Part J
Health and Human Services

Public Health – Generally

Medicaid

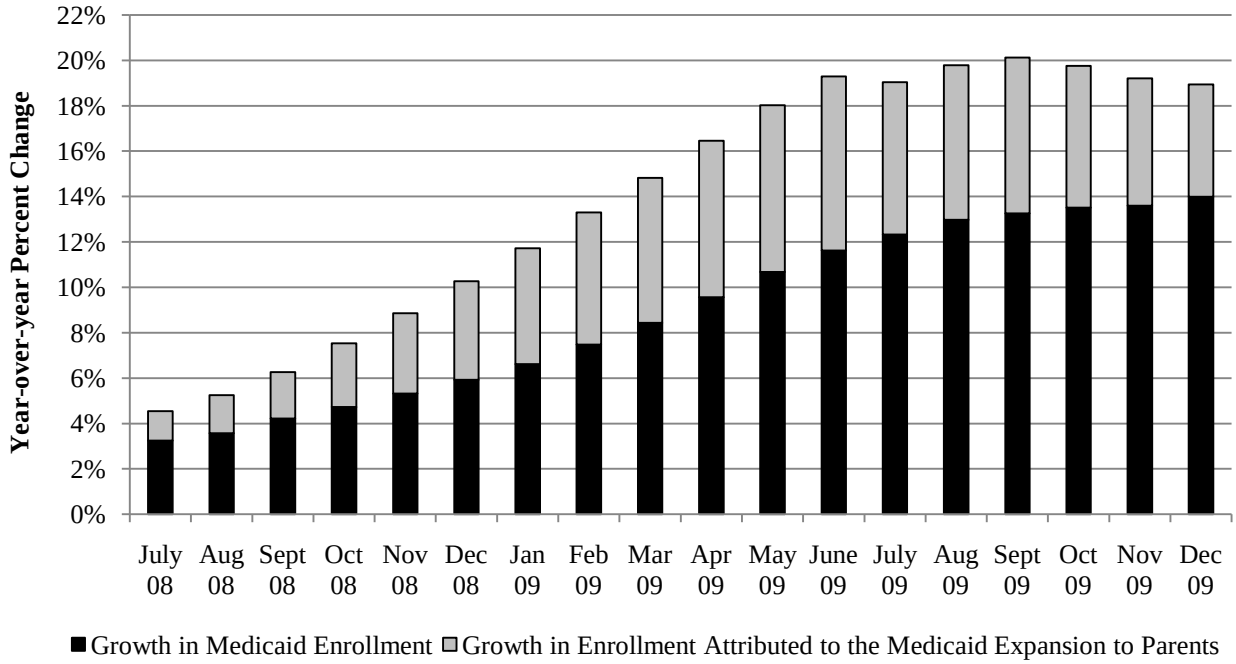
Fiscal 2011 Budget Actions

The fiscal 2011 Medicaid budget totals almost $6.2 billion. A key assumption in the fiscal 2011 budget is that the enhanced federal matching rate available under the federal American Recovery and Reinvestment Act of 2009 (ARRA) will continue until the end of fiscal 2011 rather than expire December 31, 2010, an assumption that saves $389 million in general funds. At the time of writing, that extension was expected but had not yet been enacted.

The major driver to growth in the Medicaid budget continues to be enrollment. Since the summer of 2008, enrollment in Medicaid (excluding the Maryland Children's Health Program (MCHP) and the Primary Adult Care program (PAC)) has increased steadily from just over 500,000. Enrollment growth was estimated at 15.6% in fiscal 2009. Current Department of Legislative Services (DLS) projections anticipate average monthly enrollment topping 700,000 in fiscal 2010 (a 16.5% increase over fiscal 2009) and continuing to increase, albeit at a lesser rate, to approaching 740,000 in fiscal 2011 (a 4.3% increase over fiscal 2010).

Contributions to this enrollment increase are the health care reform expansion of Medicaid to parents and the deteriorating economy. As shown in **Exhibit J1-1**, in fiscal 2009, enrollment growth was evenly fuelled by health care reform and the economy (as evidenced by the growth of Temporary Cash Assistance (TCA) enrollees, especially children). Beginning in fiscal 2010, the impact of health care expansion on enrollment, while still significant, is clearly less important than the economy. DLS anticipates that in fiscal 2011 most of the enrollment growth will continue to be from TCA enrollees.

Exhibit J1-1
Year-over-year Change in Medicaid Monthly Enrollment
Fiscal 2009-2010 Year-to-date



Note: Excludes the Maryland Children's Health Program and the Primary Adult Care Program.

Source: Department of Health and Mental Hygiene; Department of Legislative Services

The fiscal 2011 budget contains little in the way of funding for anything above that required to support enrollment and utilization trends although there is $70 million for a 5.4% Managed Care Organization (MCO) rate increase and it is anticipated (although not actually included in the fiscal 2011 budget at this point) that there will be a 2.0% rate increase for nursing homes. The funding to support the nursing home rate increase represents a portion of the increase in the nursing facility quality assessment contained in the Budget Reconciliation and Financing Act (BRFA) of 2010.

The budget also contains numerous cost containment actions, the most notable a $123.0 million general fund savings in inpatients costs. These general funds will be back-filled by a hospital assessment (70% of the assessment passed on through higher rates, 30% off hospital bottom-lines). Other significant cost containment actions included the continuation of a fiscal 2010 action aligning Medicaid and Medicare rates for certain dually eligible individuals (a fiscal 2011 savings of $31.2 million), collecting rebates on MCO pharmacy expenditures ($20.5 million, which also requires a change in federal law), savings generated from the passages

of the False Health Claims Act ($20.0 million), and savings based on swapping general funds for special funds from the higher nursing facility quality assessment ($17.0 million).

Medicaid Eligibility for Nursing Facility Level of Care

The nursing facility level of care standard is the medical eligibility standard that individuals must meet in order to receive nursing home services through Medicaid. This standard is also linked to the eligibility of most home- and community-based waiver programs, the Program of All-Inclusive Care for the Elderly, and medical day care services. In 2008, the Department of Health and Mental Hygiene (DHMH) was prompted to alter its nursing facility level of care standard in response to the final ruling in the case of *Ida Brown v. Department of Health and Mental Hygiene.*

On July 1, 2008, DHMH changed its nursing facility level of care standard to allow services to be covered for a broader range of individuals who have cognitive, functional, and behavioral needs. The amended criteria removed the requirement that an individual must require the direct involvement of a licensed health care professional to meet the nursing facility level of care standard.

Senate Bill 429/House Bill 278 ***(Chs. 143 and 144)*** require DHMH to report to the Senate Finance Committee, the House Health and Government Operations Committee, and the Medicaid Advisory Committee (MAC) at least 90 days prior to making any change to medical eligibility for Medicaid long-term care services, including nursing facility services, home- and community-based waiver services, and other services that require nursing facility level of care. DHMH must also discuss the report, which must include specified information related to the change to medical eligibility, at a meeting of MAC.

