Part J
Health and Human Services

Public Health – Generally

Medicaid

Budget

The fiscal 2012 budget for the Medical Care Programs Administration (Medicaid) included fiscal 2011 deficiency appropriations totaling $31.6 million and a fiscal 2012 appropriation of just under $7.1 billion. Despite the provision of deficiency appropriations for Medicaid's fiscal 2011 budget, it is anticipated that Medicaid will roll over $130 million in general fund bills into fiscal 2012. This estimate is derived from current estimates of fiscal 2011 enrollment growth of 13.8% over the prior year compared to the budgeted growth of 6.9%, no provision of funding for the calendar 2011 Managed Care Organizations (MCO) rate increase, and shortfalls in other revenues supporting Medicaid in fiscal 2011.

For fiscal 2012, budget growth, after adjusting for deficiency appropriations and other fiscal 2011 funding changes, amounts to just over $540 million, or 8.3%. The fiscal 2012 Medicaid budget is based on three broad assumptions/decisions:

- Enrollment growth will moderate in fiscal 2012, with an increasing proportion of enrollees served through MCOs. At this point, there is evidence of moderating enrollment growth, although it is not clear if the budget assumption of 5.6% enrollment growth will be realized.

- Significant growth in the use of special fund revenue sources as an alternative to general funds. In fiscal 2012, these revenue sources include $390 million derived from an assessment on hospitals to support Medicaid, a change in the averted uncompensated care assessment methodology on hospitals to partially support the 2007 Medicaid expansion population to a flat 1.25%, and an increase in the nursing facility quality assessment from 4% to 5.5%.

- A variety of provider cuts including a 2% rate reduction effective May 1, 2011, for MCOs (although still allowing for an annual increase of 3.1%), and a 1% rate reduction for physicians and waiver providers.

Services

Under Medicaid and the Primary Adult Care Program, eligibility for family planning services is limited to women with incomes up to 116% of federal poverty guidelines. Women with incomes up to 200% of federal poverty guidelines may retain family planning coverage for five years following a birth paid for by Medicaid. ***Senate Bill 743*/*House Bill 778* *(both passed)*** require Medicaid, beginning on January 1, 2012, to provide family planning services to all women whose family income is at or below 200% of federal poverty guidelines without regard to how recently a woman has delivered a child. Federal funds will pay for the majority of the costs of providing these services, with the general fund share of $1.2 million derived from existing programs. Savings from a reduction in unintended pregnancies and births are also anticipated.

Mental Health

The Director of the Mental Hygiene Administration may transfer, under specified circumstances, an individual from a public facility to another public facility, or if a private facility agrees, to that private facility. As a result of ***House Bill 217* *(Ch. 114)***, the director would only be authorized to transfer an individual to the Clifton T. Perkins Hospital Center if the director finds that (1) Perkins Hospital can provide more beneficial care or treatment to the individual; or (2) a transfer would further the safety or welfare of others. Before transferring the individual, the director is required to give the individual notice and an opportunity for a hearing before the Office of Administrative Hearings unless an emergency necessitates immediate transfer. The Act also outlines the requirements for the hearing and authorizes the director to transfer an individual to a public facility, other than the Clifton T. Perkins Hospital Center, without the consent of the individual if there are administrative or clinical reasons for doing so.

Prescription Drugs

Prescription drug abuse is a growing problem in the United States and has been attributed, in part, to the increased availability of prescription drugs. State prescription drug monitoring programs address this issue by requiring pharmacies to log each prescription they fill. ***Senate Bill 883* *(passed)*** establishes the Prescription Drug Monitoring Program (PDMP) within the Department of Health and Mental Hygiene (DHMH) to monitor the prescribing and dispensing of all Schedule II through V controlled dangerous substances. For each monitored prescription drug dispensed, a dispenser must electronically submit data to PDMP in accordance with regulations adopted by the Secretary of Health and Mental Hygiene. Under certain circumstances, a dispenser may submit data by other means. In addition, the bill establishes an Advisory Board on Prescription Drug Monitoring, which must make recommendations to the Secretary of Health and Mental Hygiene relating to the design and implementation of the program, including regulations, legislation, and sources of funding.

Safe disposal of prescription drugs preserves patient safety, reduces abuse or unintended ingestion of prescription drugs, and limits the impact of unused medications on the environment. ***Senate Bill 770/House Bill 460 (both passed)*** expand the purpose of the Prescription Drug Repository Program to include acceptance of prescription drugs and medical supplies returned to a pharmacy for proper disposal. Each pharmacy for which a pharmacy permit has been issued must dispose of prescription drugs or medical supplies in accordance with program policies.

Reimbursement of Health Care Costs

The Community Services Reimbursement Rate Commission is an independent unit that functions within DHMH. Each year the commission is required to submit a report to the Governor, the Secretary of Health and Mental Hygiene, and the General Assembly. Among other things, the report is to include the commission's findings regarding the relationship between changes in wages paid by community providers to changes in rates paid by DHMH and the financial condition of providers. Originally, the commission was set to terminate after three years, but it has been reauthorized four times. ***Senate Bill 202 (passed)/House Bill 58 (Ch. 94)*** extend the termination of the commission by five years to September 30, 2016.

