Part J
Health and Human Services

Public Health – Generally

Medicaid

Medicaid and Maryland Children's Health Program Funding Increases

The fiscal 2008 budget increases funding for Medicaid and the Maryland Children's Health Program (MCHP) by $290 million ($88 million of general funds) or 6.4 percent bringing total funding for the programs to $4.9 billion ($2.3 billion of general funds). About 650,000 people are expected to enroll in Medicaid or MCHP in fiscal 2008, an increase of 15,000 over projected fiscal 2007 levels.

The budget includes rate enhancements for many provider groups including physicians ($40 million) and nursing homes ($36 million). The physician rate increase represents the third year of a multiyear initiative to raise Medicaid reimbursement rates to 100 percent of Medicare rates. The nursing home rate increase of 3.8 percent will increase to $60 million, or 6.4 percent, upon enactment of ***Senate Bill 101 (passed)***. The bill imposes an assessment on nursing facilities which is then returned to the nursing facilities in the form of Medicaid payments and matched by federal dollars.

Funds are also provided in the budget to phase out hospital day limits ($34 million). Day limits produce savings by capping the number of days of hospital care that Medicaid will fund for adults. The enhanced funding will allow Medicaid to begin paying for every day of necessary hospital care by the middle of fiscal 2008.

The budget also restores State-funded Medicaid coverage for about 3,500 legal immigrant children and pregnant women beginning in fiscal 2007 at a cost of $11 million. Legal immigrants who have resided in the United States for less than five years do not qualify for federally funded Medicaid benefits. Maryland offered State-funded coverage of this population until fiscal 2006 when it was discontinued as a cost saving measure. Coverage was restored in November 2006 following a court ruling that the elimination of coverage violated the Maryland Constitution.

Managed Care Organization (MCO) Enrollment

HealthChoice, Maryland's Medicaid managed care program, provides health care to 79 percent of Medicaid recipients. ***House Bill 367*** ***(Ch. 75)*** requires the Department of Health and Mental Hygiene (DHMH) to provide certain continuity of care for individuals transitioning between the Maryland Primary Adult Care Program (MPAC) and the HealthChoice Program. DHMH must adopt regulations that establish a process through which individuals enrolled in Medicaid within 120 days of becoming eligible for MPAC must be automatically enrolled in the same MCO in which the individual was enrolled under HealthChoice. If an individual was enrolled in MPAC within 120 days of becoming eligible for Medicaid, the individual must be automatically enrolled in the same MCO in which the individual was enrolled under MPAC.

Recovery of Medicaid Payments

The federal Deficit Reduction Act of 2005 (DRA) made significant changes to the Medicaid program. DRA requires states, as a condition of federal financial participation, to enact legislation requiring health insurers to provide information to determine during what period Medicaid recipients may have been covered by a health insurer and the nature of the coverage that was provided. States are to use the information to coordinate payments for services covered under the State Medicaid plan. ***Senate Bill 953***/***House Bill 1313*** ***(both passed)*** require health insurance carriers, health maintenance organizations (HMOs), and certain third parties to provide DHMH with information about individuals eligible for or enrolled in Medicaid so DHMH may determine whether an individual or the individual's spouse or dependent is receiving health care coverage from a carrier and the nature of that coverage. Carriers must accept Medicaid's right of recovery and the assignment to Medicaid of any right of an individual or other entity to payment from the carrier for an item or service for which payment has been made under Medicaid.

Long-term Care Services Study

House Bill 594 ***(passed)*** requires DHMH to conduct a study and analysis of options available to increase access to long-term care services for individuals who are at high risk of institutionalization and meet financial eligibility criteria. The study and analysis must include a review of the provision of long-term care services in other states, a determination of the feasibility of developing criteria for an alternative level of care and increasing access to long-term care services through available waiver options, and a cost-benefit analysis of the options examined. The bill establishes a report deadline of December 1, 2007.

Medicaid Reforms

House Bill 754 ***(failed)*** would have expanded eligibility for Medicaid and MCHP. A more detailed discussion of this bill may be found under the subpart "Health Insurance" of this *90 Day Report*.

Chapter 4 of 2004 Special Session 1 required the Secretary of Health and Mental Hygiene to apply to the Centers for Medicare and Medicaid Services for a waiver to establish the Community Choice Program, a managed care system for Medicaid enrollees receiving long-term

care services. During the 2007 session, the Secretary of Health and Mental Hygiene announced that DHMH would not pursue a waiver to proceed with the Community Choice Program. As a result, legislation to extend the program termination date (***Senate Bill 10*** ***(failed)***) and limit the program scope (***Senate Bill 630***/***House Bill 796*** ***(both failed)***) did not pass.

Oral Health

Senate Bill 181/***House Bill 30*** ***(both passed)*** establish an Oral Health Safety Net Program within DHMH's Office of Oral Health to award grants to local health departments, federally qualified health centers, and entities providing dental services within State facilities to increase dental provider capacity for the underserved. Under the program, $1 million could be awarded for dental health grants in fiscal 2009, 2010, and 2011. The bills terminate September 30, 2011. The fiscal 2008 budget restricts $100,000 in DHMH's budget to support this program.

Smoking

The growing momentum to prohibit smoking in bars and restaurants in Maryland culminated in the passage of a statewide smoking ban. The statewide ban does not preempt a county or municipal government from enacting and enforcing more stringent measures to reduce involuntary exposure to environmental tobacco smoke. Beginning February 1, 2008, ***Senate Bill 91***/***House Bill 359*** ***(both passed)*** prohibit smoking in an indoor area open to the public; an indoor place where public meetings are held; a government-owned or -operated means of mass transportation including buses, vans, trains, taxicabs, and limousines; or an indoor place of employment. This prohibition does not apply to most private homes, residences, and private vehicles, up to 25 percent of hotel or motel rooms, tobacco stores, industrial facilities that involve processing, manufacturing, or distribution of tobacco products, or a research or educational laboratory for scientific research into the health effects of smoking.

Smoking ban waivers may be granted by the health officer of a county if a waiver applicant meets all conditions required under regulations adopted by the Secretary of Health and Mental Hygiene. A waiver applicant must establish in writing that compliance with a specific provision of the bills would cause undue financial hardship or other factors would render compliance unreasonable. Any waiver granted under the bill will terminate January 31, 2011, and no waiver will be granted on or after January 31, 2011.

The bills also establish progressively stringent punishments based on the number of violations for a person who violates a provision of the bills or a regulation adopted under the bills. For a further discussion of ***Senate Bill 91***/***House Bill 359***, see Part H – Labor and Industry of this *90 Day Report*.

Stem Cell Research Funding

Fiscal 2008 is the second year of State funding for stem cell research. At $23 million, the fiscal 2008 appropriation represents an $8 million increase over fiscal 2007. The stem cell

program was established by Chapter 19 of 2006 to support activity at research institutions or private companies in Maryland.

