Part J
Health and Human Services

Public Health – Generally

Medicaid

Funding Increases in Fiscal 2009

The fiscal 2009 budget increases funding for Medicaid, the Maryland Children's Health Program (MCHP), and the Primary Adult Care program by $425.3 million or 8.7 percent. Medical inflation and utilization patterns are expected to increase expenses by 5.4 percent, while enrollment growth of 2.7 percent (primarily among children in Medicaid and MCHP) accounts for $55.5 million of the overall increase. Additional monies also fund the elimination of hospital day limit cost containment, the nursing facility payment system, an expansion of Medicaid coverage per Chapter 7 of the 2007 special session, and higher dental and physician provider rates.

Hospital day limits produce savings by capping the number of days of hospital care that Medicaid will fund for adults. Funds are provided in the budget ($31.9 million) to eliminate hospital day limits beginning December 31, 2008. Legislation discussed later in this subpart, ***Senate Bill 974*/*House Bill 1587* (both passed)**, provide that funds generated from an assessment representing hospital uncompensated care savings may be used to eliminate Medicaid day limits effective July 1, 2008, six months earlier than provided in the fiscal 2009 budget.

Chapter 503 of 2007 imposed a quality assessment on nursing facilities, with revenues dedicated to fully funding the nursing facility payment system. The nursing home assessment will bring in $54.2 million in fiscal 2009, an increase of $27.1 million over fiscal 2008. The State will be increasing the assessment rate from 1.7 percent in fiscal 2008 to 2.0 percent in fiscal 2009, which is the maximum assessment allowed by statute.

The budget also includes $9.2 million of an expected $31.2 million needed to bolster Medicaid physician rates toward 100 percent of Medicare rates. The amount is lower than anticipated because revenues to the Rate Stabilization Fund (the funding source) have been lower than anticipated. ***House Bill 1522* (passed)** authorized the Insurance Commissioner to transfer

additional funds from the Rate Stabilization Fund to support higher physician rates in fiscal 2009. In addition, there is $14.0 million to increase dental reimbursement rates. Further discussion of this issue may be found under "Oral Health Initiatives" later in this subpart.

Working Families and Small Business Health Care Coverage Act of 2007

Chapter 7 of the 2007 special session enacted the Working Families and Small Business Health Coverage Act, which expands access to health care in the following ways:

- expands Medicaid eligibility to parents and caretaker relatives with household income up to 116 percent of federal poverty guidelines (FPG), which will be implemented in fiscal 2009;
- incrementally expands the Primary Adult Care program benefits over three years to childless adults with household income up to 116 percent FPG, which will phase in from fiscal 2010 through 2013; and
- establishes a Small Employer Health Insurance Premium Subsidy Program, which will be administered by the Maryland Health Care Commission (MHCC) and funded with $15 million in fiscal 2009.

Special funds, including savings from averted uncompensated care and matching federal funds, will cover the costs of the expansion in fiscal 2009 and 2010, as shown in **Exhibit J-1**; general funds will be needed beginning in fiscal 2011.

Exhibit J-1
Funding for the Health Care Expansion
Fiscal 2009-2013
($ in Millions)

	Fiscal 2009	Fiscal 2010	Fiscal 2011	Fiscal 2012	Fiscal 2013
Expenditures					
Medicaid Expansion					
Administration	$3.0	$3.4	$4.7	$7.5	$7.4
Parents	94.6	168.4	185.6	204.3	224.8
Childless Adults	0.0	69.0	171.6	492.3	545.1
Small Employer Subsidy Program	15.0	20.0	32.2	34.1	36.1
End Medicaid Day Limits	38.0	0.0	0.0	0.0	0.0
Total Expenditures	**$150.6**	**$260.9**	**$394.1**	**$738.3**	**$813.4**
Funding Sources					
General Funds	$0.0	$0.0	$68.8	$188.3	$205.2
Special Funds					
Rate Stabilization Fund	3.0	41.5	31.7	0.0	0.0
MHIP Balance	31.8	43.2	0.0	0.0	0.0
Uncompensated Care Savings	48.0	55.7	112.6	197.9	219.6
Federal Funds	67.8	120.4	181.0	352.1	388.6
Total Funds	**$150.6**	**$260.9**	**$394.1**	**$738.3**	**$813.4**

MHIP: Maryland Health Insurance Plan

Note: Exhibit reflects funding as provided under SB 974/HB 1587 of 2008. Exhibit assumes full implementation of the expansion to childless adults, although language in Chapter 7 of the 2007 special session expresses the intent that expansion to childless adults is subject to specified general fund and education trust fund (from video lottery terminals) revenue attainment. Current revenue estimates fall well short of the attainment specified in Chapter 7.

Revisions to 2007 Health Care Expansion Efforts

During the 2008 session, legislation was introduced to revise funding of expansion efforts. ***Senate Bill 974/House Bill 1587 (both passed)*** repeal the assessment of hospital uncompensated care savings established under Chapter 7 of the 2007 special session and replace it with a new assessment. Whereas the original assessment was hospital specific, retrospective, and nonuniform, the new assessment is broad-based, prospective, and uniform. The new assessment will accelerate access to uncompensated care savings thereby increasing available special funds, allowing higher federal matching funds, and reducing general fund obligations.

In addition to altering funding of health care expansion efforts, ***Senate Bill 974***/***House Bill 1587*** also repeal and reenact a new assessment to fund the Maryland Health Insurance Plan (MHIP). A more detailed discussion of the impact of these bills on MHIP may be found under the subpart "Health Insurance" within Part J – Health and Human Services of this *90 Day Report*.

Senate Bill 545 ***(passed)*** provides additional special funds for Medicaid expansion efforts under Chapter 7 by transferring funds from the balance of the Rate Stabilization Account at the end of fiscal 2008 to the Health Care Coverage Fund established under Chapter 7 in the amounts of $3.0 million for fiscal 2009 expenses and $73.3 million for fiscal 2010 and 2011 expenses. ***Senate Bill 545*** also provides additional funding for Medicaid in fiscal 2009 including $7.0 million to increase fee-for-service provider rates to dentists and up to $13.0 million of any fiscal 2008 State lottery revenue over-attainment to provide inflationary rate adjustments to community services providers both in Medicaid as well as provides care for the developmentally disabled, mentally ill, and substance abusers.

Eligibility for Medicaid Long-term Care Services

In November 2007, Maryland's Court of Special Appeals ruled in *Maryland Department of Health and Mental Hygiene v. Ida Brown* that the Department of Health and Mental Hygiene's (DHMH) Medicaid eligibility standard for home- and community-based services was more stringent than federal requirements. DHMH indicates that the decision could put the State at risk for $68.0 million in additional costs for long-term care services.

Senate Bill 545 (discussed in more detail above) authorizes DHMH to use $17.0 million in total funds currently allocated for nursing home reimbursements in the fiscal 2009 budget to fund an increase in utilization of long-term care services resulting from any changes in the level of care used to determine Medicaid eligibility. By November 1, 2008, DHMH must report on the changes made in the level of care, the number of additional individuals eligible for care as a result of the changes, and the fiscal implications of the change.

Efforts to Increase Enrollment

In 2005-2006, nearly 12 percent of Maryland children were uninsured. Several bills were introduced in 2008 to increase awareness of, and enrollment in, Medicaid and the Maryland Children's Health Program, including ***House Bill 1391*** ***(passed)***, ***House Bill 1099*** ***(failed)***, and ***Senate Bill 965***/***House Bill 1152*** ***(both failed)***.

House Bill 1391 requires the Comptroller to send taxpayers with a dependent child and income less than the highest eligibility standard for Medicaid or MCHP a notice, developed by DHMH that their dependent child may be eligible for Medicaid or MCHP. Beginning in tax year 2008, taxpayers must report on their income tax return the presence or absence of health care coverage for each dependent child for whom an exemption is claimed. If a taxpayer indicates on their tax year 2008 or 2009 return that a dependent child does not have health care coverage and the taxpayer's income is less than the highest income eligibility standard for Medicaid or MCHP, the Comptroller must send the taxpayer applications and enrollment instructions for Medicaid

and MCHP. DHMH, in consultation with the Maryland Insurance Administration and the Maryland Health Care Commission must study and make recommendations for improving the processes for determining eligibility for Medicaid and MCHP and increasing the availability and affordability of health care coverage for children with family incomes above 300 percent FPG. Fiscal 2010 and 2011 funding for this initiative was provided through ***House Bill 1522***.