Medical Marijuana

In 1996, California became the first state to allow the medical use of marijuana. Since then, 15 other states have enacted similar laws. These states generally have some form of patient registry and provide protection from arrest for possession of up to a certain amount of marijuana for medical use. Maryland law allows evidence of medical use as a mitigating factor but does not provide a means for patients to obtain marijuana. ***Senate Bill 308 (passed)*** provides that in a prosecution for the use or possession of marijuana or for the use or possession of drug paraphernalia related to marijuana, it is an affirmative defense that the defendant used or possessed the marijuana or marijuana paraphernalia because (1) the defendant has a debilitating medical condition that has been diagnosed by a physician with whom the defendant has a bona fide physician-patient relationship; (2) the debilitating medical condition is severe and resistant to conventional medicine; and (3) marijuana is likely to provide the defendant with therapeutic or palliative relief from the debilitating medical condition. The affirmative defense may not be used if the defendant was using marijuana in a public place or was in possession of more than one ounce of marijuana.

The bill defines "bona fide physician-patient relationship" as a relationship in which the physician has ongoing responsibility for the assessment, care, and treatment of a patient's medical condition. The bill further defines "debilitating medical condition" as a chronic or debilitating disease or medical condition or the treatment of a chronic or debilitating disease or medical condition that produces one or more of the following, as documented by a physician with whom the patient has a bona fide physician-patient relationship: (1) cachexia or wasting syndrome; (2) severe or chronic pain; (3) severe nausea; (4) seizures; (5) severe and persistent muscle spasms; or (6) any other condition that is severe and resistant to conventional medicine.

The bill provides that the Board of Physicians may not reprimand, place on probation, or suspend or revoke a license of a licensee for providing a patient with a written statement, medical records, or testimony that, in the licensee's professional opinion, the patient is likely to receive therapeutic or palliative relief from marijuana.

In addition, the bill requires the Secretary of Health and Mental Hygiene to convene a workgroup to develop a model program for facilitating patient access to marijuana for medical purposes. By December 1, 2011, the Secretary must report on the workgroup's findings, including draft legislation that establishes a program to provide access to marijuana in the State for medical purposes.

Miscellaneous Health Care Programs

Cord Blood

Cord blood contains all of the normal elements of blood, but it is also rich in hematopoietic (blood-forming) stem cells, similar to those found in bone marrow. Thus, cord blood can be used for transplantation as an alternative to bone marrow. ***Senate Bill 584/House Bill 983 (both passed)*** establish a Cord Blood Transplant Program within DHMH to provide funding, subject to the limitations of the State budget, to qualified medical institutions to establish or maintain a cord blood transplant program. The bills also establish a Cord Blood Transplant Center Support Fund to promote economic development by supporting cord blood transplant centers at qualified medical institutions with a goal of being recognized as a regional center of excellence in the area of cord blood transplantation. Qualified medical institutions may apply for a grant from the fund each year.

Veterans Behavioral Health

In 2008, legislation was passed that established a three-year program for behavioral health services for Maryland veterans of the Afghanistan and Iraq conflicts. The program was extended in 2009 to apply to all veterans who served on active duty in the uniformed services of the United States. The 2008 legislation also created a Veterans Behavioral Health Advisory Board that was charged with, among other things, conducting an immediate analysis of the behavioral health needs of veterans and their families, identifying the gaps in behavioral health services available to the veterans and their families, and facilitating collaboration among organizations and entities that provide behavioral health services to veterans and their families. The board was required to submit a final report of its findings and recommendations on or before December 1, 2010, to the Governor and the General Assembly. Those provisions of law are set to terminate May 31, 2011. ***Senate Bill 682/House Bill 793 (Chs. 81 and 82)*** reenact the provisions of law related to the coordination and provision of behavioral health services to eligible veterans.

Miscellaneous Public Health Issues

Medical Decisionmaking

Senate Bill 203/House Bill 82 (both passed) repeal provisions of law relating to the "Instructions on Current Life-Sustaining Treatment Options" form. The bills require DHMH, in conjunction with the Maryland Institute for Emergency Medical Services Systems and the State Board of Physicians, to develop and periodically revise a "Medical Orders for Life-Sustaining Treatment" form and instructions for its use. The form is to be given the same effect as an emergency medical services "do not resuscitate order" if the form contains an order that resuscitation not be attempted. Health care facilities, which include assisted living programs, home health agencies, hospices, hospitals, kidney dialysis centers, and nursing homes, are required to accept and update or complete the form as specified. Other health care providers are authorized, but not required, to use the form. DHMH is required to adopt regulations regarding the form, including instructions on how the form is revised or revoked, and is also required to make the form and instructions available on its website.

Organ Donation

The 2006 Revised Uniform Anatomical Gift Act (UAGA) is generally intended to resolve inconsistencies among states and reduce impediments to transplantation. A total of 45 states, the District of Columbia, and the U.S. Virgin Islands have adopted the Revised UAGA. ***Senate Bill 756 (passed)*** establishes the Maryland Revised Anatomical Gift Act, a modified version of the 2006 UAGA. The bill applies to donations of all or part of a human body taking effect after the donor's death for purposes of transplantation, therapy, research, or education.

Human Trafficking

The U.S. Department of State has estimated that approximately 600,000 to 800,000 victims are trafficked annually across international borders worldwide and approximately one-half of these victims are minors. ***House Bill 674 (Ch. 137)*** requires the Maryland State Department of Education, in collaboration with DHMH, to provide awareness and training on human trafficking for directors of student services in local school systems, including strategies for the prevention of trafficking of children.