False Claims Act

The federal Deficit Reduction Act of 2005 established incentives for states to enact certain antifraud legislation modeled after the federal False Claims Act (FCA). States that enact qualifying legislation are eligible to receive an increase of 10% of the recovery funds (by a corresponding 10% reduction in the federal share). To qualify, a state false claims act must provide (1) liability to the state for false or fraudulent claims; (2) provisions for *qui tam* actions to be initiated by whistleblowers and for the rewarding of those whistleblowers in amounts that are at least as effective as those provided by the federal FCA; (3) the placing of *qui tam* actions under seal for 60 days for review by the state Attorney General; and (4) civil penalties not less than those provided in the federal FCA, to be imposed on those who have been judicially determined to have filed false claim acts.

Senate Bill 279 ***(Ch.4)*** prohibits a person from making a false or fraudulent claim for payment or approval by the State or DHMH under a State health plan or program; (2) authorizes the State to file a civil action against a person who makes a false health claim; (3) establishes civil penalties for making a false health claim *qui tam* action; (4) permits a private citizen to file a civil action on behalf of the State against a person who has made a false health claim; (5) requires the court to award a certain percentage of the proceeds of the action to the private

citizen initiating the action; and (6) prohibits retaliatory actions by a person against an employee, contractor, or grantee for disclosing a false claim or engaging in other specified false claims-related activities. The statute of limitations for any action brought under the Act is six years from the date of the violation or three years after the date when material facts were known or reasonably should have been known by the private party initiating the action on behalf of the State, the State's Inspector General, or the director of the State's Medicaid Fraud Control Unit, but in no event more than 10 years after the date on which the violation is committed.

The Governor's proposed fiscal 2011 budget includes $20 million in reductions ($9 million in general funds, $11 million in federal funds) contingent on enactment of the Maryland False Health Claims Act of 2010. DHMH indicates that these savings will result due to associated damages in the civil process that cannot be awarded under current law and additional volume of false claims cases.

Efforts to Increase Enrollment

House Bill 1375 ***(passed)*** extends the termination date on the requirement (per Chapter 692 of 2008) for taxpayers to indicate on their income tax return whether each dependent child for whom an exemption is claimed has health insurance, and continues the penalty prohibition for not providing this information or providing inaccurate information from June 30, 2011, to June 30, 2014. The bill also extends through tax year 2012 the requirement for the Comptroller to send applications and enrollment instructions to a taxpayer who indicates that a dependent child does not have health care coverage and who does not exceed the highest income eligibility standard for Medicaid or MCHP.

The bill also requires the Comptroller to add a box on income tax returns that allows a taxpayer to "opt in" to sharing their information with DHMH for the purpose of enrolling their dependent children into Medicaid or MCHP. The bill also requires DHMH and the Comptroller to enter into a data-sharing agreement for this purpose. Sharing information will allow the Comptroller to better target the mailings of applications and enrollment instructions and will help evaluate the effectiveness of using the tax system to increase enrollment of low-income children into Medicaid and MCHP.

Community Services

Access Assistance to Nursing Facility Residents for Home- and Community-based Services

House Bill 899 ***(passed***) requires specified information provided by social workers to nursing facility residents regarding home- and community-based services to be provided upon both admission and discharge.

Home- and Community-based Services Waiver Access

House Bill 849 ***(passed)*** prohibits DHMH from denying an individual access to a home- and community-based services waiver due to lack of funding if, in addition to meeting other

existing criteria, at least 30 consecutive days of the individual's nursing facility stay are eligible to be paid for by the Medicaid program, rather than requiring that nursing home services be paid for by Medicaid for at least 30 consecutive days immediately prior to the application.

Developmental Disabilities Administration Recipient Appeals

To clarify an appeal process that is required by federal law as part of the State's Medicaid waiver agreement for home- and community-based services, ***Senate Bill 465/House Bill 900 (both passed)*** require the Secretary of Health and Mental Hygiene to provide a recipient of Medicaid-waiver services who has been denied services according to his or her plan of habilitation with a notice within 30 days of the denial and an opportunity for a Medicaid fair hearing. The notice must include the reason for the denial and appeal instructions.

Community Provider Rate Adjustments

Senate Bill 633/House Bill 1034 (both passed) require that, beginning in fiscal 2012, rates paid by DHMH to a community developmental disabilities services provider and a community mental health services provider for approved services rendered to an eligible individual be aligned with annual cost adjustments for units of State government in the Governor's proposed budget. The inflationary cost adjustments used to establish the inflationary cost adjustment for providers may not exceed 4%. The bills repeal language that makes the adjustment contingent on the limitations of the State budget and require the Community Services Reimbursement Rate Commission (CSRRC) to determine a weighted average cost structure of providers. In addition, the bills require DHMH, in consultation with specified community services stakeholders, to conduct a study for purposes of recommending a plan to develop a rate-setting methodology for providers. The study will also include an analysis of the future role of CSRRC and other entities involved in the rate-setting process. The bills terminate June 30, 2016.

Low-Intensity Support Service Program

The Low-Intensity Support Service (LISS) Program is a statewide program provided by the Developmental Disabilities Administration (DDA) for individuals with a developmental disability. Program services help individuals with developmental disabilities improve their quality of life, remain in their own homes, and increase or maintain independence. Only individuals that do not qualify for Medicaid use LISS. ***Senate Bill 920/House Bill 1226 (both passed)*** specify that individuals who wish to apply for LISS are not required to submit a DDA service application or complete a Medicaid eligibility application if the services will be provided to a minor. The bills also authorize DDA to develop a simplified LISS application process and generally codify existing waiver provisions and eligibility criteria. DDA must establish a cap of no less than $3,000 per individual *per fiscal year* to a qualifying individual and must deliver services dependent on the allocation and availability of funds.

Tobacco

Cigarette Restitution Funds for Tobacco Programs

The Tobacco Use Prevention and Cessation Program aims to reduce the use of tobacco products and to reduce the burden of tobacco-related morbidity and mortality in the State. Cigarette Restitution Funding (CRF) for statewide Academic Health Centers supports grants to State institutions for the purpose of enhancing cancer research that may lead to a cure for a targeted cancer and increases the rate at which cancer research translates into treatment protocols in the State. However, over the past several years, the State fiscal crisis has prompted reductions to the mandated funding levels for various CRF programs.

The BRFA of 2010, ***Senate Bill 141 (passed)***, continues to adjust these funding levels. Specifically, the Tobacco Use Preventions and Cessation Program is funded at $6 million in fiscal 20111 and 2012 and $10 million in fiscal 2013 and thereafter. The bill also consolidates funding for the statewide Academic Health Centers into Cancer Research Grants, repealing the Tobacco Disease Research and Network Grants. The bill sets funding for Academic Health Center grants at $2.4 million for fiscal 2011 and 2012 and $13 million in fiscal 2013 and thereafter.

Mental Health

Division of Correction facilities in the State must provide an inmate with a mental illness with a 30-day supply of medication upon release. ***Senate Bill 761/House Bill 1335 (both passed)*** require the managing official at a local correctional facility to provide an inmate diagnosed with a mental illness upon release access to a 30-day supply of medication for his or her mental illness. Part of the supply may be provided by prescription if the inmate is provided sufficient medication on release to remain medication-compliant until the prescription can be filled. The requirement only applies to an inmate who has been incarcerated in a local correctional facility for at least 60 days, and only if a treating physician determines that the possession of medication will be in the best interest of the inmate. A local correctional facility, facility employee, or agent may not be held liable for issuing or prescribing medication to an inmate on his or her release.