Oral Health Initiatives

Dental Action Committee

During the 2007 regular session, the General Assembly passed a bill establishing the Oral Health Safety Net Program. Later that year, DHMH formed a Dental Action Committee. The fiscal 2009 budget includes $16.1 million to implement a number of recommendations made by the committee.

Medicaid Oral Health Initiative: Low provider participation has been identified as the main barrier to comprehensive oral health services for Medicaid enrollees. One assessment showed that all of Maryland's Medicaid reimbursement rates are below the twenty-fifth percentile of the American Dental Association's South Atlantic charges, and many are below the tenth percentile. As a result, the Medicaid budget for fiscal 2009 includes $14.0 million to increase dental reimbursement rates. This is the first year of a three-year plan to get Medicaid dental rates up to the fiftieth percentile of the dental association's South Atlantic charges.

Improve the Public Dental Infrastructure: DHMH's Office of Oral Health will receive $1.4 million in the fiscal 2009 budget to improve access to dental care. Most of the funding ($900,000) is provided through the operating budget, and the remaining $500,000 in the capital budget. Funds will be provided as grants to local health departments, federally qualified health centers, or nonprofit community health organizations and targeted to the Upper Eastern Shore and Southern Maryland.

School-based Dental Services: The Office of Oral Health will receive $700,000 for school-based dental health services. The office plans to purchase a dental van outfitted with the equipment and supplies needed to provide comprehensive dental services. Remaining funds will be used to establish two school-linked portable dental programs that will consist of portable dental equipment staffed by a full-time dental hygienist and a full-time dental assistant.

Developmental Disabilities and Mental Health

Providers and Reimbursement Rates

The Community Services Reimbursement Rate Commission (CSRRC) was created in 1996 as an independent unit within DHMH. ***Senate Bill 305***/***House Bill 1059*** ***(both passed)*** extend the termination date for CSRRC from September 30, 2008, to September 30, 2011, and alter CSRRC's required duties, scope of issues to assess, and the information required in CSRRC's annual report. The bills also require the Maryland Board of Nursing to provide CSRRC copies of any regulations that may impact the costs incurred by community service

providers paid for by the Mental Hygiene Administration (MHA) or Developmental Disabilities Administration (DDA).

Veterans' Mental Health

The fiscal 2009 budget includes just over $2.8 million in MHA to improve access to behavioral health services for veterans. ***Senate Bill 210/House Bill 372 (both passed)*** require DHMH to establish behavioral health service coordination for certain veterans for a three-year period. The intent of the program is two-fold: to link veterans to mental health services provided by the U.S. Department of Veterans Affairs (VA) and to provide gap services if there is a delay in services available from the VA. The State will provide crisis intervention; individual, group, and family therapy; substance abuse early intervention and detoxification services; and medications until the veteran can access VA care.

The funding is aimed at the significant numbers of military personnel returning from Iraq and Afghanistan. According to the VA, one-third of all combat veterans are diagnosed as having a mental disorder. Data indicates that 10 to 15 percent of combat veterans have post-traumatic stress disorder and another 10 percent have signs of the disorder, depression, or anxiety and may benefit from care. Co-occurring substance abuse problems are also common among this population as are high suicide rates and homelessness.

Emergency Evaluation Petitions

House Bill 116 (Ch. 43) authorizes licensed clinical marriage and family therapists to diagnose a mental disorder for purposes of making a petition for emergency evaluation of an individual.

Rosewood Center

On January 15, 2008, Governor O'Malley announced plans to close the Rosewood Center, a State residential center for developmentally disabled individuals, by June 2009. The decision to close the facility was precipitated by repeated findings issued to the facility by the Office of Health Care Quality, which called into question the quality of care being provided at the facility as well as the potential loss of significant Medicaid recoveries.

There are currently 165 individuals residing at the Rosewood Center; 30 of those are committed by the court to be treated by DDA and 135 are noncourt committed. DDA has produced a detailed plan for the closure of the Rosewood Center, transitioning the noncourt committed individuals to the community and identifying an alternate facility for court-involved individuals in the DDA system.

The closure plan not only affects the residents currently residing at the facility, but also affects how the State will handle the care and treatment of court-ordered individuals in the future. Individuals directed by the court into the custody of DDA will first be evaluated at a new medium security ward at Clifton T. Perkins Hospital to determine the individual's behavioral challenges and service needs. Once individuals are properly assessed, they will be moved to

either an appropriate community placement that specializes in serving individuals with a history of challenging behaviors or to a smaller residential facility dedicated solely to the treatment of the court-ordered population.

The closure of Rosewood will cost the State an additional $1.8 million in fiscal 2008 and $4.9 million in fiscal 2009. The additional cost is attributed to the continued operation of Rosewood through the end of fiscal 2009 while also serving those individuals who have moved from Rosewood to the community. The State also loses Medicaid revenues associated with operating Rosewood as an Intermediate Care Facility for the Mentally Retarded.

Automated External Defibrillator Program

Automated external defibrillators (AEDs) are simple-to-use, life-saving devices that are effective in dramatically improving the likelihood of survival for a victim of sudden cardiac arrest. The AED program authorizes facilities to make AEDs available when physician services or emergency medical services are not immediately available. ***Senate Bill 570*** ***(passed)*** renames the AED program the Public Access Automated External Defibrillator Program and alters program requirements to remove barriers to participation and increase AED placement, particularly at high-risk locations. Facilities wishing to participate are no longer required to be authorized but instead must become registered facilities. The program fee is repealed. Each participating facility is required to • maintain each AED and all related equipment and supplies in accordance with manufacturer and U.S. Food and Drug Administration standards; • ensure that each individual who is expected to operate an AED has successfully completed an educational training course and refresher training as required by the EMS Board; and • report the use of an AED to the Maryland Institute for Emergency Medical Systems Services for review by the regional council AED committee.

HIV Testing

An estimated 6,000 to 7,000 HIV-infected women give birth each year in the United States, resulting in 280 to 370 new prenatal infections. However, antiretroviral therapy lowers the risk of mother-to-child transmission of HIV to less than 2 percent. The Centers for Disease Control and Prevention (CDC) recommends HIV screening for all patients in health care settings, including pregnant women, after the patient is notified that testing will be performed *unless* the patient declines. ***Senate Bill 826/House Bill 991*** ***(both passed)*** require a health care provider to inform an individual that an HIV test will be administered and advise the individual that the individual may refuse without penalty. Providers of prenatal care must notify each patient that she will be tested for HIV and that she may refuse without penalty. If she declines, her declination has to be documented in her medical record. The bill also specifies additional testing requirements as well as referral requirements for women who test positive.

Prescription Drugs

Senate Bill 775/House Bill 514 ***(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 of the Maryland Health Insurance Plan Fund to be transferred and appropriated to DHMH for a grant to the Maryland Medbank Program.

Prescription drug abuse makes up almost one-third of all drug abuse in the U.S., and treatment admission rates have more than doubled in the past 10 years. State prescription drug monitoring programs give health care providers and law enforcement agencies a tool for preventing misuse of controlled substances. ***House Bill 525 (passed)*** establishes an Advisory Council on Prescription Drug Monitoring in DHMH to study the establishment of a prescription drug monitoring program. The council must submit a final report by December 31, 2009, including recommendations for establishing a program that assists health care providers and law enforcement professionals regarding prescription drug abuse and unlawful prescription drug diversion; promotes a balanced use of prescription drug monitoring data; and promotes appropriate and real-time access to prescription drug monitoring data.