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 151/House Bill 4 (both passed)*** expand the existing prohibition on the use of BPA in child care articles. Specifically, on or after July 1, 2014, the State may not purchase, and an individual may not manufacture, knowingly sell, or distribute in commerce, infant formula in a container that contains BPA. A violator is guilty of a misdemeanor and subject to fines of up to $10,000 per violation.

Bittering Agents

Ethylene glycol is an odorless, sweet-tasting liquid commonly used in engine coolant or antifreeze. It is highly toxic and, if ingested, potentially lethal. Denatonium benzoate is a chemical compound, known for its extremely bitter taste, that is sold as an aversive agent for application in toxic products to prevent children and animals from consuming the products. Beginning January 1, 2012, ***House Bill 897*** ***(passed)*** prohibits a person from selling or offering to sell any engine coolant or antifreeze that contains more than 10% ethylene glycol unless the coolant or antifreeze includes a certain amount of dentonium benzoate. The bill exempts certain engine coolant or antifreeze, such as engine coolant or antifreeze reformulated through on-site recycling, from the ban. A person who violates the ban is guilty of a misdemeanor and on conviction is subject to a fine of not more than $100, with each day that a violation continues being a separate offense.

Health Occupations

Dentists and Dental Hygienists

Monitoring of Nitrous Oxide by Dental Hygienists

Senate Bill 664/***House Bill 841*** ***(both passed)*** authorize dental hygienists to monitor a patient to whom nitrous oxide is administered under the supervision of an on-site dentist. Prior to monitoring patients receiving nitrous oxide, a dental hygienist must successfully complete any educational requirements established by the State Board of Dental Examiners and pass a written and clinical examination. The board may adopt reasonable requirements for the education, training, evaluation, and examination of dental hygienists who wish to monitor nitrous oxide and for the monitoring of patients receiving nitrous oxide by a dental hygienist. The bills terminate September 30, 2014.

Temporary Dental Clinics

Senate Bill 578/***House Bill 354*** ***(both passed)*** establish a temporary volunteer dentist license, a temporary volunteer dental hygienist license, and a temporary dental clinic permit in order to allow out-of-state dentists and dental hygienists to participate in short-term charitable events in Maryland without having to obtain a full volunteer license. Temporary volunteer dentists may not use anesthesia or sedation, while temporary volunteer dental hygienists may not use local anesthesia or nitrous oxide. Temporary licenses and permits are valid only for the duration of the temporary dental clinic and may not be renewed; although, the board may issue another license or permit to qualified applicants. In addition to facilitating temporary dental clinics, the bills also specify the amount of clinical practice required for a reciprocal license if a dentist or dental hygienist has not passed a regional board examination.

Medication Technicians

***House Bill 378* (Ch. 123)** extends the time period from 90 to 180 days during which a medication technician graduate can practice without certification from the State Board of Nursing. Certain medication technicians may also practice for up to 180 days while the board processes their renewal application. The board, by December 31, 2011, must report to the Senate Education, Health, and Environmental Affairs and the House Health and Government Operations committees on the status of the online program for processing medication technician applications, the measures implemented to encourage the use of online applications, and an analysis of current staffing and projected staffing needs. The Act terminates April 12, 2013.

Perfusionists

Perfusionists offer a variety of clinical services to patients under the prescription and supervision of a physician including cardiopulmonary bypass (use of a heart-lung machine) and extracorporeal membrane oxygenation (long-term use of an artificial blood oxygenator to support or replace undeveloped, failing, damaged, or infected lungs). ***House Bill 287* (passed)** requires the State Board of Physicians to license and regulate the practice of perfusion in Maryland. The bill also establishes a Perfusion Advisory Committee within the board to develop and recommend regulations, a code of ethics, standards of care, and continuing education requirements. By October 1, 2013, an individual must be licensed in order to practice perfusion in the State, with some exceptions.

Pharmacists

The practice of pharmacy includes administering a vaccination for influenza, pneumococcal pneumonia, herpes zoster, or any other vaccination that has been determined by the State Board of Pharmacy, with the agreement of the State Board of Physicians and the State Board of Nursing, to be in the best health interests of the community. Licensed pharmacists who meet specified training requirements may administer these vaccinations to individuals age 18 or older. ***Senate Bill 845*/*House Bill 986* (both passed)** authorize pharmacists to administer an influenza vaccination to an individual who is at least nine years old if the vaccination is administered in accordance with regulations adopted by the State Board of Pharmacy, in consultation with the Department of Health and Mental Hygiene, rather than jointly with the boards of Physicians and Nursing. A pharmacist must report any influenza vaccination administered to an individual age 9 to 18 to the Maryland Immunization Registry, ImmuNet.

Physical Therapists

***Senate Bill 258*/*House Bill 188* (both passed)** alter the definitions of practicing physical therapy and practicing limited physical therapy. "Practicing physical therapy" is changed to include the design, implementation, and modification of therapeutic interventions. "Practicing limited physical therapy" is changed to include implementing and administering therapeutic interventions. The prohibition on using x-rays as part of physical therapy or limited physical therapy is repealed while the prohibition against taking x-rays is maintained. In addition, the

bills authorize the State Board of Physical Therapy Examiners to send renewal notices by electronic mail if requested by a licensee and increases the maximum criminal fine for violating the Maryland Physical Therapy Act from $5,000 to $10,000.

