Part J
Health

Public Health – Generally

Medicaid Funding

The fiscal 2006 budget increases funding for Medicaid and the Maryland Children's Health Program by $146.3 million ($83.1 million general funds) or 3.6 percent bringing total funding for the programs to $4.1 billion ($1.99 billion general funds).

Enhancements

Funds are provided in the budget to maintain 175 additional elderly nursing home eligible individuals in the community ($2 million), raise reimbursement rates for certain types of personal care from $10 to $11 and from $20 to $22 and in some cases $30 per day ($2 million), and initiate a Medicaid buy-in program for the working disabled ($4 million). About 300 people are expected to participate in the buy-in program during fiscal 2006.

Cost Containment Proposed by the Governor

The relatively modest growth in Medicaid costs reflects cost containment actions proposed by the Governor that are expected to save more than $150 million in fiscal 2006. Specific cost containment measures include:

- continuing to cap the number of adult inpatient hospital days for which Medicaid will pay at 100 percent of the average length of stay ($45.2 million);
- providing less than full funding for the nursing home reimbursement formula ($42 million);
- eliminating State funded Medicaid coverage for certain legal immigrants ($7 million);
- freezing medical day care rates ($2 million);
- ending case management for individuals with rare and expensive conditions and transferring this population to managed care ($6 million);

- reducing managed care reimbursement rates by 1 percent ($14 million); and

- expanding prior authorization requirements for drugs not on the State's preferred drug list to include atypical antipsychotic drugs ($4 million).

Funding Restored by the General Assembly

The General Assembly sought to mitigate the impact of selected cost containment actions by restricting $10 million to allow for a 2 percent rather than a 1 percent rate increase for nursing homes; $1.5 million for the purpose of providing coverage to pregnant women who are legal immigrants; almost $1 million to provide a rate increase for medical day care providers; and $6.3 million for the purpose of continuing the Rare and Expensive Case Management Program. Actions in the Budget Reconciliation and Financing Act of 2005 prohibit prior authorization requirements for atypical antipsychotic drugs and require actuarial certification that cost containment will not produce inadequate managed care reimbursement rates.

Underfunding

Despite a $58 million general fund deficiency appropriation, a $35 million general fund shortfall is anticipated for fiscal 2005. The General Assembly restricted $20 million in the State Reserve Fund's Dedicated Purpose Account to address a portion of this underfunding. Any remaining fiscal 2005 bills will be paid with fiscal 2006 dollars.

Medicaid – Community Choice Program Veto Override

Senate Bill 819 of 2004, required the Department of Health and Mental Hygiene (DHMH) to seek a federal waiver to establish the Community Choice Program. The program allows individuals with Alzheimer's and dementia to participate in the Medicaid older adults waiver and to integrate the delivery of long-term care services through a mandatory managed care system. Although the Governor vetoed the bill, the veto was overridden by the General Assembly and ***Senate Bill 819*** became ***Chapter 4*** of the 2004 Special Session.

Chapter 4 requires dually eligible Medicare and Medicaid recipients in the State to enroll in a community care organization (CCO). The CCO will promote the delivery of services in the most appropriate, cost-effective setting, with less reliance on institutional care and greater reliance on less-restrictive community settings. On an annual basis, enrollees may select the nursing home, assisted living, or adult care provider of their choice. The benefits under the program must be identical to the current Medicaid program and an enrollee may not be forced to move from their current provider.

Prior to submitting the proposed federal waiver, DHMH must consult with all relevant parties and submit a copy of the waiver to the Legislative Policy Committee for its review and comment. The program terminates on May 31, 2008.

Medicaid – Capitation Payments

***Senate Bill 707*/*House Bill 85* (both passed)** specify that if the Secretary of Health and Mental Hygiene adjusts capitation payments for a Medicaid managed care organization (MCO) or a certified health maintenance organization (HMO) due to the MCO's or HMO's loss ratio, the MCO or HMO may (1) appeal that decision to the Board of Review and (2) take any further appeal allowed by the Administrative Procedure Act. The bills also (1) require the Secretary of DHMH to adopt regulations relating to the procedures the Secretary will follow for considering MCO financial performance and adjusting MCO capitation payments; (2) provide that for calendar year 2005, the Secretary will maintain the current value based purchasing initiative used to determine MCO penalties, rewards, and disincentives; and (3) prohibit the Secretary from implementing a capitation withhold for any penalty imposed on an MCO.

