Part J
Health

Public Health – Generally

Anti-terrorism

Following the events of September 11, 2002, the Office of the Attorney General undertook a comprehensive review of Maryland law which identified that the Governor's emergency powers and the Secretary of Health and Mental Hygiene's surveillance and emergency powers were not clearly outlined with respect to a potential catastrophic health emergency. In order to clearly delineate these powers and to facilitate statewide planning for this type of emergency, legislation was introduced as part of the Administration's anti-terrorism package. ***Senate Bill 234 (Ch. 1)/House Bill 296 (passed)*** authorize the Governor to proclaim a catastrophic health emergency if the Governor determines that exposure to a "deadly agent" presents an imminent threat of extensive loss of life or serious disability to persons in the State. The bills also require the Department of Health and Mental Hygiene (DHMH) to create a Catastrophic Health Emergency Disease Surveillance and Response Program and submit a report on any plans, procedures, or protocols developed as a result of this bill. For a more detailed discussion of ***Senate Bill 234/House Bill 296***, and other anti-terrorism initiatives see the subpart "Anti-Terrorism" under Part C - State Government of this *90 Day Report*.

House Bill 361 (passed) establishes a Biological Agents Registry Program within DHMH. The Biological Agents Registry must identify specified "biological agents" possessed and maintained by any person in the State and contain other information as required by regulations. DHMH must adopt regulations to implement the program that determine and list biological agents, designate the persons required to report biological agents, designate time limits for reporting information, and establish a system of safeguards that require persons possessing, maintaining, and transferring biological agents to comply with the same federal standards that apply to persons registered to transfer the same agents under federal law.

Assisted Living and Nursing Home Residents

The General Assembly passed two significant bills geared toward helping residents in nursing homes or assisted living programs.

Personal Needs Allowance for Nursing Home Residents

Senate Bill 5/House Bill 422 ***(both passed)*** provide a $50 monthly personal needs allowance for each nursing home resident who receives Medicaid, beginning July 1, 2003, and a $60 allowance beginning July 1, 2004. The personal needs allowance must be adjusted annually, beginning July 1, 2005, by the percentage increase in Social Security benefits. The adjustment cannot exceed 5 percent in any given year.

Disclosure of Services for Individuals with Alzheimer's

Senate Bill 746 ***(passed)*** concerns assisted living programs that provide care for persons with Alzheimer's Disease or a related disorder through an Alzheimer's special care unit or program. Such programs must disclose how the form of care and treatment provided by the unit or program is specifically designed for the specialized care of individuals diagnosed with Alzheimer's Disease or a related disorder.

Cost Containment Initiatives

Medicaid spending accounts for 15 percent of the State's general fund operating budget. Given the State's current fiscal predicament, the Department of Legislative Service's fiscal 2003 budget analysis recommended careful consideration of cost containment options including duplication of pharmacy cost containment strategies proposed in Florida and Michigan, cost sharing requirements, reducing provider payments, and eliminating coverage of selected services. Several legislative measures to contain growing expenditures in the Medicaid program were also considered.

Prescription Drugs

Senate Bill 623/House Bill 1122 ***(both failed)*** would have established a prescription drug spending control program for fee-for-service Medicaid enrollees and participants in the Maryland Pharmacy Assistance Program (MPAP) that included a preferred drug list and prior authorization mechanisms. The bills also would have authorized DHMH to negotiate supplemental rebates with pharmaceutical manufacturers and to enter into alternative drug management programs and establish various processes for managing the drug therapies of certain program participants.

Nursing Home Provider Assessment

Senate Bill 624/House Bill 1078 ***(both withdrawn)*** would have established a provider assessment to raise revenue on a temporary basis from nursing homes. Revenues generated from the assessment would have been used to fund nursing homes and outpatient mental health clinics for services provided to Medicaid enrollees that qualify for federal Medicaid reimbursement.

Medical Assistance

Managed Care Organization Provider Credentialing

Senate Bill 820 ***(passed)*** permits a Medicaid managed care organization (MCO) to temporarily credential a health care provider. An MCO may deem a health care provider credentialed for a period of up to six months from the date of application if the health care provider has been credentialed by another entity in the State and has submitted an application to participate in the MCOs provider panel. The MCO must verify that the health care provider was credentialed and remains in good standing with at least one entity that previously credentialed the provider.

Maryland Children's Health Program Private Option Plan

The Maryland Children's Health Program (MCHP) private option plan allows children with family incomes between 200 and 300 percent of federal poverty guidelines to receive subsidized health insurance either through an employer's health benefit plan or through a HealthChoice MCO. The federal Centers for Medicare and Medicaid Services recently removed the requirement that employers participating in the MCHP private option plan make a contribution to the cost of family coverage equal to 60 percent of the total cost of family coverage. In response to this change, ***House Bill 84*** ***(passed)*** alters the employer premium contribution requirement from 50 to 30 percent in the MCHP private option plan. The bill provides that the State's cost for coverage of an MCHP private option plan enrollee covered by employer health insurance cannot be greater than the cost of coverage if the enrollee were covered under a HealthChoice MCO. If the State's cost is greater for an MCHP private option plan enrollee, DHMH must insure the enrollee through an MCO instead.

For a more detailed discussion of health insurance legislation, see the subpart "Health Insurance" under Part C - State Government of this *90 Day Report.*

Reimbursement Issues

***Senate Bill 481* (passed)** requires DHMH to report annually, on or before September 1 to the Governor and certain committees of the General Assembly on its progress in establishing a process to annually set the fee-for-service reimbursement rates for MCHP and the Medicaid program. DHMH must also establish and report on a process to annually set the fee-for-service reimbursement rates for the public mental health system in a manner that ensures participation of providers. The bill prohibits DHMH from implementing a pharmacy reimbursement rate reduction until October 1, 2002, and authorizes DHMH to encourage the use of medically appropriate generic drugs or brand name drugs on a preferred drug list. Furthermore, the bill provides that reimbursement under MPAP may be limited to maintenance drugs, anti-infectives, and AZT.

Notice of Waiver Applications

***House Bill 750* (Ch. 83)** requires DHMH to publish notice of any application for, or any modification or amendment to, a Medicaid waiver in the *Maryland Register*. For 30 days following publication, DHMH must make the waiver application available to the public during business hours and provide an opportunity to receive public comments on the waiver application.