As of April 9, 2007, the $15.0 million in fiscal 2007 funds had not been awarded. Requests for funding total $80.8 million and are divided into two applicant groups. One group represents investigators with some experience in stem cell research who have preliminary data supporting their research topic. There were 41 of these applications totaling $70.7 million, and the awards for this group may be up to $500,000 of direct costs per year for up to three years. The other group represents researchers who are new to the stem cell field and are developing innovative approaches or models without any preliminary data. There were 45 of these applications totaling $10.1 million, and the awards for this group may be up to $100,000 of direct costs per year for up to two years.

The Stem Cell Research Commission was established in July 2006 and is responsible for reviewing the proposed research process for each project and making final decisions about research grant and loan awards. In early 2007, the research commission formed the Scientific Peer Review Committee that considers how the projects adhere to medical research standards. Fiscal 2007 awards are expected to be made in late April 2007.

Long-term Care Insurance

***Senate Bill 335*/*House Bill 1160* (Chs. 28 and 29)** rename the Maryland Partnership for Long-Term Care Program as the Qualified State Long-Term Care Insurance Partnership and require the program to comply with § 1917(b) of the Social Security Act and any applicable federal guidelines. The bills clarify that individuals need not exhaust all benefits under a policy before becoming eligible for the program. DHMH and the Maryland Insurance Commissioner are required to report to the General Assembly by January 1, 2008, on the number of long-term care policies approved by DHMH for inclusion in the program, the measures undertaken to educate the public, and any other information related to the implementation of the program.

Prescription Drug Coverage

***Senate Bill 281*/*House Bill 1004* (both passed)** authorize up to $425,000 in funds remaining from the Senior Prescription Drug Program that have accrued to the account of the Senior Prescription Drug Assistance Program (SPDAP) of the Maryland Health Insurance Plan Fund to be transferred and appropriated to DHMH for a grant to the Maryland Medbank Program.

Minority Health

Sickle Cell Disease (SCD)

Sickle Cell Disease is an inherited blood disorder. There are approximately 1,700 adult patients in Maryland with SCD, and African Americans are the largest high-risk group in the State. ***House Bill 793* (passed)** establishes the Statewide Steering Committee on Services for

Adults with Sickle Cell Disease. The committee is required to establish institution and community partnerships; establish a statewide network of stakeholders who care for individuals with SCD; and educate individuals with SCD, the public, and health care providers about the State options for care of SCD. The steering committee also must seek grant funding to develop and establish a case management system for adults with SCD; establish an adult SCD day infusion center; develop, implement, and lead a State comprehensive education and treatment program for adults with SCD; and develop and implement a health care provider awareness and education campaign.

Prostate Cancer

African American men face a far greater risk from prostate cancer than Caucasian men. ***Senate Bill 280*** ***(passed)*** establishes the Charles County Prostate Cancer Pilot Program to fund prostate cancer screening and treatment and provide prostate cancer education to uninsured or economically challenged men in Charles County. By September 2010, DHMH is required to report on the number of individuals screened and treated by the program, including racial and ethnic data on the individuals who were screened and treated.

Collection of Racial and Ethnic Data

Senate Bill 269/***House Bill 788*** ***(Chs. 25 and 26)*** authorize an insurer that provides health insurance, nonprofit health service plan, or HMO to inquire about race and ethnicity for specified purposes. A more detailed discussion on this bill may be found under the subpart "Health Insurance" of this *90 Day Report*.

Cultural Competency of Mental Health Professionals

The Mental Health Transformation Working Group, in collaboration with the Mental Hygiene Administration (MHA) and the Office of Minority Health and Health Disparities, is required by ***House Bill 524*** ***(passed)*** to convene a Workgroup on Cultural Competency and Workforce Development for Mental Health Professionals to examine and make recommendations regarding certain barriers to access to culturally competent mental health services and providers. For a further discussion of this bill, see Part C "State Government" in this *90 Day Report*.

Laboratories

House Bill 344 ***(Ch. 74)*** allows a State-operated public health laboratory to enter into or renew a mutual aid agreement with a public health laboratory operated by another state, in order to promote the provision of aid during an emergency at a public health laboratory.

House Bill 343 ***(Ch. 73)*** alters the requirement that "limited medical laboratory tests or examinations" must be simple procedures for the laboratory to receive a letter of exception to the State's licensing requirement by repealing the word "simple." The Act will allow the Secretary of Health and Mental Hygiene to grant a letter of exception to out-of-state laboratories

performing rare and unusual tests in order to enhance access to these tests by Maryland health care providers.

House Bill 119 ***(passed)*** adds anaplasmosis and babesiosis, which are both caused by ticks, to the list of diseases or conditions that medical laboratories must report to a county health officer if the laboratory is in Maryland, or to the Secretary of Health and Mental Hygiene if the laboratory is outside Maryland. By January 1, 2010, DHMH is required to report on the continued need to monitor anaplasmosis and babesiosis. The bill terminates September 30, 2010.

HIV/AIDS

In December 2006, Congress reauthorized the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, changing the requirements for federal funding from a formula based on AIDS surveillance to a formula based on HIV surveillance and requiring submission of name-based rather than code-based HIV data. ***Senate Bill 987*****/*****House Bill 1270*** ***(both passed)*** repeal Maryland's code-based HIV reporting system and establish a name-based HIV reporting system. The bills preserve $37.5 million in federal funding for DHMH beginning in fiscal 2009. Further, the bills establish criminal penalties for any person who knowingly or willfully discloses personal identifying health information acquired for the purposes of HIV and AIDS reporting to any person who is not authorized to receive such information or otherwise is in violation of the bill or for any person who obtains information on HIV and AIDS under false pretenses or through deception.

Senate Bill 693**/*****House Bill 216*** ***(both passed)*** add a forensic scientist, working under the direction of a law enforcement agency and who is exposed to HIV while acting in the performance of duty, to the definition of a "victim" under provisions providing a right to HIV testing.

Senate Bill 746**/*****House Bill 781*** ***(both passed)*** require the AIDS Administration to convene a workgroup to review and make recommendations regarding the Centers for Disease Control and Prevention (CDC) guidelines regarding HIV/AIDS, including pre- and post-test counseling and written informed consent. The workgroup is also required to consider best practices and research and data regarding treatment for HIV/AIDS and report on any recommendations by January 1, 2008.

Sexually Transmitted Diseases

Senate Bill 349**/*****House Bill 769*** ***(both passed)*** create an Expedited Partner Therapy Pilot Program in the Baltimore City Health Department to provide antibiotic therapy to the partner of a patient diagnosed with a chlamydia or gonorrhea in order to contain the infection. The health department must report each year to the Governor and the General Assembly on the pilot program's operation and performance. The bills terminate June 30, 2010.