Consumer Product Safety

Lead-containing Children's Products

The number of children with elevated blood lead levels decreased in 2006 at both the State and national level compared to 2005. Over the past two years, three children in Maryland were tested and found to have elevated blood lead levels specifically traceable to lead-containing products. ***House Bill 62 (passed)*** prohibits a person from manufacturing, selling, offering for sale, importing, or distributing a lead-containing children's product. A "lead-containing product" is a product or a component of a product containing or coated with lead in a concentration of more than 0.06 percent of the product's total weight or the standard established under federal law. This prohibition includes products such as accessories and jewelry, clothing, decorative objects, furniture, lunch boxes and eating utensils, toys, and any other item specified by the Department of the Environment in regulation.

House Bill 62 also requires a manufacturer of a children's product to test whether the product is a lead-containing product by using an independent, accredited third-party testing entity. The manufacturer is required to issue a certificate that certifies that the product is not a lead-containing product and must ensure that the certificate is transmitted with the product to any distributor or retailer. A more detailed discussion of lead poisoning may be found under the Part K – Environment of this *90 Day Report*.

Influenza Vaccines

The United States Code of Federal Regulations requires, in general, the addition of a preservative to multi-dose vials of vaccines to prevent microbial growth. According to the Institute of Medicine, the preservative thimerosal was removed from all recommended childhood vaccines except influenza. ***Senate Bill 304*/*House Bill 586 (both passed)*** require the Statewide Advisory Commission on Immunizations to conduct a study on the current and anticipated future availability of single-dose influenza vaccines for use in the State and the anticipated future cost differential between single-dose and multi-dose influenza vaccines.

Miscellaneous Public Health Reforms

Newborn Screening

DHMH's newborn screening program provides screening for hereditary and congenital disorders. ***House Bill 216*** ***(passed)*** codifies a statewide system for screening newborn infants and specifies that the DHMH Public Health Laboratory is the only laboratory authorized to perform the screening tests, although DHMH may contract or delegate screening with the approval of the State Advisory Council on Hereditary and Congenital Disorders. While the program currently allows parents to opt out of having their children screened, ***House Bill 216*** requires DHMH to study and report by December 1, 2008, whether a coordinated statewide screening system should be applied to all newborn infants in the State.

Birth Defects

Nationally, approximately 3 percent of all babies are born with birth defects, which are the leading cause of infant death. In Maryland, the Birth Defects Reporting and Information System collects data on the number of babies born with birth defects. ***Senate Bill 828*** ***(passed)*** modifies the circumstances under which birth defects must be reported to DHMH. ***Senate Bill 828*** authorizes DHMH to inspect and maintain medical information relating to a child with a birth defect. The bill also provides legal protections for medical information relating to a child with a birth defect.

Maryland Anatomical Gift Donor Registry

Under the Maryland Anatomical Gift Act, any individual who is age 18 or older and competent to execute a will may make an anatomical gift of all or any part of the individual's body for any one or more of the purposes specified under the Act. ***Senate Bill 766***/ ***House Bill 906*** ***(both passed)*** require the Secretary of Health and Mental Hygiene to contract with a qualified nonprofit entity by April 1, 2009, for the establishment, maintenance, and operation of a donor registry. The registry is intended to facilitate the making of anatomical gifts.

Antibiotic-resistant Infection Prevention Campaign

Senate Bill 286 ***(passed)*** requires the Secretary of Health and Mental Hygiene, in collaboration with other State agencies, to establish and promote a public awareness campaign on antibiotic-resistant infections. The campaign must develop and disseminate educational materials; distribute the educational materials free of charge to health facilities, health clinics, and schools; and disseminate information about the dangers of antibiotic-resistant infections and methods to reduce their transmission through written materials, posters, or other mediums.

Health Occupations

State Board of Dental Examiners

Dentists

In May 2007, the Governor directed the Department of Health and Mental Hygiene Office of the Inspector General (OIG) to audit the State Board of Dental Examiners with the goal of determining whether the disciplinary operations and sanctioning outcomes of the board incorporate bias and inequities. OIG found no evidence that the board had exceeded its statutory or regulatory authority in sanctioning licensees. However, OIG did make recommendations to improve board functions regarding vacancies, discipline, and data collection.

***Senate Bill 764*/*House Bill 811* (both passed)** incorporate some of these recommendations. The bills provide for a balloting process to fill vacancies on the board and require the board to consult with both the Attorney General's Office and the Secretary of Health and Mental Hygiene in drafting new regulations relating to the board's complaint and disciplinary procedures.

Dental Hygienists

In response to concerns regarding a lack of access to oral health care services, the Secretary of Health and Mental Hygiene formed a Dental Action Committee in June 2007. The committee found that only 13 jurisdictions had dental clinical services in local health departments, and only 11 jurisdictions were served by Federally Qualified Health Centers (FQHCs) with dental clinics. To alleviate this access problem, the committee recommended that "public health dental hygienists" be authorized to increase preventive dental services. ***Senate Bill 818*/*House Bill 1280* (both passed)** authorize dental hygienists who are employees of the federal government, a State or local government, or FQHC, and working in specified facilities, to apply fluoride and sealants under the general supervision of a licensed dentist.

Additionally, ***Senate Bill 511* (passed)** exempts dental hygiene students who are engaged in an approved dental hygiene education program from the requirement that a person must have a license issued by the board before practicing dental hygiene.

Massage Therapists

Chapters 673 and 678 of 1996 gave the State Board of Chiropractic Examiners responsibility for regulating massage therapy. ***Senate Bill 960*/*House Bill 1563* (both passed)** require massage therapists to be licensed rather than certified by the board in order to practice massage therapy in the State. The bills also add three massage therapists to the board and rename the board to be the State Board of Chiropractic and Massage Therapy Examiners.

Morticians and Funeral Directors

Sunset Review and Program Evaluation

During the 2007 interim, the Department of Legislative Services (DLS) conducted a full evaluation of the State Board of Morticians and Funeral Directors in accordance with the Maryland Program Evaluation Act (Sunset Law). ***Senate Bill 463*** ***(passed)*** extends the termination date of the board from July 1, 2008, to July 1, 2017. Additionally, the bill:

- alters the composition of the board by removing two of the licensed members of the board and adding a consumer member to the board;

- requires a preneed contract to include a statement that informs the buyer that not all costs are covered by the contract and that lists all the funeral goods and services that may be needed by the buyer at the time of service but may not be covered by the contract; and

- requires the board to submit various reports regarding recommendations contained within the DLS evaluation, the resolution of a lawsuit to which the board is a party, the effectiveness of preneed contract regulations, and the outcome of reestablishing the funeral director license.

Family Security Trust Fund and Preneed Contracts

House Bill 1090 ***(passed)*** creates a Family Security Trust Fund within the board to reimburse consumers for losses that occur on or after January 1, 2010, regarding a transaction related to preneed contract services based on the acts or omissions of a licensee or an employee of a licensed funeral establishment. The fund is to be financed through fees imposed on licensed funeral establishments.

Nurses

The State Board of Nursing began requiring criminal history records checks of all new nurses and certified nursing assistant applicants in January 2007. ***House Bill 269*** ***(passed)*** extends to July 2009 the date on which the board will begin checking the criminal history records of existing certificate and license holders. The board may accept an alternative method other than fingerprints for a criminal history records check if two attempts to obtain legible fingerprints have failed.

Extensions of temporary licenses or temporary practice letters may be granted by the board for 90 days pending receipt of criminal history records information under ***House Bill 269***. In all other instances, under ***House Bill 923*** ***(passed)***, temporary licenses or temporary practice letters may be extended every 90 days for up to 12 months if the applicant does not meet specified practice requirements.

Senate Bill 889*/*House Bill 1140* *(both passed) authorize a registered nurse certified as a nurse practitioner to make certain determinations regarding examination of a pregnant minor and "do not resuscitate" orders under specified circumstances and to provide vital data on birth, death, and other medical certificates.

Nursing Home Administrators

House Bill 697* *(passed) increases the minimum age for licensure as a nursing home administrator from 18 to 21 years old.

Pharmacists

Senate Bill 717*/*House Bill 551* *(both passed) authorize a pharmacist to administer a vaccination for pneumococcal pneumonia or herpes zoster if the adult patient has a prescription, the vaccination is administered in accordance with regulations, and the pharmacist informs the prescribing physician and the primary care physician – if different than the prescribing physician – of the administration of the vaccination.