Disparities in Health Care

Various studies have found racial, gender, and income differences in the quality of health care provided in the United States. The federal Department of Health and Human Services has launched its Healthy People 2010 initiative, which seeks in part to eliminate health disparities by 2010. The Institute of Medicine recently released a report entitled *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* which concludes that minorities receive a lower quality of health care than nonminorities.

To address these issues in Maryland, ***Senate Bill 451* (passed)** requires the Maryland Health Care Foundation to promote public awareness of the need to reduce health disparities associated with poverty, gender, and race. The bill authorizes the foundation to provide grants to programs addressing health care disparities. In addition, the foundation must consider geographical balance by county and region in providing grants and developing programs. The geographical balance must include consideration of the following factors: (1) the percentage of uninsured individuals; (2) the extent of health disparities; and (3) the existence of programs and services addressing the needs of the uninsured and underinsured in the geographic area.

Mental Health

Crisis Response System

Senate Bill 556/House Bill 483 ***(both passed)*** establishes the Maryland Mental Health Crisis Response System within the Mental Hygiene Administration (MHA) of DHMH. The program is contingent upon the receipt of federal funds or funds from other public or private sources.

Emergency Evaluations

Under existing law, a petition for an emergency evaluation of an individual with a suspected mental disorder may only be completed by a physician, a psychologist, a clinical social worker, a health officer, a designee of a health officer who has examined the individual, or an "interested individual." ***House Bill 253*** ***(passed)*** allows a licensed clinical professional counselor to independently file and present a petition for an emergency evaluation of an individual.

Mental Health Services Funding

The fiscal 2003 appropriation for MHA represents a $62 million increase over the fiscal 2002 working appropriation (9.5 percent), $44 million in general funds and $18 million in federal funds. The bulk of this funding ($42 million) is an increase in community-based mental health services, most of which are delivered through a fee-for-service system. Most of the remainder ($19 million) is directed to State-run Psychiatric Facilities.

Although the fiscal 2003 appropriation represents a significant increase over the current year, funding for the fee-for-service community-based mental health system remains below the level of current service provision. It is anticipated that the fee-for-service community-based mental health system will close-out fiscal 2002 with a $50 million-plus deficit. Actions taken by the legislature in ***Senate Bill 323*** (The Budget Reconciliation and Financing Act) capture higher-than-anticipated federal disproportionate share payments in fiscal 2002 and 2003 and dedicate those funds to address this deficit. It is estimated that these adjusted payments will yield an additional $40 million in fiscal 2002 and $14 million in fiscal 2003.

While MHA continues to try to restrain growth in service expenditures, the fiscal 2003 appropriation is anticipated to be as much as $15 to $20 million below current service levels. This structural deficit in the fee-for-service community-based mental health system is not addressed in other legislation. Rather, budget bill language requires MHA to restructure community mental health services in order that it can live within its fiscal 2003 appropriation. This restructuring will include moving to a system

of grants and contracts to serve the uninsured, a population currently served through the fee-for-service system.

***Senate Bill 10* (failed)** would have imposed a 2 percent insurance premium tax on health maintenance organizations beginning December 31, 2002, and ending June 30, 2006. The bill also would have created the special, nonlapsing Maryland Public Mental Health System Fund administered by DHMH to hold premium tax revenues. MHA would have been authorized to use the fund to pay for: (1) the public mental health system deficit incurred prior to fiscal 2003; (2) the annual fee adjustments for community mental health providers; and (3) any additional changes made by the General Assembly with respect to off-site community-based mental health centers.

Protection of Human Subject Research Participants

***House Bill 917* (passed)** closes a loophole in federal law under which privately funded research is not subject to State or federal regulation. The bill requires a person conducting human subject research in Maryland to conduct the research in accordance with federal regulations that provide certain protections for research subjects. The bill also provides for oversight by the Office of the Attorney General and provides standards for the minutes maintained by institutional review boards that are not explicitly addressed under federal law.

Substance Abuse Funding

The budget for the Alcohol and Drug Abuse Administration (ADAA) will increase by $14 million in fiscal 2003 to support the expansion of substance abuse treatment programs across the State. The largest increase, $7 million in general funds, will support the expansion of treatment services in Baltimore City as part of a three-year commitment to increase treatment capacity in the city. With the addition of these funds, support for treatment programs in Baltimore City will total $46 million, a 114 percent increase in funding over fiscal 2000 levels. The fiscal 2003 budget also supports an increase in Substance Abuse Treatment Outcomes Partnership (STOP) funding. This program distributes matching funds to local jurisdictions for substance abuse treatment services. Funding for the STOP program will grow by 132 percent in fiscal 2003 to $7.2 million. The remaining increase in ADAA provides continuing support for treatment and prevention programs, as well as salary increases for substance abuse providers.

Developmental Disabilities Administration Funding

The budget for the Developmental Disabilities Administration (DDA) will increase by $51 million in fiscal 2003 as a result of several recent initiatives intended to increase access to and the quality of community services for individuals with

developmental disabilities. The Waiting List Initiative, which enters its fifth and final year in fiscal 2003, is designed to reduce the waiting list for community services and will serve 5,977 individuals. In the final year of the initiative, the expansion of community services totals $19 million and rate enhancements for providers of community services total $9 million.

Fiscal 2003 also marks the first 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, Chapter 110, Acts of 2001, to eliminate the wage disparity over a five-year period. In its first year, the initiative will cost $16 million. The remainder of the increase in the DDA budget will support moving individuals from State residential centers to community settings.

Health Risks – Prevention and Control

Arthritis

More than 865,000 individuals are estimated to have arthritis in Maryland. ***Senate Bill 572/House Bill 247*** ***(both passed)*** establish the Arthritis Prevention and Control Program within DHMH. Among its responsibilities, the program will promote public awareness about arthritis, disseminate information and materials to patients and health professionals, establish a solid scientific base of knowledge on the prevention of arthritis, evaluate the need for improving the quality and accessibility of existing community-based arthritis service, and coordinate programs and services to reduce the public health burden of arthritis.

