015*** ***(both passed)*** alter capital expenditure requirements for a Certificate of Need (CON) and make other changes to the CON process. The bills change the hospital capital expenditure threshold that requires a CON from $1.25 million to $10 million, and for a health care facility other than a hospital, from $1.25 million to $5 million. Further, the bills specify when a CON is not needed for a hospital for a capital expenditure over $10 million and requires a public hearing in a jurisdiction with fewer than three hospitals if a hospital is about to close.

Hospital Charges

Senate Bill 380 ***(Ch. 48)*** requires the Health Services Cost Review Commission, in consultation with the Maryland Health Care Commission, to annually publish each acute care hospital's severity-adjusted average charge per case for the 15 most common inpatient diagnosis-related groups. Adjusting treatment costs based on severity is one method of determining whether health care is being delivered in an efficient manner. In order to make a valid cost comparison, each patient's secondary diagnosis, complications, age, and other factors influencing resource consumption (*i.e.*, drugs, lab tests, supplies, therapies, and procedures) must be considered.

Health Care Disparities Policy Report Card

House Bill 58 ***(passed)*** requires the Office of Minority Health and Health Disparities, in collaboration with the Maryland Health Care Commission, to annually publish a "Health Care

Disparities Policy Report Card." The report card must be published on DHMH's web site and made available in writing upon request. The report card must include (1) an analysis on racial and ethnic variations in insurance coverage for low-income, nonelderly individuals; (2) the racial and ethnic composition of the physician population compared to the composition of the State's population; and (3) the racial and ethnic disparities in morbidity and mortality rates based on race and ethnicity for certain diseases and conditions. The commission must also incorporate racial and ethnic variations in its report cards for health maintenance organizations, nursing homes, and hospitals and ambulatory surgical centers by October 1, 2007.

Health Care-Associated Infection Information

Effective July 1, 2006, the comparable evaluation system for hospitals and ambulatory surgical facilities developed by the Maryland Health Care Commission must include health care-associated infection information from hospitals, as required by ***Senate Bill 135*** ***(Ch. 42)***. The system must adhere to the current recommendations of the federal Centers for Disease Control and Prevention and the Healthcare Infection Contract Practices Advisory Committee of the centers regarding public reporting of health care-associated infections.

Emergency Plans in Human Service Facilities

House Bill 770 ***(passed)*** requires a "human service facility" to develop an emergency plan that includes procedures that will be followed before, during, and after an emergency. Human service facilities include such facilities as nursing homes, assisted living programs, group homes, State-operated institutions for mental disease, and other types of residential facilities. A more detailed discussion of this bill can be found under Part E4 – Public Safety of this *90 Day Report*.

Sunset Review

Senate Bill 153/***House Bill 195*** ***(both failed)*** would have waived the Maryland Health Care Commission and the Health Services Cost Review Commission from full evaluation under the Maryland Program Evaluation Act. While not subject to termination, both commissions still are subject to preliminary and possibly full evaluation. With the failure of both bills, the General Assembly determines that the commissions activities and authorizing statutes warrant full evaluations.

Health Insurance

Employers and the Provision of Employee Health Insurance

This session, the General Assembly overrode the Governor's veto of Senate Bill 790/House Bill 1284 of 2005 ***(Ch. 1 and 3)***, the "Fair Share Health Care Fund Act." Chapters 1 and 3 of 2006 seek to hold large employers in Maryland responsible for providing health insurance to their employees. Historically, large employers have offered some form of health benefits to employees; however, various states claim that they have many employees or

dependents of employees of large businesses on their Medicaid rolls. Facing rapidly increasing Medicaid costs, policymakers are turning to the private sector to bear more of the costs of health care.

The Act requires an employer with 10,000 or more employees that does not spend at least 6 percent of total wages (for a nonprofit employer) or 8 percent of total wages (for a for-profit employer) on health insurance costs to pay to the Department of Labor, Licensing, and Regulation an amount equal to the difference between what the employer spends on health insurance and the required percentage of total wages paid. The Act imposes reporting requirements on large employers as well as civil penalties on those who fail to comply. An employer who fails to report as required is subject to a $250 civil penalty for each day the report is not timely filed. An employer who fails to make the required payment is subject to a $250,000 penalty. Any penalties collected are deposited in the Fair Share Health Care Fund and used to support the Medicaid program. At the time of enactment, the legislation applied to only one employer in the State: Wal-Mart.

Relationship Between Health Insurance Carriers and Health Care Providers

Several bills were considered by the General Assembly this session that addressed the contracting relationship between health insurance carriers and health care providers.