Medicaid – Incarcerated Enrollees

***House Bill 990* (Ch. 82)** specifies that if a Medicaid enrollee who is 21 to 64 years old and is incarcerated or admitted to an institution for the treatment of a mental illness, DHMH must suspend Medicaid benefits for that individual while the individual is incarcerated or institutionalized and may not terminate program benefits for that individual based on incarceration or institutionalization.

Under the Act, DHMH, the Department of Human Resources, and the Department of Public Safety and Correctional Services must convene a work group to make recommendations on actions to break the cycle of rearrest and reincarceration for individuals with mental illnesses. The work group must report its findings and recommendations by December 1, 2005, to the House Health and Government Operations Committee and the Senate Finance Committee. The benefit suspension requirements are contingent on DHMH's receipt of funding for a new computerized eligibility system for Medicaid and take effect on the date the new system is implemented.

Medicaid – Computerized Eligibility System

***Senate Bill 895* (passed)** authorizes the Maryland Health Insurance Plan (MHIP) board to transfer not more than $15 million from the MHIP fund to the Major Information Technology Development Project fund for the design and development of a computerized eligibility system for the aged, blind, and disabled in the Medicaid program. The eligibility system is subject to federal approval and attainment of federal matching funds.

Stem Cell Research

In August 2001, the Bush Administration limited federal funding for embryonic stem cell research to existing embryonic stem cell lines. Since federal law does not prohibit expansion of embryonic stem cell lines, several states (most notably California) have taken action to fund embryonic stem cell research.

***Senate Bill 751*/*House Bill 1183* (both failed)** would have created a Maryland Stem Cell Research Fund to promote embryonic stem cell research through grants and loans to public and

private entities in the State. The bills would have established a Scientific Peer Review Committee to establish a ranking and rating system for consideration of grant proposals for State-funded stem cell research. A Stem Cell Research Commission created by the bills would have reviewed grant proposals using the system established by the committee and any other criteria established by the Secretary of Health and Mental Hygiene and would have made recommendations on grant awards.

Monies from the fund would have only been used for stem cell research using donated embryos from infertility clinics. Monies from the fund could not have been used for adult stem cell research or embryonic stem cell research involving human therapeutic cloning. Human reproductive cloning would have been prohibited in the State.

House Bill 1356 ***(failed)*** would have created an Adult Stem Cell Research Program within DHMH to promote only stem cell research using adult stem cells.

Community Health

HIV Testing

The list of individuals who may require a hospital to order an HIV test if there has been an exposure between a patient in the hospital and a worker is expanded to include public safety workers under ***Senate Bill 321***/***House Bill 370*** ***(both passed)***. The bills define a public safety worker as (1) any career or volunteer member of a fire, rescue, or emergency medical services department, company, squad, or auxiliary; (2) any law enforcement officer; or (3) the State Fire Marshal or a sworn member of the Fire Marshal's office.

A hospital may also, under specified circumstances, order an HIV test of the blood sample of a patient who has refused to consent to the test. ***Senate Bill 718*** ***(passed)*** requires a hospital prior to ordering an HIV test, to inform a patient of the laws allowing the hospital to order the test and to notify a patient of the results of an HIV test. ***Senate Bill 718*** also requires DHMH and the Maryland Institute for Emergency Medical Services Systems (MIEMSS) to adopt regulations to establish information collection procedures on exposures and refusals to consent to an HIV test by a patient. DHMH and MIEMSS must report to the General Assembly annually on the collected information.

Bone Marrow Donation

House Bill 565 ***(passed)*** requires a hospital that offers bone marrow transplant services to allow an individual to donate bone marrow to any individual, so long as the physician authorizing the donation determines that the donation is in the best interest of the donee and there is not a substantial risk of medical injury to the donor.

Access to Health Care

Senate Bill 716/***House Bill 627*** ***(both passed)*** create an independent Community Health Care Resources Commission to increase access to primary and specialty health care for lower-income individuals and provide operating grants to community health resource centers around the State. The bills also alter the Maryland Pharmacy Discount Program by providing access to

prescription drugs to uninsured individuals with a family income below 200 percent of the federal poverty level and include funding for DHMH to develop a new electronic eligibility system for the aged, blind, and disabled, and require the commission to develop criteria for providing certain out-patient based specialty care.

The bills also create a joint legislative task force on universal access to quality and affordable health care, composed of four senators and four delegates and to be staffed by the Department of Legislative Services. The task force is charged with studying and making recommendations on the feasibility of implementing innovative State health care programs in Maryland.

While the bills dedicate significant funding to these programs ($3 million for fiscal 2006, $8 million for fiscal 2007, and potentially more in later years), it is expected that the bills will have little to no impact on general fund spending. Funding for the programs provided for in the bills will come from the value of the CareFirst premium tax exemption that is no longer needed to fund the Senior Prescription Drug Assistance Program.