Osteoporosis

Osteoporosis is a bone-thinning disease that is the leading cause of disability in Maryland's aged population. ***Senate Bill 22/House Bill 532*** ***(both passed)*** establish a 16-member Osteoporosis Prevention and Education Task Force in DHMH to conduct a needs assessment and make recommendations to DHMH. DHMH is required to submit, on or before December 1 of each year, a report of the task force's findings to the Governor and the General Assembly.

Asthma

Asthma is a chronic respiratory disease that affects an estimated 190,000 adults and 95,000 children in Maryland. DHMH created a Childhood Asthma Program in 1998 that has enhanced community education, provided funding to four counties for asthma intervention initiatives, directed efforts for training school personnel about asthma, and provided technical assistance to community groups and coalitions.

House Bill 420 ***(passed)*** creates the Asthma Control Program within DHMH to establish a statewide asthma coalition, develop and implement a statewide asthma intervention program, and develop and implement an asthma surveillance system. The program may fund local asthma intervention initiatives and asthma education training for school or other appropriate personnel. The Secretary is required to report to the Governor, the Senate Education, Health, and Environmental Affairs Committee, the House Environmental Matters Committee, and the Children's Environmental Health and Protection Advisory Council on or before December 1, 2005, and each December 1 thereafter on the Asthma Control Program's activities. The program will be funded by a three-year grant from the federal Centers for Disease Control and Prevention.

Health Nuisances

Under current law, a nuisance is defined as a condition that is dangerous to health or safety, such as an inadequately protected swimming pool or an improperly functioning sewage system. ***Senate Bill 672/House Bill 685*** ***(both passed)*** authorize a local health officer to perform duties related to resolving nuisances formerly reserved to the Secretary of Health and Mental Hygiene. The bills also update the powers and penalties needed by local health departments to abate nuisances and protect the public health.

Advisory Councils/Commissions

Senate Bill 269/House Bill 423 ***(both passed)*** create a 13-member State Advisory Council on Pain Management to provide advice and recommendations with respect to pain management policy. The council must issue an interim report to the General Assembly that includes recommendations on pain management issues in Maryland by September 30, 2003, and a final report by September 30, 2004. In addition, the bill adds the right to have pain assessed, managed, and treated to the patient's bill of rights for hospitals and related institutions.

Senate Bill 289/House Bill 454 ***(both passed)*** extend the Community Services Reimbursement Rate Commission's termination date by three years from September 30, 2002, to September 30, 2005. The bill also expands the commission's duties in several areas. The commission is required to: (1) assess the source of revenue for wages paid by provides; (2) assess the impact of consumer safety costs and whether the rates have been adjusted to provide for such costs; (3) develop methodologies for calculating rate update factors and recommend annual rate update factors that use these methodologies; (4) review the data reported in the DDA annual cost reports and use the data to develop relative provider performance measures; (5) work with MHA to expand the use of any billing data to evaluate performance in the public mental health system; (6) evaluate proposed regulatory changes that effect rates paid or the rate structure; and (7) include, in its annual report, findings regarding the financial condition of providers and recommendations for the calculation of rate update factors.

House Bill 1141 ***(passed)*** creates a 20-member State Advisory Council on Quality Care at the End of Life. The advisory council will: (1) monitor trends in the provision of end-of-life care; (2) study the impact of State statutes, regulations, policies, and other aspects of public policy on the provision of care at the end of life; (3) make recommendations regarding end-of-life care to the Office of the Attorney General, DHMH, the Department of Aging, and other State agencies; (4) advise the General Assembly on end-of-life care legislative proposals; (5) promote public and professional education in this area; and (6) carry out other duties requested by the Governor or the General Assembly.

Senate Bill 788 ***(passed)*** establishes a Statewide Advisory Commission on Immunizations to determine where community vaccine shortages exist and which vaccines are in short supply, recommend a plan to equitably distribute vaccines, and study and make recommendations about other related issues as determined by the commission.

Miscellaneous Program Changes

AIDS Insurance Assistance

House Bill 86 ***(Ch. 30)*** extends the termination date of the Maryland AIDS Insurance Assistance Program (MAIAP) an additional eight years. MAIAP pays for an eligible individual's private health insurance premiums under the federal Consolidated Omnibus Reconciliation Act of 1985 or other supplemental insurance. Individuals with HIV/AIDS who are too ill to continue working as a result of the disease are at risk of losing their private health insurance. Under MAIAP, DHMH pays health insurance premiums to an eligible individual's insurance carrier or employer. MAIAP permits eligible individuals to maintain their private health insurance and remain with their established medical providers without having to spend down limited assets to qualify for Medicaid. MAIAP was established as a two-year pilot program in 1990 and has been subsequently extended in 1992, 1994, and 1998.

Health Occupations

Scope of Practice

Physician Assistants

***House Bill 533* (passed)** makes several modifications and clarifications to the statute governing physician assistants. The bill clarifies the grounds on which the Board of Physician Quality Assurance (BPQA) can modify or disapprove a delegation agreement. The bill also provides that individual members of BPQA are not civilly liable for actions regarding the approval, modification, or disapproval of delegation agreements. Also, BPQA is authorized to impose a civil penalty of up to $5,000 on an individual who practices as a physician assistant without certification.

Medical Radiation Technologists and Nuclear Medicine Technologists

The Department of Legislative Services (DLS) recommended in its sunset review of BPQA that the regulatory provisions relating to medical radiation and nuclear medicine technologists, as well as the Medical Radiation and Nuclear Medicine Technology Advisory Committee, be codified in a manner similar to the Maryland Respiratory Care Practitioners Act. ***House Bill 518* (passed)** establishes the Maryland Radiation Oncology/Therapy Technologists, Medical Radiation Technologists, and Nuclear Medicine Technologists Act. The bill:

- requires BPQA to adopt regulations for the certification of radiation oncology/therapy technologists, medical radiation technologists, and nuclear medicine technologists;
- grandfathers in certain individuals that currently practice radiation/nuclear medicine technology;
- requires BPQA to set reasonable fees for certification;
- establishes a Radiation Oncology/Therapy Technology, Medical Radiation Technology, and Nuclear Medicine Technology Advisory Committee within BPQA;
- specifies certification requirements;
- authorizes disciplinary procedures under specified circumstances;
- requires hospitals and other related institutions to report disciplinary information to BPQA;

- establishes criminal and civil penalties for individuals who violate the provisions and direct payments of the monetary penalties to the BPQA fund; and

- permits BPQA to keep all certification fees collected from technologists.