Miscellaneous Public Health Issues

Prohibition on Bisphenol-A

Bisphenol-A (BPA) is a compound found in many plastics. In January 2010 the U.S. Food and Drug Administration (FDA) released findings stating that the FDA had some concern about the effects of BPA on the brain behavior and prostate gland in fetuses, infants, and young children. ***Senate Bill 213/House Bill 33 (Chs. 46 and 47)*** prohibit a person from manufacturing, distributing, or knowingly selling child care articles that contain BPA on or after January 10, 2012. The Act defines “child care article” as an empty bottle or cup to be filled with

food or liquid that is designed or intended by a manufacturer to be used by a child under the age of four years.

Biomonitoring Program

Environmental factors have been linked to numerous diseases such as asthma, leukemia, learning disabilities, cancer, and developmental disabilities. Through biomonitoring, the federal Centers for Disease Control and Prevention (CDC) collects annual data on human exposure to 212 chemicals, including pesticides, polychlorinated biphenyls, mercury, and second-hand smoke. However, the current survey design does not permit CDC to estimate exposure to environmental chemicals on a state-by-state basis. ***House Bill 181*** ***(passed)*** requires DHMH and MDE to conduct a study to determine the feasibility of establishing a biomonitoring program in the State. DHMH must report its findings to specified legislative committees by June 20, 2011.

Producer Mobile Farmer's Market License

There is extensive variation across counties regarding licenses for farmer's markets. Farmers who choose to sell produce at farmer's markets in multiple jurisdictions have to pay numerous licensing fees. ***Senate Bill 198*** ***(passed)*** addresses this variation by prohibiting local jurisdictions from requiring a license for the sale of raw agricultural products in a farmer's market and requires DHMH to establish a producer mobile farmer's market license. An individual holding a producer mobile farmer's market license may transport and sell certain goods at farmer's markets throughout the State. DHMH must inspect each mobile unit operating under the license at least once per year, and local health departments must enforce the bill and report any violations to DHMH.

Seasonal Farmer's Market Producer Sampling License

Senate Bill 199 ***(passed)*** authorizes a county to establish a seasonal farmer's market producer sampling license for a producer to prepare and offer samples of a farm product at a farmer's market. DHMH must adopt specific regulations related to the sampling license. Moreover, the county issuing the license must adopt an ordinance that sets a license fee and provides for the enforcement of provisions of law under which the license was issued, including penalties for violations. The license is valid for the season for which it is issued and for all farmer's markets in the county.

Medical Marijuana

Senate Bill 627/House Bill 712 ***(both failed)*** would have authorized the legal use of marijuana for medical purposes under specified circumstances. Among other things, the bills would have set up a system in which DHMH would license growers and dispensaries and monitor the dispensation of medical marijuana in the State.

Health Occupations

General Revisions to the Health Occupations Boards

Chapter 212 of 2008 created the Task Force on the Discipline of Health Care Professionals and Improved Patient Care. The task force submitted its report on February 2, 2009, which includes 24 recommendations. ***Senate Bill 291/House Bill 114 (both passed)*** provide statutory authority for many of the task force's recommendations by setting standardized guidelines for all health occupations boards' policies and procedures that include the composition of the boards, the appointment of specified board staff, and the disciplinary and sanctioning procedures of the boards. Significant provisions include:

- requiring the establishment of disciplinary subcommittees for complaint investigation, determination of whether to bring charges, and participation in preadjudication case resolution conferences;

- setting a statute of limitations of six years after which time a board may not bring charges against a licensee except under specified circumstances;

- requiring a board that uses peer review in standard of care cases to provide the individual being reviewed with a copy of the final peer review report and an opportunity to submit a written response to the final report before the board takes action against the individual; and

- authorizing training, mentoring, or other forms of remediation for licensees in lieu of formal hearings under specified circumstances.

Dental Hygienists

Under current law, a dental hygienist practices under the indirect supervision of a dentist, which means the dentist authorizes the procedure and remains in the office while it is being performed. To more efficiently serve patients and promote proper preventive oral health care, dentistry practices in Maryland have trended toward permitting hygienists to work under less restrictive supervisory requirements. ***Senate Bill 719/House Bill 1302 (both passed)*** authorize a dental hygienist to practice in a nursing home or an assisted living facility under the general supervision of a dentist. The dental hygienist is authorized to practice in accordance with a written agreement between the hygienist and the dentist and if specified consultation requirements, patient needs assessments, and assurances relating to the facility are met.

Electrologists

Senate Bill 241/House Bill 215 (Chs. 48 and 49) make changes to the practice of electrology in the State, which is regulated by the State Board of Nursing with the guidance of the Electrology Practice Committee. Specifically, the bills require applicants for licensure to pass both a national certification examination and a clinical examination given by the board,

extend the date by which renewal applicants must have had a criminal history records check until 2011, and thereafter require an additional criminal history records check every 12 years, rather than every 10 years. The bills also establish that a quorum is a majority of the full authorized membership of the committee, provide that members of the committee are entitled to specified compensation and reimbursement, and require the board to send renewal notices to electrology licensees three months before a license expires.

Military Health Care Providers

In 2006, the Statewide Commission on the Shortage in the Health Care Workforce reported that gaps exist between projected demand and reported supply from Maryland postsecondary health care programs. In 2007, the Secretary of Health and Mental Hygiene reported that the lack of standardization among the various branches of the military has made it difficult for educational institutions and health occupations boards to determine a veteran's level of clinical and course work training, thus making it more difficult for a veteran to obtain the necessary credentials to pursue a career in health care in Maryland. ***Senate Bill 1033*/*House Bill 1353* *(both passed)*** address both of these reports by requiring the Department of Veterans Affairs to develop a Military Health Care Provider Transition Plan to increase the number of veterans, including current and former members of the Reserve forces and National Guard, with expertise in health care workforce shortage areas to transition into civilian health care provider positions. The plan must be completed and reported to the General Assembly by January 1, 2012.

Morticians and Funeral Directors

Licensure Requirements

Under ***House Bill 200* *(passed)*** an applicant for a funeral director's license must pass the arts and sciences state board examinations administered by the Conference of Funeral Service Examining Boards (CFSEB) of the United States rather than the national board examination administered by CFSEB. Additionally, the State Board of Morticians and Funeral Directors must advise applicants for a mortician or funeral director's license that a license issued in Maryland does not necessarily allow the licensee to practice in another state.

Regulation of Crematories

House Bill 995* *(passed) requires the board and the Office of Cemetery Oversight to establish a process for regulating crematories that provides for registration and issuance of permits or licensure, as appropriate, based on the regulatory entity. A crematory is regulated either by the office or the board based on the crematory's ownership. The operation or ownership of a crematory incinerator at a licensed medical facility or educational institution is exempt from the bill's provisions. By October 1, 2011, the office and the board must adopt identical regulations in numerous specified areas and must determine whether to adopt financial stability requirements for crematories.

Nurses

Membership of the State Board of Nursing and the Certified Nursing Assistant Advisory Committee

The memberships of the State Board of Nursing and the Certified Nursing Assistant Advisory Committee are altered in ***Senate Bill 266*/*House Bill 302* *(Chs. 53 and 54)***. The bills add to the board a registered nurse member who has practiced acute care for at least five years, practices currently, and holds a bachelor of science degree in nursing, require that a registered nurse member practice in a supervised group living setting, and require that a licensed practical nurse member practice as a delegating nurse in a supervised group living setting. An adult medical day care nursing assistant is added to the committee. The bills also alter the process for board member nominations by requiring the board to notify all active licensees and appropriate professional nursing organizations of a vacancy, and then authorizing any professional nursing organization that represents at least 25 affected nurses, or any active nurse with a valid petition, to submit a list of qualified individuals for the vacancy.