In 2006, CDC's Advisory Committee on Immunization Practice recommended that Gardasil, a vaccine to protect against the Human Papillomavirus (HPV), be routinely given to girls at ages 11 and 12. HPV is the most common sexually transmitted infection in the

United States, and two types of HPV cause most cervical cancers. ***Senate Bill 774*/*House Bill 1049* *(both passed)*** establish a subcommittee on the Human Papillomavirus Vaccine within DHMH's Cervical Cancer Committee of the Maryland Comprehensive Cancer Control Plan. The subcommittee is required to examine federal and State programs relating to the HPV vaccine, develop a public awareness and education campaign about the vaccine with an emphasis on parental education, evaluate the availability and affordability of the vaccine, identify barriers to the vaccine's administration to all recommended individuals, identify and evaluate various resources to cover the vaccine's costs, and identify and evaluate appropriate mechanisms that Maryland may use to increase access to the vaccine.

Alcohol and Drug Abuse

The need for alcohol and drug abuse treatment services in Maryland and the State's approach to drug treatment will be further evaluated as a result of two bills that were passed this session. ***House Bill 850* *(Ch. 82)*** requires the Alcohol and Drug Abuse Administration (ADAA) to conduct a needs assessment every three years that identifies financial and treatment needs in each jurisdiction in the State. In the fiscal 2008 budget, $275,000 in ADAA funds were restricted to conduct such an assessment. ***Senate Bill 339* *(passed)*** requires the Maryland State Drug and Alcohol Abuse Council to include in its two-year strategic plan a review of the State's approach to drug treatment, including a review of the appropriate location of treatment services and the use of employment and housing services for individuals in treatment.

Mental Health

House Bill 281* *(passed) requires inmates with a mental illness to receive medication for that illness upon release, requires MHA to compensate case managers for initial assessments of specified inmates, and requires specified reports and plans.

Senate Bill 646*/*House Bill 640* *(both passed) restrict the use of restraints and seclusions for use only during an emergency in which the behavior of the individual places the individual or others at serious threat of violence or injury.

House Bill 1046* *(passed) requires the Maryland State Department of Education, in collaboration with DHMH, to provide awareness and training on self-mutilation, including injury by cutting, for directors of student services in local school systems. A more detailed discussion of this bill may be found under "Education – Primary & Secondary" of Part L of this *90 Day Report*.

Senate Bill 472* *(passed) specifies that all court records relating to a petition for an emergency evaluation of an individual believed to have a mental disorder and who presents a danger to the life or safety of the individual or others are confidential and the contents of the records may not be divulged, by subpoena or otherwise, except by court order on good cause shown. This does not prohibit review of the court record relating to a petition by specified individuals. An emergency evaluation petition must be considered a mental health record and may be released by a health care provider only as permitted by law.

Individuals with Disabilities

***Senate Bill 920*/*House Bill 1359* (both passed)** extend the termination date relating to the requirement that State residential centers provide respite care to September 30, 2009. Accordingly, State residential centers will continue reserving the current specified percentage of respite beds in State residential centers to care for individuals with developmental disabilities whose families are caring for those persons in their home. Families caring for individuals with developmental disabilities in their homes will continue to have a choice of obtaining respite care in a State residential center or a community setting.

Health Care Decisions

***House Bill 682* (passed)** authorizes a health care provider, other than certified or licensed emergency medical services (EMS) personnel, who sees, in a valid form, an EMS "do not resuscitate order" that is not superseded by a subsequent physician's order, to provide, withhold, or withdraw treatment in accordance with the order before a patient's cardiac or respiratory arrest. The bill also requires that health care providers withhold or withdraw treatment in accordance with the order after a patient's cardiac or respiratory arrest.

***House Bill 797* (Ch. 81)** requires the State Advisory Council on Quality Care at the End of Life and the Maryland Health Care Commission to jointly study the current services and potential care delivery alternatives for caring for children with life-threatening medical conditions. The bill establishes a report deadline of December 1, 2007.

Information Sharing

***Senate Bill 348*/*House Bill 1071* (both passed)** allow a local child fatality review team to investigate the information and records of a child convicted of a crime or adjudicated as having committed a delinquent act that caused a death or near fatality. Upon request, appropriate information maintained by a health care provider has to be provided to the review team as must information and records maintained by specified State and local government entities that provided services to such a child or to the family of such a child. However, information identifying such a child or regarding the involvement of any agency with such a child may not be disclosed during a public meeting.

Health Occupations

Physicians

Sunset Review and Program Evaluation

During the 2005 interim, the Department of Legislative Services (DLS) conducted a full evaluation of the State Board of Physicians in accordance with the Maryland Program Evaluation Act (Sunset Law). Senate Bill 398 and House Bill 121 of 2006 incorporated the majority of the

DLS recommendations but ultimately failed. In preparation for the 2007 session, DLS provided an update to the full evaluation which resulted in the introduction of ***Senate Bill 255*/*House Bill 282* (both passed)**.

Senate Bill 255*/*House Bill 282 extend the termination date of the board from July 1, 2007, to July 1, 2013, and specify that the next program evaluation of the board will be a full review without the necessity of a preliminary review. The major components of the bill include:

- **Peer Review Services:** authorizing the board to contract directly with peer reviewers; repealing the requirement for the use of a third peer reviewer in the instance that two peer reviewers do not agree; and requiring the board to report to the General Assembly regarding how often two peer reviewers disagreeing over a complaint results in the dismissal of charges.

- **Rehabilitation Services:** requiring the board to contract with a nonprofit entity for rehabilitation services or, if unable to contract with a nonprofit entity, for the board to provide the rehabilitation services directly.

- **Diversion of Fees:** reducing the diversion of physician and physician assistant licensure fees for loan repayment and scholarship funding from 14 percent of fees received to 12 percent.

- **Medical Malpractice Settlement Information:** repealing the requirement that medical malpractice settlement information be posted as part of a licensee's online profile and instead requiring the board to provide notification on its web site that settlement information within specified parameters is available upon verbal, electronic, or written request.

- **Office of Administrative Hearings:** requiring the Chief Administrative Law Judge to designate a pool of administrative law judges (ALJs) to hear board complaints and requiring the board to provide annual training to the ALJs.

Increasing the Penalty for the Unauthorized Practice of Medicine

***Senate Bill 851* (passed)** increases the penalty for the unauthorized practice of medicine, changing it from a misdemeanor to a felony. Upon conviction, an individual is subject to a fine of up to $10,000 or imprisonment of up to five years, or both. The bill does not apply to a physician licensee who fails to renew a license.