A Federally Qualified Health Center (FQHC) Grant Program is included in ***Senate Bill 716***/***House Bill 627*** and in ***Senate Bill 210***/***House Bill 250*** ***(both passed).*** On the recommendation of the Secretary of Health and Mental Hygiene, the Board of Public Works may make grants to counties, municipal corporations, and nonprofit organizations for (1) the conversion of public buildings to FQHCs; (2) the acquisition of existing buildings for use as FQHCs; (3) the renovation of FQHCs; (4) the purchase of capital equipment for FQHCs; or (5) the planning, design, and construction of FQHCs.

Health Facilities Notification

House Bill 928 ***(passed)*** requires the Secretary of Health and Mental Hygiene to notify the Howard County health officer when DHMH receives an application for licensure or certification of a health facility or program that will serve 16 or more individuals. The Howard County health officer must then inform the Howard County Council of the application.

Child Abuse and Neglect

Senate Bill 782/***House Bill 1341*** ***(both passed)*** create a Child Abuse and Neglect Centers of Excellence Initiative within DHMH. The initiative will train providers in regional centers of excellence on the diagnosis and treatment of child abuse and neglect.

House Bill 839 ***(passed)*** allows a child abuse or neglect record and report to be disclosed to an addiction specialist under specified conditions. The addiction specialist must receive the information regarding the family's circumstances and any evidence that substance abuse exists.

Autoimmune Disease

Senate Bill 909/***House Bill 1494*** ***(both passed)*** establish the Task Force to Study the Impact of Autoimmune Disease in Maryland. The task force must study various aspects of autoimmune disease, including costs, research, services and service gaps, training needs, and

public awareness campaigns. DHMH is required to report its findings to the Governor and the General Assembly on or before December 1, 2005 and 2006.

Lead Paint Poisoning Prevention

***Senate Bill 212* (failed)/*House Bill 251* (passed)** make several changes to the reduction of lead risk in housing programs administered by the Maryland Department of the Environment, including lowering the elevated blood lead level that triggers notification by local health departments. For a more in depth discussion of these bills, see the subpart "Environment" under Part K – Health of this *90 Day Report*.

Health Care Decisions and Medical Records

Advance Directives

***Senate Bill 247* (passed)** clarifies that a health care agent, as designated by an advance directive, is a personal representative who may receive protected health information to make an informed decision regarding an individual's health care when the individual is incapable of doing so. The health care agent is required to act in accordance with the federal Health Insurance Portability and Accountability Act when receiving protected health information.

Medical Decision Making Act of 2005

***Senate Bill 796* (passed)** establishes a Life Partnership Registry in DHMH for same sex and opposite sex couples who reside in Maryland for the purpose of conferring visitation rights and rights to make medical decisions in certain circumstances. The bill provides for the issuance and termination of certificates of life partnerships. DHMH must issue a confirmation number of the Life Partnership when issuing a certificate, and may not confirm the existence of a Life Partnership unless an authorized person requests the information and gives DHMH the confirmation number of the life partnership. The bill may not be construed to conflict with State policy that a valid marriage is only a marriage between a man and a woman.

Medical Record Authorization

***Senate Bill 690* (passed)** alters the requirements for disclosing a medical record without the authorization of the person in interest. A medical record must be disclosed by a health care provider if the provider receives (1) a written assurance from the party or the attorney representing the party seeking the medical records that a person in interest has not objected to the disclosure and 30 days have passed since the notice was sent, or a person in interest's objections were resolved and the disclosure request is in accordance with the resolution; (2) proof that service of the subpoena, summons, warrant, or court order was waived by the court for good cause; or (3) copies of specified documents were sent to the person in interest.

Health Records Access

***Senate Bill 251* (passed)** creates the Task Force to Study Electronic Health Records and the current and potential expansion of electronic health record utilization in Maryland, including electronic transfer, electronic prescribing, computerized physician order entry, and the cost of

implementing these functions. The task force must report its findings to the Governor and the General Assembly by December 31, 2007, when the task force terminates.

Rate Setting

***Senate Bill 577*/*House Bill 896* (both passed)** extend the termination date for the Community Services Reimbursement Rate Commission from September 30, 2005, to September 30, 2008, and extends the commission's reporting deadline to October 1, 2008. The commission, with respect to the Developmental Disabilities Administration, must study the variation in transportation costs among service providers and recommend whether the rates should be adjusted for such costs. With respect to the Mental Hygiene Administration, the commission must review the changes in the payments for and utilization of psychiatric rehabilitation services associated with the shift to paying for these services by case rates.