Senate Bill 767*/*House Bill 1387* *(both passed) authorize a pharmacist to dispense medication from a remote location for the benefit of a nursing home that uses a remote automated medication system. The remote automated medication system must meet specified requirements including the use of bar code technology, electronic reporting, and pictorial or written descriptions of the medications. The pharmacist operating a system must implement a comprehensive system training program and a quality assurance program.

House Bill 233* *(passed) extends the termination date of the Therapy Management Contract Program between the Board of Pharmacy and the Board of Physicians from May 31, 2008, to September 30, 2010. The program entails an agreement between a physician and a pharmacist that is disease-state specific and specifies the predetermined course of treatment of the patient.

Professional Counselors and Therapists

Sunset Review and Program Evaluation

During the 2006 interim, DLS conducted a preliminary evaluation of the State Board of Professional Counselors and Therapists in accordance with the Sunset Law. The preliminary report recommended a full evaluation which resulted in the introduction of ***Senate Bill 502*/*House Bill 459* *(both passed)***. In addition to reorganizing and clarifying existing statutes relating to these health occupations, the bills:

- extend the termination date of the board from July 1, 2009, to July 1, 2019;

- increase the number of board members to 13 and change the composition of the board to include 2 additional licensed clinical marriage and family therapist members and 2 additional licensed clinical alcohol and drug counselors; and

- repeal provisions authorizing the certification of new professional counselors and marriage and family therapists.

Psychological Testing

House Bill 494 ***(passed)*** alters the definition of "appraisal" to authorize a licensed counselor or therapist to engage in psychological testing if the counselor or therapist has completed training including the earning of a specified degree, the completion of 500 hours of supervised assessment testing, and passage of a national examination.

Certified Counselors – Alcohol and Drug

Senate Bill 882 ***(passed)*** authorizes the board to waive the practical experience requirements for qualification as a certified alcohol and drug counselor if the applicant obtained a minimum of five years of clinically supervised experience in alcohol and drug counseling approved by the board prior to obtaining the required educational experience.

Respiratory Care Practitioners, Radiation Therapists, Radiographers, Nuclear Medicine Technologists, and Radiologist Assistants

House Bill 1517 ***(passed)*** updates the titles relating to respiratory care practitioners, radiation therapists, radiographers, and nuclear medicine technologists regulated by the State Board of Physicians to reflect nomenclature used in the professions and requires the professionals to be licensed rather than certified. Additionally, the bill requires the board to establish a licensure program for radiologist assistants in order to have them perform fluoroscopy and selected radiology procedures, patient assessment, and patient management.

Social Workers

Senate Bill 848 ***(passed)*** adds a licensed social worker member to the State Board of Social Work Examiners who is primarily engaged in social worker education at an accredited social work program, nominated from a list of names submitted by the deans and directors of the Maryland Social Work Education Programs.

Miscellaneous

Direct Billing of Anatomic Pathology Services

Senate Bill 602*/*House Bill 1089 ***(both passed)*** require a clinical laboratory or a physician that provides anatomic pathology services for a patient in this State to bill:

- the patient directly;
- a responsible insurer or other third-party payor;
- a hospital, public health clinic, or nonprofit health clinic that ordered the services;
- a referring laboratory; or
- a governmental agency.

Task Forces and Studies

Birth Options Preservation Study: ***House Bill 1407*** ***(passed)*** requires the State Board of Nursing and the State Board of Physicians to conduct a joint study to determine whether there is an appropriate alternative written protocol for nurse midwives to replace the current requirement for a signed written collaborative agreement with a licensed physician.

The Discipline of Health Care Professionals and Improved Patient Care: ***Senate Bill 764***/***House Bill 811*** establish the Task Force on the Discipline of Health Care Professionals and Improved Patient Care. The task force is charged with studying the adequacy of all the health occupation boards' disciplinary systems and potential changes to improve the systems. A report is required by December 1, 2008.

A Review of Physician Shortages in Rural Areas: ***Senate Bill 459*** ***(passed)*** creates a Task Force to Review Physician Shortages in Rural Areas of the State. The task force must make recommendations by December 1, 2008.

Health Care Facilities and Regulation

Nursing Homes

Chapter 503 of 2007 imposed a quality assessment equal to the lesser of 2 percent of the revenues for nursing facilities in the State or the amount necessary to fully fund the nursing facility payment system, for the purpose of increasing Medicaid nursing home reimbursement rates. Beginning July 1, 2008, a portion of the revenues from the assessment was to be distributed to nursing facilities based on accountability measures that indicate quality of care or a commitment to quality of care. A workgroup was charged with developing a possible methodology for the nursing home quality incentive payments. A scoring system has yet to be finalized, but components expected to be measured include staffing levels, health outcomes, and responses to the Maryland Health Care Commission's Family Satisfaction Survey. ***Senate Bill 667***/***House Bill 809*** ***(both passed)*** repeals the requirement that the Department of Health and Mental Hygiene develop accountability measures relating to the nursing home quality assessment and instead requires the department to develop a plan for accountability measures to

use in a pay-for-performance program. Implementation of the program is delayed from July 1, 2008, to July 1, 2009.

Prompted by the recent purchase of a major nursing home chain in Maryland by a private investment firm, several bills were considered by the General Assembly that addressed the effect that purchase, and subsequent purchases, could have on the industry as a whole, and the quality of care provided in nursing homes in the State. ***House Bill 1187*** ***(passed)*** requires that information on who owns and who will operate the facility be included in applications for licensure as a nursing home. The Secretary of Health and Mental Hygiene is then authorized to approve, deny, or approve subject to conditions, applications for licensure as a nursing home or the renewal of a license. Nursing homes also have to submit changes in financial condition that could affect quality of care. Finally, the bill requires the Secretary to convene a workgroup to develop regulations that will implement the expanded licensing requirements.

Along with the expanded licensing requirements, ***House Bill 807*** ***(passed)*** establishes a task force to study financial matters relating to long-term care facilities, including studying ownership trends of long-term care facilities and the impact on quality of care, and whether there should be limitations or restrictions on certain types of ownership. In addition, the task force must consider current laws governing ownership of long-term care facilities, and whether long-term care facilities should be required to have liability insurance.

Nursing personnel are consistently listed as one of the top 10 occupations for work-related musculoskeletal disorders, with incidence rates of at least 13.5 per 100 in nursing home settings and 8.8 per 100 in hospital settings. While there has been a steady decline in the rates of most occupational injuries since 1992, work-related musculoskeletal disorders in nursing continue to rise. ***House Bill 585*** ***(passed)*** requires each nursing home in the State to establish a safe patient lifting workgroup by December 1, 2008, and a safe patient lifting policy to reduce employee injuries associated with patient lifting by July 1, 2009.

Hospitals

The Maryland Hospital Bond Program was established to provide for the payment and refinancing of public obligation bonds of a hospital in the event of closure, delicensure, or conversion. ***Senate Bill 946*** ***(passed)*** expands requirements for payment and refinancing of public obligation bonds under the Maryland Hospital Bond Program and clarifies the Health Services Cost Review Commission's authority to assess a fee on all regulated hospitals to finance the program. Finally, the bill repeals the prohibition that the annual percentage increase in commission user fees may exceed the annual update factor provided to hospitals for the same fiscal year.

Domestic Partners

Nationally, many local jurisdictions recognize domestic partnerships for purposes such as health insurance coverage, family leave, adoption rights, and health care decision making. Nine states and the District of Columbia have laws that confer state-level benefits to same-sex or

unmarried couples: California; Connecticut; Hawaii; Maine; New Hampshire; New Jersey; Oregon; Vermont; and Washington.

Senate Bill 566 ***(passed)*** defines domestic partnerships and confers rights regarding health care facility visitation and medical decisions in certain circumstances. However, the bill does not have any effect on specified provisions of law that provide that only a marriage between a man and a woman is valid in the State. In addition, under the bill, individuals who assert a domestic partnership may be required to provide an affidavit by two individuals stating that they have established a domestic partnership, as well as proof of any two of a list of specified documents.