Morticians

Sunset Extension and Program Evaluation

DLS conducted a preliminary evaluation of the State Board of Morticians in 2005. ***Senate Bill 781* (failed)** would have continued the operation of the board for an additional

10 years. Identical legislation also failed during the 2006 session. The board is set to terminate July 1, 2008.

Establishment of Funeral Director License

Senate Bill 756*/*House Bill 457 ***(both passed)*** change the name of the State Board of Morticians to be the State Board of Morticians and Funeral Directors and establish a license for funeral directors. A licensed funeral director may operate a funeral establishment, prepare a dead human body for disposition, excluding embalming, and arrange for or make final disposition of a dead human body. To become licensed as a funeral director, an individual is required to complete all of the training required to become a licensed mortician except for the practical experience of embalming.

Military Health Care Personnel

House Bill 949 ***(passed)*** requires the Secretary of Health and Mental Hygiene, with the Governor's Workforce Investment Board and appropriate health care provider regulatory boards, to identify barriers under the Health Occupations Article to licensing or certifying individuals with training and experience in providing health care through military service that is equivalent to training and experience required for licensure or certification.

Nurses

Senate Bill 118*/*House Bill 315 ***(both passed)*** require an individual applying for reinstatement of a lapsed nursing license or other certificate regulated by the board to submit to a criminal history records check. In order to renew a certificate, certificated individuals must present evidence of completion of 100 hours of practice as a certified medicine aide or a certified medication technician within the two-year period before the date of renewal. A certified medicine aide must also successfully complete a continuing education program.

House Bill 445 ***(passed)*** adds a registered nurse certified in an advanced practice nursing specialty as a member of the State Board of Nursing and requires the Governor to choose the member from a list of names submitted by various professional organizations in accordance with a rotating list of specialties as set forth in statute.

Miscellaneous

Several health occupations boards introduced legislation that made changes to their respective regulatory statutes.

Audiologists, Hearing Aid Dispensers, and Speech-language Pathologists

House Bill 326 ***(passed)*** makes revisions to the title governing the State Board of Examiners of Audiologists, Hearing Aid Dispensers, and Speech-Language Pathologists. These revisions include changing qualifications for membership on the board, requiring speech-language pathologists employed by educational institutions to be licensed by the board,

licensing speech-language pathology assistants, updating educational and experience requirements, updating grounds for discipline, and updating hearing and appeal procedures. No changes are made to the scope of practice of these individuals.

Dental Hygienists

Senate Bill 568*/*House Bill 751* *(both passed) authorize a dental hygienist practicing under the general supervision of a licensed dentist to apply fluoride, mouth rinse, or varnish without first requiring a dentist to evaluate the patient's medical history or diagnose and approve the treatment plan. The General Assembly intends for this bill to increase access to oral health care.

Social Workers

The scope of practice for social workers was brought into question during discussion on Senate Bill 808 of 2006, Juvenile Law – Competency – Services. The discussion led to an Attorney General letter which provides the opinion that as defined by § 19-101(m) of the Health Occupations Article a certified social worker-clinical cannot diagnose mental retardation. ***Senate Bill 723*/*House Bill 358* *(both passed)*** clarifies the scope of practice for an individual licensed as a certified social worker-clinical to allow the evaluation, diagnosis, and treatment of mental and emotional conditions and impairments. A subsequent Attorney General letter provides the opinion that the language in ***Senate Bill 723*/*House Bill 358*** would permit a social worker to diagnose mental retardation.

Health Care Facilities and Regulation

Facilities Regulation

Nursing Homes

In years past, the General Assembly considered several proposals to establish a nursing home assessment. Typically, revenues from an assessment are matched with federal funds and returned to nursing homes through increased Medicaid payments, providing a net increase to the industry.

Senate Bill 101* *(passed) allows the Department of Health and Mental Hygiene (DHMH), in fiscal 2008 through 2012, to impose a quality assessment on nursing homes with 45 or more beds. Continuing care retirement communities (CCRCs) are not subject to the assessment. The assessment may not exceed 2 percent of the net operating revenues for all nursing homes, and the aggregate annual assessment may not exceed the amount necessary to fully fund the nursing home reimbursement system. Revenues must be used only to supplement funding for Medicaid nursing home reimbursement. Beginning July 1, 2008, up to 25 percent of revenues from the assessment may be distributed to nursing homes based on accountability measures developed by DHMH in consultation with stakeholders.

DHMH must request permission from the federal Centers for Medicare and Medicaid Services (CMS) to exclude nursing home beds in CCRCs from the assessment, and DHMH may modify elements, including the licensed bed requirement, that are used to determine the quality assessment amount, as a condition for CMS approval. The assessment does not take effect until CMS approves a waiver to exclude CCRCs without a reduction in federal financial participation.

Hospitals

House Bill 979 ***(passed)*** establishes a Health Information Exchange Pilot Project to be operated by the Maryland/DC Collaborative, which is a nonprofit corporation. The pilot project must transmit medication history, laboratory and radiology results, and inpatient and emergency department discharge summaries to participating health care providers in a private and secure manner. The Maryland/DC Collaborative must report annually on its progress to the Health Services Cost Review Commission (HSCRC) and Maryland Health Care Commission (MHCC). Hospitals may apply to HSCRC for a one-time award through rate adjustment to provide partial compensation for the cost of developing a data interface necessary for participation in the collaborative.

The Prince George's Hospital System, including Prince George's Hospital Center, has been faced with financial difficulties for the past several years. The system has incurred lost market share, revenue losses, low liquidity, significant deferred capital needs, poor bond ratings, and a disadvantageous payor mix. ***House Bill 510*** ***(failed)*** would have established the Prince George's County Hospital Authority as a State entity to develop a long-term strategy for delivering hospital services and related health care in Prince George's County. The fiscal 2008 budget includes $20.0 million contingent upon passage of ***House Bill 510*** for crucial operating needs. With the failure of the bill, $20.0 million is available only to ensure orderly closure of Prince George's Hospital Center.

Forensic Laboratories

Senate Bill 351/***House Bill 879*** ***(both passed)*** require the Secretary of Health and Mental Hygiene to license, set standards and requirements for, and inspect forensic laboratories. The regulatory scheme the bills establish is similar to regulatory requirements for clinical laboratories, which are already regulated by DHMH. After December 31, 2011, a laboratory must be licensed by DHMH to offer or perform forensic analysis in Maryland. The Secretary must issue a letter of exception to a laboratory that only performs limited forensic analysis and meets exception requirements adopted under regulation. The Secretary may also grant an out-of-state forensic laboratory a waiver from licensure requirements if specific conditions are met. The bills also provide that the regulatory provisions of the bill only apply to 12 forensic laboratories in Maryland; field tests and other similar investigations conducted by police forces are exempted.

