

**LEGISLATIVE SESSION - 2009**

<b>SENATE BILLS</b>					
<b>BILL #</b>	<b>CROSS-FILED BILL #</b>	<b>TITLE OF BILL</b>	<b>RESPONSIBLE PERSON</b>	<b>BRIEF DESCRIPTION</b>	<b>DATE OF REVIEW</b>
SB 8		<p><b><i>Insurance – Unfair and Deceptive Practices – Limit on Offer, Promise, or Gift of Valuable Consideration Not Specified in a Contract or Policy</i></b></p> <p><b>Official Synopsis:</b> Altering to no more than \$25 the limit on the value of items that an insurer may offer, promise, or give that is not specified in specified contracts or policies.</p>		<p><b>Sponsored by:</b> Senator Haines</p> <p><b>Status:</b> <b>PASSED CHAPTER 9</b></p> <p><b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative</i>: “<b>Senate Bill 8 (Ch. 9)</b> increases from \$10 to \$25 the limit on the value of educational materials, promotional items, or merchandise that an insurer may give to a person not specified in an annuity contract or an insurance contract or policy.”</p>	
SB 75		<p><b><i>Public Information Act – Confidentiality of Security-Related Documents and Records</i></b></p> <p><b>Official Synopsis:</b> Adding specified documents and records concerning ports to the list of security-related documentation that may be exempt from disclosure under the Public Information Act.</p>	Melinda Murray	<p><b>Sponsored by:</b> Chair, Education, Health, and Environmental Affairs Committee (By Request - Departmental - Transportation)</p> <p><b>Status:</b> <b>PASSED CHAPTER 357</b></p> <p><b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative</i>: “There are numerous restrictions on the disclosure of information under the Maryland Public Information Act, including disclosure of specified information about bridges, tunnels, airports, and mass transit facilities; however, information about the ports is not specifically restricted. <b>Senate Bill 75 (passed)</b> authorizes the State and local governments to keep specified records related to ports confidential. Records may be withheld only if public inspection would jeopardize the security of any building, structure, or facility; facilitate the planning of a terrorist attack; or endanger life or safety. The bill is not intended to limit inspection of MPA or Maryland Aviation Administration records by a specified exclusive representative, as authorized by specified memoranda of understanding and federal law; however, an exclusive representative must sign a nondisclosure agreement prior to inspecting such public records.”</p>	5/29, Approved by Governor 5/7
SB 79		<p><b><i>Health Insurance - Reform</i></b></p> <p><b>Official Synopsis:</b> Expanding the applicability of specified limitations on the imposition of preexisting condition provisions by specified carriers to a policy or certificate issued to an individual; altering loss ratio requirements for specified health benefit plans and Medicare supplement policies; etc.</p>		<p><b>Sponsored by:</b> Chair, Finance Committee (By Request-Departmental-Health and Mental Hygiene)</p> <p><b>Status:</b> <b>PASSED CHAPTER 509</b></p> <p><b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative</i>: “<b>Senate Bill 79 (passed)</b> alters various aspects of the regulation of health insurance offered in the individual market.</p> <p><b>Preexisting Conditions</b> In the individual market, carriers may medically underwrite policies. The carrier may inquire about conditions for which the applicant has received medical care or advice during the seven years immediately preceding the date</p>	5/29 Approved by Governor 5/19

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				<p>of application. This is known as the “look back” period. An insurer or nonprofit health service plan must cover any condition revealed in the application or add an exclusionary rider for that particular condition. However, the insurer or nonprofit health service plan may exclude coverage for a preexisting condition identified in the look back period that is not revealed in the initial application for up to two years.</p> <p>All states allow preexisting condition limitations in the individual market. Sixteen states have a look back period of 6 months or less, and 28 states have a maximum exclusion period of 12 months or less (including Pennsylvania, Virginia, and West Virginia). Twelve states and the District of Columbia have no limit on the look back period, and 8 states and the District of Columbia have no limit on the maximum exclusion period.</p> <p><i>Senate Bill 79</i> alters preexisting condition provisions for individual health benefit plans by providing that a health insurance application form or nonprofit health service plan application form for specified individual health benefit plans may not contain inquiries about (1) a preexisting condition, illness, or disease for which the applicant has not received medical care or advice during the five years immediately before the date of application; or (2) medical screening, testing, monitoring, or any other similar medical procedure that the applicant received during the five years immediately before the date of application.</p> <p>Under the bill, a carrier may not attach an exclusionary rider to an individual health benefit plan unless the carrier obtains the prior written consent of the policyholder. A carrier may impose a preexisting condition exclusion or limitation on an individual for a condition that was not discovered during the underwriting process only if the exclusion or limitation (1) relates to a condition for which medical care was received during the 12-month period immediately preceding the effective date of the individual’s coverage; (2) extends for a period of not more than 12 months after the effective date of the coverage; and (3) is reduced by the aggregate of any applicable periods of creditable coverage.</p> <p>Finally, a preexisting condition exclusion or limitation may not be imposed on an individual who is covered under any creditable coverage as specified but may be imposed on or after the end of the first 63-day period during which the individual was not covered for the entire period under any creditable coverage. <i>House Bill 32 (passed)</i> contains provisions that are identical to the preexisting condition provisions of <i>Senate Bill 79</i>.</p> <p><b>Out-of-state Association Contracts</b></p> <p>Individuals may purchase health insurance through an association that has been issued a group contract for its members. Association health plans provide</p>	

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				<p>an alternative to individual policies for those who do not have access to employer-based group coverage; however, they are not group insurance plans and, therefore, are not subject to the same regulation. Generally, Maryland law does not apply to contracts sold through associations in other states, even when coverage is provided to residents of Maryland.</p> <p>Twelve carriers offer nonemployment based health insurance coverage to individuals in Maryland on a medically underwritten basis. Of these, three require the individual to join an out-of-state association (Golden Rule/FACT, Mega Life Insurance Company/NASE, and Time Insurance/Health Advocate Alliance). Other carriers offer coverage directly to an individual or through an association plan (such as AARP).</p> <p><i>Senate Bill 79</i> requires carriers that require evidence of individual insurability and offer coverage under an out-of-state association contract to Maryland residents to disclose certain information to applicants for coverage under the contract. A carrier must disclose (1) that coverage is conditioned on association membership; (2) all costs related to joining and maintaining membership in the association; (3) that membership fees or dues are in addition to the premium for coverage; (4) that the terms and conditions of coverage are determined by the association and carrier; (5) the health insurance benefits otherwise mandated in Maryland that are not included in the contract; (6) that the Maryland resident may purchase an individual health benefit plan that includes the mandated benefits that are not included in the contract; (7) that the contract is not regulated by the Maryland Insurance Commissioner; and (8) that the terms and conditions of coverage may be changed without the consent of a member. Carriers that collect membership fees or dues on behalf of an association must disclose this information on the enrollment application. The bill also authorizes the Insurance Commissioner to require a carrier that provides coverage under an out-of-state association contract to report annually to the Commissioner on the number of State residents covered under the out-of-state association contract.</p> <p><i>House Bill 39 (passed)</i> contains identical provisions on the regulation of out-of-state association contracts.</p> <p><b>Restrictions on Rescission of Contracts and Certificates</b></p> <p>After two years from the date of issue of a policy, no misstatements, except fraudulent misstatements, made by the applicant in the initial application for coverage may be used to void the policy or deny a claim for loss incurred or disability.</p> <p>In 2008, the U.S. House of Representatives Committee on Oversight and</p>	

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				<p>Government Reform investigated rescission practices in the individual health insurance market after regulators in California and Connecticut uncovered evidence of improper rescissions.</p> <p><i>Senate Bill 79</i> prohibits an insurer, nonprofit health service plan, or a health maintenance organization that conditions coverage on evidence of individual insurability from rescinding coverage on the basis of written information submitted on or with or omitted from an application unless the carrier completed medical underwriting and resolved all reasonable medical questions related to the written information before issuing the health benefit plan. A carrier must prove that any rescission of a health benefit plan complies with these provisions.</p> <p><i>House Bill 235 (passed)</i> contains identical provisions to the rescission provisions of <i>Senate Bill 79</i>.</p> <p><b>Loss Ratios</b></p> <p>Loss ratios are the ratios of incurred claims to premiums earned (the share of premium revenues spent on medical care). Carriers must include loss ratios for all health benefit plans specific to the State in their required annual reports to the Insurance Commissioner. <i>Senate Bill 79</i> requires the Maryland Insurance Administration to study options to raise or define medical loss ratios in the individual, small group, and large group health insurance markets that incentivize reduction of health care costs and improvement of health care quality and report its findings by December 1, 2009. Specifically, the administration is required to (1) study medical loss ratio requirements in other states to determine innovative ways to encourage health insurance carriers to incentivize adoption of electronic health records, implement wellness programs, and implement chronic care management programs; and (2) examine tiered B 576 medical loss ratio requirements in the small group market.”</p>	
SB 173	HB 41	<p><b><i>Health Insurance – Mandated Benefits – Hospitalization and Home Visits Following a Mastectomy</i></b></p> <p><b>Official Synopsis:</b> Requiring specified insurers, nonprofit health service plans, and health maintenance organizations to provide inpatient hospitalization coverage for a specified minimum length of time following a mastectomy that is performed for the treatment of breast cancer; prohibiting specified insurers, nonprofit health service</p>	Melinda Murray	<p><b>Sponsored by:</b> Senators Kelley, Conway, Currie, Della, Exum, Forehand, Frosh, Klausmeier, Kramer, Madaleno, Munson, Peters, Pugh, Raskin, and Robey</p> <p><b>Status:</b> <b>PASSED CHAPTER 516</b></p> <p><b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative</i>: “The estimated incidence of mastectomies nationally for women younger than age 65 is 0.018%, with 65% of patients sent home within 24 hours. Anecdotal evidence suggests that, in the absence of a mandate, 48-hour inpatient stays are often covered or approved by carriers when medically necessary or requested by the physician or patient. In 2008, 20 states required coverage for an inpatient stay following a mastectomy,</p>	5/29 – Governor signed 5/19

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		plans, and health maintenance organizations from imposing cost-sharing requirements or refusing reimbursement for services if the services do not occur within a specified time period; etc.		<p>with 8 requiring a minimum 48-hour stay, and the remainder generally requiring that length of stay be determined by the physician.</p> <p><i>Senate Bill 173/House Bill 41 (both passed)</i> require insurers, nonprofit health service plans, and HMOs to provide coverage for a minimum 48-hour inpatient hospital stay following a mastectomy. A patient may request a shorter length of stay. For a patient who receives less than a 48-hour inpatient stay or who undergoes a mastectomy on an outpatient basis, a carrier must provide coverage for one home visit scheduled to occur within 24 hours after discharge and an additional home visit if prescribed. Carriers may not deny, limit, or impair the participation of physicians under contract with the carrier for advocating the interest of mastectomy patients, including lengthier inpatient stays or additional home visits. Carriers must provide notice annually about the coverage provided under the bills.”</p> <p><i>Melinda Murray’s Comment:</i> This is a consumer-driven, popular bill that is supposed to prevent “drive through mastectomies.” In fact, studies from Hopkins and elsewhere suggest that properly prepared and educated women may actually have better outcomes because they have fewer narcotics and have the psychological benefit of making the choice to have the procedure on an outpatient basis. By requiring a minimum hospitalization, the patient is not at the mercy of the provider and payor to determine medical necessity. This bill could lead to higher premiums since it is another mandated benefit of insurance plans in Maryland.</p>	
SB 231	HB 487	<p><b><i>State Health Services Cost Review Commission – Health Care Facilities – Annual Reports of Compensation</i></b></p> <p><b>Official Synopsis:</b> Requiring specified health care facilities to submit to the State Health Services Cost Review Commission annual reports of the compensation of officers, directors, and executives of the health care facilities and of regulated lobbyists engaged by those facilities.</p>	Emily Wein	<p><b>Sponsored by:</b> State Health Services Cost Review Commission - Health Care Facilities - Annual Reports of Compensation</p> <p><b>Status: PASSED</b></p> <p><b>Summary / Analysis:</b> Pursuant to this bill § 19-216 of the Health General Article would be amended to require health facilities to file IRS form 990 that was filed with the IRS at the end of the facility’s fiscal year, at least 120 days following a merger or consolidation, or at any other time that the Commission sets.</p>	
SB 242		<p><b><i>Pharmacy Permit Holders – Signs for Reporting Incorrectly Filled Prescriptions</i></b></p> <p><b>Official Synopsis:</b> Requiring pharmacy permit holders to post signs that include specified information regarding the process</p>	Melinda Murray	<p><b>Sponsored by:</b> Senators Pugh, Garagiola, Harrington, King, Lenett, Muse, and Raskin</p> <p><b>Status: PASSED CHAPTER 45</b></p> <p><b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative</i>: “Regulations of the State Board of</p>	5/29, Approved by Governor 4/14