Licensure and Certification Requirements

Applicants to the board for licensure or certification must submit to an examination by a board-designated health care provider if the board has objective evidence that an applicant under review may cause harm to a patient (***Senate Bill 632*/*House Bill 624* *(both passed)***). The bills also establish biennial renewal beginning in January 2013 and provide for the staggering of license renewal so that licensees born in even-numbered years renew in even-numbered years and licensees born in odd-numbered years renew in odd-numbered years. The bills remove skilled nursing assistants from the list of certified professionals regulated by the board, require the board to send renewal notices to licensees and certificate holders three months before a license expires, and exempt from licensure applicants who have passed a board-approved examination but are waiting for the completion of the required criminal history records check. Thereafter, the bills require an additional criminal history records check every 12 years, rather than every 10 years.

Nurse Practitioners

In order to provide more independence from physician supervision, ***Senate Bill 484*/*House Bill 319* *(Chs. 77 and 78)*** alter the scope of practice for nurse practitioners. The bills require a nurse practitioner to have an approved attestation of a collaboration agreement with a licensed physician and to both refer to, and consult with, physicians and health care providers as needed. Further, the bills define a nurse practitioner's scope of practice, authorize temporary practice letters under specified circumstances, and provide title protection for nurse practitioners. The bills repeal the requirement that the board and the State Board of Physicians jointly adopt regulations concerning the prescriptive authority of nurse practitioners and requires the board, in consultation with the State Board of Physicians, to develop a plan to implement the Maryland Nurse Practice Act.

Pharmacists

Therapy Management Contracts

The Drug Therapy Management Program, established by Chapter 249 of 2002, authorizes a physician and a pharmacist to enter into a therapy management contract that specifies treatment protocols that may be used to provide disease specific care to a patient. The termination date of the Therapy Management Contract Program was extended from May 31, 2008, to September 30, 2010, by Chapter 650 of 2008. ***Senate Bill 165*/*House Bill 600*** ***(Chs. 44 and 45)*** repeal the September 30, 2010 termination date for the authorization of therapy management contracts.

Wholesale Distributors

The Wholesale Distributor Permitting and Prescription Drug Integrity Act, established by Chapters 352 and 353 of 2007, imposed additional permitting requirements for wholesale prescription drug distributors. Among other requirements, the Act requires a pedigree, or history of the distribution chain, for prescription drugs that are distributed in Maryland. ***Senate Bill 163*/*House Bill 868*** ***(both passed)*** clarify the conditions under which the State Board of Pharmacy may exempt wholesale distributors under "deemed status" from initial and routine inspection requirements. The Department of Health and Mental Hygiene may purchase and distribute prescription drugs and devices for public health purposes in accordance with regulations adopted by the department in consultation with the board. These purchases and distributions are exempt from wholesale distribution requirements. Under the bills, wholesale distributors in states that do not qualify for reciprocity and that seek a permit in the State must be accredited by an organization approved by the board. Out-of-state wholesale distributors that receive a permit by reciprocity are subject to criminal history record checks and surety bond requirements.

Physician Assistants

Senate Bill 308*/*House Bill 323 ***(both passed)*** require physician assistants to be licensed rather than certified by the State Board of Physicians to practice in the State. The bills remove the requirement for a delegation agreement between a physician and a physician assistant to be approved by the board before a physician assistant may practice under certain circumstances. Specifically, the bills clarify the supervisory roles of the primary and alternate supervising physicians, increase the number of physician assistants a physician may supervise in specified settings from two to four, and establish an approval process for delegation agreements containing advanced duties that:

- allows physician assistants to begin performing advanced duties in credentialed facilities on submission of a delegation agreement to the board while providing the board 90 days to approve, reject, or alter the delegation agreement; and

- requires the board to approve delegation agreements before physician assistants may practice advanced duties in non-credentialed facilities or administer general or neuroaxial anesthesia.

Physicians

Under ***House Bill 870*** ***(passed)***, the State Board of Physicians may take disciplinary action against a licensed physician who performs a cosmetic surgical procedure in an office or facility that is not accredited by specified organizations or certified to participate in the Medicare program.

Professional Counselors and Therapists

Membership of the State Board for Professional Counselors and Therapists

In order to allow individuals to serve on the State Board for Professional Counselors and Therapists who have been lawfully practicing in their field as certified counselors and were grandfathered into licensure without meeting the educational and training requirements of the new law, ***House Bill 1188*** ***(passed)*** repeals the requirement that members of the board need to hold a master's or doctoral degree in the field and need to meet the educational and supervised practice requirements of the law.

Licensure Requirements

House Bill 863 ***(passed)*** clarifies that an applicant for licensure to practice clinical marriage and family therapy must hold a master's or doctoral degree in a marriage and family field from an accredited educational institution approved by the board. The bill also increases the requisite credit hours for certification as a professional alcohol and drug counselor and an associate alcohol and drug counselor.

Psychologists

Senate Bill 1041/***House Bill 1064*** ***(both passed)*** require an applicant for licensure as a psychologist to submit to a State and national criminal history records check. The State Board of Examiners of Psychologists may not issue a license if the criminal history records information for an applicant has not been received.

Social Workers

Chapters 86 and 87 of 2009 required the State Board of Social Work Examiners to establish a workgroup to examine issues affecting the status of clinical social workers in the workforce. The General Assembly had concerns that many highly qualified employment candidates, experienced licensed social workers from other states, were lost because of certain board statutes and regulations. ***House Bill 927*** ***(passed)*** is a product of the workgroup. The bill provides that to become licensed as a certified social worker or a certified social worker-clinical

in Maryland, an out-of-state applicant must be of good moral character, be at least 18 years old, pay an application fee, be licensed in another state at a specified level of licensure, have passed an examination in that other state as a condition of licensure, and have performed a specified number of clinical hours.

Sunset Legislation

Approximately 70 entities, including each of the boards regulated under the Health Occupations Article, are subject to periodic evaluation conducted by the Department of Legislative Services in accordance with the Maryland Program Evaluation Act. The Act establishes a process better known as "sunset review" as most agencies evaluated are also subject to termination or "sunset." This year, the General Assembly reauthorized the State Board of Physical Therapy Examiners through ***Senate Bill 146 (Ch. 40)/House Bill 131 (passed)***, the State Board of Examiners in Optometry through ***Senate Bill 145/House Bill 132 (both passed)***, the State Board of Chiropractic and Massage Therapy Examiners through ***Senate Bill 104 (passed)/House Bill 135 (Ch. 133)***, and the State Board of Dental Examiners through ***Senate Bill 325/House Bill 501 (both passed)***.