The Secretary must adopt regulations that define satisfactory proficiency testing performance and set standards and requirements that a laboratory must meet. DHMH must additionally review a forensic laboratory's proficiency testing program. The Secretary may deny a license to an applicant or suspend, revoke, or limit a license or the authority of a licensee to

offer or perform tests if the laboratory, or associated staff, does not meet the standards and requirements established by the Secretary.

Freestanding Medical Facilities

In 2005, the General Assembly established a new category of "freestanding medical facility" and required licensure of such facilities by DHMH. MHCC is required to adopt regulations to establish a process for reviewing any facilities seeking a license to operate as a freestanding medical facility. A freestanding medical facility pilot project was also established in Montgomery County, which is exempt from the above mentioned MHCC regulations but is subject to the licensing standards adopted by DHMH.

Senate Bill 750 ***(passed)*** is an emergency bill that adds a second project, located in Queen Anne's County, to the freestanding medical facility pilot project. The project must be established by and operated administratively as part of an acute-care general hospital located in Talbot County, operate in Queen Anne's County, meet current certificate of need (CON) requirements for capital expenditures, and meet DHMH licensing requirements specified in regulation. Carriers and managed care organizations must reimburse the project at contract rates, while Medicaid must pay fee-for-service claims at a rate at least equal to the rate paid by Medicare. Language in the bill also specifies that a hospital in Talbot County is not exempt from CON requirements and may not be viewed as authorization to move a hospital from Talbot County to Queen Anne's County.

Wholesale Distributors of Prescription Drugs and Devices

Senate Bill 759/House Bill 1030 ***(both passed)*** repeal existing standards for drug distribution permits and then reestablishes the standards by expanding the requirements for a wholesale distributor of prescription drugs or devices to obtain a State Board of Pharmacy permit. Permits are valid for two years, instead of the current one year, and may be renewed for an additional two years. The bills also require prescription drugs distributed outside the "normal distribution channel" to have a pedigree that records each distribution. Any person knowingly violating any provision of the bills may be subject to a board-imposed fine of up to $500,000. The board has to adopt regulations to implement the bill by January 1, 2008.

Health Regulatory Commissions

In 2006, the Department of Legislative Services (DLS) conducted full sunset evaluations of two of Maryland's three independent health care commissions. Legislation was introduced during the 2007 session to implement DLS's recommendations regarding the regulatory scope and activities of MHCC and HSCRC.

House Bill 800 ***(passed)*** extends the evaluation date for MHCC to July 1, 2017, and increases MHCC's user fee cap from $10.0 to $12.0 million. The bill also makes permanent DHMH's authority to assess an administrative charge on MHCC to cover administrative, or indirect, costs incurred by DHMH for providing overhead services to MHCC.

Based on DLS's recommendations, the bill standardizes quorum and voting requirements; authorizes MHCC to collect data on payments to hospitals; requires MHCC to report on plans to collect data on facility costs and insurance product design; modifies the due date for MHCC's annual report on the Maryland Trauma Physician Services Fund to November 1 and requires the 2007 report to include options for reducing the trauma fund surplus; repeals the requirement that MHCC annually determine the full cost of mandated benefits and, instead, requires an assessment of the full cost of mandated benefits as a percentage of premiums every four years; and requires several studies and reports, including reporting on alternatives for individuals enrolled in the State's Limited Health Benefit Plan.

House Bill 844 ***(passed)*** extends HSCRC's evaluation date to July 1, 2017, and maintains the authorization for DHMH to assess an administrative charge on HSCRC to fund overhead services provided by DHMH to HSCRC. HSCRC user fees may be used to cover these costs and HSCRC's user fee cap is increased from $4.0 to $5.5 million.

Based on DLS's recommendations, the bill requires HSCRC's annual report to include an update on the status of the State's Medicare waiver, a summary of HSCRC's role in hospital quality of care activities, and fund balance information. The board of the Maryland Health Insurance Plan must annually report on the number of plan enrollees, any increase or decrease in enrollees from the previous year, actions taken by the board to increase enrollment or benefits, and the amount of any fund surplus. Several one-time reports are also required.

Health Insurance

Access to Health Insurance Coverage

Responding to the rising number of individuals without health insurance, states across the country are looking at ways to expand coverage. For example, Massachusetts enacted groundbreaking legislation in 2006 which requires employers to provide and individuals to obtain insurance or face penalties. In Maryland, about 784,000 people, or 14 percent, of the State's population live without health insurance. During the 2007 session, multiple bills were introduced to make health insurance more accessible to Maryland's uninsured. Some limited reforms were passed.

Major Reform Proposals

House Bill 754 ***(failed)*** would have expanded eligibility for Medicaid and the Maryland Children's Health Program (MCHP) and continued coverage for adult child dependents. These efforts would have been funded by a $1.00 increase in the tobacco tax, savings from hospital uncompensated care, and the transfer of funds from the Maryland Health Insurance Plan Fund and the Maryland Health Care Provider Rate Stabilization Account and Fund.

The Administration's proposal, ***Senate Bill 149***/***House Bill 132*** ***(both failed)***, would have expanded access to MCHP, established a Maryland Health Care Quality Coordinating Council,

and created a Task Force on Expanding Access to Affordable Health Care. A study on establishing a health insurance exchange also would have been required.

Continuation of Coverage for Child Dependents

Generally, children are allowed to remain on the policy of a parent until age 19 or until age 23 if the child is a full-time student. However, after reaching the limiting age of the policy, many young adults lose access to insurance. Several bills sought to continue coverage by allowing a "child dependent" to remain on an insured's policy beyond the limiting age of the plan. Under ***House Bill 1057*** ***(passed)***, insurers, nonprofit health service plans, and health maintenance organizations must allow a child dependent to remain on an insured's plan until age 25.

Access to Coverage for Domestic Partners

House Bill 1057 also requires individual and group health insurance policies and contracts that allow family coverage to provide, at the request of an insured or group policy holder, the same benefits and eligibility guidelines that apply to other covered dependents for a domestic partner or the child dependent of a domestic partner of the insured.

Personal Responsibility Study

House Bill 572 ***(passed)*** requires the Maryland Health Care Commission, in consultation with other specified agencies, to study the issue of personal responsibility for obtaining health care coverage. The study must address such issues as affordability, subsidization, and incentives to encourage purchase of health insurance.

Relationship between Health Insurance Carriers and Health Care Providers

Several bills were considered by the General Assembly this session that addressed the contracting relationship between health insurance carriers and health care providers. The bills largely result from a perceived imbalance in the negotiating power between carriers and providers, particularly as carriers have merged and a small number of carriers dominate the insurance market.