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		for resolving incorrectly filled prescriptions in accordance with specified regulations; and requiring that the signs be conspicuously positioned and readable by the consumer at the point where prescription drugs are dispensed to consumers.		<p>Pharmacy require a pharmacy permit holder to provide patients with information regarding the patient’s role and responsibility in preventing medication errors and how to report medication errors. <i>Senate Bill 242 (Ch. 45)</i> requires pharmacy permit holders to inform consumers of the process for resolving incorrectly filled prescriptions by posting a readable sign in a conspicuous location at the point where prescriptions are dispensed to consumers or by including that information with each filled prescription. Licensed dentists, physicians, or podiatrists who prepare and dispense their own prescriptions must comply with these requirements; however, an exemption exists for a pharmacy to which the public does not have access that is owned or operated by specified facilities, such as a hospital.”</p> <p><i>Melinda Murray’s Comment:</i> By requiring pharmacists to post a sign and to include instructions about how to resolve problems with mis-filled prescriptions as part of licensure, the Board of Pharmacy appears to be providing a mechanism to stave off lawsuits. Patients would likely prefer a quick resolution to these problems. Pharmacists would prefer to avoid the publicity and costs of litigation.</p>	
SB 247	HB 173	<p><b><i>Health Occupations – Maryland Athletic Trainers Act</i></b></p> <p><b>Official Synopsis:</b> Establishing the Athletic Trainer Advisory Committee as a subunit of the State Board of Physicians; establishing specified fees for services provided by the Board to athletic trainers; providing for the composition, appointment, and terms of the Committee members; establishing the powers and duties of the Committee; requiring specified individuals to be licensed by the Board as athletic trainers before performing specified work; etc.</p>	Thomas Pedroni	<p><b>Sponsored by:</b> Senators Rosapepe, Colburn, Greenip, Harrington, Harris, and Kelley</p> <p><b>Status:</b> <b>PASSED CHAPTER 529</b></p> <p><b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative</i>: “<i>Senate Bill 247/House Bill 173 (both passed)</i> require that on or after October 1, 2011, an individual be licensed by the State Board of Physicians before practicing athletic training in the State. The practice of athletic training is defined as applying the principles and methods of prevention, clinical evaluation and assessment, immediate care, and treatment, rehabilitation, and reconditioning to the management of athletic injuries for athletes in good overall health under the direction of a licensed physician. The bills establish an Athletic Trainer Advisory Committee within the board to develop and recommend regulations, continuing education requirements, and practice protocols for athletic trainers.”</p> <p><i>Thomas Pedroni’s comments:</i> No additional comments necessary.</p>	
SB 341	HB 579	<p><b><i>Prosthetic Parity Act</i></b></p> <p><b>Official Synopsis:</b> Requiring insurers, nonprofit health service plans, and health maintenance organizations to provide coverage for prosthetic devices, components</p>	Thomas Pedroni	<p><b>Sponsored by:</b> Senators Pugh, Astle, Della, Exum, Gladden, Glassman, Harrington, Jones, Kelley, Klausmeier, Lenett, Madaleno, McFadden, Raskin, and Rosapepe</p> <p><b>Status:</b> <b>PASSED CHAPTER 243</b></p> <p><b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-</i></p>	

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		of prosthetic devices, and repairs to prosthetic devices; prohibiting covered benefits from being subject to a specified copayment or coinsurance requirement; prohibiting insurers, nonprofit health service plans, and health maintenance organizations from imposing a specified dollar maximum on specified coverage; etc.		<p><i>Day Report-A Review of 2009 Legislative:</i> “<b>Senate Bill 341/House Bill 579 (both passed)</b> require insurers, nonprofit health service plans, and health maintenance organizations to provide coverage for prosthetic devices, components of prosthetic devices, and repair of prosthetic devices. “Prosthetic device” means an artificial device to replace, in whole or in part, a leg, arm, or eye. Prosthetic devices may not be subject to a higher copayment or coinsurance requirement than those required for any primary care benefits. A carrier may not impose an annual or lifetime dollar maximum on coverage for prosthetic devices, separate from any maximum that applies in the aggregate to all covered benefits. A carrier may not establish requirements for medical necessity or appropriateness for prosthetic devices that are more restrictive than those under the Medicare Coverage Database.”</p> <p><b>Thomas Pedroni’s comments:</b> No additional comments necessary except that Bill is effective October 1, 2009</p>	
SB 471		<p><b><i>Assisted Living Managers – Certification Requirement</i></b></p> <p><b>Official Synopsis:</b> Establishing a certification process for assisted living managers; requiring the Department of Health and Mental Hygiene to require that assisted living managers be certified; renaming the Board of Nursing Home Administrators to be the Board of Nursing Home Administrators and Assisted Living Managers; altering the composition of the Board; altering the appointment process and qualifications for the executive director of the Board; etc.</p>	Chris Dean	<p><b>Sponsored by:</b> Senator Kelley</p> <p><b>Status:</b> <b>PASSED CHAPTER 71</b></p> <p><b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative:</i> “<b>Senate Bill 471 (Ch. 71)</b> expands the membership of the State Board of Nursing Home Administrators by adding an additional nursing home administrator member and a representative of the Office of Health Care Quality as an <i>ex officio</i> member. The bill also establishes new requirements for board members and the executive director including that:</p> <ul style="list-style-type: none"> <li>• one of the nursing home administrator members have experience with the Eden Alternative Green House or a similar program, if practicable;</li> <li>• of the two required non-nursing home professional members, one be a doctor or nurse who specializes in geriatrics and the other be a geriatric social worker;</li> <li>• One of the consumer members have or have had a family member living in a nursing home; and the executive director possess, at a minimum, a bachelor’s degree.”</li> </ul> <p>The first reading of this bill included a certification requirement for managers of assisted living programs, which requirements were removed by amendment by the Senate Finance Committee on the third reading.</p>	6/14/09

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SB 556	HB 1192	<p><b><i>State Funding Accountability Act</i></b></p> <p><b>Official Synopsis:</b> Requiring a for profit or nonprofit entity or association that receives specified State aid to submit a report containing specified information to the Department of Budget and Management by September 1 after the close of specified fiscal years; requiring the Department to develop and operate a searchable website; authorizing the Office of Legislative Audits to conduct specified audits; requiring the Office to identify for an audit a specified percentage of grantees each year; etc.</p>	Maureen Dove/Melinda Murray	<p><b>Sponsored by:</b> Senators Jones, Miller, Brinkley, Colburn, Conway, Currie, DeGrange, Exum, Forehand, Frosh, Garagiola, Gladden, Glassman, Greenip, Haines, Harrington, Harris, Jacobs, Kasemeyer, Kelley, King, Kittleman, Klausmeier, Lenett, Madaleno, McFadden, Middleton, Munson, Muse, Peters, Pinsky, Pugh, Raskin, Robey, Simonaire, Stoltzfus, Stone, and Zirkin</p> <p><b>Status:</b> <b>PASSED CHAPTER 558</b></p> <p><b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative</i>: “<b>House Bill 1192</b> (passed) requires a for-profit or nonprofit entity or association that receives State aid during a fiscal year and is not a unit of State or local government to submit a report to the Department of Information Technology (DoIT) by September 1 after each fiscal year the grantee receives State aid. DoIT must develop and operate a searchable web site, accessible to the public at no cost, which provides grantee report information in a specified format. The Office of Legislative Audits is authorized to conduct audits or reviews of grantees. State aid is defined as a contribution, grant, or subsidy of \$50,000 or more provided through the State operating or capital budget or by the action of a unit of State government from State funds appropriated to that unit. State aid does not include reimbursements to providers participating in a State program. Grantee reports must contain the following information: a summary of the purpose for which the State aid was provided; the number of jobs created or retained as a result of the State aid; the amount and source of any funds, other than State aid, the grantee secured for the same purpose for which the State aid was provided, or as a result of the State aid; a description of how the State aid served the citizens of the State; and the number of citizens served as a result of the State aid.”</p> <p><b>Maureen Dove’s Comments:</b> This bill as enacted is substantially amended from the original version. The enacted version requires state grantor units to submit to DBM annual reports containing: 1) name, address and zip code of each of the unit’s grantees, 2) the amount of State aid, and 3) a description of the State aid. “State aid” is defined as a contribution, grant or subsidy of \$50,000 or more; reimbursements to providers participating in State programs are expressly excluded. Provisions in the original bill that required much more detailed annual reports from <b>grantees</b> were not adopted.</p> <p>The Department of Information Technology must develop and implement a searchable website that contains the above information.</p> <p>The Office of the Legislative Auditor may conduct an audit of a grantee. Under current law, OLA needs the authorization of the General Assembly or its Joint Audit Committee to audit a grantee.</p>	

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				<p><i>Melinda Murray's Comments:</i> In an era of closer scrutiny of non-profits, this bill will provide accountability and transparency at both ends of the procurement process. Through a searchable website, the public will be able to see where state grants of \$50,000 or more are going, while non-profits are subject to audit by the Office of Legislative Audits to prove that they used the state aid for the public good. A somewhat analogous bill is pending before Congress relating to the pharmaceutical industry, The Physician Payment Sunshine Act.</p>	
<p>SB 602 (Same as HB 576 – but not officially cross-filed)</p>		<p><b><i>Dental Hygienists – Expanded Functions</i></b></p> <p><b>Official Synopsis:</b> Altering the definition of “practice dental hygiene”; authorizing the State Board of Dental Examiners to adopt specified regulations; altering the authority of the Board to adopt rules and regulations concerning the administration of specified anesthesia by dental hygienists; and authorizing dental hygienists to administer specified anesthesia under specified circumstances.</p>	<p>Thomas Pedroni</p>	<p><b>Sponsored by:</b> Senators Pinsky, Colburn, Conway, Dyson, Harrington, Lenett, and Rosapepe</p> <p><b>Status:</b> <b>PASSED CHAPTER 565</b></p> <p><b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative: “Senate Bill 602/House Bill 576 (both passed)</i> expand the scope of practice for a licensed dental hygienist to include specified manual curettage (removal of dead tissue from gums) and the administration of local anesthesia. The bills authorize the Board of Dental Examiners to adopt regulations governing the education, training, evaluation, examination, and administration associated with this expanded scope of practice. The bills also allow more flexibility in the unsupervised clinical hours that dental hygienists may work by making the 60% threshold currently applicable to any given calendar week applicable to a three-month period instead.”</p>	
<p>SB 627</p>	<p>HB 714</p>	<p><b><i>Loan Assistance Repayment and Practice Assistance for Physicians</i></b></p> <p><b>Official Synopsis:</b> Altering the eligibility for the Janet L. Hoffman Loan Assistance Repayment Program in a specified manner; repealing a specified requirement that the Department of Health and Mental Hygiene may not hire more than one staff member to administer a specified program; establishing the Maryland Loan Assistance Repayment Program for Physicians; requiring the Office of Student Financial Assistance to assist in the repayment of specified loans owed by specified physicians; etc.</p>	<p>Chris Dean</p>	<p><b>Sponsored by:</b> Senators Middleton, Colburn, Dyson, Edwards, Kasemeyer, and Klausmeier</p> <p><b>Status:</b> <b>PASSED, CHAPTER 575</b></p> <p><b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative: “To address the workforce shortage of physicians in the State, Senate Bill 627/House Bill 714 (both passed)</i> alter the eligibility for the Janet L. Hoffman Loan Assistance Repayment Program by removing primary care physicians from the program and establishing a separate Maryland Loan Assistance Repayment Program for these health care practitioners. A more detailed discussion of these bills may be found under Part L – Education of this <i>90 Day Report</i>.</p> <p>As stated in Part L – Education:</p> <p>The Janet L. Hoffman Loan Assistance Repayment Program (LARP) provides loan repayment assistance in exchange for certain service</p>	<p>6/14/09</p>

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				<p>commitments to help ensure that sufficient numbers of primary care physicians, dentists, and professionals are serving underserved areas of the State or low-income families. <i>Senate Bill 627/House Bill 714 (both passed)</i> alters the eligibility for LARP, by removing primary care physicians from the program (currently known as the LARP-PCS program) and establishing a separate Maryland Loan Assistance Repayment Program for physicians. The bill also creates a Maryland Loan Assistance Repayment Program Fund, consisting of revenue generated through an increase to the rate structure of all hospitals in the State and any other money. The new special fund must be used by the Office of Student Financial Assistance in MHEC to administer the program. The bill sets program eligibility standards, prioritizes funding for loan repayment, and specifies a role for the Department of Health and Mental Hygiene in identifying additional physician shortages. The Maryland Health Care Commission and the Department of Business and Economic Development must report to the General Assembly on or before December 1, 2009, on the feasibility of providing assistance to physician practices.”</p> <p><i>Chris Dean’s Comments:</i> <i>Chapter 575</i> alters the eligibility for the Janet L. Hoffman Loan Assistance Repayment Program by removing primary care physicians from the program and establishing a separate Maryland Loan Assistance Repayment Program for these health care practitioners. A primary care physician includes internal medicine, obstetricians, pediatricians, geriatricians, emergency medicine providers and psychiatrists.</p> <p>In general, the Janet L. Hoffman Loan Assistance Repayment Program (LARP) provides loan repayment assistance in exchange for certain service commitments to help ensure that sufficient numbers of primary care physicians, dentists, and professionals are serving underserved areas of the State or low-income families. In fiscal year 2009, 26 primary care physicians received loan repayment awards of \$25,400, on average.</p> <p>The new law creates a Maryland Loan Assistance Repayment Program Fund. The fund's primary funding source will be from a rate increase approved by the Health Services Cost Review Commission (HSCRC) and applied to all hospitals. According to the Fiscal and Policy note for this law, the HSCRC requested a ruling from the Center for Medicare and Medicaid Services if such a rate increase would be consistent with Maryland's Medicare waiver. The fund may also receive money from any other source, including license fees collected by the Board of Physicians.</p> <p>The bill sets program eligibility standards, prioritizes funding for loan repayment, and specifies a role for the Department of Health and Mental</p>	