A person who violates any provision is guilty of a misdemeanor and subject to a maximum fine of $1,000, or imprisonment not exceeding one year, or both. A violator is also subject to a maximum civil fine of $5,000. The bill also provides that the Radiation Oncology/Therapy Technologists, Medical Radiation Technologists, and Nuclear Medicine Technologists Advisory Committee is subject to termination effective July 1, 2013.

Pharmacists

Senate Bill 676/House Bill 781 ***(both passed)*** authorize physicians and pharmacists to enter into voluntary drug therapy managements contracts. The bill provides for the several steps involved in the establishment of a drug therapy management contract. First, a pharmacist must be approved by the State Board of Pharmacy to enter into a physician-pharmacist agreement. Second, a disease-state specific protocol, which sets out the predetermined course of treatment that the physician and pharmacist will follow when managing a patient, must be approved by BPQA and the State Board of Pharmacy. Third, a physician-pharmacist agreement, which is disease-state specific and specifies the approved protocols under which the physician and pharmacist may manage patients, must be approved by BPQA and the State Board of Pharmacy. Finally, a physician initiates a therapy management contract with a patient and a pharmacist that provides for a patient-specific agreement and can only be in relation to conditions that have approved protocols.

BPQA and the State Board of Pharmacy must report to the Governor and General Assembly by October 1, 2006, on the effect of these provisions and make any recommendations for legislative or regulatory action. The Department of Health and Mental Hygiene (DHMH) must conduct a study to assess the outcomes achieved by drug therapy management agreements. ***Senate Bill 676/House Bill 781*** are subject to termination as of May 31, 2008.

Nurses

Senate Bill 466/House Bill 805 ***(both passed)*** require the State Board of Nursing, in consultation with health maintenance organizations (HMOs) operating in the State, to report on whether HMOs should individually credential nurse practitioners and allow HMO members to designate a nurse practitioner as a primary care provider. A more detailed discussion of these bills may be found under "Health Insurance" within this Part J.

Dental Hygienists

To increase access to dental care, the State Board of Dental Examiners has issued waivers on a case-by-case basis to allow dental hygienists to practice under the "general supervision" of dentists in government-owned facilities serving the poor, elderly, or disabled. "General supervision" means the supervising dentist maintains overall responsibility for quality of care, but may or may not be on the premises when the dental hygienist provides services.

Chapter 595, Acts of 1998 authorized licensed dental hygienists to practice dental hygiene under the "general supervision" of a licensed dentist in a facility that reports to the State Board of Dental Examiners. The provisions of Chapter 595, Acts of 1998 terminated on September 30, 2001. In response, ***Senate Bill 261 (passed)*** was introduced in order to continue the ability of authorized dental hygienists to practice dental hygiene under this "general supervision." ***Senate Bill 261*** requires the board to report to the General Assembly by December 31, 2003, and annually thereafter on the facilities operating under general supervision pursuant to the bill and the identities of supervising dentists providing general supervision.

Professional Counselors and Therapists

To increase employment opportunities for graduate counseling students who must acquire clinical experience before qualifying for State licensure, ***Senate Bill 575/House Bill 421 (both passed)*** establish new licenses for graduate alcohol and drug counselors, graduate professional counselors, and graduate marriage and family therapists. These graduate students may practice counseling without licensure for a limited time if the individual:

- has passed the appropriate board-approved national professional counseling examination;
- is working under the supervision of a licensed practitioner;
- is fulfilling experiential requirements for licensure; and
- has a master's or doctoral degree in professional counseling or marriage and family therapy that meets specified educational requirements. Individuals must be approved by the board before they can represent to the public that they are approved to practice and use the appropriate corresponding titles and initials.

House Bill 253 (Ch. 49) authorizes a licensed clinical professional counselor to independently file and present a petition for emergency psychiatric evaluation of an individual. The bill adds licensed clinical professional counselors to the list of individuals who may currently petition for emergency psychiatric evaluation which

includes clinical social workers, physicians, psychologists, police officers, and health officers and their designees.

Social Workers

***Senate Bill 575* (passed)** creates a provisional graduate social worker license. An eligible applicant must have received a master's degree from a program that had formal "candidacy" status from the Council on Social Work Education (CSWE) at the time the degree was awarded. The license may be issued for three years or until the program attains accreditation status from CSWE, whichever is less. If a provisional licensee's degree program becomes accredited during the license period, the licensee is permitted to apply for a license as a graduate social worker.

Morticians

***House Bill 516* (passed)** establishes an executor license under the State Board of Morticians. The license authorizes a personal representative of a deceased mortician's estate to continue operation of the morticians funeral business for up to one year and assist with the planning and conducting of funeral services. A licensed mortician must directly supervise the business and provide embalming services.

Health Occupations Boards

State Board of Psychologists

***Senate Bill 327/House Bill 686* (both passed)** increase the number of days from 60 to 120 within which the State Board of Examiners of Psychologists must provide notice to a licensed psychologist if a complaint has been filed against the psychologist. The bills also clarify that a suspension of a psychologist's license for more than one year may not be stayed pending judicial review.

Sunset Evaluations

During the 2002 session, several Health Occupations Boards were subject to the Maryland Program Evaluation Act ("Sunset Law"). The following boards were extended in response to the recommendations and findings of the sunset review and evaluation process conducted by DLS and will ensure the continuation of the boards' mandated responsibilities of protecting the citizens of Maryland through the regulation of the health professionals governed by the boards:

Preliminary Sunset Evaluations

Senate Bill 126/House Bill 149 ***(both passed)*** extend the termination date for several health occupations boards and one advisory committee as a result of preliminary sunset evaluations conducted by DLS. The following boards were waived from full sunset evaluation and extended as follows:

- State Board of Examiners of Audiologists, Hearing Aid Dispensers, and Speech-Language Pathologists, extended until July 1, 2016;
- State Board of Professional Counselors and Therapists, extended until July 1, 2009;
- State Board of Occupational Therapy Practice, extended until July 1, 2015; and
- Physician Assistant Advisory Committee, extended until July 1, 2013.