***Senate Bill 686*/*House Bill 1003* (both passed)** require health insurance carriers to maintain adequate provider networks in accordance with regulations developed by the Department of Health and Mental Hygiene (for health maintenance organizations (HMOs)) or the Maryland Insurance Administration (MIA) (for other health insurance carriers). The bills also require health insurance carriers to verify with each provider on the carrier's provider panel, at the time of credentialing and recredentialing of the provider, whether the provider is accepting new patients. Carriers are also required to update information about providers participating in their networks within 15 working days after receipt of written notification from the participating provider of a change in the provider's information. Finally, the bills require carriers to provide for referrals to a specialist who is not part of the carrier's provider panel if the carrier cannot provide reasonable access to a specialist with the professional training and expertise needed to treat a condition without unreasonable delay or travel. When a carrier provides this out of network referral, the carrier must treat the referral as in-network for the purpose of a member's co-payment, coinsurance, or deductible.

***Senate Bill 1086*/*House Bill 897* (both passed)** prohibit health insurance carriers from including in a contract with a provider, ambulatory surgical facility, or hospital a term or condition that:

- prohibits the provider, ambulatory surgical facility, or hospital from offering to provide services to another carrier's enrollees at a lower reimbursement rate;
- requires the provider, ambulatory surgical facility, or hospital to provide the carrier with the same reimbursement arrangement that the provider or hospital has with another

carrier, if the reimbursement arrangement with the other carrier is for a lower reimbursement rate; or

- requires the provider, ambulatory surgical facility, or hospital to certify that the reimbursement rate being paid by the carrier is not higher than the reimbursement rate being paid by another carrier.

Senate Bill 636 ***(Ch. 54)***/***House Bill 597*** ***(passed)*** prohibit carriers from requiring participating providers to be recredentialed by the carrier based on a change in the federal tax identification number of the provider or a change in the employer of the provider, if the new employer is a participating provider on the carrier's provider panel. This Act also requires providers to give written notice to carriers of changes in the provider's federal tax identification number or employer not less than 45 days before the effective date of the change. Within 30 business days after receipt of this notice from a provider, a carrier must acknowledge receipt of the notice and, if necessary, issue a new provider number to the provider. The Act also requires MIA to conduct a study on credentialing systems.

House Bill 868 ***(passed)*** prohibits a health insurance carrier from requiring a health care provider, as a condition of participation on a provider panel, to also serve on a provider panel for workers' compensation services. Carriers must include in their health care provider contracts or agreements a disclosure that informs the provider of the provider's right to elect not to serve on a panel for workers' compensation services. Carriers are prohibited from terminating or limiting a contract with a health care provider on the basis that the health care provider elected not to serve on a provider panel for workers' compensation services.

Maryland Health Insurance Plan

The Maryland Health Insurance Plan is a State-run insurance pool for medically uninsurable individuals. The plan also operates the Senior Prescription Drug Assistance Program, which is a program that provides assistance to low-income seniors in the State who participate in Medicare Part D (the new federal prescription drug coverage program that was implemented beginning on January 1, 2006) and are not eligible for other subsidies. Several bills were considered by the General Assembly this session to change the operation of the Maryland Health Insurance Plan.

Senate Bill 283/***House Bill 702*** ***(both passed)*** alter the subsidy provided by the Senior Prescription Drug Assistance Program by allowing it to be used to pay for all or some of the deductibles, coinsurance payments, premiums, or other copayments that an enrollee in the program might face. The program is also authorized to provide an additional subsidy, up to the full amount of the Medicare Part D prescription drug plan premium, for individuals who qualify for a partial federal low-income subsidy. The program is required to provide a subsidy to the maximum number of individuals eligible for enrollment in the program, subject to available funds. The Board of Directors of the Maryland Health Insurance Plan must make an annual determination on the number of individuals to be enrolled in the program and the amount of subsidy to be distributed through the program. The bills also provide for $14 million in funding

for the program in fiscal 2008 and extend the termination date of the program to December 31, 2007.

Senate Bill 284 ***(passed)*** requires health insurance carriers that deny coverage to an individual under a medically underwritten health benefit plan to provide the name and address of the individual to the Maryland Health Insurance Plan. However, this requirement is contingent on a Health Insurance Portability and Accountability Act exception determination from the federal Department of Health and Human Services. The bill also authorizes the Board of Directors of the Maryland Health Insurance Plan to charge different premiums based on the benefit package delivery system when more than one delivery system is offered. Currently the plan offers two delivery systems: a preferred provider organization and an exclusive provider organization (similar to an HMO).

Mandated Benefits

Several bills this session addressed mandated health benefits. ***House Bill 1405*** ***(passed)*** requires a health insurer, nonprofit health service plan, or HMO (carrier) that provides health benefits to a full-time student over the age of 18 to provide benefits to a student over the age of 18 who is enrolled less than full-time as a result of a documented disability that prevents the student from maintaining a full-time course load, and who is maintaining a course load of at least seven credit hours per semester. The carrier may require an enrollee to provide verification of the disability from a disabilities services professional at the school or a health care provider with special expertise in and knowledge of the disability. It is unknown how many adult children could enroll in the State Employee and Retiree Health and Welfare Benefits Plan under the bill; however, for each child who enrolls, State expenditures could increase by about $3,540 in fiscal 2007.