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				<p>Hygiene in identifying additional physician shortages. Eligible physicians include those employed by a §501(c)(3) or §501(c)(4) organization, state or local government office.</p> <p>The Maryland Health Care Commission and the Department of Business and Economic Development must report to the General Assembly on or before December 1, 2009, on the feasibility of providing assistance to physician practices.</p>	
SB 628		<p><b><i>Health Occupations – Licensure of Social Workers</i></b></p> <p><b>Official Synopsis:</b> Requiring the State Board of Social Work Examiners to notify applicants for licensure whether the applicants have been approved to take a specified examination within 30 days after the applicant submitted an application to the Board; and altering requirements for a waiver of examination requirements for specified applicants who are licensed or registered to practice social work in other states.</p>		<p><b>Sponsored by:</b> Senators Dyson, and Middleton</p> <p><b>Status:</b> <b>PASSED CHAPTER 86</b></p> <p><b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative: “Senate Bill 628/House Bill 510 (Chs. 86 and 87)</i> require the Board of Social Work Examiners, when reviewing an application for licensure to practice social work, to notify each applicant of whether the applicant has been approved to take the licensure examination within 60 days after the application was submitted. The board is also required to establish a workgroup of interested stakeholders to examine and make recommendations to the General Assembly regarding the substance of licensure and the process by which licenses are issued.”</p>	
SB 664	HB 782	<p><b><i>Nursing Facilities – Accountability Measures – Pay-for-Performance Program</i></b></p> <p><b>Official Synopsis:</b> Requiring the Department of Health and Mental Hygiene to consult with specified individuals on or before October 1, 2009, to reevaluate accountability measures; requiring the Department to make a specified report to the General Assembly on or before December 1, 2009; prohibiting the Department from distributing specified revenues until the later of July 1, 2011 or the termination of specified rate reduction imposed on nursing facilities by the State; etc.</p>	Chris Dean	<p><b>Sponsored by:</b> Senators Garagiola, Currie, Klausmeier, McFadden, Peters, and Robey</p> <p><b>Status:</b> <b>PASSED, CHAPTER 418</b></p> <p><b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative: “Senate Bill 664/House Bill 782 (both passed)</i> require DHMH to phase in the distribution of revenues to nursing facilities under the P4P program beginning July 1, 2010. By July 1, 2009, DHMH must send each nursing facility the scoring criteria, the performance of the facility relative to the scoring criteria, and the monies that would be received by the facility using the scoring criteria. Beginning July 1, 2010, DHMH must distribute 50% of the revenues from the quality assessment being used in the P4P program based on the scoring criteria. Beginning July 1, 2011, DHMH must fully implement the P4P program. By December 1, 2009, and annually thereafter, DHMH has to make necessary changes to the P4P program to determine the effect on providers and whether the measures are objective, measurable, and, when considered in combination, have a correlation to residents’ quality of life and care. The bill also requires DHMH to consult with stakeholders to assess the State’s long-term care reimbursement methodology</p>	

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BILL #	CROSS-FILED BILL #	TITLE OF BILL	RESPONSIBLE PERSON	BRIEF DESCRIPTION	DATE OF REVIEW
				<p>and report its findings by October 1, 2010.”</p> <p><i>Chris Dean’s Comments: <a href="#">Senate Bill 664</a>/<a href="#">House Bill 782</a> (Chp. 417) require DHMH to phase in the distribution of revenues to nursing facilities under the P4P program beginning July 1, 2010. Funding for the pay for performance initiative will come from a quality assessment tax on nursing facilities with forty-five or more beds and Federal matching funds. Nursing facilities that are in a continuing care retirement community are exempt from the tax. Nursing facilities exempt from the tax are ineligible for pay for performance incentives. The new law also delays certain provisions of an existing pay for performance law.</i></p> <p>By July 1, 2009, DHMH must send each nursing facility the scoring criteria, the performance of the facility relative to the scoring criteria, and the monies that would be received by the facility using the scoring criteria. The scoring criteria will include the Maryland Health Care Commission Family Satisfaction Survey (40%), staffing levels adjusted by resident acuity (20%) and staffing level stability (20%), Minimum Data Set quality indicators (16%), employment of infection control professionals and staff immunizations.</p> <p>Beginning July 1, 2010, DHMH must distribute 50% of the revenues from the quality assessment being used in the P4P program based on the scoring criteria. Under the previous law, the payments would have begun in July of 2009.</p> <p>Beginning July 1, 2011, DHMH must fully implement the P4P program. By December 1, 2009, and annually thereafter, DHMH has to make necessary changes to the P4P program to determine the effect on providers and whether the measures are objective, measurable, and, when considered in combination, have a correlation to residents’ quality of life and care.</p> <p>The new law also requires DHMH to consult with stakeholders to assess the State’s long-term care reimbursement methodology and report its findings by October 1, 2010.</p>	
SB 670	HB 393	<p><b><i>Discriminating in Employment – Expansion of Disability Rights</i></b></p> <p><b>Official Synopsis:</b> Altering the definition of disability applicable to provisions prohibiting discrimination in employment; prohibiting an employer from failing or refusing to make reasonable accommodations for known disabilities of otherwise qualified employees;</p>		<p><b>Sponsored by:</b> Senators Raskin, Kelley, and Stone</p> <p><b>Status:</b> <b>PASSED CHAPTER 299</b></p> <p><b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative: As state in Chapter F: “<a href="#">Senate Bill 670</a>/<a href="#">House Bill 393</a> (both passed) are designed to make State law more consistent with the ADA and to codify existing case law and regulations. The bills expand the definition of “disability” applicable to provisions of law relating to employment discrimination. Under the bills, “disability” includes a</i></p>	Concern was expressed for expansion of disability rights to include

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		<p>providing that an employer is not required to reasonably accommodate an employee's disability if the accommodation would cause undue hardship on the employer's business; and prohibiting retaliation against specified individuals.</p>		<p>record of having a physical or mental impairment or being regarded as having a physical or mental impairment. The bills prohibit an employer from failing or refusing to make a reasonable accommodation for the known disability of an otherwise qualified employee unless the accommodation would cause undue hardship on the conduct of the employer's business. The bills also prohibit an employer or labor organization from retaliating against any employee, applicant, or member who has opposed any prohibited employment practice or participated in an investigation, proceeding, or hearing relating to a discrimination charge.</p> <p><i>As also stated in Chapter J: <b>Senate Bill 670/House Bill 393 (both passed)</b> expand the definition of a disability to include a record of having a physical or mental impairment or being regarded as having a physical or mental impairment. The bill prohibits an employer from failing or refusing to make a reasonable accommodation for the known disability of an otherwise qualified employee. However, an employer is not required to accommodate an employee's disability if doing so would cause undue hardship on the employer's business. In addition, the bill prohibits an employer from retaliation against an employee, applicant, or member who has opposed any prohibited employment practice or participated in an investigation, proceeding, or hearing relating to a discrimination charge."</i></p>	<p>not only <u>having</u> a physical or mental impairment, but also <u>being regarded</u> as having a physical or mental impairment</p>
SB 700		<p><b><i>Pharmacists – Administration of Vaccinations – Expanded Authority</i></b></p> <p><b>Official Synopsis:</b> Expanding the authority of pharmacists to administer specified vaccinations to individuals under specified circumstances; and altering a definition.</p>		<p><b>Sponsored by:</b> Senator Klausmeier</p> <p><b>Status:</b> <b>PASSED CHAPTER 304</b></p> <p><b>Summary / Analysis:</b> As stated in the Maryland General Assembly's <i>The 90-Day Report-A Review of 2009 Legislative</i>: "Under current law, a pharmacist may administer an influenza vaccination to any person or a pneumococcal pneumonia or herpes zoster vaccination to an adult who has a prescription from a physician, in accordance with regulations set jointly by the Board of Pharmacy, Board of Physicians, and Board of Nursing. <b><i>Senate Bill 700 (passed)</i></b> expands the types of vaccinations that may be administered by a pharmacist to any vaccination that the Board of Pharmacy, Board of Physicians, and Board of Nursing determines is in the best interest of the community and is administered in accordance with regulations adopted jointly by the three boards. The vaccinations may only be administered by a pharmacist who has verified successful completion of a certification course that included instruction in the Centers for Disease Control and Prevention's guidelines and recommendations regarding vaccinations and who is certified in basic cardiopulmonary resuscitation."</p>	

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SB 776		<p><b><i>Health Services Cost Review Commission – Financial Assistance and Debt Collection Policies</i></b></p> <p><b>Official Synopsis:</b> Requiring each hospital in the State to develop a financial assistance policy for providing free care and reduced-cost care to specified patients; requiring a hospital to post a specified notice in the billing office; requiring each hospital to develop an information sheet that meets specified requirements; requiring the Health Services Cost Review Commission to establish uniform requirements for the information sheet and review each hospital’s implementation of and compliance with the requirements; etc.</p>	Emily Wein	<p><b>Sponsored by:</b> Senator Della</p> <p><b>Status:</b> <b>PASSED CHAPTER 310</b></p> <p><b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative: “Senate Bill 776/House Bill 1069 (both passed)</i> alter requirements for hospital financial assistance and debt collection policies. At a minimum, hospitals must provide free care to patients with family incomes up to 150% of federal poverty guidelines and reduced-cost care to low-income patients with higher family incomes in accordance with the mission and service area of the hospital. Each hospital has to 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. HSCRC is required 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 on incentives for hospitals to provide free and reduced-cost care to patients without the means to pay their hospital bills.”</p> <p>Note: Mandatory hospital oversight over debt collection Prohibition against sale of debt. Prohibition against prejudgment interest on patient debt.</p> <p><b>Emily Wein’s Comments:</b> Pursuant to this bill §§ 19-214(b) and 19-214.1 are amended and §§ 19-214.2 and 19-214.3 are added to the Health General article to have the Health Services Cost Review Commission require each hospital to develop a financial assistance policy for providing free and reduced cost care to patients who lack health care coverage or whose health care coverage does not pay the full cost of the hospital bill. The bill contains the necessary elements of the policy which include provision of free care to patients with family income at or below 150% of the federal poverty level and reduced cost care to low-income patients with family income above 150% of the poverty level. Hospitals will also be required to develop information sheets to disburse to patients regarding this policy, provide staff who are trained to work with patients to understand their bill and rights regarding such bill as well as the Medical Assistance application process and how to contact the hospital for assistance. The hospital’s policy shall also provide a debt collection process and how the hospital determines a patient’s eligibility for assistance (i.e., consideration of income and assets). The HSCRC will review each hospital’s compliance with this policy. If a hospital does not comply with these provisions the HSCRC may impose a fine not exceeding \$50,000 per violation.</p>	

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HB 20		<p><b><i>Intellectual Disability (Rosa’s Law)</i></b></p> <p><b>Official Synopsis:</b> Changing references to mental retardation to an intellectual disability; changing references to a mentally retarded individual to an individual with an intellectual disability; renaming State residential centers for the mentally retarded to be State residential centers for individuals with an intellectual disability; renaming an intermediate care facility for the mentally retarded (ICF-MR) to be an intermediate care facility for individuals with an intellectual disability (ICF-ID); altering definitions; etc.</p>	Melinda Murray	<p><b>Sponsored by:</b> Delegate Sophocleus</p> <p><b>Status:</b> <b>PASSED CHAPTER 119</b></p> <p><b>Summary / Analysis: <i>Current Law:</i></b> “Mental retardation” means a developmental disability that is evidenced by significantly subaverage intellectual functioning and impairment in the adaptive behavior of an individual.</p> <p><b>Background:</b> In 2008, the Virginia legislature passed a bill to replace the term “mentally retarded” or “mental retardation” with “intellectual disability” in the state code.</p> <p>At the federal level, in 2003, the President’s Committee on Mental Retardation was renamed the President’s Committee on Intellectual Disabilities by executive order.</p> <p><b><i>Melinda Murray’s Comment:</i></b> The law was named after a child from Edgewater who had Down Syndrome. It officially brings current the language used in the disability community for the last several years, in part because of the negative connotations of the term “mentally retarded.”</p>	5/29
HB 70		<p><b><i>Department of Health and Mental Hygiene – Commissions, Programs and Reports – Revisions</i></b></p> <p><b>Official Synopsis:</b> Repealing provisions establishing the Community Services Advisory Commission; repealing the reporting requirement for the Department of Health and Mental Hygiene regarding the Substance Abuse Treatment Outcomes Partnership Fund; repealing the reporting requirement for the State Advisory Council on Arthritis and Related Diseases; repealing the reporting requirement for the Maryland Medical Advisory Committee; repealing the community choice program; etc.</p>		<p><b>Sponsored by:</b> Delegates Morhaim, Hammen, Pendergrass, Benson, Bromwell, Donoghue, Elliott, Kach, Kipke, Krebs, Kullen, McDonough, Montgomery, Nathan-Pulliam, Oaks, Pena-Melnyk, Reznik, Riley, Tarrant, V. Turner, and Weldon</p> <p><b>Status:</b> <b>PASSED CHAPTER 656</b></p> <p><b>Summary / Analysis:</b></p>	