Polysomnographic Technologists

Polysomnography is the monitoring and recording of physiologic data during sleep or use of such data to assist a licensed physician in the diagnosis and treatment of sleep and wake disorders. Chapter 595 of 2006 required the State Board of Physicians to license and regulate polysomnographic technologists by October 1, 2009. However, Chapters 261 and 262 of 2009 delayed the licensing requirement until October 1, 2011. ***Senate Bill 641/House Bill 560 (both passed)*** further delay the date by which polysomnographic technologists must be licensed until October 1, 2013. The bills also extend the date by which licensure applicants can fulfill the requirements for a waiver of educational requirements from September 30, 2011, to September 30, 2013.

Professional Counselors and Therapists

Senate Bill 476/House Bill 311 (both passed) repeal a provision of law that prohibits the State Board of Professional Counselors and Therapists from authorizing home study toward the completion of continuing education requirements.

Residential Child Care Providers

Chapter 218 of 2008 expanded the purview of the State Board for Certification of Residential Child Care Program Administrators to include the certification of residential child and youth care practitioners. Chapter 583 of 2010 delayed the date by which residential child and youth care practitioners must be certified from October 1, 2013, until October 1, 2015. ***Senate Bill 344/House Bill 387 (both passed)*** require the Governor's Office for Children (GOC) to establish a workgroup comprising specified representatives to determine whether it is feasible to implement this certification by 2015 and submit an implementation plan to the Governor; the Senate Education, Health, and Environmental Affairs Committee; and the House Health and Government Operations Committee by September 1, 2011. The implementation plan must specify the adjustment in rates needed to support the additional costs of certification, recommendations for addressing the needed rate increase in the State budget, and a recommendation for an alternate date for implementation of certification if warranted.

Sunset Evaluation and Related Legislation

Approximately 70 regulatory entities and activities, including each of the boards regulated under the Health Occupations Article, are subject to periodic evaluation conducted by the Department of Legislative Services (DLS) 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 Electrology Practice Committee through ***Senate Bill 84/House Bill 65 (both***

passed), the State Board of Examiners of Nursing Home Administrators through ***Senate Bill 93 (Ch. 24)***, the State Board of Podiatric Medical Examiners through ***Senate Bill 90***/***House Bill 66 (both passed)***, and the State Board of Examiners of Psychologists through ***Senate Bill 89***/***House Bill 75 (both passed)***.

Electrology Practice Committee

In its 2010 preliminary sunset evaluation of the Electrology Practice Committee, which is regulated by the State Board of Nursing, DLS found that there is no State examination available, the board is not administering a State law portion of an examination, and the statutory and regulatory examination requirements of the board could be clearer. ***House Bill 183 (Ch. 107)*** specifies that each applicant for licensure as an electrologist must pass an examination approved by the board and a clinical examination approved by the board. The board may purchase an exam or administer one that it develops. The Act also extends the term of an electrologist license from one to two years beginning January 1, 2013.

State Board of Podiatric Medical Examiners

In the 2009 preliminary sunset evaluation of the State Board of Podiatric Medical Examiners, DLS recommended that the board ask for an Attorney General's opinion seeking clarity of the board's statutory requirement to inspect podiatrists' offices and, if necessary, introduce legislation to clarify the law. In response, ***Senate Bill 117***/***House Bill 36 (both passed)*** clarify that the board is only required to conduct an unannounced inspection of a podiatrist's office if a complaint has been filed with the board regarding a violation of the federal Centers for Disease Control and Prevention's guidelines on universal precautions.

Miscellaneous

Discipline of Health Care Practitioners for Failure to Comply with Governor's Order

In the event that the Governor issues a catastrophic health emergency proclamation, he or she may order any health care practitioner who does not voluntarily do so, to participate in disease surveillance, treatment, and suppression efforts or comply with the directives of the Secretary of Health and Mental Hygiene or other designated official. Violators are guilty of a misdemeanor and subject to imprisonment for up to one year and/or a fine of up to $5,000. ***Senate Bill 371***/***House Bill 503 (both passed)*** exempt a health care practitioner who knowingly and willfully fails to comply with such orders from the associated fine and prison sentence and instead subjects them to discipline by the respective health occupations board.

Prescription Drug Monitoring Program

Senate Bill 883/***House Bill 1229 (both passed)*** establish a Prescription Drug Monitoring Program to monitor the prescribing and dispensing of certain controlled dangerous substances. For each monitored prescription drug dispensed, a dispenser must electronically submit certain data to the program. Prescription monitoring data may not be used as the basis for imposing

clinical practice standards. For further discussion of ***Senate Bill 883***/***House Bill 1229***, see the subpart "Public Health – Generally" within Part J – Health and Human Services of this *90 Day Report*.

Health Care Facilities and Regulation

Hospitals and Freestanding Ambulatory Care Facilities

With respect to hospital licensure, minimum standards exist for physician credentialing and reappointment processes, including formal documentation of a physician's pattern of performance. Regarding the licensure of a freestanding ambulatory care facility, the Secretary of Health and Mental Hygiene must by regulation establish standards, including procedures for credentialing and peer review, to ensure quality of care and patient safety. ***House Bill 286 (passed)*** requires a hospital or freestanding ambulatory care facility to establish, as a condition of licensure, a practitioner performance evaluation process that objectively evaluates the performance of each member of the medical staff at the hospital or facility. With respect to a hospital, the practitioner evaluation process must include a review of care provided to patients at the hospital. With regard to the licensure of a freestanding ambulatory care facility, the Secretary of Health and Mental Hygiene must by regulation establish procedures for practitioner performance evaluation.