Developmental Disabilities

***Senate Bill 834*/*House Bill 579* (both passed)** create a Pilot Program to Study and Improve Screening Practices for Autism Spectrum Disorders administered by the Maryland State Department of Education. The pilot program's purpose includes assessing autism spectrum disorders screening practices used in pediatric health care settings and implementing those screening practices at well visits for 12 to 36-month old children in at least two Maryland jurisdictions. The bill takes effect July 1, 2005, and terminates June 30, 2008.

***Senate Bill 395*/*House Bill 309* (both passed)** codify the existing State Traumatic Brain Injury Advisory Board. The advisory board consists of 36 members and is charged with investigating the needs of individuals with traumatic brain injuries. The advisory board must report annually to the Governor and the General Assembly until its termination on September 30, 2008.

Mental Health

Clinical Review Panels

Senate Bill 163 ***(Ch. 91)*** permanently repeals the termination date of the statute that governs the forcible administration of anitpsychotic medication in nonemergency situations to involuntarily committed patients with mental disorders. A clinical review panel determines whether the medication should be administered to the patient. Procedural due process protections are provided in the law as the patient has the right to attend the review panel and may appeal the decision of the review panel.

Other Mental Health Issues

Senate Bill 830/***House Bill 459*** ***(both passed)*** allow Baltimore City to designate Baltimore Mental Health Systems, Inc., the city's core service agency, as the Mental Health Advisory Committee for the city.

Senate Bill 544/***House Bill 796*** ***(both passed)*** establish a Joint Committee on Access to Mental Health Services to monitor access to public mental health services for eligible individuals and medically necessary mental health services for individuals covered by private insurance. An annual report is due to the Governor and the General Assembly on the systemic barriers to accessing mental health services and recommendations to mitigate these barriers.

House Bill 1273 ***(passed)*** alters the composition and number of members on the renamed Task Force on the Needs of Persons with Co-Occurring Mental Health and Substance Use Disorders created by Chapter 297 of 2003. The bill modifies existing study and reporting requirements. The termination date of Chapter 297 is extended from December 31, 2005, to December 31, 2006.

Prescription Drugs

Maryland Pharmacy Discount Program

Senate Bill 728/***House Bill 1143*** ***(both passed)*** alter eligibility requirements for the Maryland Pharmacy Discount Program (MPDP) to cover individuals who earn less than 200 percent of the federal poverty level guidelines, who do not have prescription drug coverage, and who are not eligible for Medicare. The bills also repeal the required amount of a State subsidy for drugs. DHMH must apply to the Centers for Medicare and Medicaid Services for an amendment to the State's existing waiver to implement the eligibility changes. If the amendment is approved, all individuals enrolled in MPDP on or before the date of the amendment application may remain enrolled in MPDP through December 31, 2005. The expansion takes effect on the date the federal government approves the amendment. Other provisions of the bills take effect June 1, 2005.

Maryland Medbank Program

House Bill 1263 ***(passed)*** requires DHMH and the Maryland Medbank Program to report to the Governor and the General Assembly by September 1, 2005 on (1) the effect on program participation of the implementation of Medicare Part D under Title XVIII of the Social Security Act, as amended; (2) the program's availability to uninsured individuals with an annual household income of below 200 percent of the federal poverty level; and (3) the effect that program participation will have on ongoing program costs and the program's efforts to minimize administrative expenses and reduce reliance on public funds.

Prescription Drug Repository Task Force

Senate Bill 441/***House Bill 317*** ***(both passed)*** create the Task Force on the Establishment of a Prescription Drug Repository Program. The task force must examine such issues as the types of drugs that may be donated, who may make or receive donations, standards and procedures for the program, inspection procedures, liability issues, fees, and any other relevant issues. A report with findings and recommendations is due to the Governor and the General Assembly by January 1, 2006. The task force terminates June 30, 2006.

Controlled Dangerous Substances

House Bill 1318 ***(Ch. 91)*** authorizes DHMH to provide for staggered renewal periods for the registration of manufacturers, distributors, and dispensers of controlled dangerous substances. A registration may not be renewed for more than two years. DHMH must adopt regulations to govern the transition to the new expiration date for registrants.

Laboratories

Creutzfeldt-Jakob Disease

House Bill 434 ***(passed)*** adds Creutzfeldt-Jakob Disease to a list of diseases and conditions that medical laboratories must report to specified agencies. Creutzfeldt-Jakob Disease (CJD) is a rare, degenerative brain disorder. There has been concern that bovine spongiform encephalopathy, or "mad cow" disease, may be associated with CJD.