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HB 113	SB 761	<p><b><i>DHMH – Long-Term Care Supports and Services – Report [title after amendment] [Original title - Interagency Committee on Aging Services – Modifications]</i></b></p> <p><b>Official Synopsis:</b> Requiring the Secretary of Health and Mental Hygiene to submit interim and final reports to the General Assembly by specified dates regarding the feasibility of creating a coordinated care program to reform the provision of long-term care services under the Medical Assistance Program and other State programs designed to meet the differing needs of seniors and adults with disabilities; etc. <b>[Original Synopsis: Altering the membership of the Interagency Committee on Aging Services; requiring the Interagency Committee to make a specified report to the General Assembly on or before January 1, 2010; requiring the Interagency Committee to create specified subcommittees, review specified plans and reports, and identify specified service needs of seniors and adults with disabilities in the State; etc.]</b></p>	Maureen Dove	<p><b>Sponsored by:</b> Delegates Hubbard and Hammen</p> <p><b>Status: PASSED CHAPTER 371</b></p> <p><b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative: “Senate Bill 761/House Bill 113 (both passed)</i> require DHMH to study the feasibility of creating a coordinated care program to reform the provision of Medicaid long-term care services in a manner that improves and integrates the care of individuals to meet the differing needs of seniors and adults with disabilities in the State. DHMH must submit an interim report by September 1, 2009, and a final report by December 1, 2010. The bills require the Secretary of Health and Mental Hygiene to convene specified stakeholders to evaluate and make recommendations related to a Coordinated Care Program. The stakeholder process must include a review of long-term plans, consensus reports, experiences, and best practices in the State and in other states relating to the management and coordination of long-term care supports and services, as well as DHMH’s plan for evaluating the existing home- and community-based services infrastructure. If the General Assembly passes legislation that requires the submission of a federal waiver, DHMH must submit the waiver by June 1, 2011.”</p> <p><b>Maureen Dove’s Comments:</b> The enacted bill, and the substantially similar SB 761, requires the Secretary of DHMH to convene a group of stakeholders to report on the feasibility of creating a coordinated care program to reform the provision of long term care services under the Medical Assistance program and other State programs in a manner that improves and integrates the care of individuals, including health care services, designed to meet the differing needs of seniors and adults with disabilities. An interim report is due December 2009, based on a literature review and to include a process for convening the stakeholders; the final report is due December 2010.</p> <p>The original House Bill would have added several members to the Interagency Committee on Aging Services and required the Committee to submit consensus recommendations to reform the provision of medical assistance program long term care services, including health services designed as necessary to meet the differing needs of seniors and adults with disabilities in the State. SB 761 as submitted would have required DHMH to submit an application for a long term coordinated care waiver.</p>	

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HB 127		<b><i>Death Certificate – Correction – Notice of Right to Appeal Denial</i></b>  <b>Official Synopsis:</b> Requiring the Secretary of Health and Mental Hygiene to include with a copy of a death certificate a specified notice advising a person in interest of the right to appeal a denial of a request to correct findings and conclusions as to the cause and manner of death recorded on a death certificate; and requiring the Department to take a specified action at a specified time.		<b>Sponsored by:</b> Delegates Pena-Melnyk, Benson, Costa, Howard, Hubbard, Kullen, Levi, Nathan-Pulliam, Reznik, Riley, Tarrant, V. Turner, Waldstreicher, and Weldon  <b>Status: PASSED CHAPTER 130</b>  <b>Summary / Analysis:</b>	
HB 141		<b><i>Insurance – Contracts Between Insurers and Health Care Providers - Prohibitions</i></b>  <b>Official Synopsis:</b> Prohibiting insurers and entities that contract with health care providers on behalf of insurers from assigning, transferring, or subcontracting a health care provider’s contract to specified insurers without first informing the health care provider and obtaining the health care provider’s express written consent; etc.	Chris Dean	<b>Sponsored by:</b> Chair, Health and Government Operations Committee (By Request - Departmental - Insurance Administration, Maryland)  <b>Status: PASSED CHAPTER 131</b>  <b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative</i> : “ <b>House Bill 141 (Ch. 131)</b> prohibits an insurer from using an insurance provider panel if the provider contract for the insurer provider panel requires a provider to participate on the insurer provider panel as a condition of participating on an HMO or non-HMO provider panel. An entity arranging an insurer provider panel must provide a health care provider with a schedule of applicable fees for up to the 50 most common services billed by a provider in that specialty at the time of contract, 30 days prior to a change, or upon request.”	
HB 142		<b><i>Insurance – Antifraud Plans</i></b>  <b>Official Synopsis:</b> Requiring health maintenance organizations and third party administrators to institute and maintain a specified antifraud plan; allowing an insurer to require an insured who is receiving benefits under a workers’ compensation insurance policy or a disability insurance policy to affirm periodically continued entitlement to the benefits; etc.		<b>Sponsored by:</b> Chair, Health and Government Operations Committee (By Request - Departmental - Insurance Administration, Maryland)  <b>Status: PASSED CHAPTER 372</b>  <b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative</i> : “Under current law, if an insured has a compensable injury or disability at the time of a claim, insurers have no way to determine if the insured later ceases to be entitled to the benefit. In some cases, an insured no longer entitled to benefits may continue to collect payments, which is insurance fraud subject to existing penalties. In the absence of affirmative statements of continued eligibility, prosecuting these cases of insurance fraud has been difficult for the Maryland Insurance Administration.  Authorized insurers, nonprofit health service plans, and fraternal benefit societies are required to create and file with the Insurance Commissioner an	

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				<p>insurance antifraud plan that includes specific procedures to prevent and report insurance fraud and facilitate prosecution of insurance fraud cases. <i>House Bill 142 (passed)</i> extends this requirement to third-party administrators.</p> <p>In addition, the bill provides that as part of an antifraud plan, authorized insurers may require in writing that individuals receiving disability benefits periodically affirm that they remain entitled to the benefits and have had no change in the condition entitling them to the benefits. An insurer that requires affirmation must disclose to the individual receiving benefits that knowingly and willfully providing false information or knowingly and willfully failing to provide information is a crime subject to a fine and imprisonment.”</p>	
HB 145	SB 481	<p><b>Health Insurance – Dental Provider Panels – Provider Contracts</b></p> <p><b>Official Synopsis:</b> Repealing the exception of provider contracts for dental provider panels from specified provisions of law; requiring a provider contract for a dental provider panel to disclose the carriers comprising each provider panel; prohibiting a provider contract for a dental provider panel from containing a provision requiring a provider to accept specified schedules of fees under specified circumstances; prohibiting a provider contract for a dental provider panel from requiring a provider to treat specified enrollees; etc.</p>		<p><b>Sponsored by:</b> Delegates Kach and Boteler</p> <p><b>Status:</b> <b>PASSED CHAPTER 550</b></p> <p><b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative</i>: “<i>Senate Bill 481/House Bill 145 (both passed)</i> prohibit a provider contract from requiring a provider, as a condition of participating in a fee-for-service dental provider panel, to participate in a capitated dental provider panel. The bills also require the Maryland Insurance Administration to review 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 by December 31, 2009, to the House Health and Government Operations Committee and the Senate Finance Committee”</p>	
HB 235		<p><b>Health Insurance – Rescission of Contracts and Certificates – Restrictions</b></p> <p><b>Official Synopsis:</b> Prohibiting specified carriers from rescinding a contract or certificate under specified circumstances; requiring the carrier to have the burden of persuasion that a rescission complies with specified provisions of the Act; applying provisions of the Act to health maintenance organizations; etc.</p>	Chris Dean	<p><b>Sponsored by:</b> Delegates Tarrant, Bromwell, Kullen, V. Turner, and Weldon</p> <p><b>Status:</b> <b>PASSED, CHAPTER 663</b></p> <p><b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative</i>: “After two years from the date of issue of a policy, no misstatements, except fraudulent misstatements, made by the applicant in the initial application for coverage may be used to void the policy or deny a claim for loss incurred or disability.</p> <p>In 2008, the U.S. House of Representatives Committee on Oversight and Government Reform investigated rescission practices in the individual health insurance market after regulators in California and Connecticut uncovered evidence of improper rescissions.</p>	6/5/09

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				<p><i>Senate Bill 79</i> prohibits an insurer, nonprofit health service plan, or a health maintenance organization that conditions coverage on evidence of individual insurability from rescinding coverage on the basis of written information submitted on or with or omitted from an application unless the carrier completed medical underwriting and resolved all reasonable medical questions related to the written information before issuing the health benefit plan. A carrier must prove that any rescission of a health benefit plan complies with these provisions.</p> <p><i>House Bill 235 (passed)</i> contains identical provisions to the rescission provisions of <i>Senate Bill 79</i>.”</p> <p><i>Chris Dean’s Comments: Chapter 663</i> prohibits an insurer, nonprofit health service plan, or a health maintenance organization that conditions coverage on evidence of individual insurability from rescinding coverage on the basis of written information submitted on or with or omitted from an application unless the carrier completed medical underwriting and resolved all reasonable medical questions related to the written information before issuing the health benefit plan. A carrier must prove that any rescission of a health benefit plan complies with these provisions</p>	
HB 250	SB 759	<p><b><i>Public Health – Authority to Certify Incapacity or Death – Nurse Practitioners</i></b></p> <p><b>Official Synopsis:</b> Authorizing nurse practitioners to make a determination of incapacity or debilitation under specified circumstances; authorizing nurse practitioners to fill out and sign a certificate of death under specified circumstances; authorizing nurse practitioners to certify that specified patients are incapable of making an informed decision under specified circumstances; etc.</p>	Maureen Dove	<p><b>Sponsored by:</b> Delegates Kullen, Eckardt, Bromwell, Kipke, Montgomery, Pena-Melnyk, Reznik, Riley, V. Turner, and Weldon</p> <p><b>Status: PASSED CHAPTER 600</b></p> <p><b>Summary / Analysis: <i>Maureen Dove’s comments:</i></b> The bill was significantly amended from the provisions described in the official synopsis. (1) The provision that would have authorized a nurse practitioner to make a determination of incapacity or debilitation in the guardianship context was removed. (2) The provisions that would have authorized a nurse practitioner to certify in writing that the patient is incapable of making an informed decision in order to make certain health care decisions and to make an advance directive effective were removed.</p> <p>Last year, 2008 Laws Ch. 233 broadened the scope of practice of nurse practitioners in certain circumstances. Among these, nurse practitioners were authorized to fill out a certification of death, <b>when in collaboration with a physician.</b></p> <p>What remains of this bill, as finally adopted, permits a nurse practitioner to certify death, without the requirement of collaboration with a physician.</p>	

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<b>BILL #</b>	<b>CROSS-FILED BILL #</b>	<b>TITLE OF BILL</b>	<b>RESPONSIBLE PERSON</b>	<b>BRIEF DESCRIPTION</b>	<b>DATE OF REVIEW</b>
HB 252	SB 309	<p><b><i>State Board of Pharmacy – Pharmacy Permit – Term and Renewal</i></b></p> <p><b>Official Synopsis:</b> Increasing the term of a pharmacy permit from 1 year to 2 years; and requiring the State Board of Pharmacy to send out a renewal notice within 1 month of the expiration of a pharmacy permit.</p>		<p><b>Sponsored by:</b> Delegate Costa</p> <p><b>Status:</b> <b>PASSED CHAPTER 533</b></p> <p><b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative</i>: “<b><i>Senate Bill 309/House Bill 252 (both passed)</i></b> extend the term of a pharmacy permit from one to two years and require the State Board of Pharmacy to send each permit holder a renewal notice by October 1 of the year in which the permit expires. The bills also remove the requirement that, along with a renewal notice, the board send a renewal application to a permit holder.”</p>	
HB 255	SB 380	<p><b><i>Health Maintenance Organizations – Payments to Nonparticipating Providers</i></b></p> <p><b>Official Synopsis:</b> Altering the rate that health maintenance organizations must pay to specified trauma physicians for specified covered services provided to specified enrollees of the health maintenance organization; requiring health maintenance organizations to pay specified health care providers for specified evaluation and management services no less than a specified rate; etc.</p>		<p><b>Sponsored by:</b> Delegates Pena-Melnyk and Costa</p> <p><b>Status:</b> <b>PASSED CHAPTER 664</b></p> <p><b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative</i>: “In its final report, the Task Force on Health Care Access and Reimbursement recommended changes to the formula used to determine what a health maintenance organization must pay to a nonparticipating provider for covered services provided to an enrollee of a health maintenance organization. <b><i>Senate Bill 380/House Bill 255 (both passed)</i></b> alter these rates. The bills take effect January 1, 2010, and terminate on December 31, 2014. For a nonevaluation and management service, the bills require a health maintenance organization (HMO) to pay noncontracting health care providers no less than 125% of the average rate the HMO paid as of January 1 of the previous calendar year in the same geographic area, to a similarly licensed contracting provider for the same covered service.</p> <p>For covered evaluation and management services, an HMO must pay a noncontracting health care provider at the greater of:</p> <ul style="list-style-type: none"> <li>• 125% of the average rate the HMO paid as of January 1 of the previous calendar year in the same geographic area, for the same covered service, to similarly licensed contracting providers; or</li> <li>• 140% of the Medicare rate for the same covered service, to a similarly licensed provider in the same geographic area as of August 1, 2008, inflated by the Medicare Economic Index.</li> </ul> <p>The bills require an HMO to calculate the average rate paid to similarly licensed providers under written contract with the HMO for the same covered service using a specified calculation (the sum of the contracted rate for all occurrences of the Current Procedural Terminology (CPT) code for that service</p>	