Health Care Facilities and Regulation

Hospital Financial Assistance, Debt Collection, and Patient Notification Policies

In February 2009, the Health Services Cost Review Commission (HSCRC) released a report on the financial assistance and credit and collection practices of Maryland hospitals. HSCRC found that while Maryland hospitals generally adhere to voluntary standards for financial assistance, the State lacked standards for hospital credit and collection policies, hospitals' policies were ambiguous and varied, and oversight of third-party collection agencies may have been insufficient. In response, Chapters 310 and 311 of 2009 required hospitals to provide free care to patients with family incomes up to 150% of federal poverty guidelines (FPG) and reduced-cost care to low-income patients with higher family incomes. Each hospital must develop a financial assistance information sheet for patients and submit to HSCRC a debt collection policy that adheres to specified standards. A hospital that knowingly violates any financial assistance policy or regulation is subject to a fine of up to $50,000 per violation.

Chapters 310 and 311 also required HSCRC to establish a workgroup on patient financial assistance and debt collection to review the need for uniform policies among hospitals and to study and make recommendations by October 1, 2009, on incentives for hospitals to provide free and reduced-cost care to patients without the means to pay their hospital bills.

HSCRC's report included 36 recommendations, and ***Senate Bill 328/House Bill 933 (Chs. 60 and 61)***, largely based on those recommendations, further alter the requirements for hospital financial assistance and debt collection policies and make the requirements applicable to chronic care hospitals that are subject to rates set by HSCRC. The Acts require hospitals to

provide reduced-cost medically necessary care to patients with family income below 500% FPG who have a financial hardship. However, hospitals may seek and HSCRC may approve a different income threshold based on specified factors. In addition, the Acts (1) outline practices a hospital must follow if it finds a patient to be eligible for free care after collecting money from the patient for services provided; (2) further refine information that must be provided to patients, in specified places, and at specified times, and; (3) set uniform standards for hospital debt collection policies including a prohibition on a hospital forcing the sale or foreclosure of a patient's primary residence to collect an outstanding debt.

Freestanding Medical Facilities

A "freestanding medical facility" is a facility in which medical and health services are provided that is physically separate from a hospital or hospital grounds and is an administrative part of a hospital or related institution. Freestanding medical facilities must be open 24 hours a day, seven days a week, and provide stabilizing treatment to a patient presenting with an emergency medical condition regardless of a patient's medical condition, insurance status, or ability to pay. There are three freestanding medical facilities in the State; two are pilot projects.

With the exception of the freestanding medical facility in Bowie, the State Health Services Cost Review Commission (HSCRC) does not set rates for freestanding medical facilities. ***Senate Bill 593/House Bill 699 (both passed)*** require HSCRC to set rates for hospital services provided at freestanding medical facilities issued a certificate of need (CON) by the Maryland Health Care Commission (MHCC) after July 1, 2015; a freestanding medical facility licensed prior to July 1, 2007; and freestanding medical facility pilot projects. The bills require all payors subject to the rate-setting authority of HSCRC, including insurers, nonprofit health service plans, health maintenance organizations (HMOs), managed care organizations (MCOs), and the Medical Assistance Program (Medicaid), to pay the HSCRC rates for hospital services at a freestanding medical facility issued a CON after July 1, 2015, and freestanding medical facility pilot projects. However, the bills limit HSCRC's fiscal 2011 rate setting authority to hospital services provided at the freestanding medical facility pilot project in Queen Anne's County and requires that those rates be set in a manner that does not impact the State budget in fiscal 2011.

The Department of Health and Mental Hygiene must issue a license to a freestanding medical facility that meets licensure requirements and, after July 1, 2015, receives a certificate of need from the MHCC. The bills essentially prohibit the licensure of any additional freestanding medical facilities before that date.

Health Insurance

Assignment of Benefits

An assignment of benefits, in the context of health insurance, is when an insured assigns the right to receive payment from a health insurance plan to a provider. Some health insurance plans do not honor the assignment of benefits by an insured to a provider that does not

participate in a health insurer's provider panel, instead sending payment directly to the insured. In the 2009 interim, the Joint Committee on Health Care Delivery and Financing studied issues relating to the assignment of benefits and issued a report on recommendations for legislation that would require health insurers to honor an assignment of benefits by an insured to a nonparticipating physician.

***Senate Bill 314* (passed)** requires preferred provider insurance policies (PPOs) issued by health insurers to honor an assignment of benefits by an insured to a nonpreferred physician. If the assignment is made to a nonpreferred on-call physician or a hospital-based physician, the physician may not balance bill an insured for the difference between the insurer's payment and the physician's billed charges. The bill specifies formulas for rates that health insurers must pay nonpreferred on-call physicians and hospital-based physicians that receive an assignment of benefits from an insured of a PPO. For on-call physicians, the formula for payment is the greater of 140% of the average rate the insurer pays to participating providers, or the average rate that the insurer paid on January 1, 2010, indexed by the Medicare Economic Index, to a nonparticipating provider. For hospital-based physicians, the insurer must pay the greater of 140% of the average rate the insurer pays to providers under contract or the final allowed amount for the same covered service as of January 1, 2010, that the insurer paid the physician.

Nonhospital-based physicians that seek assignment of benefits must first give an insured a disclosure specified in the bill.

The bill's provisions relating to assignment of benefits take effect July 1, 2011, and terminate September 30, 2015.

The bill requires the Maryland Health Care Commission, in consultation with the Maryland Insurance Administration and the Office of the Attorney General, to study various aspects of the impact of the bill and submit reports to the General Assembly by July 1, 2012, and October 1, 2014. The Maryland Insurance Administration is required to study payments by PPOs before the effective date of the bill and report on the amounts to the Governor and the General Assembly on or before December 1, 2010.

Patient Centered Medical Homes and Improved Coordination of Care

As health care costs continue to rise more quickly than inflation, providers, insurers, and policymakers are examining ways to coordinate care in an effort to improve quality and control costs.

Patient Centered Medical Homes

The medical home model is one way to provide comprehensive care that is designed around the patient's needs. The Maryland Health Quality and Cost Council studied ways to implement a medical home demonstration project in the State. A workgroup established by the council found several legal issues that needed to be overcome before moving forward with a demonstration project, including potential antitrust issues, State laws regarding incentive payments, and State standards for confidentiality of medical records.

Senate Bill 855/House Bill 929 ***(Chs. 5 and 6)*** address issues raised by the council as barriers to implementing a medical home demonstration project in the State. The Acts require the Maryland Health Care Commission to establish the Maryland Patient Centered Medical Home Program (the program) if the commission concludes that the program will likely result in the delivery of more efficient and effective health care services and is in the public interest. The Acts require prominent health insurance carriers in the State to participate in the program, while other carriers may participate. The commission is also permitted to authorize single carrier medical homes.

Health insurance carriers that participate in the program or that implement a single carrier medical home may pay a patient centered medical home, including specified incentives, for coordinated covered medical services provided to covered individuals. These carriers may also share medical information about a covered individual who elects to participate in a medical home with the individual's medical home and other treating providers.

The Maryland Health Care Commission must conduct an independent evaluation of the program's effectiveness in reducing health care costs and improving health care outcomes, and report its findings to specified committees by December 1, 2014. The Acts terminate December 21, 2015.

Clinically Integrated Organizations

TriState Health Partners (TriState), a physician-hospital organization based in Hagerstown, Maryland, is working to integrate and coordinate the provision of health care to patients by TriState's physician members and the Washington County Hospital. The Federal Trade Commission's Bureau of Competition advised TriState in April 2009, that it would not raise an antitrust challenge to the organization's clinical integration program because the proposed cooperation among doctors and a hospital had the potential to lower health care costs and improve quality of care.