Retests and Public Notification

Issues with regulation of Maryland's laboratories were brought to light in 2004 when Maryland General Hospital's medical laboratory issued possibly invalid HIV and hepatitis C test results to more than 450 individuals. ***Senate Bill 621*** ***(passed)*** provides that if a medical laboratory provided erroneous or questionable test results that pose a threat to the health and safety of patients, the Secretary of Health and Mental Hygiene may order the laboratory to (1) notify physicians or other individuals who ordered the tests of the erroneous or questionable test results; and (2) take any additional measures necessary to reduce or eliminate the threat to the health and safety of patients, including notifying patients and offering retests.

Nursing Facilities and Services

Nursing Home and Assisted Living Facility Oversight

***Senate Bill 701*/*House Bill 893* (both passed)** expand the Oversight Committee on Quality of Care in Nursing Homes' responsibilities to include investigating the quality of care in assisted living facilities. The committee's name is changed to the Oversight Committee on Quality of Care in Nursing Homes and Assisted Living Facilities and the committee's membership is altered to include individuals from the assisted living industry. The committee's December 31, 2005, termination date is repealed and the committee is made a permanent entity within DHMH.

Automated External Defibrillators

***House Bill 1054* (passed)** modifies requirements for the operation of automated external defibrillation (AED) equipment. The bill expands the circumstances in which an individual may use an AED by allowing an individual to operate an AED without restricting operation to an authorized facility. It also removes age of majority requirements for authorized operation of an AED and changes a facility's certification requirements. The bill creates Regional Councils and Regional Council AED committees to provide the Emergency Medical Services Board with better regulatory oversight.

Food Safety and Regulation

Carroll County – Religious Organizations

***Senate Bill 495* (passed)** authorizes a religious organization in Carroll County to sell certain homemade-style food if the food is produced at the organization and meets DHMH health and safety standards.

State and Local Government Operated Food Service Facilities

***Senate Bill 519* (passed)** specifies that food service facilities owned or operated by a State or local unit of government are subject to the health and safety regulation by DHMH.

On-farm Food Service Facilities

***Senate Bill 866* (passed)** provides for an on-farm food service facility license for a food service facility that is located on a farm and operates for up to 30 calendar days each year. The bill allows for up to two renewals of the on-farm food service facility license in a one-year period.

Civil Actions

***Senate Bill 413*/*House Bill 829* (both passed)** allow the Attorney General, on behalf of an indirect purchaser of drugs, medicines, cosmetics, foods, food additives, or commercial feed, to collect damages from a seller or distributor that has been found guilty of overcharging for those products under State antitrust laws.

Health Occupations

Board of Physicians – Patient Safety Initiatives

House Bill 2 ***(Ch. 5 of 2004 Special Session)***, the Maryland Patients' Access to Quality Health Care Act of 2004, enacted two patient safety initiatives that relate directly to the Maryland Board of Physicians (MBP). Specifically, the bill lowered the standard of review for factual findings in a disciplinary proceeding against a physician from being supported by "clear and convincing evidence" – highly probable – to being supported by a "preponderance of the evidence" – more probable than not. The bill also authorized the MBP to directly impose a civil penalty of up to $5,000 against a hospital or a related institution for failing to report a disciplinary action against a licensed physician rather than requiring that this penalty be judicially imposed. A more detailed discussion of other provisions of the Act may be found under Part F – Courts and Civil Proceedings and Part H – Business and Economic Issues of this *90 Day Report*.

Board of Nursing – Temporary Practice Letter

House Bill 399 ***(passed)*** is an emergency bill that authorizes the Board of Nursing to issue a temporary practice letter to a certified nurse practitioner or a certified nurse-midwife subject to the approval of the MBP. This letter allows a certified nurse practitioner or a certified nurse-midwife to continue to practice while awaiting formal approval from the board regarding the written agreement between the nurse and a physician that outlines the nurse's duties. The bill also authorizes the board to issue a temporary practice certificate to certified nursing assistants.

Board of Examiners of Nursing Home Administrators – Inactive Status, Penalties, and Disciplinary Actions

An individual must be licensed by the Board of Examiners of Nursing Home Administrators to practice as a nursing home administrator in Maryland. ***House Bill 873*** ***(passed)*** authorizes the board to issue an inactive license to nursing home administrators and provides that an inactive licensee may not practice as a nursing home administrator in Maryland. Individuals may apply for licensure reactivation if specified requirements are met. The bill also provides the board with additional disciplinary powers.