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				<p>divided by the total number of occurrences of the CPT code).</p> <p>The bills also authorize the Maryland Insurance Administration to investigate and enforce a violation of the bills and require the Maryland Health Care Commission to annually review payment to health care providers to determine compliance with the bill and report its findings to the Maryland Insurance Administration.”</p>	
HB 374		<p><b><i>Radiation Therapists, Radiographers, Nuclear Medicine Technologists, and Radiologist Assistants – Renewal Requirements for Licenses</i></b></p> <p><b>Official Synopsis:</b> Repealing a renewal requirement for licensed radiation therapists, radiographers, nuclear medicine technologists, and radiologist assistants; and requiring specified licensees to meet any new license renewal requirements established by the State Board of Physicians</p>		<p><b>Sponsored by:</b> Delegate Reznik</p> <p><b>Status:</b> <b>PASSED CHAPTER 138</b></p> <p><b>Summary / Analysis:</b></p>	
HB 411	SB 492	<p><b><i>Community Mental Health Services Programs – Financial Statements and Salary Information</i></b></p> <p><b>Official Synopsis:</b> Requiring a community mental health services program to submit annually financial statements and salary information in accordance with the Department of Health and Mental Hygiene’s regulations; and authorizing the Mental Hygiene Administration to impose a penalty on a community mental health services program for failing to submit financial statements and salary information.</p>		<p><b>Sponsored by:</b> Delegate Hubbard</p> <p><b>Status:</b> <b>PASSED CHAPTER 73</b></p> <p><b>Summary / Analysis:</b></p>	
HB 412	SB 493	<p><b><i>Mental Health Programs and Facilities – Reports of Death</i></b></p> <p><b>Official Synopsis:</b> Defining the term “program or facility” so as to restrict the application of specified reporting requirements regarding the death of a</p>		<p><b>Sponsored by:</b> Delegate Hubbard</p> <p><b>Status:</b> <b>PASSED CHAPTER 75</b></p> <p><b>Summary / Analysis:</b></p>	

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		mentally ill individual to specified mental health programs and facilities; specifying that specified programs or facilities are required to submit only one report of death; requiring the administrative head of specified nonresidential psychiatric rehabilitation programs to make a report of death to the Director of the Mental Hygiene Administration by a specified time; etc.			
HB 415	SB 874	<p><b><i>Mental Hygiene Administration – Rights of Individuals with Mental Disorders in Facilities</i></b></p> <p><b>Official Synopsis:</b> Altering policies of the State concerning the rights of individuals with mental disorders who receive services in specified facilities; repealing the authority of staff in specified facilities to use a technique to transition individuals to a restraint position; etc.</p>	Maureen Dove	<p><b>Sponsored by: Delegates Kullen, Benson, Costa, Hubbard, Kipke, McDonough, Montgomery, Nathan-Pulliam, Oaks, Pena-Melnyk, Reznik, Tarrant, and V. Turner</b></p> <p><b>Status: PASSED CHAPTER 621</b></p> <p><b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s The 90-Day Report-A Review of 2009 Legislative: “Senate Bill 874/House Bill 415 (both passed) allow an individual in a mental health facility to designate an advocate to participate in the treatment and discharge planning process except when the individual is a child or disabled adult whose parent or legal guardian has requested that a specific advocate not participate. The bills require an individual in a mental health facility to receive treatment in accordance with his or her advance directive and clarify use of restraints. Finally, the bills place conditions on advocate participation and prohibit the bills’ provisions from being construed to grant certain authority not otherwise in law or limit authority established elsewhere in law.”</p> <p><b>Maureen Dove’s Comments:</b> The bill allows individuals in a facility (who are not minors or under legal guardianship) to designate advocates to participate in the patient’s treatment and discharge planning process. The advocate has no legal standing, has no independent right of access to medical records of the patient, and does not replace or limit the authority that “an attorney or other person otherwise has under law to participate in the treatment planning and discharge planning process or to otherwise act of behalf of an individual in a facility.</p> <p>The bill prohibits of use of “prone restraint,” defined as “restricting the free movement of all or a portion of an individual’s body through the use of physical force or mechanical devices while the individual is in a prone position.” Current law already limits restraints or seclusions for use only during an emergency in which the behavior of the individual places the individual or others at serious threat of violence or injury. They must be ordered by a</p>	

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				physician or may be directed by a registered nurse, if a physician's order is obtained within 2 hours. Current law also mandates that the individual be free from a physical restraint or hold that places the individual face down with pressure applied to the back, obstructs the airway of the individual or impairs the individual's ability to breathe; obstructs a staff member's view of the individual's face; or restricts the individual's ability to communicate distress. Techniques for transitioning an individual to a restraint position that involve placing an individual face down or obstructing the view of an individual's face are not prohibited.	
HB 440	SB 439	<b><i>Health Insurance – Prompt Pay – Modifications and Clarifications</i></b>  <b>Official Synopsis:</b> Requiring an insurer, nonprofit health service plan, or health maintenance organization to comply with specified requirements when reprocessing a claim; clarifying that, notwithstanding compliance with specified notice requirements, if an insurer, nonprofit health service plan, or health maintenance organization fails to pay a clean claim or otherwise violates specified provisions of law, the insurer, nonprofit health service plan, or health maintenance organization shall pay interest on a specified amount; etc		<b>Sponsored by:</b> Delegate Bromwell  <b>Status:</b> <b>PASSED CHAPTER 67</b>  <b>Summary / Analysis:</b> As stated in the Maryland General Assembly's <i>The 90-Day Report-A Review of 2009 Legislative</i> : "Errors may occur during the electronic processing of claims submitted by health care providers that result in the initial denial of a claim that was properly submitted (a "clean claim"). The health care provider must then resubmit the claim. <i>Senate Bill 439/House Bill 440 (Chs. 66 and 67)</i> clarify that if a health insurance carrier fails to pay a clean claim for reimbursement or otherwise violates clean claims requirements, the carrier must pay interest on the amount of the claim that remains unpaid 30 days after the receipt of the initial clean claim for reimbursement."	
HB 452	SB 806	<b><i>Business Regulation – Charitable Organizations – Audits and Reviews</i></b>  <b>Official Synopsis:</b> Increasing the minimum gross income amount by which the registration statement of a charitable organization must include an audit by an independent certified public accountant; altering the range of gross income amounts by which the registration statement of a charitable organization must include a review by an independent certified public accountant; and altering the range of gross income amounts by which the Secretary of State may		<b>Sponsored by:</b> Delegates Haddaway, Eckardt, Aumann, Bartlett, Beitzel, Boteler, Burns, Dwyer, Elliott, Elmore, Frank, Harrison, Hecht, Jameson, Jennings, King, Kirk, Krebs, Krysiak, Lafferty, Manno, McComas, McConkey, McHale, Murphy, Myers, Norman, O'Donnell, Riley, Serafini, Shank, Shewell, Smigiel, Sossi, Stocksdale, Stull, Taylor, Vaughn, Walkup, and Wood  <b>Status:</b> <b>PASSED CHAPTER 101</b>  <b>Summary / Analysis:</b> As stated in the Maryland General Assembly's <i>The 90-Day Report-A Review of 2009 Legislative</i> : " <i>Senate Bill 806/House Bill 452 (Chs. 100 and 101)</i> raise the income levels that determine whether a charitable organization in the State must submit an audit or review. Charitable organizations with gross annual incomes of more than \$500,000 from charitable donations must submit an audit performed by an independent certified public accountant (CPA) when registering with the Secretary of State. Charitable	

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		require a specified audit or review of a charitable organization.		organizations with gross incomes between \$200,000 and \$500,000 must submit a review by a CPA; the Secretary of State may require an audit or review if the amount of gross income is less than \$500,000.”	
HB 456	SB 985	<p><b><i>Health Insurance – Coverage for Off-Label Use of Drugs – Standard Reference Compendia</i></b></p> <p><b>Official Synopsis:</b> Altering the definition of “standard reference compendia” for purposes of health insurance coverage for off-label use of drugs.</p>		<p><b>Sponsored by:</b> Delegate Morhaim</p> <p><b>Status:</b> <b>PASSED CHAPTER 113</b></p> <p><b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s The 90-Day Report-A Review of 2009 Legislative: “Off-label use of a drug is the prescription of a medication in a manner different from that approved by the federal Food and Drug Administration. As many as one of every five drugs prescribed in the United States may be for off-label use. Off-label use is particularly prevalent in cancer therapy, where as many as 50% to 75% of all drug uses are off-label.</p> <p>Under Maryland law, if a policy or contract of health insurance provides coverage for drugs, coverage must be provided for an off-label use of the drug if the drug is recognized for treatment in any of the standard reference compendia or in the medical literature. Coverage of an off-label use of a drug must include medically necessary services associated with the administration of the drug. The mandate does not require coverage of a drug if has determined use of the drug to be contraindicated or if the drug is experimental and not approved for any indication. <i>Senate Bill 985/House Bill 456 (Chs. 112 and 113)</i> alter the definition of “standard reference compendia” for purposes of mandated coverage of off-label use of drugs to mean any authoritative compendia as recognized periodically by the federal Secretary of Health and Human Services or the Maryland Insurance Commissioner.”</p>	
HB 462		<p><b><i>Medicaid State Plan and Medical Assistance Program – Amendments and Waiver Applications</i></b></p> <p><b>Official Synopsis:</b> Requiring the Department of Health and Mental Hygiene to publish in the Maryland Register notice of amendments to the Medicaid State Plan or Medical Assistance Program; requiring the Department of Health and Mental Hygiene to submit amendments to the Medicaid State Plan or Medical Assistance Program to the Medicaid Advisory Committee; requiring the Department to make amendments to the</p>	Maureen Dove	<p><b>Sponsored by:</b> Delegates Hubbard, Costa, Kipke, V. Turner, and Weldon</p> <p><b>Status:</b> <b>PASSED CHAPTER 395</b></p> <p><b>Summary / Analysis:</b> <i>Maureen Dove’s Comments:</i> With regard to Medical Assistance requests to the federal government for waivers and changes to waivers, current law requires that DHMH</p> <ol style="list-style-type: none"> <li>1. Publish notice of the requests in the Maryland Register;</li> <li>2. Submit the requests to the Medicaid Advisory Committee for discussion at a Committee meeting; and</li> <li>3. Make the requests available to the public, with an opportunity for public comments.</li> </ol> <p>This bill adds Medicaid State Plan Amendments to the covered documents, and requires DHMH to submit them as well as waiver applications to the</p>	

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		Medicaid State Plan or Medical Assistance Program available to the public and to provide an opportunity for public comment; etc.		Committee within five business days after submission to the federal government.	
HB 510		<p><b><i>Health Occupations – Licensure of Social Workers</i></b></p> <p><b>Official Synopsis:</b> Requiring the State Board of Social Work Examiners to notify applicants for licensure whether the applicants have been approved to take a specified examination within 30 days after the applicant submitted an application to the Board; and altering requirements for a waiver of examination requirements for specified applicants who are licensed or registered to practice social work in other states.</p>		<p><b>Sponsored by:</b> Delegates Nathan-Pulliam, Bromwell, Elliott, Kipke, Kullen, Montgomery, Morhaim, and Riley</p> <p><b>Status:</b> <b>PASSED CHAPTER 87</b></p> <p><b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative</i>: “<b><i>Senate Bill 628/House Bill 510 (Chs. 86 and 87)</i></b> require the Board of Social Work Examiners, when reviewing an application for licensure to practice social work, to notify each applicant of whether the applicant has been approved to take the licensure examination within 60 days after the application was submitted. The board is also required to establish a workgroup of interested stakeholders to examine and make recommendations to the General Assembly regarding the substance of licensure and the process by which licenses are issued.”</p>	
HB 521	SB 464	<p><b><i>Maryland Trauma Physician Services Fund – Rural Trauma Centers</i></b></p> <p><b>Official Synopsis:</b> Altering the definition of trauma center to include Peninsula Regional Medical Center, the Western Maryland Health System, and Washington County Hospital.</p>		<p><b>Sponsored by:</b> Delegates Donoghue, Conway and Mathias</p> <p><b>Status:</b> <b>PASSED CHAPTER 547</b></p> <p><b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative</i>: “<b><i>Senate Bill 464/House Bill 521 (both passed)</i></b> expand eligibility for reimbursement for Level III trauma centers from the Maryland Trauma Physician Services Fund by doubling the maximum number of reimbursable trauma on-call hours annually and authorizing reimbursement for costs incurred to maintain trauma physicians on-call in plastic surgery, major vascular surgery, oral or maxillofacial surgery, and thoracic surgery. Reimbursement is contingent upon availability of funds. Each year by May 1, the Maryland Health Care Commission (MHCC) must determine appropriate levels of payment that can be sustained from the trauma fund given expected revenue. If revenue is insufficient to meet expected payments, MHCC is prohibited from reimbursing Level III trauma centers for more than 35,040 trauma on-call hours or for those practice areas specified under the bills until the remaining costs eligible for reimbursement are fully funded.”</p>	