Under current Maryland Health Care Commission (MHCC) regulations, percutaneous coronary intervention (PCI) services may be performed only by a hospital that has a certificate of need (CON) to perform cardiac surgery. In 2006, MHCC initiated a "primary PCI waiver program" that allowed certain community hospitals without on-site cardiac surgery programs to perform emergency angioplasties for patients experiencing certain types of heart attacks. In 2007, MHCC initiated a "non-primary PCI research waiver program" that allowed certain hospitals in the primary PCI waiver program to perform *elective* angioplasties as part of a clinical trial to study the safety and efficacy of non-primary angioplasty in hospitals without on-site cardiac surgery programs. According to MHCC, the results of the study are anticipated in early 2012 and will be used to review and update State Health Plan policies governing the co-location of PCI and cardiac surgery services. ***House Bill 1182 (passed)*** prohibits a hospital from establishing a non-primary PCI program or providing non-primary PCI services unless the hospital was operating a PCI program on January 1, 2011, through (1) a CON for an open heart surgery program; or (2) a non-primary waiver issued by MHCC. In addition, the bill requires MHCC to develop and report on recommendations for statutory changes needed to provide appropriate oversight of PCI services. The bill terminates June 30, 2012.

Health Information Sharing

The health information exchange is a statewide infrastructure that provides organizational and technical capabilities to enable the electronic exchange of health information between health care providers and other health services organizations authorized by MHCC. MHCC has advised that the exchange, which is in an early phase of implementation, has limited data sharing to that

which is adequately protected by current law. Thus, data sharing is currently limited to results delivery, discharge summaries, and select clinical information. ***Senate Bill 723/House Bill 784 (both passed)*** require MHCC to adopt regulations for the privacy and security of protected health information obtained or released through a health information exchange by either a health care provider or a payor that holds a valid certificate of authority issued by the Maryland Insurance Commissioner. The bills also establish requirements for entities to connect to the State-designated health information exchange.

Senate Bill 960/House Bill 600 (passed) add two entities to the list of entities to which the Health Services Cost Review Commission (HSCRC) may disclose certain identifying physician information: (1) the Office of Health Care Quality (OHCQ); and (2) an investigatory body under the State or federal government. In addition, the bills require the State Board of Physicians to disclose – for the purpose of investigating quality or utilization of care – any information contained in a record to the Secretary of Health and Mental Hygiene, OHCQ, or HSCRC. The bills also alter the definition of "medical review committee" to include a committee appointed by or established in the Department of Health and Mental Hygiene.

Miscellaneous Facilities

In September 2010, a female patient was allegedly murdered by a male patient who was housed just two doors away in a co-ed, medium-security ward at Clifton T. Perkins Hospital. According to the Maryland Disability Law Center, up to 81% of men and women in psychiatric hospitals nationwide have experienced physical and/or sexual abuse. A task force convened in 2005 by the law center urged the Mental Hygiene Administration (MHA) to separate the bedrooms of male and female patients to the extent possible. ***Senate Bill 556/House Bill 1150 (both passed)*** require MHA to develop and implement a plan (including a three-year pilot program) to secure the sleeping quarters of male and female patients at all State mental health facilities. The bills also establish training and reporting requirements related to sexual abuse and sexual harassment.

Maryland's statutory requirement that certain health care facilities obtain CON approval prior to closure was intended to ensure public notice and scrutiny of the impact of any closure on access to care. However, the number of CON applications has increased and enforcement of this requirement is challenging. Although closure of health care facilities in Maryland is rare, ***Senate Bill 57 (passed)*** replaces the CON requirement with public notice requirements, establishing consistent CON policy with respect to closure of hospitals and other health care facilities.

Senate Bill 384/House Bill 346 (both passed) alter the definition of "abuse" for purposes of certain reporting requirements related to State facilities and residential centers. The bills specify that "abuse" does not, for those purposes, include an action taken by an employee that complies with applicable State and federal laws and DHMH policies on the use of physical intervention.

Recovery homes provide temporary residential services for individuals recovering from alcohol or drug addiction. DHMH does not currently regulate recovery homes. ***Senate Bill 562***

(passed) requires DHMH to identify and report on standards for best practices for recovery homes.

Miscellaneous Provisions

HSCRC, an independent commission within DHMH, was established in 1971 to contain hospital costs; maintain fairness in hospital payment; provide for financial access to hospital care; and disclose information on the operation of hospitals in the State. The commission is special funded by user fees assessed on hospitals. The annual user fee cap is $5.5 million, although the commission is projected to generate $5.85 million in fiscal 2012. Assessed user fees must be used only to cover the actual documented direct costs of fulfilling HSCRC's specified statutory and regulatory duties and any administrative costs for services provided to the commission by DHMH. ***House Bill 216*** ***(passed)*** increases HSCRC's annual user fee cap from $5.5 to $7.0 million

At least once annually, the Developmental Disabilities Administration (DDA) or its agent must inspect each site or office operated by an individual licensed by DDA to provide services. The administration must keep a report of each inspection and must bring any deficiencies to (depending on the type of facility) the attention of either (1) the executive officer of the licensee; or (2) both the State Planning Council and the State-designated protection and advocacy agency. ***House Bill 265*** ***(Ch. 116)*** requires DDA or its agent to periodically evaluate the performance of surveyors of licensee-operated sites to ensure the consistent and uniform interpretation and application of licensing requirements.