House Bill 1497 ***(passed)*** repeals the September 30, 2006, termination date on the provision of law that requires mandated hospitalization or home care benefits for a patient who has a mastectomy or the surgical removal of a testicle. In addition, it requires the Maryland Health Care Commission (MHCC) to assess the social, medical, and financial impacts of requiring health insurance carriers to provide coverage for the cost of inpatient hospitalization services and medical complications related to a mastectomy or surgical removal of a testicle. MHCC must report to the General Assembly by January 1, 2007, on the results of its assessment. Similarly, ***Senate Bill 491*** ***(passed)*** repeals the September 30, 2006, termination date. This bill, however, does not require that MHCC conduct the assessment required under ***House Bill 1497***.

Small Group Market

Senate Bill 325 ***(Ch.6)***/***House Bill 608*** ***(passed)*** extend the date by which the Joint Legislative Task Force on Small Group Market Health Insurance must report to specified legislative committees from January 1, 2006, to July 1, 2007. In addition, the task force is required to study and report on the use of a State-subsidized reinsurance pool and the feasibility of establishing a health insurance exchange to strengthen the small group market. The task force was created by Chapter 409 of 2005 to study and make recommendations on rate adjustments,

medical loss ratios, association health plans and the Limited Benefit Plan. The task force met twice during the 2005 interim but had not yet issued a report.

Private Review Agents

Private review agents are persons or entities who undertake utilization reviews of health care services. ***House Bill 549*** ***(passed)*** alters requirements for private review agents making determinations on admissions for treatment of a mental, emotional, or substance abuse disorder. The bill requires private review agents who require prior authorization for emergency inpatient admissions or admissions for residential crisis services to make all determinations about authorization within two hours after the agent receives the necessary information and to promptly notify the health care provider of the determination. Private review agents must also submit to MIA their procedures to ensure that a representative of the private review agent is accessible to health care providers to make determinations on whether to authorize or certify an emergency inpatient admission or an admission to residential crisis services within two hours after the agent receives the information necessary to make the determination. The bill also prohibits private review agents from rendering an adverse decision about the admission of a patient to a hospital for up to 72 hours when the patient's treating physician has determined the admission to be medically necessary, the admission is involuntary, and the hospital immediately notifies the private review agent of the admission of the patient and the reasons for the admission.

Senate Bill 158 ***(Ch. 43)***/***House Bill 270*** ***(passed)*** make an exception to the mandatory use of the uniform treatment plan form by a private review agent when the agent is conducting utilization review of treatment provided to a patient for mental illness, an emotional disorder, or a substance abuse disorder. If a health care service was provided in another state, the Act requires a private review agent to accept treatment plan forms mandated by the state in which the service was provided.

Task Force on Universal Access

Senate Bill 60 ***(Ch. 21)*** extends the termination date for the Joint Legislative Task Force on Universal Access to Quality and Affordable Health Care from June 30, 2006, to June 30, 2007, and changes the due date for the task force's report to the Governor and the General Assembly from December 31, 2005, to December 31, 2006. Further, it permits the task force to appoint additional members and form subcommittees to conduct detailed studies as necessary. Chapter 280 of 2005 created the task force to study and make recommendations on how to make quality, affordable health care, including primary care, specialty care, hospitalization, and prescription drug coverage, accessible to all citizens of the State. The task force met once on January 4, 2006. Due to the complexity of the subject matter, several members suggested it would be helpful to have subcommittees that could study different approaches to expanding access to health care.

Required Studies

Senate Bill 770 ***(passed)*** requires MHCC to study (1) the financial aspects of inter-hospital patient transfer and scene transport by air ambulance services operating in Maryland; (2) State and federal laws applicable to the operation of air ambulance services in the State; and (3) mechanisms available to the State to regulate financial aspects of air ambulance services and to ensure cost-effective use of air ambulance services for interhospital patient transfer and scene transport. The study must be conducted in conjunction with the Health Services Cost Review Commission (HSCRC) and the Maryland Institute for Emergency Medical Services Systems (MIEMSS), and with the assistance of the Office of the Attorney General. By December 1, 2006, MHCC, HSCRC, and MIEMSS must submit a report on the study and any findings and recommendations to the Governor and specified legislative committees.

Senate Bill 728 ***(passed)*** requires the University of Maryland School of Medicine to study issues regarding the use of and reimbursement for telemedicine, including the following: (1) the current use of telemedicine in the State; (2) the use of and reimbursement for telemedicine in other states; (3) the potential for telemedicine to improve access to health care in underserved areas of the State; (4) how any reimbursement for telemedicine in other states has increased access to health care; and (5) any current barriers in the State to reimbursement for telemedicine. The School of Medicine must report by January 1, 2007, on its findings to specified legislative committees.