Sunset Review of the Board of Dental Examiners

The Department of Legislative Services recommended extending the Board of Dental Examiners in its sunset review of the board in 2004. ***House Bill 420*** ***(passed)*** extends the board's termination date until July 1, 2011, and revises the board's membership by adding another licensed dental hygienist to the board, increasing the total number of members on the board.

Podiatrists and Optometrists – Scope of Practice – Expansion

Senate Bill 304/House Bill 611 ***(both passed)*** expand the scope of practice of a licensed podiatrist to include the diagnosis or treatment of the soft tissue below the mid-calf and authorize

a licensed podiatrist to perform specified surgical procedures in a licensed ambulatory surgical center. A licensed podiatrist who chooses to do so must have current surgical privileges at a licensed hospital for the same procedure and meet the ambulatory surgical center's requirements. ***Senate Bill 474/House Bill 719*** ***(both passed)*** expand an optometrist's scope of practice by authorizing a therapeutically certified optometrist to administer or prescribe topical steroids in accordance with a collaborative practice protocol established by the Board of Optometry in consultation with and subject to the approval of the MBP. The bill also adds continuing education and certification requirements for these optometrists.

Miscellaneous

Legislation was introduced on behalf of the Board of Morticians, the Board of Physical Therapy Examiners, and massage therapists. Consumers often purchase "pre-need" burial contracts well in advance of ill health or death to ease funeral preparations when the time comes for burial. ***House Bill 573*** ***(passed)*** is intended to provide some recourse to consumers who find that a funeral establishment has mishandled their funds and does not provide the refund with interest as required by law. The bill authorizes the Board of Morticians to conduct an audit of a licensee that receives pre-need funds, places pre-need funds in a trust, or enters into a pre-need contract. ***House Bill 926*** ***(Ch. 80)*** repeals the limitation that a licensed physical therapist must provide onsite supervision and instruction to a licensed physical therapy assistant practicing limited physical therapy. ***Senate Bill 635/House Bill 545*** ***(both passed)*** revise the educational requirements for certification as a massage therapist or registration as a massage practitioner in the State. These occupations are regulated by the Board of Chiropractic Examiners. An applicant may satisfy the educational component for certification or registration if the applicant was enrolled in a massage therapy school approved by the board on or after March 1, 2004 and graduated by December 31, 2004.

Health Care Facilities and Regulation

Regulation of Freestanding Emergency Departments

Generally, the Maryland Health Care Commission (MHCC) must issue a certificate of need (CON) before a person may build, develop, or establish a new health care facility. The CON process helps the State identify medical needs in the community and prevent the duplication of high-cost capital investments for medical facilities. In 2004, Shady Grove Adventist Hospital, a member of Adventist HealthCare (located in Montgomery County) applied for a CON to construct a five-bed hospital and emergency department located in Germantown. The application was denied by MHCC.

Senate Bill 231/House Bill 426 ***(both passed)*** establish a freestanding medical facility pilot project in Montgomery County. The bills also establish a category of "freestanding medical facility" and require the Department of Health and Mental Hygiene (DHMH) to license these new freestanding medical facilities, which are currently only certified by the department. Emergency regulations are required that would establish a process for reviewing any facilities seeking a license to operate as a freestanding medical facility. The pilot project would be exempt from these regulations. Using information from the pilot project, MHCC, in consultation

with the Health Services Cost Review Commission, must conduct a study of the operations, utilization, and financing of freestanding medical facilities. The findings must be reported to specified committees by December 31, 2007. Third party payors, including Medicaid, must reimburse the pilot project facility at specified rates.

Developmental Disability and Community Mental Health Providers

***Senate Bill 831*/*House Bill 737* (both passed)** specify eligibility requirements for licensure or State funding for an entity that provides either developmental disability services or mental health services. The bills specify residency requirements for the governing bodies of providers and require a provider to submit a detailed business plan to DHMH demonstrating the provider's ability to provide services and its experience in the field. There are approximately 3,220 licensed community programs for individuals with developmental disabilities and about 554 community mental health service providers. The Developmental Disabilities Administration (DDA) is in the process of promulgating regulations that require prospective programs to provide DHMH with substantially similar information as required by the bills.

***Senate Bill 714*/*House Bill 794* (both passed)** require an individual with a developmental disability living in a DDA residential center to receive resource coordination services and have the individual's written plan of habilitation reflect the coordinator's recommendations. For a more detailed discussion, see subpart "The Disabled" within Part M – Human Resources of this *90 Day Report*.