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HB 526	SB 646	<b><i>Credentialing of Health Care Providers by Managed Care Organizations and Hospitals</i></b>  <b>Official Synopsis:</b> Providing that specified provisions of law relating to credentialing of health care providers by carriers apply to managed care organizations; and requiring the Secretary of Health and Mental Hygiene to designate a specified form as the uniform standard credentialing form for hospitals.		<b>Sponsored by:</b> Delegates Pena-Melnyk and Costa  <b>Status: PASSED CHAPTER 91</b>  <b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative</i> : “Finding that credentialing of health care providers is time consuming and expensive for hospitals and health plans, the Task Force on Health Care Access and Reimbursement recommended that the Maryland Insurance Administration and the Office of Health Care Quality should align their standards using the Council for Affordable Quality Healthcare provider data source. <i>Senate Bill 646/House Bill 526 (Chs. 90 and 91)</i> authorize the Insurance Commissioner to designate as the uniform credentialing form a credentialing application developed by a nonprofit alliance of health plans and trade associations for an online credentialing system if the application is available to providers at no charge and use of the application is not conditioned on submitting the application to a carrier online.”	
HB 576 (Same as SB 602 – but not officially cross-filed)	HB 576	<b><i>Dental Hygienists – Expanded Functions</i></b>  <b>Official Synopsis:</b> Altering the definition of “practice dental hygiene”; authorizing the State Board of Dental Examiners to adopt specified regulations; altering the authority of the Board to adopt rules and regulations concerning the administration of specified anesthesia by dental hygienists; and authorizing dental hygienists to administer specified anesthesia under specified circumstances.	Thomas Pedroni	<b>Sponsored by:</b> Delegates Bromwell, Costa, Donoghue, Elliott, Hammen, Hubbard, Kach, Kullen, Riley, and Weldon  <b>Status: PASSED CHAPTER 566</b>  <b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative</i> : “ <i>Senate Bill 602/House Bill 576 (both passed)</i> expand the scope of practice for a licensed dental hygienist to include specified manual curettage (removal of dead tissue from gums) and the administration of local anesthesia. The bills authorize the Board of Dental Examiners to adopt regulations governing the education, training, evaluation, examination, and administration associated with this expanded scope of practice. The bills also allow more flexibility in the unsupervised clinical hours that dental hygienists may work by making the 60% threshold currently applicable to any given calendar week applicable to a three-month period instead.”  <b>Thomas Pedroni’s Comments:</b> Expands scope of practice for dental hygienists to include administration of local anesthesia and removal of dead tissue from gums. Alters the previous practice pattern significantly.	
HB 580		<b><i>Foster Kids Coverage Act</i></b>  <b>Official Synopsis:</b> Requiring the Maryland Medical Assistance Program to provide health care services for independent foster care adolescents.		<b>Sponsored by:</b> Delegates Mizeur, Carr, Carter, Donoghue, Frick, Haynes, Healey, Hecht, Hixson, Kullen, Lafferty, Levy, Manno, Minnick, Murphy, Oaks, Reznik, Riley, Robinson, Shewell, F. Turner, Waldstreicher, and Weldon  <b>Status: PASSED CHAPTER 681</b>  <b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-</i>	

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				<p><i>Day Report-A Review of 2009 Legislative:</i> “Youth in State foster care receive medical care through Medicaid. However, this coverage often terminates when the youth turns 18 and leaves the foster care system. Many continue to qualify for Medicaid or MCHP through their nineteenth or twenty-first birthdays.</p> <p><b>House Bill 580 (passed)</b> requires Medicaid to provide coverage for independent foster care adolescents who are not otherwise eligible for Medicaid benefits and who have annual household incomes up to 300% of federal poverty guidelines. Independent foster care adolescents are individuals younger than age 21 who, on their eighteenth birthday, were in State foster care.”</p>	
HB 583	SB 304	<p><b>Crimes – Financial Exploitation of Elderly – Penalty</b></p> <p><b>Official Synopsis:</b> Prohibiting a person from knowingly and willfully obtaining by deception, intimidation, or undue influence the property of an individual that the person knows or reasonably should know is at least 68 years old with intent to deprive the individual of the individual’s property.</p>	Maureen Dove	<p><b>Sponsored by:</b> Delegates Kramer, Ali, Barkley, Heller, Kelly, Levi, Manno, McComas, Ramirez, Reznik, Rice, Shank, Simmons, Smigiel, and Valderrama</p> <p><b>Status: PASSED CHAPTER 237</b></p> <p><b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative:</i> “Generally, Maryland criminal law does not provide criminal sanctions based on the age of the victim. <b>Senate Bill 304/House Bill 583 (both passed)</b> expand the prohibition against financial exploitation of vulnerable adults to include persons who are at least 68 years old. The bills prohibit a person from knowingly and willfully obtaining by deception, intimidation, or undue influence the property of an individual that the person knows or reasonably should know is at least 68 years old, with intent to deprive the individual of the individual’s property. The bills are intended to protect seniors that may be vulnerable to exploitation by sales persons, service providers, in-home care providers, or even family and friends because they may be lonely and isolated and may suffer from loss of memory.” A violator is subject to existing penalties applicable when the victim is a vulnerable adult. When the value of the property obtained is \$500 or more, a violator is guilty of a felony and subject to maximum penalties of 15 years imprisonment and/or a \$10,000 fine. When the value of the property is less than \$500, a violator is guilty of a misdemeanor and subject to maximum penalties of 18 months imprisonment and/or a \$500 fine.”</p> <p><b>Maureen Dove’s Comments:</b> Current law (Criminal Law §8-801(b)) makes criminal the knowing and willful obtaining by deception, intimidation, or undue influence the property of an individual that the person knows or reasonably should know is a “vulnerable adult,” with intent to deprive the individual of his or her property. “Vulnerable adult” is defined as an adult who lacks the physical or mental capacity to provide for his or her daily needs. (CL§3-604)</p> <p>This bill makes criminal the same actions, if perpetrated against an individual whom the persons knows or reasonably should know is at least 68</p>	

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				years old.  <i>Comment:</i> Particularly as I get closer to that magic number, I find it insulting and ageist to assume folks 68 and older are incapable of providing for their daily needs.	
HB 585	SB 661	<b><i>Health Insurance – Use of Physician Rating Systems by Carriers</i></b>  <b>Official Synopsis:</b> Providing that a carrier may only use a physician rating system for specified health benefit plans if the system meets specified requirements; providing that a carrier may only use specified categories of measurements in a physician rating system; prohibiting a carrier from rating a physician based solely on cost efficiency; requiring a carrier to calculate and disclose specified measures in a specified manner; etc.		<b>Sponsored by:</b> Delegates Costa and Pena-Melnyk  <b>Status:</b> <b>PASSED CHAPTER 586</b>  <b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative</i> : “ <b><i>Senate Bill 661/House Bill 585 (both passed)</i></b> establish requirements for the Maryland Health Care Commission to approve ratings examiners to review physician rating systems. The bill prohibits health insurance carriers from using a physician rating system unless the system is approved by a ratings examiner. The bills require health insurance carriers to establish an appeals process for physicians to contest a rating in the system and to disclose any changes in evaluations to physicians at least 45 days before making the information available to enrollees. The bills also require the Maryland Insurance Administration to report annually to the Governor and the General Assembly on the number and types of appeals that have been filed by physicians with carriers regarding an evaluation in a physician rating system and the number of entities that the Maryland Health Care Commission has approved as ratings examiners. The bills take effect January 1, 2010.”	
HB 597	SB 433	<b><i>State Board of Physicians – Polysomnographic Technologists – Education and Licensing Requirements</i></b>  <b>Official Synopsis:</b> Requiring the State Board of Physicians by September 30, 2012, to waive specified education requirements for polysomnographic technologists who meet specified requirements; and altering to October 1, 2012, the date by which an individual must be licensed before the individual may practice polysomnography in the State.		<b>Sponsored by:</b> Delegate Benson  <b>Status:</b> <b>PASSED CHAPTER 262</b>  <b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative</i> : “Chapter 595 of 2006 required the State Board of Physicians to license and regulate the practice of polysomnography – the monitoring and recording of physiologic data during sleep, including sleep-related respiratory disturbances. <b><i>Senate Bill 433/House Bill 597 (both passed)</i></b> delay the date by which a polysomnographic technologist must be licensed by the State Board of Physicians in order to practice in the State until October 1, 2011, and extend the date by which licensure applicants can fulfill the requirements for a waiver of education requirements.”	
HB 610	SB 638	<b><i>Health Insurance – Discrimination or Rebates – Bona Fide Wellness Programs</i></b>  <b>Official Synopsis:</b> Altering the conditions under which it is not discrimination or a	Chris Dean	<b>Sponsored by:</b> Delegate Morhaim  <b>Status:</b> <b>PASSED, CHAPTER 682</b>  <b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative</i> : “ <b><i>Senate Bill 638/House Bill 610</i></b>	6/14/09

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		rebate for an insurer, a nonprofit health service plan, a health maintenance organization, or a dental plan organization to provide reasonable incentives for participation in a bona fide wellness program; providing that it is not discrimination or a rebate for a carrier to provide reasonable incentives for participation in a bona fide wellness program if the bona fide wellness program satisfies specified requirements; etc.		<p><i>(both passed)</i> authorize a carrier to provide reasonable incentives to an insured, subscriber, or member for participation in a bona fide wellness program under specified circumstances and clarify that it is not discrimination or a rebate for a carrier to provide such incentives if the incentives are provided as specified. The definition of “bona fide wellness program” is expanded to include programs designed to promote health or prevent and control injury, but no longer includes promoting healthy lifestyle choices. “Health factor” means health status, medical condition, claims experience, receipt of health care, medical history, evidence of insurability, or disability. “Incentive” means a discount of a premium or contribution, a waiver of all or part of a cost-sharing mechanism, the absence of a surcharge, the value of a benefit that would otherwise not be provided, or a specified rebate. The definition of “wellness benefit” in the small group health insurance market is also altered to conform to the provisions of the bills.</p> <p>A carrier may not make participation in a bona fide wellness program a condition of coverage. Participation must be voluntary, and a penalty may not be imposed on an insured, subscriber, or member for nonparticipation. A carrier may not market the bona fide wellness program solely as an incentive or inducement to purchase coverage from the carrier. A bona fide wellness program may not condition an incentive on an individual satisfying a standard related to a health factor except as specified.</p> <p>Incentives may be based on an individual satisfying a standard related to a health factor if (1) all incentives for participation do not exceed 20% of the cost of specified coverage under the plan; (2) the program is reasonably designed to promote health or prevent disease; (3) the program gives individuals the opportunity to qualify for the incentive at least annually; (4) the program is available to all similarly situated individuals; and (5) individuals are provided a reasonable alternative standard or a waiver of the standard.</p> <p>A bona fide wellness program must be construed to be reasonably designed to promote health or prevent disease if the program (1) has a reasonable chance of improving the health of or preventing disease in participating individuals; (2) is not overly burdensome; (3) is not a subterfuge for discriminating based on a health factor; and (4) is not highly suspect in the method chosen to promote health or prevent disease.</p> <p>A carrier must provide a reasonable alternative standard or a waiver of the standard for any individual for whom it is unreasonably difficult due to a medical condition or medically inadvisable to attempt to satisfy the otherwise applicable standard. A carrier may seek verification that a health factor makes it</p>	

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				<p>unreasonably difficult or medically inadvisable to satisfy or attempt to satisfy the otherwise applicable standard. A carrier must disclose the availability of a reasonable alternative standard or waiver. A denial by a carrier of a request for an alternative standard or waiver of a standard constitutes an adverse decision.</p> <p>The Insurance Commissioner may request a review of a carrier’s bona fide wellness program by an independent review organization to determine if the program meets the bills’ requirements. The expense of the review must be paid by the carrier.”</p> <p><b>Chris Dean’s Comments:</b> <i>Chapter 683</i> authorizes a carrier to provide reasonable incentives to an insured, subscriber, or member for participation in a bona fide wellness program under specified circumstances. The new law clarifies that it is not discrimination or a rebate for a carrier to provide these incentives. The new law also clarifies that a carrier includes an insurer, a nonprofit health services plan, a health maintenance organization or a dental plan organization.</p> <p>The federal Health Insurance Portability and Accountability Act (HIPAA) nondiscrimination provisions generally prohibit a carrier from charging similarly situated individuals different premiums or contributions based on a health factor. However, the HIPAA nondiscrimination provisions permit a carrier to provide incentives for health promotion and disease prevention programs. The bona fide wellness program law was structured to comply with these HIPAA nondiscrimination provisions.</p> <p>A "bona fide wellness program" is a program designed to promote health or prevent or detect disease or illness. Bona fide wellness program includes programs designed to reduce or avoid poor clinical outcomes, prevent complications from medical conditions, promote healthy behavior or prevent and control injury. Bona fide wellness programs no longer include promoting healthy lifestyle choices, which had existed under the previous law.</p> <p>“Incentive” means a discount of a premium or contribution, a waiver of all or part of a cost-sharing mechanism, the absence of a surcharge, the value of a benefit that would otherwise not be provided, or a rebate.</p> <p>A carrier may not make participation in a bona fide wellness program a condition of coverage and participation must be voluntary. A penalty may not be imposed on an insured, subscriber, or member for nonparticipation, notwithstanding that non-participants do not get the benefit of the incentives available to participants.</p>	