State Board of Morticians

Senate Bill 420/House Bill 465 ***(both passed)*** extend the termination date of the State Board of Morticians by six years to July 1, 2008. The bills also codify the board's existing inspection policy to provide for greater flexibility when inspecting funeral homes.

State Board of Nursing

Senate Bill 459/House Bill 461 ***(both passed)*** extend the termination date of the State Board of Nursing by ten years to July 1, 2013. The bills also authorize the board to set the per diem allowances of board members according to the board's budget. In addition, the bills require the board to report on the implementation of non-statutory changes included in the full sunset evaluations of the board, including:

- developing an action plan to improve the board's communication with licensees;
- improved monitoring of nursing staff agencies through the implementation of a memorandum of understanding with the Office of Health Care Quality;
- developing an action plan to reduce the backlog in complaints; and
- enhancing efficient use of personnel and technology in order to reduce operating costs.

State Board of Examiners of Nursing Homes

Senate Bill 718/House Bill 847 ***(both passed)*** extend the date for the State Board of Examiners of Nursing Home Administrators until July 1, 2013. The bills also expand

the statute of limitations for prosecuting misdemeanor offenses and alter the definition of unauthorized practice to include persons who knowingly induce, aid, direct, or supervise an unlicensed nursing home administrator. In addition, the bills require the board to report to the General Assembly on Maryland's requirements for an administrator-in-training program.

State Board of Pharmacy

Senate Bill 418/House Bill 462 ***(both passed)*** extend the sunset termination date for the State Board of Pharmacy until July 1, 2013. The bills also codify the board's current practice of annually inspecting pharmacies, repeal the State manufacturer's permit, and limit discovery of medication orders in order to facilitate pharmacists in voluntarily tracking medication errors.

State Board of Examiners of Psychologists

Senate Bill 458/House Bill 463 ***(both passed)*** extend the sunset termination date for the State Board of Examiners of Psychologists until July 1, 2013. The bills also require the board to report to the General Assembly on a financial plan to bring expenditures in line with revenues.

State Board of Physician Quality Assurance

Senate Bill 613/House Bill 846 ***(both failed)*** would have extended the termination date of the State Board of Physician Quality Assurance (BPQA) by five years.

The bills incorporated several recommendations of the full evaluation of the BPQA conducted by DLS, including:

- repealing the requirement that factual evidence in a disciplinary hearing be supported by clear and convincing evidence, thereby returning to a preponderance of the evidence standard;
- restructuring the peer review process, to authorize the board to competively contract with an outside entity to conduct peer review;
- altering the membership of the board to include more physicians and more consumers;
- establishing a new process for nominating physicians to the board;
- requiring the board to maintain a web site that serves as a single point of entry where all physician information is available to the public;

- requiring that profiles for new licensees be developed within 30 days after a license is issued and include medical education, criminal history, and final disciplinary acts; and

- repealing the requirement that BPQA distribute 14 percent of the fees received by the board to the State Scholarship Administration.

If the General Assembly does not pass a bill extending the termination date of the BPQA during the 2003 session, the BPQA will terminate July 1, 2003.

Health Care and the Workplace

House Bill 329 ***(passed)*** prohibits an employer from taking or refusing to take certain actions regarding a licensed or certified health care employee because the employee discloses or threatens to disclose unlawful activity of the employer to a supervisor or board. The bill also applies to an employee who testifies before a public body that is conducting an investigation into an employer's unlawful activity, or an employee that objects to or refuses to participate in unlawful activity. The protection provided by the bill applies if the employee has a reasonable, good faith belief that the employer has, or still is, engaged in an action or policy that is a violation of law and poses a substantial, specific public health safety risk. An employee who is subject to a violation of the bill's provisions may bring a civil action for the removal of an adverse personnel record, reinstatement of the employee's position, including full fringe benefits and seniority rights, compensation for lost wages and other income, and, if the employee prevails, reasonable attorney's fees. The civil action must be brought within one year after the alleged violation or within one year after the employee first became aware of the alleged violation. The bill does not apply to State employees, who are protected by a separate whistleblower statute.

Nurse Overtime

Senate Bill 537 ***(passed)*** prohibits an employer from requiring a nurse to work more than the nurse's regularly scheduled hours according to a predetermined work schedule except in specified emergency circumstances. A nurse may be required to work overtime if a condition of the nurse's employment requires on-call rotation or the nurse works in community-based care. The bill provides that a nurse may not be considered responsible for a patient's care beyond the nurse's predetermined work schedule if the nurse has notified another appropriate nurse of the patient's status and has transferred responsibility for the patient's care to another appropriate nurse or properly designated individual. The employer must exhaust all good-faith, reasonable attempts to ensure that appropriate staff is available to accept responsibility of a patient's care beyond a nurse's predetermined work schedule.

Statewide Commission on the Crisis in Nursing

Chapters 257 and 258 Acts of 2000 established the Statewide Commission on the Crisis in Nursing in order to examine workplace issues, including work hours and workloads, and how these issues impact the State's ability to attract and retain nurses. ***Senate Bill 46/House Bill 590*** ***(both passed)*** require the commission to identify a technology-driven point-of-care application, in consultation with an individual with expertise in technology-driven point-of-care applications, to: (1) maximize nursing productivity and increase the quality of patient care; and (2) improve the work environment infrastructure in health care facilities.

Medical Review Committees

Medical review committees are committees or boards within an alternative health care system that: (1) evaluate and seek to improve the quality of health care provided; (2) evaluate the need for, and the level of, performance of health care; (3) evaluate the qualifications, competence, and performance of providers of health care; or (4) evaluate and act on matters that relate to the discipline of any health care provider. The proceedings, records, and files of a medical review committee are not discoverable and are not admissible in evidence in any civil action. ***Senate Bill 421*** ***(passed)*** clarifies that all health care practitioners have the protections afforded to those reporting to a medical review committee and provides that certain good faith communications intended to lead to redress of a matter within the scope of a medical review committee are protected even when they are not made directly to a medical review committee.