Assisted Living Programs

***Senate Bill 265*/*House Bill 222* (both passed)** broaden the training requirements that currently apply to assisted living managers employed by assisted living programs with 17 or more licensed beds. The bills apply the same training requirements for assisted living managers who are employed by programs that have five or more licensed beds. Chapters 309 and 310 of 2004 provided that, with certain exceptions, by January 1, 2006, an assisted living manager employed by a program with 17 or more licensed beds must complete a DHMH-approved training course.

***Senate Bill 701*/*House Bill 893* (both passed)** require the Oversight Committee on Quality of Care in Nursing Homes, in addition to its quality of care oversight functions for nursing homes, to investigate quality of care in assisted living facilities. Therefore, the oversight committee's name is changed and membership expanded. Additionally, as part of its oversight duties, the committee must take into consideration standards for the identification of the onset of dementia and Alzheimer's disease. The committee must study the provision and quality of mental and behavioral health care services to meet the needs of nursing home and assisted living residents. The bills also repealed the committee's December 31, 2005, termination date.

Proposed Regulatory Changes

DHMH identified several areas where regulation of health care facilities could be strengthened or changed to better serve patients. ***House Bill 1320* (failed),** a departmental bill, would have repealed current accreditation provisions for hospitals, health maintenance

organizations (HMOs), ambulatory care facilities, assisted living facilities, laboratories, home health agencies, comprehensive rehabilitation facilities, and residential treatment centers and instead subject these facilities to a uniform accreditation regulatory system. State law provides for deeming, *i.e.*, the use of independent accreditation for certain specified health care settings that include hospitals, ambulatory care facilities, HMOs, assisted living providers, and laboratories. The lack of regulatory consistency among these settings in the requirements for deeming has resulted in fragmentation of the accreditation and deeming process.

***House Bill 1326* (failed)**, also a departmental bill, would have altered the definition and licensure requirements for assisted living programs to establish three categories of assisted living by the number of people served. When the State's regulation of assisted living programs was developed, proponents recommended that all programs be subject to uniform requirements.

Health Insurance

Small Group Market

Faced with increasing premiums in the small group health insurance market, several bills were introduced in an effort to maintain or increase the affordability of health insurance. One recurring issue is whether self-employed individuals or sole proprietors increase insurance costs for all small businesses. A self-employed individual may purchase insurance either in the individual market, subject to medical underwriting, or in the small group market, which is guaranteed issue. Given such a choice, self-employed individuals or sole proprietors who are very healthy enroll in the individual market and enjoy lower premiums. Those with chronic illnesses enroll in the small group market and tend to make premiums more costly for the entire market. Accordingly, ***Senate Bill 1014* (passed)** prohibits self-employed individuals and sole proprietors from obtaining health insurance in the small group market. An exception is made for those self-employed individuals or sole proprietors who already hold small group policies on September 30, 2005, as long as they maintain their self-employed or sole proprietor status. Further, the Maryland Insurance Administration and Maryland Health Insurance Plan must study the effect of this exclusion on small group market premiums.

***Senate Bill 961*/*House Bill 1017* (both passed)** creates a Joint Legislative Task Force on Small Group Market Health Insurance. The task force must study and make recommendations regarding the small group market relating to rate adjustments, range of products offered, medical loss ratios, association plans, and any other issue the task force deems important. A report on the findings and recommendations is due to specified committees by January 1, 2006.

Large Employers and the Provision of Employee Health Insurance

***Senate Bill 790*/*House Bill 1284* (both passed)** 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 larger 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.

Senate Bill 790*/*House Bill 1284 require 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 bills impose reporting requirements on large employers, as well as civil penalties. 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.

Pharmacy Assistance Programs

Coordination with the New Medicare Part D Prescription Drug Benefit

The federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Medicare Modernization Act or MMA) will provide Medicare-eligible individuals with a prescription drug benefit (Part D) beginning in January 2006. As a result, many State pharmacy assistance programs may be abolished or modified. ***Senate Bill 282*/*House Bill 324* (both passed)** modify a variety of Maryland pharmacy assistance programs to continue to provide pharmacy assistance to low-income individuals as well as maximize State savings that result from the new Medicare drug benefit.

These bills change the eligibility requirements and benefits of the Senior Prescription Drug Program and rename it as the Senior Prescription Drug Assistance Program (SPDAP). SPDAP provides Medicare Part D beneficiaries who meet program requirements with a subsidy for a portion of their Medicare Part D or Medicare Advantage Plan premiums and deductibles.