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				<p>A carrier may not market the bona fide wellness program in a manner where that marketing's primary purpose is to induce the purchase of coverage from that carrier.</p> <p>The new law generally prohibits bona fide wellness programs from using health factors, which includes an individual's health status, medical condition, claims experience, receipt of health care, medical history, evidence of insurability, or disability, as a standard to determine an incentive.</p> <p>Notwithstanding the foregoing, broad exceptions to the general rule permit incentives that require an individual to satisfy a standard related to a health factor if (1) all incentives for participation do not exceed 20% of the cost of specified coverage under the plan; (2) the program is reasonably designed to promote health or prevent disease; (3) the program gives individuals the opportunity to qualify for the incentive at least annually; (4) the program is available to all similarly situated individuals; and (5) individuals are provided a reasonable alternative standard or a waiver of the standard.</p> <p>A bona fide wellness program must be construed to be reasonably designed to promote health or prevent disease if the program (1) has a reasonable chance of improving the health of or preventing disease in participating individuals; (2) is not overly burdensome; (3) is not a subterfuge for discriminating based on a health factor; and (4) is not highly suspect in the method chosen to promote health or prevent disease.</p> <p>A carrier must provide a reasonable alternative standard or a waiver of the standard for any individual for whom it is unreasonably difficult due to a medical condition or medically inadvisable to attempt to satisfy the otherwise applicable standard. A carrier may seek verification that a health factor makes it unreasonably difficult or medically inadvisable to satisfy or attempt to satisfy the otherwise applicable standard. A carrier must disclose the availability of a reasonable alternative standard or wavier. A denial by a carrier of a request for an alternative standard or waiver of a standard constitutes an adverse decision.</p> <p>The Insurance Commissioner may request a review of a carrier's bona fide wellness program by an independent review organization. The expense of the review must be paid by the carrier.</p> <p>The definition of "wellness benefit" in the small group health insurance market is also altered with this law.</p>	

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HB 635		<p><b><i>Criminal Procedure – Occupational Licenses or Certificates – Issuance of a Certificate of Employability</i></b></p> <p><b>Official Synopsis:</b> Requiring specified State departments, boards, or commissions that issue occupational licenses or certificates to follow specified procedures in deciding whether to issue a license or certificate to an applicant who has been issued a certificate of employability; establishing specified procedures for a court or the Maryland Parole Commission to issue a certificate of employability to an eligible offender who commits a nonviolent offense; etc.</p>		<p><b>Sponsored by:</b> Delegates Levi, Anderson, Barnes, Burns, Carr, Carter, Conaway, Dumais, Gutierrez, Healey, Reznik, Riley, Robinson, Ross, Schuler, F. Turner, and Valderrama</p> <p><b>Status:</b> <b>PASSED CHAPTER 686</b></p> <p><b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative</i>: “<b>House Bill 635 (passed)</b> prohibits a department from denying an occupational license or certificate to an applicant solely on the basis that the applicant has previously been convicted of a crime, other than a crime of violence, unless the department determines that (1) there is a direct relationship between the applicant’s previous conviction and the specific occupational license or certificate sought; or (2) the issuance of the license or certificate would involve an unreasonable risk to property or to the safety or welfare of specific individuals or the general public. The bill defines “department” as the Maryland Department of Agriculture; the Maryland Department of the Environment; the Department of Health and Mental Hygiene; the Department of Human Resources; the Department of Labor, Licensing, and Regulation; or the Department of Public Safety and Correctional Services, or any unit of one of these agencies. The bill also states that it is the policy of the State to encourage the employment of nonviolent ex-offenders and remove barriers to their ability to demonstrate fitness for occupational licenses or certifications required by the State.”</p>	
HB 654	SB 951	<p><b><i>Health Occupations – License to Practice Psychology – Doctoral Degree in Psychology</i></b></p> <p><b>Official Synopsis:</b> Clarifying specified qualifications of applicants for a license to practice psychology in the State; and altering the definition of “doctoral degree in psychology.”</p>		<p><b>Sponsored by:</b> Delegate Hubbard</p> <p><b>Status:</b> <b>PASSED CHAPTER 330</b></p> <p><b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative</i>: “<b>Senate Bill 951/House Bill 654 (both passed)</b> alter the definition of a doctoral degree in psychology to expand the types of doctoral programs the State Board of Examiners of Psychology may recognize as qualifying an applicant for a license to practice psychology in the State. A qualifying degree may be accredited by the Canadian Psychological Association or meet the qualifying criteria determined by the Council for the National Register of Health Service Providers in Psychology if the degree was received from a doctoral program in psychology that meets specified requirements. The bills also repeal the requirement that at least one year of required supervised professional experience occur after a doctoral degree has been awarded.”</p>	

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HB 705	SB 862	<p><b>Child Fatality Review – Child Death Review Case Reporting System</b></p> <p><b>Official Synopsis:</b> Authorizing members and staff of specified State teams to provide identifying information to a national center for child death review in accordance with data use agreements that require the national center to act as a fiduciary agent of certain State and local teams; and establishing that specified information provided to a national center for child death review is confidential and subject to specified confidentiality and discovery protections.</p>	Maureen Dove	<p><b>Sponsored by:</b> Delegates Pen-Melnyk and Ivey</p> <p><b>Status:</b> <b>PASSED CHAPTER 108</b></p> <p><b>Summary / Analysis: Maureen Dove’s Comments:</b> SB 862 permits members of State or local child death review team to share identifying information, which is otherwise confidential, with the national center for child death review, under the conditions that:</p> <ol style="list-style-type: none"> <li>1. the information is provided under a data use agreement;</li> <li>2. the agreement authorizes access to identifiable information to the State team;</li> <li>3. the agreement authorizes the national center for child death review to access only de-identified information;</li> <li>4. the agreement requires the national center to act as a fiduciary agent of the State and local teams.</li> </ol> <p><b>Note:</b> The bill seems to contain contradictory provisions, or I am misreading it. It permits the State Team to “provide identifying information to a national center for child death review in accordance with a data use agreement.” (HG 5-704(d) (2)). The data use agreement must authorize access to identifiable information only to the state team, and authorize the national center “to access only de-identified information.” (HG 5-704(d)(1)(1) and (2)).</p>	
HB 706	SB 744	<p><b>Electronic Health Records – Regulation and Reimbursement</b></p> <p><b>Official Synopsis:</b> Requiring the Maryland Medical Assistance Program to reimburse specified health care providers in accordance with specified provisions of the Act; requiring the Maryland Health Care Commission, in consultation with the Department of Health and Mental Hygiene and the Maryland Insurance Administration, to adopt specified regulations on or before a specified date requiring specified payors to include specified costs in a specified reimbursement structure; etc</p>	Emily Wein	<p><b>Sponsored by:</b> Delegate Pen-Melnyk</p> <p><b>Status:</b> <b>PASSED CHAPTER 689</b></p> <p><b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative</i>: “<b>House Bill 706 (passed)</b> requires the Maryland Health Care Commission (MHCC) to adopt regulations requiring the State Employee and Retiree Health and Welfare Benefits Program and carriers that issue or deliver health benefit plans in the State (“State-regulated payors”) to provide incentives to providers to promote the adoption and meaningful use of EHR. Any incentives must have monetary value, facilitate the use of EHR, recognize and be consistent with existing payor incentives, and take into account certain federal incentives. MHCC and the Health Services Cost Review Commission (HSCRC) must designate a State health information exchange (HIE), while MHCC has to designate one or more management service organizations to offer EHR services. Beginning the later of January 1, 2015, or the date established for the imposition of penalties under ARRA, each provider using EHR that seeks payment from a State-regulated payor must use EHR that are certified by a national certification organization designated by</p>	

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				<p>MHCC and capable of connecting to and exchanging data with the State HIE. State-regulated payors may reduce payments to health care providers for noncompliance with these requirements.</p> <p><i>House Bill 706</i> also requires HSCRC, in consultation with hospitals, payors, and the federal Centers for Medicare and Medicaid Services (CMS), to assure that hospitals receive payments provided under ARRA and implement any changes in hospital rates required by CMS to ensure compliance with ARRA. DHMH, in consultation with MHCC, has to develop a mechanism to assure that health care providers that participate in Medicaid receive the payments provided for adoption and use of EHR technology under ARRA.”</p> <p><i>Emily Wein’s Comments:</i> Pursuant to this bill, the Health General, Insurance, and State Personnel and Pensions articles are amended to add provisions requiring the Maryland Health Care Commission, on or before Oct. 1, 2010, to adopt regulations that require state-regulated payors to include the costs of electronic health records in their reimbursement structure for health providers. The Commission must also designate a health information exchange between health care providers and other health services organizations that incorporates federal and state privacy rules and makes its services available to health care providers, state-regulated payors and other health care services organizations. The “exchange” is a statewide infrastructure that provides organization and technical capabilities to enable the electronic exchange of health information between health car providers and other health services organization authorized by the Commission.</p> <p>The Commission will determine the amount of additional reimbursement to be required pursuant these regulations but may not require such for any hospital regulated by the HSCRC. If federal law is amended to allow the state to regulate self-insured entities and Medicare, the Commissions regulations will apply to such.</p> <p>On or before Oct. 1, 2012, the Commission must adopt regulations that specify certification requirements for electronic health records which will include requirements that such records meet any applicable federal law requirements. The Commission must designate a management service organization to offer hosted electronic health records and other management services throughout the state and may use grants and loans from the federal government to subsidize the use of this organization by health care providers.</p> <p>On or after, October 1, 2013, every health car providers in the state shall use electronic health records that are certified in accordance with the Commission’s</p>	

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				standards and are interoperable with, are connected to, and exchange data with the health information exchange designated by the Commission.  On or after October 1, 2014, a state regulated payor may not reimburse a health care provider that does not meet the electronic health record requirement summarized above. Again, if federal law is amended to allow state regulation of self-insured entities and Medicare, this provision will apply to such. On or after Oct. 1, 2014, a hospital regulated by the HSCRC that does not meet the above electronic health record requirements may not be reimbursed by any payor for health care services.	
HB 725	SB 791	<b><i>Group Model Health Maintenance Organizations – Drug Therapy Management</i></b>  <b>Official Synopsis:</b> Requiring licensed physicians and licensed pharmacists who provide drug therapy management to patients in a group model health maintenance organization to have a physician-pharmacist agreement approved by the State Board of Pharmacy and the State Board of Physicians in place; requiring physician-pharmacist agreements to prohibit substitutions of chemically dissimilar drug products, subject to specified exceptions; etc.		<b>Sponsored by:</b> Delegates Tarrant, Benson, Bromwell, Costa, Pena-Melnyk, Reznik, Riley, and V. Turner  <b>Status: PASSED CHAPTER 315</b>  <b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative</i> : “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. <i>Senate Bill 791/House Bill 725 (both passed)</i> exempt group model health maintenance organizations from this law and set standards for licensed physicians and licensed pharmacists who wish to provide drug therapy management to patients in a group model health maintenance organization. For a further discussion of <i>Senate Bill 791/House Bill 725</i> , see the subpart “Health Insurance” within this part of this <i>90 Day Report</i> ”.	
HB 739	SB 952	<b><i>Maryland Medical Assistance Program – Substance Abuse Services</i></b>  <b>Official Synopsis:</b> Requiring that individuals receiving specified Maryland Medical Assistance Program benefits receive specified substance abuse benefits; authorizing the Governor in fiscal year 2010 to transfer by State budget amendment \$6,700,000 for a specified substance abuse benefit and to increase specified fees; requiring the Governor to provide specified funding in fiscal year 2011 and each fiscal year thereafter to provide specified substance abuse benefits; etc.	Chris Dean	<b>Sponsored by:</b> Delegates Hammen, Kach, Morhaim, and Pendergrass  <b>Status: PASSED, CHAPTER 332</b>  <b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative</i> : “ <i>Senate Bill 952/House Bill 739 (both passed)</i> require substance abuse services equivalent to those provided to adults under the Medicaid program to be provided to adults covered under PAC. In fiscal 2010, the bills authorize the Governor to transfer \$3.3 million in general or special funds from the Alcohol and Drug Abuse Administration (ADAA) to Medicaid to provide substance abuse services under PAC and to increase the rates paid to providers for substance abuse services provided through PAC and Medicaid. Beginning in fiscal 2011, the bills require the Governor to include sufficient funding to provide these services. Separate budget action restricted fiscal 2010 funds in the Alcohol and Drug Abuse Administration budget for these same purposes. In addition, the bills require	6/14/09