Senate Bill 723/House Bill 1093 ***(both passed)*** authorize contracts between health insurance carriers and clinically integrated organizations (CIOs) to include a provision to pay for coordination of care services and bonuses or incentives to promote efficient, medically appropriate delivery of medical services. The Insurance Commissioner may adopt regulations that specify the types of payments and incentives that are permissible. The bills require health insurance carriers to share medical information about covered individuals with a CIO and its members if there is a written agreement specifying how medical information will be shared, the information is used by the CIO to promote efficient, medically appropriate health care delivery or to coordinate care, and there are procedures for disclosing to individuals how information will be shared. A CIO is defined in the bills as a joint venture between a hospital and physicians (such as TriState) that has received an advisory opinion from the Federal Trade Commission and has been established to improve the practice patterns of the participating health care providers and promote the efficient, medically appropriate delivery of covered services, as well as a joint venture that the Insurance Commissioner determines meets the federal criteria for an accountable care organization.

Mandated Benefits Coverage

Coordination of State Law with Federal Mandated Benefit Requirements

***Senate Bill 57* (Ch. 17)** conforms State law to the new federal Mental Health Parity and Addiction Equity Act of 2008 by requiring that large group contracts that offer mental health or substance abuse disorder benefits offer the benefits in parity with medical and surgical benefits. The Act also conforms the State's reconstructive breast surgery mandate to federal law.

Expansion of Child Wellness Mandate

Maryland's child wellness benefit mandate requires insurers and nonprofit health service plans to provide coverage for a package of child wellness benefits that includes a specified list of services. ***Senate Bill 700*/*House Bill 1017* (both passed)** require health insurers and nonprofit health service plans to include in the minimum package of child wellness services coverage for visits for obesity evaluation and management and visits for and costs of developmental screening as recommended by the American Academy of Pediatrics.

Repeal of Reporting Requirement on Surgical Treatment of Morbid Obesity

Chapter 486 of 2004, as amended by Chapter 301 of 2005, required the Maryland Insurance Administration to report annually on complaints filed with the Administration relating to the denial of coverage for the surgical treatment of morbid obesity and the outcome of those complaints. The Administration's last two annual reports recommended that the reporting requirement be eliminated because all regulated markets in the State now mandate this coverage and complaints are limited to cases outside the jurisdiction of the Administration. ***Senate Bill 1031* (passed)** repeals this annual reporting requirement.

The Maryland Health Insurance Plan and the Senior Prescription Drug Assistance Program

The Maryland Health Insurance Plan (MHIP) is the State's high-risk pool for medically uninsurable individuals. The Board of MHIP is also charged with oversight of the Senior Prescription Drug Assistance Program, a program that provides a subsidy to low-income seniors for Medicare Part D premiums and coverage gap costs.

Extension of Termination Date for Senior Prescription Drug Assistance Program

***House Bill 67* (Ch. 119)** extends the termination date for the Senior Prescription Drug Assistance Program to December 31, 2012, and extends the limit of $14 million on the subsidy for the program through fiscal 2013.

Maryland Health Insurance Plan and Option for Governmental Payers

Some MHIP members have premiums paid for by third-party governmental units, including the Maryland AIDS Drug Assistance Program and some county governments. Placing

individuals in MHIP and paying their premiums is advantageous for the governmental units because it allows them to shift medical and prescription drug costs to MHIP. However, MHIP has reported that these members tend to have substantially higher plan costs compared to average plan members.

House Bill 1050 ***(Ch. 166)*** authorizes MHIP to establish a plan option for members whose premiums are paid by a governmental unit. The bill also authorizes MHIP, in setting premium rates and cost-sharing arrangements for this plan option, to include amounts to limit cost shifting from another governmental unit to the plan as long as they are not set at a level that would make it cost-prohibitive for the governmental unit. Finally, the bill authorizes MHIP to limit plan option eligibility and limit or eliminate any premium subsidy based on income for a member whose premiums are paid by a governmental unit.

Insurance Producers and Sales to Seniors

Required Continuing Education for Insurance Producers

House Bill 71 ***(Ch. 121)*** requires insurance producers who market the Senior Prescription Drug Assistance Program or assist a Medicare beneficiary to enroll in the program to receive continuing education that directly relates to the program. The Act authorizes the Board of Directors of the Maryland Health Insurance Plan to adopt regulations that require the training.

Insurance Producers and the Misleading Use of a Senior or Retiree Credential or Designation

Senate Bill 774/***House Bill 882*** ***(both passed)*** prohibit insurance producers from using a senior or retiree credential or designation in a way that is or would be misleading in connection with the offer, sale, or purchase of life insurance, health insurance, or annuities. For a further discussion of ***Senate Bill 774***/***House Bill 882***, see the subpart "Insurance" within Part H – Business and Economic Issues of this *90 Day Report*.

Financial Oversight of Insurers

House Bill 69 ***(Ch. 120)*** makes various changes to requirements regarding financial audits, investments, and other operations as they relate to insurers, nonprofit health service plans, dental plan organizations, managed care organizations, and health maintenance organizations. The changes include specifying the criteria that nonlife insurers must consider regarding investments in securities lending transactions and authorizing the Insurance Commissioner to require insurance carriers to file an audited financial report earlier than the statutory deadline. For a more detailed description of the Act, see the subpart "Insurance" within Part H – Business and Economic Issues of this *90 Day Report*.

Coordination of Health Insurance Benefits with Personal Injury Protection Coverage

In general, an insurer that issues, sells, or delivers a motor vehicle liability insurance policy in the State must provide personal injury protection coverage, known as PIP, for the medical, hospital, and disability benefits to individuals injured in a motor vehicle accident. Benefits are payable despite the fault or nonfault of the insured or benefits recipient, or any collateral source of medical, hospital, or wage continuation benefits. The minimum medical, hospital, and disability benefit under PIP is $2,500 for payment of all reasonable and necessary expenses that arise from a motor vehicle accident and are incurred within three years after the accident for specified services and lost income. If an insured has both PIP coverage and collateral coverage, the insurer or insurers may coordinate the policies to ensure nonduplication of benefits, subject to appropriate reductions in premiums for one or both of the policies. The insured may choose to coordinate the policies by indicating which policy will be the primary policy, or reject the coordination of policies and nonduplication of benefits.

A decision by the Maryland Special Court of Appeals in October 2009 upheld a health insurer's right to exclude liability for medical expenses covered by an auto insurer's PIP coverage. The court ruled that health insurance was not included under the "collateral source of medical, hospital, or wage continuation benefits" referenced in Title 19 of the Insurance Article.

Senate Bill 704*/*House Bill 1073* *(both passed) prohibit health insurance policies, policies of nonprofit health service plans, and health maintenance organization contracts from containing a provision that requires PIP benefits to be paid before benefits under the health insurance policy or contract.

Provisions of Health Insurance Bills Relating to Federal Health Care Reform

On March 23, 2010, the federal Patient Protection and Affordable Care Act was enacted. The Act significantly expands Medicaid and makes many changes to insurance regulation. As a result, the General Assembly passed several bills that dealt with various provisions of federal health reform.