Senate Bill 107 ***(passed)*** establishes a Task Force on Health Care Access and Reimbursement. The task force must study reimbursement rates and total payments to health care providers; the impact of changes in reimbursement on access to health care, health care disparities, volume of services, and quality of care; the effect of competition on payments to health care providers; trends for health care provider shortages; the amount of uncompensated care provided by health care providers and trends in uncompensated care; the extent to which current reimbursement methods recognize and reward higher quality of care; methods used by large purchasers of health care to evaluate adequacy and cost of provider networks; and the practice by certain carriers of requiring providers who join a provider network to also serve on the provider network of a different carrier.

Senate Bill 557*/*House Bill 515 ***(both passed)*** exempt carriers that use specified credentialing intermediaries from the requirement to use the uniform credentialing form and from certain time frames for credentialing decisions. Carriers must use a credentialing intermediary that is a hospital or academic medical center, is a participating provider on the carrier's provider panel, and acts as a credentialing intermediary for that carrier for health care practitioners that participate on the carrier's provider panel and have privileges at the hospital or academic medical center. The Insurance Commissioner is authorized rather than required to adopt credentialing regulations.

Senate Bill 263*/*House Bill 519 ***(both passed)*** require health insurance carriers to establish and implement a procedure by which a member may request a referral to a nonphysician specialist who is not part of the carrier's provider panel if the carrier cannot provide reasonable access to a nonphysician specialist with the expertise needed to treat a condition or disease. A nonphysician specialist is defined as a health care provider who (1) is not a physician; (2) is licensed or certified under the Health Occupations Article; and (3) is certified or trained to treat or provide health care services for a specified condition or disease in a manner that is within the scope of the license or certification of the health care provider.

Senate Bill 601*/*House Bill 947 ***(both passed)*** address the situation of health care providers, particularly psychiatrists, who work primarily in private practice but also see patients in clinics. Although the provider may have negotiated a fee schedule with a health insurance carrier for treating patients in the private practice, the carrier may pay the provider at the lower clinic rate. The lower reimbursement is a disincentive for providers to practice in clinics, where indigent patients often receive care. ***Senate Bill 601*/*House Bill 947*** redress this problem by prohibiting a health insurance carrier from requiring a provider in a group practice or facility that participates under a contract on the carrier's provider panel to accept the reimbursement fee schedule applicable under the contract when providing services to enrollees of the carrier through a noncontracting practice or facility and billing for services provided to enrollees of the carrier with a different federal tax identification number.

Maryland Health Insurance Plan

The Maryland Health Insurance Plan (MHIP), an independent unit of the Maryland Insurance Administration, was created by Chapter 153 of 2002 as a high-risk pool to provide health insurance coverage to medically uninsurable individuals. MHIP is funded primarily by enrollee premiums and an assessment on hospitals. In addition to administering a health insurance plan, MHIP also runs the Senior Prescription Drug Assistance Program (SPDAP), which provides a State subsidy for Medicare Part D prescription drug benefits.

Senate Bill 824*/*House Bill 1370 ***(both passed)*** extend the termination date for the SPDAP from December 31, 2007, to December 31, 2009. The $14.0 million in funding from the State's largest nonprofit health service plan is extended through fiscal 2010. SPDAP is authorized to limit payment of any subsidy by paying the subsidy only on behalf of eligible individuals enrolled in a Medicare Part D prescription drug plan or Medicare Advantage Plan that coordinates with SPDAP in accordance with federal requirements.

MHIP is authorized by law to impose a preexisting condition limitation on enrollees who have not maintained continuous insurance coverage. This limitation is intended to discourage individuals from purchasing insurance only when they are sick and need the coverage. In March 2007, the MHIP Board of Directors voted to impose a two-month preexisting condition limitation. ***House Bill 1283*** ***(passed)*** authorizes MHIP to offer members an optional endorsement to remove a preexisting condition limitation. MHIP may charge an actuarially justified additional premium amount for the endorsement, subject to approval by the Insurance Commissioner. MHIP may also charge different premiums based on the cost-sharing arrangement when more than one cost-sharing arrangement is offered. As MHIP currently offers five different cost-sharing arrangements, this provision codifies current practice.

Senate Bill 893 ***(failed)*** would have made MHIP an independent unit of State government, altered membership on the MHIP board, repealed the board's exemption from State personnel and pensions requirements, and largely exempted MHIP from State insurance laws.

Small Group Market

Rating and Discounts in the Small Group

In the small group health insurance market, health insurance carriers must establish a community rate and then may only vary the rate charged to a group based on age and geography between specified percentages above or below the community rate.

House Bill 339 ***(passed)*** increases the range of rates a carrier may charge by authorizing carriers in the small group market to charge a rate that is between 40 percent above and 50 percent below the community rate. The bill also allows carriers to offer a discount of up to 20 percent to a small employer for participation in a wellness program. Any discount for participation in a wellness program must be (1) applied to reduce the rate otherwise payable by the small employer; (2) actuarially justified; (3) offered uniformly to all small employers; and (4) approved by the Insurance Commissioner. The bill terminates June 30, 2011.

Senate Bill 427/***House Bill 579*** ***(both passed)*** authorize health insurance carriers to offer an administrative discount to a small employer if the small employer elects to purchase for its employees additional types of insurance through the carrier. The administrative discount must be offered under the same terms and conditions for all qualifying small employers.

Sole Proprietors

Chapter 347 of 2005 made self-employed individuals and sole proprietors ineligible for health insurance coverage in the small group market. However, self-employed individuals and sole proprietors enrolled on September 30, 2005, were permitted to remain covered with the same carrier on the same policy provided the enrollee continued to work and reside in the State and remained self-employed. ***Senate Bill 952*** ***(Ch. 59)*** permits self-employed individuals and sole proprietors enrolled in the small group market on September 30, 2005, to remain covered under any policy issued by the carrier to small employers and selected by the enrollee at renewal.

Regulation of Discount Medical and Drug Plans

In 2004, the Maryland Insurance Administration (MIA) held an informational hearing and issued a report on consumer concerns with medical and pharmacy discount plans. Such plans are not subject to State regulation and, since they are not "insurance," MIA has no authority over their conduct. ***Senate Bill 596*/*House Bill 847* *(both passed)*** require registration with MIA as a discount medical plan organization or a discount drug plan organization before selling, marketing, or soliciting a discount medical plan (DMP) or discount drug plan (DDP). MIA may deny registration or refuse to renew, suspend, or revoke the registration if the applicant or registrant engages in specified activities. The bill provides for limitations on advertising, plan access, payment to medical providers, and termination of plan membership. Various disclosure and notification requirements to plan members are also set forth. MIA may examine the affairs, transactions, accounts, records, and assets of a DMP or DDP organization; issue a cease and desist order for violations; require corrective action, including restitution; and impose penalties.