Visitation and medical decisionmaking rights afforded under ***Senate Bill 566*** are as follows:

- *Health Care Facility Visitation*: Hospitals, nursing homes, and residential treatment centers must allow visitation by a patient's or resident's domestic partner, the children of the domestic partner, and the domestic partner of the patient's or resident's parent or child, with specified exceptions.

- *Nursing Homes*: Domestic partners who are both residents of a nursing home must be given the opportunity, if feasible, to share a room. Each nursing home resident who has a domestic partner must have privacy during a visit by the other domestic partner. A domestic partner of a nursing home resident may file a complaint about a violation of these provisions.

- *Medical Emergencies*: In the case of a medical emergency, two adults must be treated as domestic partners if one of the adults, in good faith, tells the emergency provider or hospital personnel that they are in a mutually interdependent relationship but only for the purposes of allowing one adult to accompany the ill or injured adult to a hospital in an emergency vehicle, and visiting with the ill or injured adult admitted to a hospital for an emergency.

- *Health Care Decisions*: A domestic partner may make decisions about health care for a person who has been certified to be incapable of making an informed decision and who has not appointed a health care agent or whose health care agent or appointed guardian is unavailable. If a domestic partner has a health care agent, that health care agent retains the authority to make any decisions for a domestic partner until the authority is revoked. An individual may not be transferred to or from any mental health facility by the Mental Hygiene Administration unless accompanied by an authorized ambulance attendant or specified family member, including a domestic partner. A domestic partner may petition the circuit court to enjoin the provision or withholding of medical treatment to the patient upon a finding by a preponderance of the evidence that the action is not lawfully authorized by State or federal law.

- *Tissue and Organ Donation*: A domestic partner may have priority to consent to the donation of the decedent's organs or tissues. A hospital may not bill a domestic partner for the costs associated with the removal of the decedent's organs or tissues. Any remaining parts of a body after an anatomical gift must be returned to a domestic partner for final disposition.

- *Final Disposition of a Body*: A domestic partner may provide consent for a postmortem examination of the decedent; have priority in arranging for the final disposition of a body; and request reasonable access to a burial site for restoring, maintaining, or viewing. A domestic partner who arranges for the final disposition of a body is liable for the reasonable costs of preparation, care, and disposition of the decedent. The Department of Health and Mental Hygiene may not deny inspection of a disinterment or reinterment permit record to a domestic partner of the deceased whose human remains have been disinterred or reinterred.

Prince George's County Health System

The Prince George's County Health System, including Prince George's Hospital Center, has been faced with financial difficulties for the past several years. The system has experienced lost market share, revenue losses, low liquidity, significant deferred capital needs, poor bond ratings, and a disadvantageous payor mix. In recent years, both Prince George's County and the State have provided funding in an effort to help the hospital meet its financial needs.

House Bill 1039 ***(passed)*** establishes the Prince George's County Hospital Authority as a State entity to implement a competitive bidding process for transferring the Prince George's County Health System to a new owner or owners. For fiscal 2009, the Governor is authorized to provide $12.0 million, and the county must provide a match of $12.0 million, for the financial support of the facilities, assets, and obligations held or operated by Dimensions Healthcare System, the entity responsible for running the system. Funding may be allocated for the operation of the system during fiscal 2008 should conditions warrant, but these payments would be made against the fiscal 2009 allocation. For fiscal 2010, the Governor and the county each have to provide an additional $12.0 million for the financial support of the system, unless an agreement is reached for the sale or transfer of the system that renders financial support no longer necessary.

Specifically, ***House Bill 1039*** requires the Governor and the county to reach agreement on State and county funding commitments, if the system is transferred to a new owner, and that if agreement on long-term funding is not reached within a specified time frame, State and county support could be withheld and other provisions in the bill will not apply. The authority must issue requests for proposals for the sale or transfer of the system and must determine a timeframe for selection of a successful bidder. A successful bidder must be selected before the beginning of the 2009 session, and if a bidder is not selected within the timeframe, the State and county are relieved of their long-term financial commitments. Finally, upon successful conclusion of the bidding process, the bill requires the county to transfer title of all developed property to the new owner.

Health Services Cost Review Commission

Chapter 7 of the special session expanded eligibility for Medicaid to parents, caretaker relatives, and childless adults with incomes up to 116 percent of federal poverty guidelines, effective July 1, 2008. If the expansion of health care coverage provided for in that legislation reduced hospital uncompensated care, the Health Services Cost Review Commission was to determine the savings realized in averted uncompensated care for each hospital individually and could assess an amount in each hospital's rates equal to a portion of the savings realized for that hospital. Each hospital was to remit any assessment to the Health Care Coverage Fund. The commission also had to ensure that any savings not subject to the assessment was shared equitably among purchasers of hospital services.

Senate Bill 974/House Bill 1587 ***(both passed)*** repeals provisions relating to the assessment of hospital uncompensated care savings to finance health care expansion efforts under Chapter 7 of the 2007 special session and the current hospital assessment that funds the Maryland Health Insurance Plan. The bill instead requires the commission to implement a uniform assessment on hospital rates to reflect the aggregate reduction in hospital uncompensated care from the expansion of health care coverage under Chapter 7, and to operate and administer the Maryland Health Insurance Plan.

Trauma Physicians

The Maryland Trauma Physician Services Fund was established in 2003 to subsidize:

- uncompensated and under-compensated care incurred by trauma physicians;
- costs incurred by a trauma center to maintain trauma physicians on-call; and
- the costs to administer and audit reimbursement requests to assure appropriate payments are made from the fund.

Payments from the fund had not approached anticipated amounts after three years, resulting in a significant surplus. The fund receives approximately $12.0 million in revenues annually, and the fiscal 2008 fund balance is expected to be $20.6 million.

Senate Bill 916 ***(passed)*** allows the fund balance to be spent down over several years through the awarding of grants. Specifically, the bill expands and specifies eligibility for reimbursement from the Maryland Trauma Physician Services Fund and requires the Maryland Health Care Commission to develop a grant process to fund equipment for Level II and III trauma centers. The bill allows up to 10 percent of any fund balance to be used to award the grants, and prohibits expenditures from the fund from exceeding revenues in any given fiscal year. Finally, the bill increases by $25,000 the cap on annual reimbursement to emergency physicians from the fund, and increases the amount of an annual grant from the fund to an

out-of-sate pediatric trauma center if the trauma center has an agreement with the Maryland Institute for Emergency Services Systems.

Health Insurance

Relationship between Health Insurance Carriers and Providers

In the 2008 session, several bills passed that addressed the contractual relationship between health insurance carriers and health care providers. Bills were also passed to extend the length of a task force to study the relationship between health care providers and health insurance carriers and to add to the duties of the task force.

"Cram Down" Provisions

Some health insurance carriers require health care providers, as a condition of participating on one provider panel, to participate on other provider panels. Chapters 253 and 254 of 2000 prohibited carriers from requiring participation on one provider panel of a carrier as a condition of participation on another provider panel of a carrier. However, some carrier affiliates or entities that arrange provider panels have been requiring a provider, as a condition of participation on a provider panel of one carrier, to participate on a provider panel of a different carrier. Most prominently, United HealthCare, since its acquisition of MAMSI, has required providers to participate on its MAMSI capitated HMO panel, as a condition of participating on its United fee-for-service HMO panel. This practice has been referred to as "cram down."

House Bill 1219 ***(passed)*** addresses the practice of "cram down" by specifying that a provider contract may not contain a provision that requires a provider, as a condition of participating in a non-HMO provider panel, to participate in an HMO provider panel or dental provider panel. The bill also addresses the United/MAMSI issue by prohibiting a provider contract that includes more than one schedule of fees from containing a provision that requires a provider, as a condition of participation on a provider panel, to accept each schedule of applicable fees included in the provider contract. Provider contracts, with the exception of provider contracts for a dental provider panel, must also disclose the carriers comprising each provider panel. The bill specifies several exceptions to these prohibitions, including allowing a provider contract to require a provider to participate in a Medicaid managed care organization and allowing a provider contract to include a provision that requires a provider, as a condition of participation, to accept each schedule of applicable fees for a carrier that is not affiliated through common ownership with the entity arranging the provider panel. This latter exception will allow the large carriers, such as United HealthCare, to rent out their provider networks to smaller carriers. Without this exception, small carriers could have difficulty gaining a foothold in the State. The bill applies to all provider contracts issued or renewed on or after October 1, 2009, or for provider contracts in effect on October 1, 2009, but not subject to renewal before October 1, 2010, no later than October 1, 2010.