Health Insurance

Implementation of Federal Health Care Reform

In the 2011 session, the General Assembly passed several bills relating to the implementation of the federal Patient Protection and Affordable Care Act (Affordable Care Act). The legislation creates the framework for a health insurance exchange in the State and authorizes the Maryland Insurance Commissioner to enforce provisions of federal health reform that have already taken effect.

Maryland Health Benefit Exchange

The Affordable Care Act requires states that elect to operate a health benefit exchange to implement the exchange by January 1, 2014. ***Senate Bill 182/House Bill 166*** ***(Chs. 1 and 2)*** establish the governance, structure, and funding of the Maryland Health Benefit Exchange (the Exchange). The primary function of the Exchange is to certify and make available qualified health plans to individuals and businesses and to serve as a gateway to an expanded Medicaid program under the Affordable Care Act.

Chapters 1 and 2 establish the Exchange as a public corporation and an independent unit of State government. The Exchange will be governed by a nine-member board of trustees

consisting of the Secretary of Health and Mental Hygiene, the Insurance Commissioner, the Executive Director of the Maryland Health Care Commission, and six other members appointed by the Governor with specified expertise. ***Chapters 1 and 2*** also require the Exchange to consult with and consider the recommendations of stakeholder advisory committees in exercising its duties.

The Exchange must study and, on or before December 23, 2011, make recommendations on:

- the feasibility and desirability of the Exchange engaging in selective contracting and multistate or regional contracting within the State;
- the rules under which health benefit plans should be offered inside and outside the Exchange;
- the design and operation of the Exchange's consumer assistance mechanisms; and
- how the Exchange can be self-sustaining by 2015.

The Exchange may not exercise many of its powers and duties under the Affordable Care Act until the required studies have been completed and the General Assembly and the Governor have enacted additional legislation.

The Exchange must also study whether it should remain an independent public body or should become a nongovernmental, nonprofit entity and report its recommendations to the Governor and the General Assembly on or before December 1, 2015. ***Senate Bill 107*/*House Bill 516* (both failed)** would have required an exchange established in the State to be a nonprofit entity and would have prohibited an exchange from being established as a governmental agency.

Enforcement of Health Insurance Requirements under the Affordable Care Act

***Senate Bill 183*/*House Bill 170* (Chs. 3 and 4)** require health insurance carriers to follow, and, therefore, allow the Maryland Insurance Commissioner to enforce specific provisions of the Affordable Care Act currently in effect, including:

- coverage of children up to age 26;
- preexisting condition exclusions, policy rescissions;
- wellness programs;
- lifetime limits;
- annual limits for essential benefits;
- waiting periods;
- designation of primary care providers;
- access to obstetrical and gynecological services;
- emergency services;
- summary of benefits and coverage explanation;
- minimum loss ratio requirements and premium rebates; and

- disclosure of information.

Chapters 3 and 4 also make several changes to health insurance appeals and grievance laws to meet federal requirements regarding appeals and grievance processes.

Mandated Benefits

Though many bills were introduced in the 2011 session that would have required health insurance carriers in the State to provide additional mandated benefits, most did not ultimately pass due to uncertainty over the composition of the "essential benefits package" under the federal Patient Protection and Affordable Care Act. However, the General Assembly did pass legislation that clarified how health insurance carriers must deliver benefits that they already offer.

Coverage of Hearing Aids

***Senate Bill 702*/*House Bill 452* (both passed)** require health insurance carriers that provide coverage for hearing aids for adults to allow an insured adult or enrollee to choose a hearing aid that is above the benefit limit and pay the difference in cost.

Coverage of Refills of Prescription Eye Drops

***Senate Bill 701*/*House Bill 888* (both passed)** require health insurance carriers that provide coverage for prescription eye drops to provide coverage for a refill of the eye drops in accordance with a Medicare Part D guidance on early refills if:

- the prescribing health care practitioner indicates on the original prescription that additional quantities of eye drops will be needed;
- the refill does not exceed the number of additional quantities indicated on the original prescription; and
- the eye drops are a covered benefit under the policy or contract of the insured.

Oversight of Health Insurance Carriers

Evaluation of Health Benefit Plans

***Senate Bill 56* (Ch. 11)** requires the Maryland Health Care Commission to establish and implement a system to comparatively evaluate the quality of care and performance of *all* health benefit plans, rather than just health maintenance organizations. The commission must annually publish the summary findings of the comparative evaluation.

Financial Oversight of Health Insurers

***Senate Bill 59* (Ch. 13)** subjects health insurers to additional regulation by the Maryland Insurance Administration by altering when a company action level event occurs for health

insurers. The Act provides that a company action level event occurs when the company's risk-based capital (RBC) is less than a specified amount and triggers the trend test calculation in the health RBC instructions. The Act allows regulators to identify health insurers with deteriorating financial conditions earlier to prevent conservation, rehabilitation, or liquidation.

Small Group Market Regulation

Chapter 347 of 2005 made self-employed individuals and sole proprietors ineligible for health insurance coverage in the small group health insurance market. Self-employed individuals and sole proprietors that were enrolled in the small group market on September 30, 2005, were permitted to retain their coverage, provided they continue to work and reside in the State and are self-employed. Self-employed individuals not already insured in the small group market have the option of enrolling in the Maryland Health Insurance Plan, the State's high-risk pool, if they cannot get coverage in the individual market. ***House Bill 156 (Ch. 104)*** extended to December 31, 2013, the termination date of the provisions of law excluding self-employed individuals and sole proprietors from the small group market.