Credentialing

A health insurer, nonprofit health service plan, health maintenance organization, and dental plan organization must use a uniform credentialing form for credentialing a health care provider for participation on a provider panel. ***Senate Bill 819/House Bill 1157*** ***(both passed)*** require the Secretary of Health and Mental Hygiene, in consultation with relevant stakeholders, to develop a uniform standard credentialing form for hospitals. Once the form is developed, each hospital will be required to use the form as a condition of licensure.

Access to Capital for Nonprofit Health Service Plan

Senate Bill 412 ***(passed)*** expands the types of institutions and facilities the Maryland Health and Higher Educational Facilities Authority may assist to include a nonprofit health service plan that holds a certificate of authority and provides health insurance policies or contracts in the State. A more detailed discussion of this bill may be found under the subpart "Health Insurance" within this Part J.

Health Care Facilities and Regulation

Continuing Care Retirement Communities

***House Bill 321* (Ch. 57)** and ***Senate Bill 180* (passed)** repeal the June 30, 2002, termination date for provisions that allow Continuing Care Retirement Communities (CCRCs) to have direct admissions to their nursing home beds and still retain their Certificate of Need (CON) exemption. Prior to 2000, CCRCs were excluded from CON regulation because they limited their nursing home bed admissions to subscribers of their own communities and were not perceived as direct competitors with CON-regulated nursing homes. Permitting direct admission to CCRC nursing home beds, as provided by Chapter 248 of 2000, puts CCRCs in direct competition with traditional nursing homes, potentially reducing nursing home admissions. According to a January 1, 2002, report by the Maryland Health Care Commission, there were 86 direct admissions to CCRCs during a one-year period, a number that did not significantly impact admissions to traditional nursing homes.

***Senate Bill 355* (passed)** adopts recommendations made by the Department of Aging's Continuing Care Advisory Committee. It broadens the health related services CCRCs must provide and what it means to make medical and nursing services or other health related services available to subscribers. Health related services must include priority admission to a nursing home or assisted living program, or assistance in daily living activities that do not include meals. Making available either medical and nursing services or other health related services means the provider or affiliate has the services readily accessible for subscribers whether or not the services are specifically offered in the written agreement for shelter.

The bill also enables people to receive refunds from CCRCs more quickly if they move out within the first 90 days. It also requires providers to refund an individual's entrance fee within 60 days of an agreement being terminated or the individual's death under certain circumstances. This bill is also discussed in Part M - Elderly of this *90 Day Report*.

Health Insurance

CareFirst, Inc. Conversion and Acquisition

The conversion of nonprofit health entities, including hospitals, health maintenance organizations, and health service plans, has been the subject of great debate in recent years. State regulators have grappled with preserving the public assets of nonprofit entities that choose to convert to for-profit corporations. Traditionally, nonprofit entities do not have to pay taxes on the basis that they provide a direct benefit to the community. The assets accrued by a nonprofit are generally considered public assets and in the event of a conversion must remain with the public.

On November 20, 2001, CareFirst BlueCross BlueShield announced its intention to convert to a for-profit company and subsequently be acquired by California-based WellPoint Health Networks, Inc. CareFirst is statutorily obligated to file a conversion application with all three jurisdictions to which its charitable assets would inure: Maryland, the District of Columbia, and Delaware. That application was filed with the Maryland Insurance Administration on January 11, 2002. The $1.3 billion purchase price is to be paid in cash ($450 million) and stock options ($850 million) and divided among the three jurisdictions.

The General Assembly introduced a variety of bills this session that addressed CareFirst's application for acquisition. Some would have banned the acquisition entirely. Others would have codified CareFirst's historical nonprofit mission if the acquisition were not completed. Many were intended to modify the acquisition process, giving more power to the State regulator entity. The two House bills passed by the General Assembly modify the acquisition process. The Senate bills modify the acquisition process and permit a nonprofit health service plan to finance capital improvement projects through the Maryland Health and Higher Educational Facilities Authority.

***Senate Bill 487/House Bill 2* (both passed)** shift the burden of proving whether an acquisition is in the public interest from the regulating entity to the proponents of the acquisition. The bills also repeal a provision of current law that deems an application approved if the appropriate State regulating entity fails to take action on the application within 60 days after the record has been closed. Both changes give the appropriate regulating entity more control over the determination of whether an acquisition is in the public interest.

***House Bill 1254* (passed)** incorporates various regulatory goals that had been introduced in other bills this session. The bill prohibits a nonprofit health service plan (plan) from organizing under the laws of another jurisdiction unless the Insurance Commissioner determines that it is in the public interest. It prohibits a plan from altering its structure, operations, or affiliations if such alterations result in the plan's for-profit

activities becoming so substantial that the Insurance Commissioner determines the plan's purpose may no longer be characterized as operating as a nonprofit health service plan.

The bill also authorizes the Insurance Commissioner to revoke the certificate of authority of a foreign corporation operating a nonprofit health service plan that is affiliated with a Maryland nonprofit health service plan, if the affiliation is terminated.

The bill prohibits a nonprofit health service plan officer, director, or trustee from receiving any immediate or future remuneration as the result of an acquisition or proposed acquisition.

The bill requires public or charitable assets distributed to a public or nonprofit charitable entity under the State's nonprofit health entity acquisition laws to be in the form of cash. In addition, the appropriate regulating entity must determine whether a payment or "break-up fee," required under an acquisition contract or agreement if the agreement or contract is broken by the nonprofit health entity, is in the public interest.

The bill further provides that a determination regarding the acquisition of a nonprofit health entity may not take effect until 90 calendar days after the date the determination is made. This provision effectively reserves the right of the General Assembly to review and disapprove, by an act of the legislature, the acquisition of a nonprofit health entity.

Senate Bill 412 ***(passed)*** authorizes a nonprofit health service plan to finance capital improvement projects through the Maryland Health and Higher Educational Facilities Authority.

Health Maintenance Organizations

Acquisitions Disclosure and Control Act

Senate Bill 90 ***(passed)*** subjects Health Maintenance Organizations (HMOs) and Managed Care Organizations to the Maryland Insurance Acquisitions Disclosure and Control Act. That Act protects the interests of policyholders and stockholders who may be adversely affected when control of an insurer is sought by another entity or when acquisition of an insurer would lessen competition or create a monopoly in the insurance business.