Carrier Credentialing and Reimbursement

Senate Bill 595 ***(passed)*** addresses the situation of a health care provider in a group practice who treats patients of a health insurance carrier during the period while the provider is undergoing the carrier's review of the provider's credentials prior to signing a contract. The bill requires a carrier to reimburse a group practice on the carrier's provider panel at the participating provider rate for covered services provided by a nonparticipating provider if the provider • is employed by or a member of the group practice; • has applied for acceptance on the carrier's provider panel and has an active credentialing application; • has a valid license to practice in the State; and • is currently credentialed by an accredited hospital in the State or has professional liability insurance. A nonparticipating provider eligible for reimbursement may not hold an enrollee liable for the cost of any covered services provided except for any deductible, copayment, or coinsurance amount owed. A group practice must disclose in writing to an enrollee at the time services are provided that • the treating provider is not a participating provider and has applied to become a participating provider; • the carrier has not completed its assessment of the qualifications of the treating provider; and • any covered services received must be reimbursed at the participating provider rate.

Disclosure of Formulary and Fees

House Bill 815 ***(passed)*** requires health insurance carriers to make the pharmaceutical formulary used by the carrier available to a health care practitioner electronically, unless a written copy is requested in writing. The bill also requires carriers to provide health care practitioners with a schedule of applicable fees for up to the 50 most common services billed by a practitioner in that specialty (current law requires the carrier to provide a schedule of fees for up to the 20 most common services) and specifies the format in which the schedule of fees must be provided.

Task Force on Health Care Access and Reimbursement

The Task Force on Health Care Access and Reimbursement, established by Chapter 505 of 2007, is charged with studying and developing specific recommendations relating to health care provider reimbursements. The task force was scheduled to terminate effective June 30, 2008; however, ***House Bill 289*** ***(passed)*** extends from June 30 to December 1, 2008, both the termination date and the date by which the task force must submit a final report of its findings and recommendations. ***Senate Bill 744***/***House Bill 818*** ***(both passed)*** require the task force to develop recommendations regarding (1) whether there is a need to provide incentives for physicians and other health care practitioners to be available to provide care on evenings and weekends; and (2) the ability of primary care physicians to be reimbursed for mental health services provided within their scope of practice.

Regulation of Entities Other than Health Insurers

Several bills passed during the 2008 session that established regulatory schemes for or clarified regulation of health care entities by the Maryland Insurance Commissioner. Though the

entities regulated in these bills are not health insurers, they administer health care benefits or provide some form of health care coverage.

Pharmacy Benefits Managers

Pharmacy benefits managers (PBMs) are businesses that administer and manage prescription drug benefit plans either through health insurance products or separately. Approximately 95 percent of all patients with prescription drug coverage receive benefits through a PBM. In recent years, concerns have been raised by consumer organizations and states regarding the business practices of PBMs. Some of these business practices, such as switching patients from one brand-name drug to another brand-name drug, led to multistate settlement agreements between PBMs and state attorney generals. Demands for greater transparency in financial relationships between PBMs and drug manufacturers have prompted states to propose regulation of PBM activities.

Several bills were enacted during the 2008 session to regulate PBMs. In the bills, PBMs are defined as entities that provide pharmacy benefits management services for beneficiaries of health insurers that are regulated by the State or the State Employee and Retiree Health and Welfare Benefits Program. PBMs that provide services for employer plans that are subject to federal regulation under ERISA are exempted from the bills.

Registration: ***Senate Bill 722/House Bill 419 (both passed)*** require a PBM to register with the Maryland Insurance Commissioner before providing pharmacy benefits management services in the State. Registration is effective for two years and may be renewed for an additional two years. Subject to hearing provisions, the Insurance Commissioner may deny, suspend, revoke, or refuse to renew a registration under specified circumstances. The Insurance Commissioner is authorized to assess a civil penalty of up to $10,000 against any person that violates the registration requirements or require PBMs that violate the Act to cease and desist; take specific affirmative corrective action; or make restitution of money, property, or other assets. A PBM may not ship, mail, or deliver drugs or devices to a person in the State through a non-resident pharmacy unless the non-resident pharmacy holds a pharmacy permit from the Board of Pharmacy. A PBM that is operating in the State on October 1, 2008, may continue to operate as a PBM if the PBM registers with the Insurance Commissioner by July 1, 2009, and complies with all other applicable registration provisions.

Transparency: ***Senate Bill 724/House Bill 120 (both passed)*** establish what a PBM must disclose to a purchaser both before and after entering into a contract for pharmacy benefits management services. PBMs must inform a purchaser that the PBM may • solicit and receive manufacturer payments; • pass through or retain the manufacturer payments; • sell aggregate utilization information; and • share aggregate utilization information. A PBM must offer to provide the purchaser a report containing information about net revenues and manufacturer payments. If a purchaser has a rebate sharing contract, a PBM must offer to provide the purchaser a report for each fiscal quarter and each fiscal year that contains information regarding net revenues, prescription drug expenditures, manufacturer payments, and rebates.

Pharmacy and Therapeutics Committees: ***Senate Bill 720/House Bill 580*** ***(both passed)*** establish requirements for a PBM's pharmacy and therapeutics (P&T) committee, which is a committee that advises a PBM regarding the composition of a prescription drug formulary. A PBM's P&T committee must include clinical specialists that represent the needs of a purchaser's beneficiaries and at least one practicing pharmacist and one practicing physician who are independent of any developer or manufacturer of prescription drugs. Members of a P&T committee must sign a conflict of interest statement updated at least annually. A majority of members must be practicing physicians or pharmacists. PBMs must ensure that a P&T committee has • policies and procedures to address conflicts of interest; • processes to evaluate medical and scientific evidence concerning the safety and efficacy of prescription drugs; and • a process to enable the P&T committee to consider the need to recommend a formulary change to a purchaser at least annually. On request of a purchaser, a PBM must disclose information about the composition of its P&T committee to the purchaser. PBMs may not require a pharmacy to participate on a P&T committee.

Therapeutic Interchanges: ***Senate Bill 723/House Bill 343*** ***(both passed)*** establish guidelines for therapeutic interchanges (any change from one prescription brand-name drug to another, excluding specified circumstances). A PBM may only request a therapeutic interchange for medical reasons that benefit the beneficiary or if the interchange will result in financial savings and benefits to the purchaser or the beneficiary. Before making a therapeutic interchange, a PBM must obtain authorization from a prescriber and make specified disclosures to the prescriber. If a therapeutic interchange occurs, the PBM must make specified disclosures to the beneficiary and include with the new dispensed prescription drug a patient package insert about potential side effects and a toll-free number to communicate with the PBM. A PBM must cancel and reverse a therapeutic interchange on instruction from a prescriber, beneficiary, or the beneficiary's representative. If a therapeutic interchange is reversed, the PBM must obtain a prescription for and dispense the originally prescribed drug and charge the beneficiary no more than one copayment. A PBM may not be required to cancel and reverse a therapeutic interchange if the beneficiary is unwilling to pay a higher copayment or coinsurance. A PBM must maintain a toll-free telephone number for prescribers, pharmacy providers, and beneficiaries and establish appropriate policies and procedures to implement the requirements of the bill.

Contracts with Pharmacies: ***Senate Bill 725/House Bill 257*** ***(both passed)*** require a PBM to disclose to a pharmacy or pharmacist its reimbursement policy, the process for verifying beneficiary eligibility, the dispute resolution and audit appeals process, and the process for verifying the prescription drugs that are included on the PBM's formulary. The bills also require a PBM to follow specified procedures when auditing a pharmacy. Finally, the bills require a PBM to adopt specified review processes to allow a pharmacy or pharmacist to request review of a discrepancy or disputed claim in an audit and to allow a pharmacy to request a review of a failure to pay the contractual reimbursement amount of a submitted claim.