Maryland Health Insurance Plan and Ability to Apply for National High Risk Pool Funds

The Patient Protection and Affordable Care Act made $5 billion available to states to create high-risk pools meeting federal standards that will operate until the significant insurance reforms enacted in federal health care reform take effect in 2014. ***House Bill 1564* *(Ch. 173)*** authorizes the Board of Directors for MHIP, to elect for MHIP to administer a national temporary high-risk pool program for the State and enter into any necessary administration agreements. The Act authorizes the MHIP board to limit enrollment based on the amount of federal funding available to the program and to establish a separate benefit package delivery

system and premium rate for enrollees according to standards for benefit packages and premium rates established under federal law for the program.

Authority of Insurance Commissioner to Enforce Federal Insurance Reforms

Some provisions in the Patient Protection and Affordable Care Act relating to insurance regulation will take effect in the next year, including:

- prohibiting health plans from denying coverage to children with pre-existing conditions;
- banning insurance companies from dropping people from coverage when they get sick;
- requiring health plans to allow young people up to the age of 26 to remain on their parents' insurance policy; and
- banning lifetime caps on health coverage.

Senate Bill 57 makes these provisions applicable to health insurance plans in the State and gives the Insurance Commissioner the authority to enforce these provisions against regulated health insurance plans in the State. This applicability and authority terminate on June 30, 2011.

Effect of State Health Insurance Laws on Grandfathered Health Plans

The Patient Protection and Affordable Health Care Act exempts grandfathered health plans from certain aspects of health reform. A grandfathered health plan is any health plan that was in effect on March 23, 2010. However, it is currently not clear whether State insurance laws enacted after March 23, 2010, will impact the grandfathered status of a health plan. ***Senate Bill 57*** provides that a State insurance law enacted after January 1, 2010, does not apply to a grandfathered health plan if the law would prevent a group health plan or health insurance coverage from being considered a grandfathered health plan.

Health Insurance Regulation – Miscellaneous

Electronic Transmission of Uniform Consultation Referral Forms

Health insurers that require insureds to have a written referral to receive consultation services must use a uniform consultation form adopted by the Insurance Commissioner. ***House Bill 292 (passed)*** authorizes the uniform consultation form to be transmitted electronically. The bill also requires the Insurance Commissioner, in consultation with the Maryland Health Care Commission, to adopt standards for the electronic transmission of the data elements in the uniform consultation referral form by regulation.

Required Bonus Payments for After Hours and Weekend Care

House Bill 435 (passed) requires health insurance carriers to pay a bonus to primary care providers for services provided in the office after 6 p.m. and before 8 a.m. or on weekends and

national holidays. A carrier must provide for and describe the terms of the required bonus payment in a separate clause in the carrier's contract with the primary care provider. However, a group model health maintenance organization is not required to make bonus payments to physicians that are employed by the physician group under contract with the group model health maintenance organization.

Prohibited Provisions in Dental Provider Contracts

Chapters 549 and 550 of 2009 directed the Maryland Insurance Administration to conduct a review of dental provider contracts, the terms and conditions of the contracts, and the impact that the contracts have on the dental profession and report its findings and recommendations. In its findings, the Administration indicated that dentists' negotiating power is potentially limited when new fee schedules are introduced by carriers and recommended that, to provide dentists with additional negotiating power, the General Assembly pass legislation allowing a dentist to opt out of a new fee schedule introduced by a carrier after the date the dentist and the carrier entered into a contract.

Senate Bill 637*/*House Bill 804* *(both passed) prohibit a provider contract from containing a provision that requires a participating dental provider, as a condition of continued participation in a capitated dental provider panel or a fee-for-service dental provider panel, to accept an added, revised, or amended fee schedule that contains a lower fee.

Individual Health Benefit Plans and Frequency of Premium Increases

House Bill 814* *(passed) prohibits health insurance carriers from increasing an individual's premium for an individual health benefit plan more frequently than once every 12 months, unless the increase is solely due to the enrollment of a new family member in the plan.

Coverage of Annual Preventive Care

Senate Bill 313*/*House Bill 878* *(both passed) require health insurance carriers to provide coverage for a single annual preventive care visit that is covered under the health insurance policy or contract at any time during the plan year established in the policy or contract.

Medicare Supplement Policies and Repeal of Requirement to Offer Plan I

Effective June 1, 2010, the federal government will no longer offer Medicare supplement policy plan I. ***Senate Bill 56* *(Ch. 16)*** repeals a requirement that insurance carriers make available Medicare supplement policy plan I to an individual who is eligible for Medicare due to a disability during the six-month period following the individual's enrollment in Part B of Medicare.

Health Maintenance Organizations and Administrative Service Provider Contracts

Senate Bill 885*/*House Bill 261* *(both passed) specify that medical laboratories are not subject to oversight requirements regarding health maintenance organizations and administrative service provider contracts.

Social Services – Generally

Current law requires financial and compliance audits of local departments of social services at least once every two years. However, current staffing levels of the Office of the Inspector General of the Department of Human Resources (DHR) do not permit two year audits. Thus, ***House Bill 368* *(Ch. 147)*** alters the frequency of these audits from at least once every two years to at least once every three years. This change ensures adequate audit coverage and is consistent with the three-year audit cycle utilized by the Office of Legislative Audits and most other State audit agencies.

"2-1-1" is the abbreviated dialing code assigned by the Federal Communications Commission for consumer access to community information and referral services. ***Senate Bill 527*/*House Bill 693* *(both passed)*** replace four self-funded pilot programs used to administer the Health and Human Services Referral System with "2-1-1 Maryland," a State nonprofit information network that may approve up to five nonprofit call centers to provide 2-1-1 services in the State. In addition, the bills alter the membership, term limits, and duties of the Health and Human Services Referral Board.

The Elderly

The Maryland Long-Term Ombudsman Program within the Maryland Department of Aging receives and resolves complaints made by or for residents of long-term care facilities. In order to align State law with the long-term care provisions of the federal Older Americans Act (OAA) and to ensure continued federal funding, ***House Bill 536* *(Ch. 155)*** conforms State law regarding the State's Long-Term Care Ombudsman Program to OAA. In response to the recommendations contained in a March 2009 consultant report regarding how to improve ombudsman services among local jurisdictions in the State, the bill establishes the Office of the Long-Term Care Ombudsman in the Department of Aging and the selection process for a State Long-Term Care Ombudsman. In addition to other responsibilities, the ombudsman must personally, or through designated ombudsmen, identify, investigate, and resolve complaints from any source made by, or on behalf of, a resident of a long-term care facility in the State relating to any action, inaction, or decision that may adversely affect a resident under specified circumstances.

Children

Child Abuse and Neglect

Senate Bill 559/House Bill 811 ***(both passed)*** authorize an individual to notify the local department of social services or the appropriate law enforcement agency if the individual has reason to believe that a parent, guardian, or caregiver of a child allows the child to reside with or be in the regular presence of an individual, other than the child's parent or guardian, who (1) is registered on the sexual offender registry based on the commission of an offense against a child; and (2) based on additional information, poses a substantial risk of sexual abuse to the child. For a more detailed discussion of this issue, see the subpart "Family Law" within Part F – Courts and Civil Proceedings of this *90 Day Report*.