Regulation of Dental Plans

Senate Bill 705 (Ch. 85) prohibits a carrier, in a dental provider contract, from requiring a dental provider to provide services that are not "covered services" at a fee set by a carrier. The Act was introduced in response to dental carriers setting rates in provider contracts for services that require enrollees to pay up to 100% of the costs of the dental services.

Prohibition on Discretionary Clauses in Disability Insurance Policies

Discretionary clauses in insurance contracts generally give the carrier full discretion to determine when benefits are payable. If an insurance contract has a discretionary clause, judicial review regarding a carrier's decision is based on an "abuse of discretion" standard, which limits the court to determining if a carrier's decision was unreasonable. Absent a discretionary clause, review is *de novo,* which allows the court to consider all available evidence and gives claimants a better chance of receiving benefits. ***House Bill 1085 (Ch. 155)*** prohibits insurers and nonprofit health service plans from selling, delivering, or issuing a disability insurance policy that contains a clause that reserves sole discretion to the carrier to interpret the terms of the policy or to provide standards of interpretation or review that are inconsistent with the laws of the State.

Incentives for Adoption of Electronic Health Records

Maryland is the first state to require State-regulated payors to provide incentives of monetary value to select health care providers to promote the adoption and use of electronic health records. ***Senate Bill 722/House Bill 736 (both passed)*** specify that these incentives, as required under regulations adopted by the Maryland Health Care Commission (MHCC), must be paid in cash, unless an incentive of equivalent value is agreed upon by the State-regulated payor and the health care provider. The regulations adopted by MHCC may not require a group model health maintenance organization (HMO) to provide an incentive to certain providers under

contract with the group model HMO and must allow a State-regulated payor to request information from a provider to verify a claim and reduce the incentive amount in the event of overpayment or duplicative payment. MHCC may conduct compliance audits and request corrective action if warranted. The bills also require MHCC, in consultation with stakeholders, to study and report to the Senate Finance and House Health and Government Operations committees by January 1, 2013, on whether the scope of health care providers eligible for incentives should be expanded beyond primary care providers.

Required Payments to Ambulance Service Providers

Most ambulance service providers do not contract with or become participating providers with every health insurance carrier. If an ambulance service provider is a nonparticipating or nonpreferred provider, the health insurance carrier typically sends a check to the patient for covered services, instead of reimbursing the provider. Ambulance service providers then bill the patient, but the providers reported that frequently, reimbursement is not received. ***Senate Bill 154*/*House Bill 83* *(both passed)*** require insurers, nonprofit health service plans, and HMOs (carriers) to *directly* reimburse certain ambulance service providers for covered services provided. The bills apply only to ambulance service providers that are owned, operated, under the jurisdiction of, or contracted with, a political subdivision of the State, or a volunteer fire company or rescue squad. A carrier, except for an HMO, must obtain an assignment of benefits from the insured. An ambulance service provider that receives direct reimbursement from a carrier may not balance bill a patient for covered services, but may bill the patient for any copayment, coinsurance amount, or deductible owed under the patient's contract or policy with the carrier. Reimbursement to an ambulance service provider that is a nonparticipating or nonpreferred provider may not be less than the allowed amount paid to a participating or preferred provider in the same geographic region. The bills also include reporting requirements for MHCC regarding changes in claims for ambulance service providers under the bills.

Required Notice of Receipt of Applications for Provider Panels

Health care providers seeking to participate on a carrier's provider panel must submit an application to the carrier. If a carrier receives an incomplete application, the carrier must return the application within 10 days and indicate what information is required for completion. ***Senate Bill 710*/*House Bill 444* *(both passed)*** require carriers to notify a health care provider when a *complete* application is received. A notice from an online credentialing system to the provider that the carrier has received the application serves as notice that an application is complete. A carrier that arranges a dental provider panel is exempt from the notice requirement until the Insurance Commissioner certifies that the online credentialing system is capable of accepting the uniform credentialing form for dental provider panels.

Authorization of Insurance Producers to Provide Information on State Programs

Senate Bill 850*/*House Bill 1178* *(both passed) authorize licensed insurance producers, in accordance with regulations adopted by the Insurance Commissioner, to provide small employers

with information about Medicaid and the Maryland Children's Health Program for the small employer to distribute to its employees during the enrollment period. The information provided must be general information only, including income eligibility thresholds and application instructions.

Regulation of Pharmacy Benefits Managers

Senate Bill 974/House Bill 1338 ***(both passed)*** prohibit a pharmacy benefits manager (PBM) from denying a claim from a pharmacy or pharmacist based on a minor error. The bills specify that a clerical, recordkeeping, typographical, or scrivener's error in a required document or record does not constitute fraud or grounds for recoupment of a claims payment if the prescription was otherwise legally dispensed and the claim was otherwise materially correct. Though the claims may not be denied outright, they remain subject to recoupment of overpayment or payment of any undiscovered underpayment by the PBM.

Social Services

In General

Senate Bill 81 ***(Ch. 21)*** repeals a requirement that the Maryland Higher Education Commission and the Department of Human Resources (DHR) identify, promote, and coordinate specified activities at institutions of higher education related to recipients of family investment program services and related reporting requirements. According to DHR, repeal of these requirements does not impact Family Investment Program recipients because the intent of the requirements is being met through other means.