The bills also exclude Medicare-eligible individuals from coverage under the Maryland Pharmacy Assistance Program (MPAP), which currently covers anyone with a household income under 116 percent of the federal poverty level guidelines. The bills abolish the Maryland Pharmacy Discount Program (MPDP) which provides discounts and, in some cases, a subsidy to Medicare beneficiaries. Since the new Medicare Part D benefit is more comprehensive than what is offered under MPDP, the program is no longer needed. The Department of Health and Mental Hygiene (DHMH) expects to save about $13 million from the MPAP changes and $1 million from the termination of MPDP in fiscal 2006.

The bills create a new State pharmacy assistance program, the Medicare Option Prescription Drug Program (MOPDP), within Medicaid. Subject to federal approval, MOPDP provides low-income Medicare beneficiaries with a coordinated prescription drug plan that maximizes an individual's cost-sharing requirements. DHMH is permitted to contract with one or more prescription drug plans to coordinate drug benefits provided under the program and Medicare Part D drug benefits. While total program costs are expected to be about $17.6 million (50 percent general funds, 50 percent federal funds), DHMH may receive as much as $29.5 million revenues (50 percent general funds, 50 percent federal funds) from prescription drug rebates. Due to the potential windfall programs like the MOPDP could realize for states, the

federal Centers for Medicare and Medicaid announced in March 2005 its disapproval of such programs. Thus, the MOPDP's implementation is uncertain.

Containing State Prescription Drug Costs

House Bill 1287 ***(passed)*** establishes the Maryland Rx Program to achieve savings on prescription drugs for the State Employee and Retiree Health and Welfare Benefit Plan and any local government or other qualifying entity that chooses to participate. Maryland Rx must seek savings through (1) a preferred list of covered prescription drugs, (2) drug manufacturer rebates, (3) negotiated discounts, and (4) other cost-saving measures. This program is similar to one implemented in Wisconsin, Badger Rx, which currently saves Wisconsin more than $25 million annually on the prescription drugs it purchases for state employees. DHMH has also implemented, or is planning to implement, similar savings mechanisms in the Medicaid program. Its preferred drug list saved Medicaid about $31 million in its first year.

Increase Access to Prescription Drugs: ***Senate Bill 728/House Bill 1143*** ***(both passed)*** alter requirements for the Maryland Pharmacy Discount Program to provide access to lower cost prescription drugs for low-income Marylanders who have no pharmaceutical coverage and are not eligible for Medicare. Under the bills, individuals whose annual household income is below 200 percent ($19,140 for a family of one) of federal poverty level guidelines may buy prescription drugs at the Medicaid price, minus any manufacturer rebates and State contribution amounts. Federal approval is required before the program may be implemented. An estimated 37,000 individuals may be eligible for the program.

Mandated Health Benefits

There are currently 40 mandated health benefits that health insurance carriers must cover, and several more were proposed during the 2005 session.

Senate Bill 542/House Bill 458 ***(both passed)*** modify Maryland's mental health mandated benefit to include psychological and neuropsychological testing. The bills result from the findings of the Task Force to Study Access to Mental Health Services. In its final report in December 2004, the task force noted many carriers will not pay for psychological testing even when used for diagnostic purposes. Since diagnostic testing for many physical illnesses is included in commercial health insurance contracts, the inclusion of psychological testing for diagnostic purposes would increase the level of parity between mental health and somatic services in Maryland.

Senate Bill 521 ***(passed)*** creates an exemption from the current law that prohibits a carrier from imposing any copayment, coinsurance, or deductible for specified home visits for mothers and newborn children. Under federal requirements for high-deductible health plans, home visits must be subject to the plan's deductible.

Senate Bill 772 ***(passed)*** prohibits a carrier from charging an enrollee a copayment that is greater than 50 percent of the daily cost of methadone maintenance treatment.

Senate Bill 779 ***(passed)*** requires a carrier to provide coverage for a human papillomavirus (HPV) screening at specified intervals. High-risk types of HPV may lead to cancer.

House Bill 303 ***(passed)*** requires a carrier to provide coverage for specified smoking cessation treatments.

Other

Senate Bill 316/***House Bill 417*** ***(both passed)*** require, beginning October 1, 2006, that if a health insurance carrier requires a pharmacy to submit claims electronically, the carrier must also reimburse the pharmacy electronically, at the pharmacy's request.

Senate Bill 191 ***(passed)*** makes a basic Medicare supplement policy more affordable for people with disabilities. The bill requires a health insurance carrier to make available to an individual who qualifies for Medicare due to a disability, a Medicare Supplement policy plan A, in addition to the policy plans Ca and I that are currently required. The carrier may not charge an individual who is under the age of 65 and Medicare-eligible due to a disability a higher rate for the policy plan A than the average rate charged to an individual age 65 years and older.