Authorization of Additional Health Insurance Products

Senate Bill 427*/*House Bill 579* *(both passed) authorize new types of health insurance products to be sold in the State. The bills authorize health insurance carriers to offer a product that provides for payment of services rendered only by preferred providers if the product meets specified access standards and does not restrict payment for emergency services. Carriers that offer this type of product must also offer an option to include preferred and nonpreferred providers as an optional additional benefit for an employee or individual and provide a disclosure to the policy holder regarding the optional additional benefit. A group policy holder may require the employer or individual to pay a greater premium for the optional additional benefit.

The bills also authorize health insurance carriers to offer limited benefit plans to employees that do not qualify for group coverage, such as seasonal, temporary, and part-time employees. The limited benefit plans need not comply with most health insurance mandates but must provide coverage for specified services, including mental health services. A carrier must disclose in a policy that the limited benefit product does not provide comprehensive health coverage.

Regulation of Nonprofit Health Service Plans

Senate Bill 936*/*House Bill 487* *(both passed) remove limits on compensation for board members of nonprofit health service plans. Instead, the bills specify that board members may receive reimbursement for ordinary and necessary expenses, an amount of base compensation, and compensation for attendance at meetings proposed by the Compensation Committee of the board. The bills require the Compensation Committee to develop proposed guidelines for compensation of board members that is reasonable in comparison to compensation for board members of similar nonprofit health service plans. A copy of the guidelines must be provided to each board member and the Insurance Commissioner. The Insurance Commissioner must annually review board member compensation and may issue an order prohibiting payment if the Commissioner finds that the compensation exceeds the amount authorized under the guidelines.

By June 30 of each year, each nonprofit health service plan must submit a report to the Commissioner with various compensation and reimbursement data.

Wellness Incentives

***Senate Bill 714*/*House Bill 157* (both passed)** authorize health insurance carriers to provide reasonable incentives to an insured for participation in a bona fide wellness program offered by the carrier. A bona fide wellness program is a program designed to prevent or detect disease or illness, reduce or avoid poor clinical outcomes, prevent complications from medical conditions, or promote healthy behaviors and lifestyle choices. A carrier may not make participation in a wellness program a condition of coverage or impose a penalty on an insured for nonparticipation. Insureds may not be required to achieve any specific outcome in order to receive an incentive for participation in a wellness program. Any incentive offered for participation must be reasonably related to the program and may not have a value that exceeds any limit established in regulations adopted by the Insurance Commissioner.

Inquiries Regarding Race or Ethnicity

Generally, insurance carriers are prohibited from making any inquiry about the race or ethnicity of their insureds. ***Senate Bill 269*/*House Bill 788* (Chs. 25 and 26)** authorize health insurance carriers to inquire about race and ethnicity in an insurance form, questionnaire, or other manner requesting general information, provided the information is used solely for the evaluation of quality of care outcomes and performance measurements. The bills prohibit these carriers from using race or ethnicity data to in any way affect the terms or conditions of a health insurance policy or contract. The Insurance Commissioner may refuse to renew, suspend, or revoke a certificate of authority or issue a cease and desist order to a carrier that uses racial or ethnic variations data in a prohibited manner.

Regulation of Managed Care Organizations

Since the establishment of the Medicaid HealthChoice program in 1998, there has been uncertainty about the extent to which State insurance laws apply to Medicaid managed care organizations (MCOs). ***House Bill 1082* (passed)** provides that MCOs are not subject to the insurance laws of the State or to the provisions of Title 19 of the Health – General Article, with the exception of laws relating to appropriate risk-based capital standards, payment for hospital services on the basis of approved rates, annual financial reporting and submission of business plans, medical loss ratios, and retroactive denial of claims. MCOs may retroactively deny a claim submitted for services provided to a Medicaid enrollee during a time period for which Medicaid has permanently retracted the capitation payment for the recipient from the MCO. The bill applies to claims paid by Medicaid MCOs on or after July 1, 2007.

Prescription Drug Coverage

House Bill 1033 ***(passed)*** prohibits health insurance carriers from imposing a co-payment or co-insurance requirement for a covered prescription drug or device that exceeds the retail price of the prescription drug or device.

Social Services

Out-of-home Placements

Program Evaluation

Chapter 536 of 2004 required the Office for Children, Youth, and Families, now the Governor's Office for Children (OC), in cooperation with the Department of Human Resources (DHR) and the Department of Juvenile Services (DJS), to plan for and determine the cost of an objective and standardized system of outcomes evaluation for out-of-home placements made by State agencies.

Senate Bill 177/***House Bill 53*** ***(both passed)*** require (1) the creation and implementation of a system for outcomes evaluation of residential child care programs; (2) program providers to collect and report information necessary for the evaluation system; and (3) residential child care program direct care staff to meet minimum qualifications. The bills require the Department of Health and Mental Hygiene (DHMH), DHR, DJS, and OC to jointly adopt regulations related to residential child care program direct care staff. Specifically, each direct care staff member must be at least 21 years old and complete a training program that is approved by the licensing agency.

Certification of Program Administrators

Chapter 438 of 2004 created the State Board for Certification of Residential Child Care Program Administrators within DHMH. In general, child care program administrators are required to be certified on or after October 1, 2007. Certificates may be renewed for two-year periods.

While the board has been appointed and is in the process of drafting regulations, the number of administrators the board currently expects to certify is significantly less than the estimate at the time of the board's establishment. Since special-fund boards have to set fees to cover their costs, this reduction in the estimated number of certified administrators would necessitate a significant increase in the certification fee.

To avoid this occurrence, ***Senate Bill 937***/***House Bill 1177*** ***(both passed)*** require the board to be supported by general funds instead of special funds by repealing the State Board for Certification of Residential Child Care Program Administrators Fund. Although the board retains its fee-setting authority, it no longer has to set its fees to cover its direct and indirect costs. The General Assembly took action in the budget to provide general fund support of $111,000 for the board in fiscal 2008.

Care Review

The State Citizens Board of Review of Foster Care for Children examines the policies, procedures, and cases of State and local agencies to evaluate the extent to which State and local agencies are effectively discharging their child protection responsibilities. A local board of review monitors cases of children who live in out-of-home placement under its jurisdiction. A local government may establish a local citizens review panel to assist and advise the State board and the State Council on Child Abuse and Neglect. Among other duties, a local panel must evaluate the extent to which the State and local agencies in that jurisdiction are effectively fulfilling their responsibilities according to various child protection standards and criteria.

In an effort to conform State law with changes in the federal Child Abuse Prevention and Treatment Act and to enhance implementation of the Child Welfare Accountability Act of 2006 (Chapters 31 and 475 of 2006), ***Senate Bill 431*** ***(passed)*** (1) renames the State board as the State Citizens Review Board for Children (CRBC); (2) expands CRBC's duties to include examining the practices of State and local agencies and reviewing specific cases; (3) requires local boards to monitor services provided to a child in aftercare following out-of-home placement; and (4) expands the duties of local citizen review panels to include carrying out case reviews.