Noncontracting Providers

Senate Bill 466/House Bill 805 (***both passed***) extend the termination date from June 30, 2002, to June 30, 2005, of Chapter 275 of 2000 and Chapter 423 of 2001, which specify certain HMO reimbursement rates for noncontracting providers and trauma physicians who provide services to HMO enrollees. The bill also requires two studies, the first by the Maryland Health Care Commission (MHCC) and the Health Services Cost Review Commission (HSCRC) on health care provider reimbursements by commercial insurers and self-pay patients in Maryland, and the second study by the Board of Nursing on the use of nurse practitioners by HMOs to provide primary care services.

Senate Bill 562/House Bill 936 ***(both failed)*** would have required an HMO to reimburse a noncontracting emergency room physician at the greater of 140 percent of the rate paid by Medicare, or the rate as of January 1, 2001, that the HMO paid in the same geographic area to a similarly licensed provider. ***Senate Bill 466/House Bill 805*** contain language which requires MHCC and HSCRC to study the feasibility of expanding the hospital rate setting system to include reimbursement of hospital-based physicians.

Substantial, Available, and Affordable Coverage (SAAC) Reform and Senior Prescription Drug Program (Health Insurance Safety Net Act of 2002)

Approximately 30 states operate high-risk pools or other programs that grant medically uninsurable individuals access to health insurance coverage. Risk pool premiums are generally higher than comparable private insurance, but all pools have caps on premiums set by legislation to benefit consumers. Most risk pools have premiums that are 125 to 150 percent of the average premium for comparable individual market coverage. The National Association of Insurance Commissioners' model risk pool legislation calls for an initial floor equal to 125 percent of the average premium, and a cap of not more than 200 percent of the average premium. Because the individuals enrolled in risk pools tend to be less healthy and more likely to use health care services, the pool's costs always exceed the premiums that can be collected. As a result, premium revenue is generally supplemented with other funds. Some states choose to tax health insurers or health care providers to supplement the enrollees' premiums. Others fund high risk pool losses with general revenues or money from excise taxes on alcohol, cigarettes, and other items.

In Maryland, instead of operating a high risk pool, the State offers a financial incentive to health insurance carriers that offer a Substantial, Available, and Affordable Coverage (SAAC) product to individuals who are medically uninsurable because of their health status. Carriers that offer a SAAC product receive a four percent differential on hospital rates allowing them to pay less for hospital charges for certain enrollees than

carriers that do not offer a SAAC product. Prior to the start of the 2002 session, each of the State's three insurance carriers that offer a SAAC product expressed their intention to withdraw from the program. As a result, the General Assembly passed legislation during the 2002 session reforming the SAAC product and the related Short-Term Prescription Drug Subsidy Plan.

House Bill 1228 ***(passed)*** establishes the Maryland Health Insurance Plan (MHIP) for medically uninsurable individuals and the Senior Prescription Drug Program for Medicare beneficiaries whose household income is at or below 300 percent of the federal poverty level.

The Maryland Health Insurance Plan is an independent unit of the Maryland Insurance Administration, established to decrease uncompensated care costs by providing access to affordable, comprehensive health benefits for medically-uninsurable residents by July 1, 2003. Under the bill, a five-member board is established for MHIP whose responsibilities include:

- adopting a plan of operation for MHIP and submitting the plan to the Insurance Commissioner for approval;
- adopting regulations necessary to operate and administer the plan;
- establishing a standard benefit package to be offered by MHIP;
- establishing premium rates for MHIP that must be from 110 to 200 percent of a standard risk rate;
- selecting a third party administrator to administer MHIP that will perform such functions as: (1) eligibility determination; (2) data collection; (3) case management; (4) financial tracking and reporting; (5) claims payment; and (6) premium billing; and
- creating the Maryland Health Insurance Plan Fund, a special nonlapsing fund, consisting of certain premiums and assessments in segregated accounts to be used to operate and administer MHIP and the Senior Prescription Drug Program.

House Bill 1228 provides funding for MHIP through the State's hospital rate setting system. The bill establishes a methodology under which HSCRC collects funds from each acute care hospital in an amount proportionate to the 2002 value of the SAAC differential provided by each hospital. Prior to the start of enrollment under MHIP on July 1, 2003, the bill requires health insurance carriers that currently participate in the SAAC program to continue to insure SAAC enrollees and specifies that one of the three carriers must hold two open enrollment periods for SAAC eligible individuals during

calendar 2002. The bill also requires HSCRC to establish a plan for transitioning from the SAAC program to MHIP in the last quarter of fiscal 2003.

House Bill 1228 renames and alters both the funding mechanism and regulatory oversight of the Short-Term Prescription Drug Subsidy Plan. Beginning July 1, 2003, the Senior Prescription Drug Program will provide 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. The program must be administered by a nonprofit health service plan that issues comprehensive health care benefits in Maryland. Enrollment is limited to the maximum number of eligible individuals subject to funding. An enrollee is subject to a $10 monthly premium, no deductible, and copayments ranging from $10 to $35 per prescription. The board may limit the total annual benefit to $1,000 per enrollee.

The bill also requires a nonprofit health service plan that insures 10,000 or more lives in the State to have a corporate headquarters located in the State.

Continuation of Coverage – Voluntary Employment Termination

House Bill 1158 ***(passed)*** expands Maryland's continuation of health coverage provisions to include an individual who voluntarily terminates employment. Maryland has adopted continuation coverage laws that cover employees who have been involuntarily terminated from employment other than for cause. Maryland's continuation coverage applies to most employers, including those businesses that employ fewer than 20 employees.

Coverage Under Medical Support Notices

House Bill 1192 ***(passed)*** requires the child support enforcement administration to issue a notice in a format prescribed by federal law to enforce the health insurance coverage provisions of a child support order. The Office of the Attorney General advised the Department of Human Resources on March 4, 2002, that legislation must be developed to comply with requirements in the Federal Child Support Performance and Incentive Act of 1998. Federal law requires State child support enforcement agencies to enforce orders for health insurance coverage through the use of the National Medical Support Notice. For a more detailed discussion of child support enforcement legislation see the subpart "Family Law" under Part F - Courts and Civil Proceedings of this *90 Day Report*.