Public-private Health Care Programs

Howard County has proposed establishing a public-private partnership to offer basic health care coverage to uninsured county adults with incomes up to 300 percent of federal poverty guidelines on a sliding scale basis. As the program does not fit the traditional definition of health insurance and would be unable to meet financial requirements placed on health insurance carriers such as capital reserves, legislation was sought to regulate this type of health care program without placing an undue burden on the ability of a program to operate.

Senate Bill 852/House Bill 872 ***(both passed)*** define, establish, and regulate public-private health care programs. A person must be certified before operating a public-private health care program. Applicants must file specified documents with the Insurance Commissioner. The Commissioner must certify an applicant that • has been organized in good faith for the purpose of establishing and operating a public-private health care program; • is committed to a nonprofit corporate structure; and • has sufficient funds to meet its obligations. A certification expires after three years and may be renewed if the applicant otherwise is entitled to certification. A certified nonprofit corporation will be subject to unfair claim settlement practices under current law and the associated civil monetary penalties. Public-private health care programs may not approve for enrollment individuals who voluntarily terminated coverage under a small group market health benefit plan within six months of the date of application.

Managed Care Organizations

Managed care organizations (MCOs) are entities that provide health care coverage to enrollees of the State's Medicaid managed care program. ***House Bill 395*** ***(Ch. 70)*** alters financial reporting requirements for MCOs to remove unnecessary and outdated requirements. The Act repeals the requirement that an MCO file a consolidated financial statement and instead requires each MCO to submit an audited financial statement, but at a later date. Annually by March 1, each MCO must file a report that shows the financial condition of the MCO on the last day of the preceding calendar year. Annually by June 1, each MCO must file an audited financial report for the preceding calendar year. This report must be certified by an audit of an independent certified public accountant. All reports are public records.

Medical Stop-loss Insurance

House Bill 272 ***(passed)*** is intended to enhance consumer protections and promote more effective oversight of stop-loss insurance. Although stop-loss insurance is regulated by the State, the Maryland Insurance Administration has had difficulty enforcing the law. The bill replaces the definition of "stop-loss insurance" in the Health Insurance Title of the Insurance Article with "medical stop-loss insurance." The bill defines "medical stop-loss insurance" as insurance purchased by a person other than a carrier or a health care provider to protect the person against losses incurred by that person's obligations to a third party under the terms of a health benefit plan. The bill also prohibits medical stop-loss insurance from being sold on the surplus lines market; prohibits the sale of medical stop-loss insurance by unauthorized carriers; and clarifies that medical stop-loss insurance may only be sold, issued, or delivered by a carrier that holds a

certificate of authority issued by the Insurance Commissioner that authorizes the insurer to engage in the business of health insurance or to act as a nonprofit health service plan.

Maryland Health Insurance Plan

The Maryland Health Insurance Plan (MHIP) is the State's high risk pool. ***House Bill 238 (passed)*** removes MHIP from the Maryland Insurance Administration, making it an independent unit of State government, as well as making other administrative changes. The bill removes the Insurance Commissioner from MHIP's board and adds the Secretary of Health and Mental Hygiene and a hospital representative. MHIP will now be regulated by the Insurance Commissioner; however, not subject to State insurance laws other than those related to • MIA examinations; • provider panels and provider reimbursement; • continuation coverage provisions; • specialist referrals; • prescription drug coverage; • utilization review; • the complaint process for adverse decisions or grievances; • private review agents; • the complaint process for coverage decisions; and • unfair trade practices. If the Insurance Commissioner finds that MHIP has violated specified provisions, the Insurance Commissioner may require MHIP to make restitution to each claimant who has suffered actual economic damages.

The MHIP board must develop a master plan document that sets forth in detail all the terms and conditions of the standard benefit package, including the types of benefits provided, any exclusions, and other specified conditions of coverage. The board must file the master plan with the Insurance Commissioner and provide a copy of the document to a member upon request. The board must develop a certificate of coverage informing members of their rights and obligations. The board must report to specified legislative committees by September 1 of each year on the current standard benefit package and any changes to the package implemented during the previous fiscal year.

Currently, MHIP cannot refer individuals who commit fraudulent acts to the Insurance Fraud Division for investigation and possible prosecution as the provisions of the insurance fraud law do not apply to MHIP. ***Senate Bill 192 (Ch. 25)*** imposes provisions of law relating to fraudulent insurance acts on MHIP.

MHIP is expected to deplete its current fund balance by the end of fiscal 2010. Due to this declining fund balance, MHIP indicates it is likely to cap enrollment in the near future. MHIP is funded by an annual assessment on hospital rates and premium revenues from enrollees. The current MHIP assessment is equal to 0.8128 percent and funds two-thirds of MHIP's operating costs. ***Senate Bill 974/House Bill 1587 (both passed)*** allow the assessment to be increased. A more detailed discussion of this bill may be found under the subpart "Health Care Facilities and Regulation" within Part J – Health and Human Services of this *90 Day Report*.

Senior Prescription Drug Assistance Program

The Senior Prescription Drug Assistance Program (SPDAP), administered by the Maryland Health Insurance Plan, provides subsidies to low-income seniors in the State to help pay for their Medicare Part D premiums. By law, CareFirst BlueCross BlueShield provides

$14 million each year for the program, from the value of the CareFirst premium tax exemption. Of this amount, $11 million subsidizes the Part D premiums, while the remaining $3 million has not been allocated. In February 2008, CareFirst announced that it would pay additional funds for the program to subsidize the costs of program participants in the Medicare Part D coverage gap.

Senate Bill 906/House Bill 1492 ***(both passed)*** require CareFirst, beginning January 1, 2009, to annually provide $4 million to the Senior Prescription Drug Assistance Program. Funds must be provided only if CareFirst's surplus exceeds 800 percent of the consolidated risk-based capital for the preceding calendar year. Funds must be used to subsidize the Medicare Part D coverage gap. SPDAP must provide an annual subsidy up to the full amount of the Medicare Part D coverage gap, subject to the availability of funds. It is anticipated that the $4 million in new money, when combined with the $3 million that is currently unallocated, could assist 7,500 Medicare beneficiaries with their expenses in the coverage gap or "donut hole." The bill also extends the termination date for SPDAP by one year until December 31, 2010.

Small Group Health Insurance Market

Chapter 347 of 2005 made self-employed individuals and sole proprietors ineligible for health insurance coverage in the small group market. Self-employed individuals and sole proprietors enrolled in the small group market on September 30, 2005, were permitted to remain covered, provided the enrollee continues to work and reside in the State and is a self-employed individual. Self-employed individuals not already insured in the small group market have the option of enrolling in MHIP, if they cannot get coverage in the individual market. ***House Bill 462*** ***(Ch. 76)*** extends from September 30, 2008, to September 30, 2011, the termination date on the provision of law that excludes self-employed individuals and sole proprietors from the small group health insurance market.

Long-term Care Insurance

Current law prohibits insurers from using a genetic test or its results to reject or otherwise impact on a health insurance policy or contract. However, long-term care insurance is specifically excluded from this prohibition. ***Senate Bill 918/House Bill 29*** ***(both passed)*** prohibit a carrier or an insurance producer that provides long-term care insurance from requesting or requiring a genetic test or using specified genetic information to (1) deny or limit long-term care insurance coverage; or (2) charge a different rate for the same long-term care insurance coverage. Long-term care insurers are permitted to use genetic information or the results of a genetic test if the use is based on sound actuarial principles.

Mandated Benefits

Amino acid-based elemental formula is hypoallergenic formula designed for infants and children with milk protein and/or multiple food allergies or intolerance. Many insurance carriers provide coverage for the formula only when it is delivered through a surgically implanted tube, and not when provided orally. ***House Bill 578*** ***(passed)*** requires health insurance carriers to

provide coverage for amino acid-based elemental formula, regardless of the delivery method, for the diagnosis and treatment of specified allergies, syndromes, or disorders. A physician must issue a written order stating that the formula is necessary for the treatment of a disease or disorder. A private review agent, acting on behalf of a carrier, may review the physician's medical necessity determination.