Post Adoption Support Services Pilot Program

House Bill 968 ***(passed)*** establishes a Post Adoption Support Services Pilot Program within DHR to provide post adoption support services to adopted children and their families and to provide additional State funds for adopted children. Post adoption support services are medical treatment, mental health services, parenting classes, or any other direct services provided by DHR after a child is adopted that aid an adopted child or adoptive family in which an adopted child is in crisis and assist in preventing the child from being returned to DHR's care and supervision. An adopted child or adoptive family is eligible for post adoption support services if the adoption was without prior termination of parental rights and was ordered by a juvenile court.

Funding Programs for Seniors

Statewide Empowerment Zones for Seniors Commission

Maryland is home to several examples of a new aging-in-place model called Naturally Occurring Retirement Communities (NORC) Supportive Services Programs, which combine public, nonprofit, and private sector entities to provide a comprehensive array of housing, social, medical, and transportation services to help seniors age in place. ***Senate Bill 611*****/*****House Bill 605*** ***(both passed)*** establish the Statewide Empowerment Zone for Seniors Commission in the Department of Aging. The purpose of the commission is to recommend a plan to develop an empowerment zones for seniors program in Maryland that directs financial and regulatory incentives to local communities that develop a plan to enhance aging-in-place services and facilitate the personal independence and civic and social engagement of seniors in the community. The commission is required to recommend State incentives to provide to a

community that submits a qualifying comprehensive empowerment zones for seniors plan. The commission terminates September 30, 2009.

Senior Citizen Activities Centers' Capital Improvement Grants Program

Senior citizen community centers are community or neighborhood facilities where a broad spectrum of services are provided to individuals age 60 or older or to their spouses. Services provided include health, social, nutritional, educational, and recreational services. A local government may apply to the Secretary of Aging for a grant for the cost of capital improvements for senior citizen activity center projects. ***Senate Bill 534*/*House Bill 880* *(Chs. 37 and 38)*** increase the maximum amount the State may award for a project under the Senior Citizen Activities Centers' Capital Improvement Grants Program from $600,000 to $800,000.

Continuing Care Fund

House Bill 1423* *(Ch. 108) establishes a Continuing Care Fund within the Department of Aging to defray the costs of administering continuing care statutory requirements. The fund will consist of fees collected from continuing care retirement communities, money appropriated in the State budget to the fund, investment earnings of the fund, and any other money appropriated to the fund's benefit. The establishment of this fund generally codifies a former practice of not reverting unspent special fund revenues from continuing care retirement community fees to the general fund.

Community-based Services

New Funding

The fiscal 2008 budget includes $16.5 million for community-based services for children not in the State's custody. The funds are available pursuant to Chapter 428 of 2003 which:

- required the Department of Health and Mental Hygiene (DHMH) to apply for a waiver under Medicaid to allow the State to receive federal funding for part of the non-room and board portion of the costs of eligible residential care that are related to the rehabilitative components of care provided by State and local agencies through public or private providers to individuals under age 21; and

- requires the Governor to include general funds in the Children's Cabinet Interagency Fund in an amount equal to the federal funds received under the waiver in the most recently completed year.

Of the fiscal 2008 funding, approximately $4.5 million is one-time funding. The ongoing annual amount is estimated to be $12 million. The funds are to be used to provide community-based services and community-based out-of-home placements needed by children with mental or developmental disabilities, regardless of eligibility for the State Medical Assistance Program. The General Assembly added language to the appropriation restricting

expenditure of the funds until a report is submitted which provides specific details on how the funds will be spent.

Money Follows the Person

The federal Deficit Reduction Act of 2005 created the Money Follows the Person demonstration project. States selected to participate in the demonstration project will receive funding to provide long-term care services to individuals in their home or community. The program targets Medicaid eligible individuals who have resided in an institutional setting for at least six months. In January 2007, the Centers for Medicare and Medicaid Services (CMS) awarded Maryland an initial $1.0 million Money Follows the Person grant. Maryland's five-year funding commitment from CMS is $67.2 million. ***Senate Bill 302*/*House Bill 325* *(both passed)*** require DHMH to report on the status of the State's Money Follows the Person grant to specified legislative committees by January 1 of each year. The report must include an update on grant communications between DHMH and CMS; information on CMS grant funding; the number of individuals moved out of institutional settings under the grant, by type of institution; and any DHMH plans or policies to move individuals out of institutional settings.

Rate Payment System

The Task Force to Study the Developmental Disabilities Administration Rate Payment Systems is established by ***Senate Bill 485*/*House Bill 1009* *(Chs. 33 and 34)***. The task force must review the existing rate system for community-based services funded by the Developmental Disabilities Administration (DDA) and determine its strengths and weaknesses; identify current service delivery mandates; consider costs as reported in the DDA cost report; compare the cost of current service delivery mandates to levels of State funding provided; consider promising practices in other states' rate systems that cost effectively fund appropriate and individualized supports, consistent with best practices; identify reimbursement system changes that further support self-directed services and the implementation of best practices; and develop recommendations to address the structural underfunding of community services. The task force must report its findings and recommendations to the Governor and specified legislative committees by December 31, 2007. After its final report, the task force must continue to advise the Governor and the General Assembly on implementing its recommendations. The bills take effect July 1, 2007 and terminate July 31, 2008.

Human Services Laws – Code Revision

Senate Bill 6* *(Ch. 3) revises, restates, and recodifies the laws of the State that relate to human resources. The new article is a nonsubstantive revision of the statutes that pertain to the Department of Human Resources; community services; the Department of Disabilities; the Blind Industries and Services of Maryland; the Department of Juvenile Services; the Department of Aging; and the confidentiality and sharing of information by certain agencies. This article derives primarily from Article 10 – Legal Officials; Article 30 – Deaf, Mute or Blind; Article 41 – Governor – Executive and Administrative Departments; Article 49C – Maryland Commission for Women; Article 49D – Children, Youth, and Family Services; Article 70B – Department of

Aging; Article 83C – Juvenile Services; Article 88A – Department of Human Resources; and the State Government Article. ***Senate Bill 7*** ***(Ch. 8)*** corrects specified cross-references to the Human Services Article of the Annotated Code of Maryland.

Baby Boomers

Senate Bill 700/***House Bill 599*** ***(both passed)*** establish a Baby Boomer Initiative Council staffed by the University of Maryland's College of Health and Human Performance, in cooperation with Johns Hopkins Institutions. The University of Maryland and Johns Hopkins Institutions representatives on the council must initiate a study documenting the economic and social impact of older workers' roles in the economy and in the community. The bills terminate December 31, 2011.