Nonrenewal of Individual Health Benefit Plan

Senate Bill 651/House Bill 754 **(*both passed*)** require a carrier that offers health insurance through an affiliate in the individual market and that elects not to renew all individual health benefit plans in the State, to give notice to each affected individual at least 180 days before the effective date of the nonrenewal. The notice must inform the individual of the option to purchase all other individual health benefit plans currently offered by the carrier's affiliate. A carrier must offer the plan on a guarantee issue basis (i.e., the plan must be offered regardless of health status) and cannot rate the coverage on a substandard basis unless the individual was rated on a substandard basis under the prior coverage. A carrier must waive the preexisting coverage waiting period to the extent that the individual has satisfied a waiting period under the individual's prior policy. If applicable, the Insurance Commissioner can disapprove a plan of withdrawal for health insurance if the carrier has failed to demonstrate compliance with certain renewal provisions in the small group market or the individual market.

Mandated Health Benefits

Mandated health insurance benefits are health care services that must be covered in a health insurance policy or contract. Depending on the mandate, a commercial insurance carrier, nonprofit health service plan, HMO, or dental plan organization must provide the benefit. Currently, Maryland has 39 mandated benefits or offerings for services and provider reimbursement.

Mandated benefits impact health insurance premiums. Legislation passed by the General Assembly in 1999 (Chapter 582) established a statutory affordability cap on mandated benefits of 2.2 percent of Maryland's average annual wage. According to the Maryland Health Care Commission's (MHCC) 2001 report, the full cost of existing mandates is just under 2.1 percent of Maryland's average annual wage. If MHCC determines that the full cost of mandated benefits meets or exceeds the affordability cap, the commission is required by law to perform a comprehensive evaluation of each existing mandate and to present this evaluation to the General Assembly for its consideration. The following mandates were considered by the General Assembly during the 2002 session.

Habilitative Services

House Bill 692 ***(passed)*** defines congenital or genetic birth defect and specifies that the definition includes autism, autism spectrum disorder, and cerebral palsy for the purpose of receiving habilitative services through private health insurance. A carrier determination denying a request for habilitative services or denying payment for habilitative services on the grounds that the condition is not a congenital or genetic birth defect is considered an "adverse decision" and therefore subject to appeal under Maryland's appeals and grievance procedures.

Residential Crisis Services

House Bill 896 ***(passed)*** requires a health insurance carrier that provides hospital, medical, or surgical benefits to individuals or groups to provide coverage for medically necessary residential crisis services and specifies that the services may be delivered through a managed care system.

In Vitro Fertilization

House Bill 738 ***(failed)*** would have modified the requirement for coverage of in vitro fertilization services by health insurance carriers to include situations of male infertility.

Mental Illness – Coverage for Children

House Bill 891 ***(failed)*** would have provided that if a health insurance policy covers inpatient treatment of acute or chronic mental illness at a hospital or residential treatment facility for children, the coverage must extend from the date of admission to the facility to the date when the child becomes potentially eligible for Medicaid coverage.

Policy Exclusions

House Bill 939 ***(failed)*** would have permitted a carrier to offer a limited benefits health insurance policy that excludes mandated health benefits from coverage. The limited benefits policies could not exceed ten percent of the total health benefit policies issued by a particular carrier.

Vaccinations Against Meningococcal Disease

House Bill 1129 ***(failed)*** would have required a carrier to provide coverage for vaccinations against meningococcal disease for an enrollee who is an on-campus resident student enrolled in an institution of higher education.

Small Group Market Reforms

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. CSHBP is a standard health benefit package that carriers must sell to small businesses (50 or fewer employees). CSHBP includes guaranteed issuance and renewability, adjusted community rating with rate bands, and the elimination of preexisting condition limitations.

Chapter 388 of 2001 required an independent evaluation of Maryland's small group market. This study required an examination of the existing small group delivery system in comparison to similar small group markets in other states. The report, issued on February 19, 2002, found that the small group market in Maryland is functioning well and that Maryland's performance on key measures is generally comparable to, and in some instances better than, the study states as a whole. The following issues relating to the small group market were considered by the General Assembly during the 2002 session.

Open Enrollment

Senate Bill 888/House Bill 1427 ***(both passed)*** change the frequency of the open enrollment periods offered to self-employed individuals in the small group market from one every six months to one every 12 months. The recommendation to alter the frequency of the open enrollment periods with respect to the so-called "groups of one," was made in the independent evaluation.

House Bill 1144 ***(failed)*** would have required a carrier to establish an annual open enrollment period for at least 30 consecutive days in each six-month period for self-employed individuals and small employers with fewer than ten eligible employees. As provided under ***House Bill 1144***, a carrier could not deny coverage to a small employer with fewer than ten employees if the small employer was transferring from one carrier to another without a break in coverage and the coverage had been in effect for at least 12 months prior to the date of transfer. Under current law, only self-employed individuals can be required to wait for an open enrollment period to purchase small group health insurance.

Producer Commissions

House Bill 85 ***(Ch. 29)*** prohibits a carrier from implementing a producer commission schedule that varies the amount of a commission based on the size of a small employer group unless the variation: (1) is inversely related to the size of the small employer group; (2) applies to the cumulative premium paid over a specific period of time, is uniformly applied, and is inversely related to the cumulative premium paid during the period of time; or (3) is established by a contract between the carrier and each outside producer.

Community Rate Adjustment

House Bill 1159 ***(failed)*** would have amended the community rate setting methodology for the small group health insurance market by authorizing a carrier to adjust the community rate up to 15 percent based on a particular small employer group's loss or expense experience. In addition, the bill would have increased the allowable community rate adjustment cap from 40 to 50 percent.

Preexisting Conditions

House Bill 935 ***(failed)*** would have allowed a carrier to impose a 12-month preexisting condition provision on a new enrollee if the enrollee had received medical advice, diagnosis, care, or treatment for the condition during the six-month period immediately preceding the effective date of coverage. Additionally, the bill would have changed the preexisting condition provision for a late enrollee from a maximum 12-month period to an 18-month period.

Prescription Drug Coverage

House Bill 679 ***(failed)*** would have required the Maryland Health Care Commission, when determining the benefit package for the Comprehensive Standard Health Benefit Plan, to limit the annual prescription drug benefit to no more than $4,000 per individual.