Senate Bill 948/House Bill 1141 ***(both passed)*** require the director of a local department of social services or the Secretary of Human Resources to disclose, on request, specified information regarding child abuse or neglect if (1) the information is limited to actions or omissions of the local department, DHR, or an agent of DHR; (2) the child named in a report has suffered a fatality or near fatality; and (3) the State's Attorney's Office has consulted with and advised the local director or the Secretary that disclosure of the information would not jeopardize or prejudice a related investigation or prosecution. For a more detailed discussion of this issue, see the subpart "Family Law" within Part F – Courts and Civil Proceedings of this *90 Day Report*.

In order to provide the Division of Parole and Probation in the Department of Public Safety and Correctional Services with information about sex offenders in close contact with children, ***Senate Bill 892/House Bill 1330*** ***(both passed)*** require the disclosure of a report or record concerning child abuse or neglect to the Division of Parole and Probation if, as a result of a report or investigation of suspected child abuse or neglect, the local department of social services has reason to believe that an individual who lives in or has a regular presence in a child's home is registered on the sexual offender registry based on the commission of an offense against a child. For a more detailed discussion of this issue, see the subpart "Family Law" within Part F – Courts and Civil Proceedings of this *90 Day Report*.

Advocacy for Children

A child advocacy center is a child-focused entity within or outside a health care facility that investigates, diagnoses, and treats children who may have been abused or neglected. ***House Bill 1043*** ***(passed)*** requires the Governor's Office of Crime Control and Prevention to establish and sustain child advocacy centers in the State. For further discussion of this issue, see the subpart "Criminal Procedure" within Part E – Crimes, Corrections, and Public Safety of this *90 Day Report*.

Family Day Care Homes, Child Care Centers, Residential Services Agencies, and Foster Homes

In order to codify an executive order and a resulting memorandum of understanding, ***House Bill 465*** ***(passed)*** establishes collective bargaining rights for "family child care providers" who participate in Maryland's Child Care Subsidy Program. ***House Bill 465*** authorizes family child care providers to designate which provider organization, if any, is to be the exclusive representative of all family child care providers in the State. For a more detailed discussion of this issue, see the subpart "Personnel" within Part C – State Government of this *90 Day Report*.

According to the U.S. Consumer Product Safety Commission, almost once a month a child between seven months and ten years dies from window cord strangulation and another child suffers a near strangulation. ***Senate Bill 605***/***House Bill 646*** ***(both passed)*** require that all new and replacement window coverings installed in a foster home, family day care home, or child care center in the State on or after October 1, 2010, be cordless. The bills require window coverings in place before the bill's effective dates to meet minimum safety standards established in regulations jointly adopted by DHR and the Maryland State Department of Education (MSDE). For further discussion of this issue, see the subpart "Family Law" within Part F - Courts and Civil Proceedings of this *90 Day Report*.

Due to the various incident reporting systems of DHR, the Department of Juvenile Services (DJS), and the Department of Health and Mental Hygiene (DHMH), there is concern that the best interests of children in out-of-home placements are not being met because treatment decisions can be made without knowledge of all of the relevant incident reports that have generated on a particular child. ***Senate Bill 478*** ***(passed)*** requires DHMH, DJS, and DHR, in conjunction with licensed providers of residential child care services, to establish an interagency workgroup to develop a uniform reporting system to be used by any State agency that licenses or purchases care and services for children who are placed in State-licensed residential facilities. The workgroup must also recommend regulations that require the interagency sharing of certain incident reports and that require any department that licenses or monitors residential child care facilities to adhere to specific incident reporting policies and practices. The bill requires the workgroup to report its findings and recommendations on or before September 1, 2011, to the Governor's Office for Children, the Governor, and the General Assembly.

Senate Bill 61 ***(Ch. 18)*** adds employees and employers of a licensed home health or residential service agency, authorized to provide home- or community-based health services for minors, to the list of entities that must apply for a national and State criminal history records check. The Act also expands this requirement to include employees and employers of privately operated recreation centers or programs. For further discussion of this issue, see the subpart "Family Law" within Part F – Courts and Civil Proceedings of this *90 Day Report*.

Senate Bill 176 ***(passed)*** alters the requirements for regulations that MSDE must adopt relating to inspections of family day care homes and child care centers. For registered family day care homes, the regulations must require announced inspections prior to the issuance of an initial or continuing registration and repeals the requirement for announced inspections at least

every two years afterwards. For child care centers, the bill specifies that announced inspections are to be made prior to issuing the initial or continuing license or letter of compliance and repeals the requirement for announced inspections of these child care centers every two years afterwards. For further discussion of this issue, see the subpart "Family Law" within Part F – Courts and Civil Proceedings of this *90 Day Report*.

Child Support

Maryland has not updated its child support schedule since it, under mandate from the federal government, adopted guidelines in 1989. ***Senate Bill 252*/*House Bill 500* *(both passed)*** revise the schedule of basic child support obligations used to calculate child support amounts under the State's child support guidelines. The bills establish that the adoption or revision of the child support guidelines is not a material change of circumstance for the purpose of a modification of a child support award. For a more detailed discussion of this issue, see the subpart "Family Law" within Part F – Courts and Civil Proceedings of this *90 Day Report*.

Current law authorizes the Child Support Enforcement Administration (CSEA) to certify to the State Comptroller that any obligor is in arrears in paying child support if the amount of the arrearage exceeds $150. The State Comptroller may withhold the amount of the arrearage from any payment or tax refund due to the obligor and forward the amount to CSEA. ***House Bill 963* *(passed)*** extends the interception program to include the value of any abandoned property that is held by the State Comptroller. For further discussion of this issue, see the subpart "Family Law" within Part F – Courts and Civil Proceedings of this *90 Day Report*.

The Disabled

Developmental Disabilities Administration

The Developmental Disabilities Administration (DDA) provides direct services to individuals in institutions operated by DDA and through funding of a service delivery system supporting individuals in the community. In order to clarify an appeals process that is currently required by federal law as part of the State's Medicaid waiver agreement for home- and community-based services, ***Senate Bill 465*/*House Bill 900* *(both passed)*** require the Secretary of Health and Mental Hygiene to provide a recipient of Medicaid-waiver services who has been denied services according to his or her plan of habilitation with specified written notice within 30 days after the denial and an opportunity for a Medicaid fair hearing.

In order to enable a family to provide for the needs of a child or an adult with a developmental disability living in the home or support an adult with a developmental disability living in the community, ***Senate Bill 290*/*House Bill 1226* *(both passed)*** establish a Low-Intensity Support Services Program in DDA. The services must be flexible to meet the needs of individuals or families. DDA must establish a cap of no less than $3,000 of services per individual per fiscal year to a qualifying individual. DDA may waive the cap under specified circumstances.

Closed Captioning

According to the National Institute on Deafness and Other Communication Disorders, approximately 17% of American adults say that they have some degree of hearing loss. These numbers are likely to increase as the baby boomer generation ages, as roughly one-third of Americans 65 to 74 years of age and 47% of those 75 and older have hearing loss. In addition, hearing damage is the most common disability for veterans. ***Senate Bill 68*/*House Bill 1501* (both passed)** require a place of public accommodation, on request, to keep closed captioning activated on any closed-captioning television receiver that is in use during regular hours in any public area. The bills exclude places of public accommodation from this requirement if (1) no television receiver of any kind is available in the public area; or (2) the only public television receiver available is not a closed-captioning television receiver. For further discussion of this issue, see the subpart "Human Relations" within part F – Courts and Judicial Proceedings of this *90 Day Report*.