Health Insurance for Children

House Bill 1391 ***(passed)*** requires the Department of Health and Mental Hygiene, in consultation with the Maryland Insurance Administration and the Maryland Health Care Commission, to study and make recommendations for increasing the availability and affordability of health care coverage for children with family income that exceeds 300 percent of the applicable poverty income level. A more detailed discussion of this bill and its other provisions may be found under the subpart "Public Health – Generally" within Part J – Health and Human Services of this *90 Day Report*.

Human Services

The Elderly

Continuing Care Retirement Communities

Continuing Care Retirement Communities (CCRCs) offer a full range of housing, residential services, and health care in order to serve older residents as their medical needs change over time. There are 34 CCRCs serving 15,000 subscribers in Maryland. ***House Bill 1351*** ***(passed)*** requires registered CCRCs, by December 1, 2008, to submit to the Maryland Department of Aging and the Health Education and Advocacy Unit in the Office of the Attorney General (1) the number of written grievances submitted to the provider during calendar 2007; (2) a brief summary of each grievance filed during calendar 2007 using only nonindividually identifiable information; and (3) any action taken by the provider regarding the resolution of each grievance filed during calendar 2007.

The Disabled

Assistive Technology Loan Program and Fund

The Assistive Technology Guaranteed Loan Program in the Department of Disabilities provides financial assistance to individuals with disabilities to purchase assistive technology to help individuals with disabilities to become more independent or more productive members of the community with an improved quality of life. ***House Bill 273*** ***(Ch. 62)*** renames the program as the Assistive Technology Loan Program and renames the Assistive Technology Guaranteed Loan Fund as the Assistive Technology Loan Fund. The bill authorizes the program's board of directors to provide borrowers of loans to purchase assistive technology with interest rates equivalent to guaranteed rates by either guaranteeing the loan or subsidizing the interest rate on

non-guaranteed loans. The bill also requires the program's board of directors to set the total aggregate amount of loan guarantees provided from the fund each year.

Public Accommodations and Service Animals

Blind, visually impaired, deaf, and hard of hearing individuals, including individuals using a service animal, have the same rights of access to public places, accommodations, and conveyances, including housing, as individuals without disabilities. ***Senate Bill 577*/*House Bill 767* *(both passed)*** extends these rights to all individuals with disabilities and to parents of a minor child with a disability. The bills provide that physical modifications of places or vehicles are not required for individuals who are authorized to use a service animal and who are accompanied by a service animal. The bills define "service animal" as a guide dog, signal dog, or other animal individually trained to do work or perform tasks for the benefit of an individual with a disability.

Children

Childhood Obesity

In response to surveys that indicate increasing rates of childhood obesity, ***House Bill 1176* *(passed)*** establishes a Committee on Childhood Obesity in the Department of Health and Mental Hygiene. The legislation requires the committee to report to the Governor and the General Assembly on or before December 1, 2009. The committee must report on (1) the insurance reimbursements paid to health care providers to diagnose and treat childhood obesity; (2) a system for collecting, analyzing, and maintaining statewide data; (3) best and promising practices; (4) methods to enhance public awareness of the chronic diseases related to childhood obesity; and (5) methods to increase the rate of obesity screenings for children.

Children in Need of Assistance Proceedings

Chapter 503 of 2005 prohibits health care providers from disclosing medical information without a person's authorization, unless the person has been given notice of the request and has 30 days to object to the disclosure. These requirements may result in the postponement of hearings in civil and criminal matters. ***House Bill 910* *(passed)*** authorizes the expedited disclosure of medical records in Child in Need of Assistance Proceedings. Under this bill the timeframe that a person in interest has to object to the disclosure of a medical record that is requested for these proceedings is reduced from 30 to 15 days.

Residential Child Care Programs

Chapter 438 of 2004 created the State Board for Certification of Residential Child Care Program Administrators within the Department of Health and Mental Hygiene. Child care program administrators are required to be certified on or after October 1, 2007. Furthermore, Chapter 133 of 2007 required the Governor's Office for Children, in cooperation with specified stakeholders, to develop recommendations for certification of direct care staff employed by residential child care programs. The recommendations included professionalizing the role of

direct care workers to attract and retain dedicated individuals to this field of work. ***Senate Bill 783*** ***(passed)*** expands the purview of the board to include the certification of residential child and youth care practitioners, requires practitioners to be certified by the board no later than October 1, 2013, and renames the board as the State Board for Certification of Residential Child Care Program Professionals. The bill does not require the certification of an individual assigned to perform direct responsibilities related to activities of daily living, self-help, and socializations skills in a residential child care program licensed by the Developmental Disabilities Administration.

In order to promote the growth of residential child care programs (*e.g.* group homes) in underserved areas, while limiting further expansion in areas with greater concentrations of existing providers, ***Senate Bill 782*** ***(passed)*** requires the Department of Human Resources (DHR) and the Department of Juvenile Services (DJS) to issue a county-specific statement of need before a residential child care program is issued a license, an existing program is relocated, an existing site is expanded, or the number of placements in an existing program is increased. The bill requires DHR and DJS to consider the special needs of the affected children and consult with relevant stakeholders when developing a statement of need. DHR, DJS, and the Governor's Office for Children must report to the General Assembly by October 1, 2008, on (1) processes for developing a statement of need and documenting the needs of children affected by a statement of need; (2) how agencies will coordinate the appropriate development of placement resources; and (3) actions taken and planned to develop resources in underserved areas to match the specialized needs of children, including strategies to overcome community resistance.

Legislation was also introduced to redirect focus from the responsibilities of residential child care program providers to the rights of children served in these facilities. ***Senate Bill 742*** ***(passed)*** requires a residential child care provider, including those licensed by the Developmental Disabilities Administration, to conspicuously post a Residents' Bill of Rights in the facility. The bill of rights establishes a resident's right to be treated fairly and receive appropriate educational and guidance services in an environment that is free of discrimination or abuse. The resident and his or her family have a right to communicate with each other, as appropriate, and express their opinions about services provided. The bill requires residential child care providers to develop and distribute a handbook that includes specified information regarding the provider's policies and procedures and to document the receipt of the handbook by each child receiving care and his or her parents or guardians.

Miscellaneous

Child Specific Benefit

The Family Investment Program in the Department of Human Resources assists temporary cash assistance applicants and recipients in becoming self-sufficient. The child-specific benefit was enacted to remove incentives for having additional children while receiving temporary cash assistance (TCA). Under the provision, payment of an incremental TCA benefit to a welfare recipient following the birth of a child 10 months after the recipient has been determined eligible for assistance was prohibited. Instead, the value of additional

assistance for the additional child was transferred to a third-party payee, which may include an extended family member or a faith-based or nonprofit organization, to manage the benefit on behalf of the child. Efforts to recruit third-party payees were largely unsuccessful, and fees were high for participating organizations. In addition, the department determined that families receiving TCA were not expanding. In December 2002, because of the costs associated with administering the child-specific benefit, the Secretary of Human Resources, as authorized by law, granted waivers to local departments of social services from implementing the child-specific benefit provision. Therefore, increments for additional children have been paid to TCA recipients since 2002. ***Senate Bill 799/House Bill 1356*** ***(both passed)*** codifies current practice by repealing the child-specific benefit.

Immigration

In recent years, immigration has emerged as a major issue in the U.S. Congress, state legislatures, and at the local level. Maryland continues to be a major destination for immigrants. According to population estimates prepared by the U.S. Census Bureau, international immigration added 129,730 people to the State's population between 2000 and 2006. The impact of immigration varies greatly among Maryland's jurisdictions.

House Bill 1602 ***(passed)*** establishes a Commission to Study the Impact of Immigrants in Maryland, which includes studying the demographic profile of immigrants in the State and the economic and fiscal impacts of immigrants on the State. The commission is required to report its findings and recommendations to the Governor and the General Assembly by January 1, 2011.

A more detailed discussion of immigration issues may be found under subpart "State Agencies, Offices, Officials" within Part C – State Government of this *90 Day Report*.