Chapter 553 of 2008 established the Commission to Study the Impact of Immigrants in Maryland. The commission began its work in 2010 by examining the demographic and socioeconomic profile of the State's immigrant community. The commission also reviewed information concerning the economics of immigration, federal and State immigration enforcement programs, local law enforcement policies, and compliance efforts with the federal REAL ID requirement. Chapter 553 of 2008 required the commission to report its findings and recommendations to the Governor and the General Assembly by January 1, 2011, and terminate on May 31, 2011. ***Senate Bill 15/House Bill 34*** ***(both passed)*** extend the termination date for the commission by one year to May 31, 2012, and extend the date the final report is due to January 1, 2012.

The Elderly

Senate Bill 822 ***(passed)*** creates a "Maryland Communities for a Lifetime Program" within the Maryland Department of Aging (MDOA). The purpose of the program is to establish a State plan to address the aging-in-place preference of seniors, provide available resources to local communities to enhance aging-in-place services, and promote a State aging-in-place

program that overcomes specified barriers. MDOA must collect and make available best practices on policies to encourage aging-in-place.

The bill also authorizes a county or municipal corporation to establish a certification process for "Communities for a Lifetime" (CFLs) under the program. In addition, the bill adds a CFL representative to the membership of the Innovations in Aging Services Advisory Council, which advises the Secretary of Aging on the Innovations in Aging Services Program.

The Disabled

Senate Bill 994* (passed)** increases the State sales and use tax rate imposed on alcoholic beverages from 6% to 9% beginning in fiscal 2012. The bill requires a supplementary appropriation of $15.0 million for fiscal 2012 to be used to fund a Waiting List initiative for the Developmental Disabilities Administration (DDA). Priority will be given to individuals in the Crisis Prevention and Crisis Resolution categories of the Waiting List. As of January 2011, there were 5,384 people on the waiting list for DDA, requesting 16,180 services. Of the individuals on the waiting list as of January 2011, 1,072 fit into the priority group. DDA estimates that the total general fund cost of serving the entire waiting list is approximately $167.0 million. For a further discussion of ***Senate Bill 994, see subpart "Sales Tax" within Part B – Taxes of this *90 Day Report*.

Children

Coordination of Services for Children

As a result of the Child and Family Services Interagency Strategic Plan of 2008, a State-local workgroup was convened in 2009 with the purpose of recommending an improved interagency structure for the development and implementation of individualized plans of care for youth involved with multiple child-family serving agencies. ***House Bill 840* (passed)** is intended to address recommendations proposed by the workgroup. The bill alters the composition of the Local Management Boards, the body within each county that assists in the coordination of services for children and families, to include family members or family advocates, and youth and youth advocates. The bill also repeals duties of local coordinating councils and instead provides for local care teams in each county. These local care teams must:

- be a forum for families of children with intensive needs to receive assistance;
- be a forum for interagency discussions and problem solving for individual child and family needs and system needs;
- refer children and families to care management entities, when appropriate, and available local and community resources;
- provide training and technical assistance to local agency and community partners;

- identify and share resource development needs and communicate with the care management entity, local core service agencies, provider networks, local management boards, and other local care teams in surrounding jurisdictions; and

- discuss requests for voluntary placement agreements for children with developmental disabilities or mental illnesses who are in out-of-home placements.

Finally, the bill alters the membership and duties of the State Coordinating Council for Children.

Foster Care and Adoption

The Department of Human Resources must provide adoption "search, contact, and reunion services" to locate adopted individuals, siblings, and biological parents of adopted individuals. ***House Bill 255*** ***(passed)*** expands these services to include contacting the adopted siblings of a minor in out-of-home placement to develop a placement resource or facilitate a family connection. For a more detailed discussion of this bill, see the subpart "Family Law" within Part F – Courts and Civil Proceedings of this *90 Day Report*.

Child Neglect

Senate Bill 178/***House Bill 162*** ***(both passed)*** establish the crime of child neglect. The bills prohibit parents or family members who have permanent or temporary responsibility for the supervision of a minor from neglecting the minor. "Neglect" is defined in the bills as the intentional failure to provide necessary assistance and resources for the physical needs or mental health of a minor that creates a substantial risk of harm to the minor's physical health or a substantial risk of mental injury to the minor. 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*.

Residential Child and Youth Care Practitioners

Senate Bill 344/***House Bill 387*** ***(both passed)*** require the Governor's Office for Children to establish a workgroup to determine whether it is feasible to implement the certification of residential and youth care practitioners in 2015 and to develop an implementation plan. For a more detailed discussion of this issue, see subpart "Health Occupations" within Part J – Health and Human Services of this *90 Day Report*.

Child Care

Senate Bill 925 ***(passed)*** defines a "large family child care home" as a residence in which family child care is provided for at least 9 but no more than 12 children and a "family child care home" as a residence in which child care is provided for up to 8 children. The bill also expands the definition of "child care provider" to include an adult who has primary responsibility for the operation of a large child care home. Lastly, the bill repeals a reference to "centers" serving between 7 and 12 children within residences and changes multiple references from "family day care" to "family child care." The Maryland State Department of Education advises that

eliminating references to "centers" for residences that provide care for 12 or fewer children will align Maryland with the standard practice in other states. 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 282* (passed)** repeals an obsolete provision of law which established an amnesty period for unregistered family day care providers between October 1, 1994, and September 30, 1997.