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				<p>MCOs to submit specific information regarding substance abuse treatment services. The Department of Health and Mental Hygiene (DHMH) has to collaborate with MCOs to establish a process and criteria to qualify certified addiction treatment programs as paneled providers.”</p> <p><b>Chris Dean’s Comments:</b> <b>Chapter 331</b> requires substance abuse services equivalent to those provided to adults under the Medicaid program to be provided to adults covered under the Primary Adult Care Program (PAC). According to the fiscal and policy note, this law will require \$3.3 million in FY 2010 and an additional \$28.8 million for FY 2011 to FY 2014.</p> <p>For fiscal year 2010, the General Assembly authorized the Governor to transfer \$3.3 million in general or special funds from the Alcohol and Drug Abuse Administration (ADAA) to Medicaid to provide substance abuse services under PAC and to increase the rates paid to providers for substance abuse services provided through PAC and Medicaid. Beginning in fiscal year 2011, the Governor must include sufficient funding to provide these services.</p> <p>The new law requires Managed Care Organizations (MCOs) to submit specific information regarding substance abuse treatment services. The Department of Health and Mental Hygiene also has to collaborate with MCOs to establish a process and criteria to qualify certified addiction treatment programs as paneled providers.</p>	
HB 756		<p><b><i>Cultural and Linguistic Health Care Provider Competency Program</i></b></p> <p><b>Official Synopsis:</b> Establishing a Cultural and Linguistic Health Care Provider Competency Program; providing for the purpose of the Program; requiring the Program to operate through specified professional associations; requiring specified professional societies to develop a specified training program; providing for the funding for the Program; requiring the Office of Minority Health and Health Disparities to convene a specified workgroup; etc.</p>		<p><b>Sponsored by:</b> Delegates Nathan-Pulliam, Ali, Benson, Braveboy, Gutierrez, Haynes, Ivey, Kaiser, Lee, Levy, Montgomery, Pena-Melnyk, Ramirez, Reznik, Taylor, and Valderrama</p> <p><b>Status:</b> <b>PASSED CHAPTER 414</b></p> <p><b>Summary / Analysis:</b></p>	

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HB 843		<p><b><i>Continuing Care Retirement Communities – Subscriber Complaints and Investigations</i></b></p> <p><b>Official Synopsis:</b> Adding to the requirements for a continuing care retirement community’s internal grievance procedure; shortening the time frame within which specified subscribers have the right to meet with management of a provider; authorizing subscribers to submit a specified request to the Long-Term Care Ombudsman under specified circumstances; requiring the Long-Term Care Ombudsman to provide specified written conclusions to specified individuals and to the Department of Aging; etc.</p>	Howard Sollins	<p><b>Sponsored by:</b> Delegates Love, Cardin, Costa, Kipke, Lafferty, Montgomery, Simmons, Stein, V. Turner, Kullen, Pena-Melnk, Nathan-Pulliam, Morhaim, Donoghue, Kach, McDonough, Benson, Tarrant, and Oaks</p> <p><b>Status:</b> <b>PASSED CHAPTER 694</b></p> <p><b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative</i>: “Continuing care retirement communities (CCRCs) offer a full range of housing, residential services, and health care in order to serve older residents as their medical needs change over time. CCRCs are required to establish internal grievance procedures. <b>House Bill 843 (passed)</b> expands the required components for internal grievance procedures and allows subscribers and providers to seek nonbinding mediation within 30 days after the conclusion of an internal grievance procedure. Internal grievance procedures must at least allow a subscriber or group of subscribers to submit a written complaint, require the provider to assign personnel to investigate the grievance, and give a subscriber the right to meet with management within 30 days after submission of a written grievance.”</p> <p><b>HL Sollins Comments:</b> This bill shortens the time for a meeting with management from 45 to 30 days. Mediation is before a Community Mediation Center or another mediation provider. Mediation is nonbinding and counsel may not represent a party.</p>	
HB 952	SB 778	<p><b><i>Continuing Care Agreements and Related Agreements</i></b></p> <p><b>Official Synopsis:</b> Requiring the Department of Aging to review and approve or disapprove specified continuing care agreements and any other related agreements within 120 days; authorizing the Department to submit comments to or request additional information from a provider who has submitted agreements to the Department; providing for the suspension of the 120-day review period if the Department submits comments or a request for additional information; etc.</p>	Howard Sollins	<p><b>Sponsored by:</b> Delegates Hubbard, Costa, Krebs and Weldon</p> <p><b>Status:</b> <b>PASSED CHAPTER 750</b></p> <p><b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative</i>: “The Maryland Department of Aging regulates CCRCs, including providing approval of continuing care agreements – an agreement between a provider and a subscriber to provide continuing care. <b>House Bill 952 (passed)</b> requires the department to review continuing care agreements or any other related agreements within 120 days of receipt, instead of the current 180 days. However, if the department submits comments or requests additional information from the provider, the 120-day review period is frozen until the requested information is received. If a provider seeks to modify an approved agreement, the department must limit its review to that modification.”</p> <p><b>HL Sollins comment:</b> Failure of the DOA to act within 120 days will result in deemed approval of the agreement. Separate assisted living and comprehensive care agreements need not be approved by the DOA.</p>	

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HB 1071	SB 854	<p><b>Health Insurance – Definition of Coverage Decisions – Pharmacy Inquiries</b></p> <p><b>Official Synopsis:</b> Altering the definition of “coverage decision” so that it does not include a pharmacy inquiry for purposes of a specified complaint process; etc.</p>		<p><b>Sponsored by:</b> Delegate Kach</p> <p><b>Status:</b> <b>PASSED CHAPTER 104</b></p> <p><b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative</i>: “When filling a prescription for a patient, a pharmacist or pharmacy staff member may call a carrier or pharmacy benefits manager (PBM) to inquire as to whether a particular medication is covered, whether prior authorization is required, or what the appropriate copayment amount is. <i>Senate Bill 854/House Bill 1071 (Chs. 103 and 104)</i> exclude a “pharmacy inquiry” from the definition of coverage decision for purposes of the internal appeals process for carrier coverage decisions and subsequent complaints to the Maryland Insurance Commissioner. A “pharmacy inquiry” is defined as an inquiry submitted by a pharmacist or pharmacy on behalf of a member to a carrier or a PBM at the point of sale about the scope of pharmacy coverage, pharmacy benefit design, or formulary under a health benefit plan.”</p>	
HB 1150		<p><b>Health Occupations – Anatomic Pathology Services – Billing</b></p> <p><b>Official Synopsis:</b> Requiring a clinical laboratory, a physician, or a group practice that provides anatomic pathology services on a PAP test specimen for a patient in the State to present a bill for services to a specified referring physician under specified circumstances.</p>	Emily Wein	<p><b>Sponsored by:</b> Delegate Donoghue</p> <p><b>Status:</b> <b>PASSED CHAPTER 163</b></p> <p><b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative</i>: “<i>House Bill 1150 (Ch. 163)</i> authorizes a clinical laboratory, a physician, or a group practice that provides anatomic pathology services for a patient in Maryland to bill the health care practitioner who orders but does not supervise or perform an anatomic pathology service on a Pap test specimen provided that the health care practitioner complies with specific disclosure and ethics requirements. The bill also authorizes a health care practitioner who collects a Pap specimen to bill a patient or payor for the service as long as the same disclosure and ethics requirements are met.”</p> <p><b>Emily Wein’s Comments:</b> Pursuant to this bill, § 1-306 of the Health Occupations Bill is amended to require a provider that provides an anatomic pathology service for a patient to present a claim or bill to a health care practitioner who orders but does not supervise or perform an anatomic pathology service on a Pap test specimen provided the health care practitioner complies with disclosure requirements specified in § 14-404(A)(16) and the AMA’s ethical policies that relate to referring physicians billing for laboratory services. In addition, the section specifies that a health care practitioner who takes a Pap test specimen from a patient and who orders but does not supervise or perform an anatomic pathology service on the specimen is not prohibited</p>	

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				from billing a patient or payor for the service provided by the practitioner.	
HB 1194		<p><b><i>Open Meetings Act – Expansion of Definition of Public Body</i></b></p> <p><b>Official Synopsis:</b> Expanding the definition of “public body” under the Open Meetings Act to include specified entities appointed by specified public bodies or officials of the public bodies if the membership of the entity has a specified composition.</p>	Howard Sollins	<p><b>Sponsored by:</b> Delegates Benson, Weldon, Bromwell, and Costa</p> <p><b>Status:</b> <b>PASSED CHAPTER 164</b></p> <p><b>Summary / Analysis:</b></p> <p><b><i>HL Sollins comment:</i></b> This is potentially a very significant bill, as it would expose to Public Meetings Requirements a broader array of entities that are not typically considered units of government. As originally proposed it would have had a broader impact. Now applies to boards, commissions, or committees that are appointed by certain entities or officials in the Executive Branch of State government and include certain members.</p>	
HB 1195		<p><b><i>Prescription Drugs – Wholesale Drug Distribution – Surety Bond Requirements</i></b></p> <p><b>Official Synopsis:</b> Altering surety bond requirements for an applicant for a wholesale distributor permit; specifying the entity to which the surety bond is payable; specifying the amount of the surety bond, depending on the receipts of the applicant; and making the Act an emergency measure.</p>		<p><b>Sponsored by:</b> Delegates Montgomery, Bartlett, Bobo, Carr, G. Clagett, Hecht, Hucker, Manno, Rice, Robinson, and Stull</p> <p><b>Status:</b> <b>PASSED CHAPTER 170</b></p> <p><b>Summary / Analysis:</b></p> <p><b><i>HL Sollins comment:</i></b> Amount is tied to gross receipts. Enforced by Pharmacy Board. Alternative security to bond may be approved. Grandfather provision included. Effective April 14, 2009.</p>	
HB 1273		<p><b><i>Criminal Law – Limited Immunity – Seeking Medical Assistance for Alcohol or Drug-Related Overdose</i></b></p> <p><b>Official Synopsis:</b> <b>SUBSTANTIALLY AMENDED FROM THIS TEXT</b> Providing that a person who seeks medical assistance for a person experiencing an alcohol or a drug-related overdose may not be charged with or prosecuted for possession of drugs under specified circumstances; providing that a person who seeks medical assistance for a person experiencing an alcohol or a drug-related overdose may not be detained on an outstanding warrant for another nonviolent crime under specified circumstances; etc.</p>	Howard Sollins	<p><b>Sponsored by:</b> Delegates Valderrama, Anderson, Barnes, Carter, Conaway, Dumais, Gutierrez, Kramer, Lee, Ramirez, Rosenberg, Schuler, and Vallario</p> <p><b>Status:</b> <b>PASSED CHAPTER 714</b></p> <p><b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative</i>: “<b>House Bill 1273 (passed)</b> provides that the act of seeking medial assistance for another person who is experiencing a medical emergency after ingesting alcohol or drugs may be used as a mitigating factor in a criminal prosecution”</p> <p><b><i>HL Sollins comment:</i></b> Original bill substantially amended so that the synopsis was substantially amended. The act of seeking medical assistance for a another person who is experiencing an alcohol or a drug-related overdose a medical emergency after ingesting alcohol or drugs may be used as a mitigating factor in a criminal prosecution.</p>	

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HB 1347		<p><b><i>Criminal Procedure – Drug or Alcohol Abuse – Court-Ordered Evaluation and Treatment of Defendant</i></b></p> <p><b>Official Synopsis:</b> Authorizing a circuit court or the District Court to extend probation for a defendant for a specified period of time for the purpose of a commitment to the Department of Health and Mental Hygiene for drug or alcohol abuse treatment; requiring the Division of Parole and Probation to supervise the defendant’s extended probation period; altering the circumstances under which a court may order the Department to evaluate a defendant for drug treatment; etc.</p>		<p><b>Sponsored by:</b> Delegate Anderson</p> <p><b>Status:</b> <b>PASSED CHAPTER 720</b></p> <p><b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative</i>: “<b>House Bill 1347 (passed)</b> specifies that for the purpose of commitment of an individual to the Department of Health and Mental Hygiene (DHMH) under the provision of law authorizing substance abuse treatment as an alternative to incarceration, a court may extend probation for one year beyond the usual maximum time period of five years in circuit court or three years in District Court. The extended probation must be under the supervision of the Division of Parole and Probation. The court may extend probation only if the defendant consents in writing and the extension is only for a commitment to DHMH for treatment. The bill also clarifies that a court ordered alcohol or drug abuse evaluation or commitment of a criminal defendant may occur before or after sentencing or before or during a term of probation.”</p>	
HB 1460	SB 789	<p><b><i>State Board of Chiropractic and Massage Therapy Examiners – Massage Therapy Advisory Committee</i></b></p> <p><b>Official Synopsis:</b> Reestablishing the Massage Therapy Advisory Committee under the State Board of Chiropractic and Massage Therapy Examiners; specifying the membership and duties of the Advisory Committee; making the Act an emergency measure; etc.</p>		<p><b>Sponsored by:</b> Delegate Hubbard</p> <p><b>Status:</b> <b>PASSED CHAPTER 313</b></p> <p><b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative</i>: “Chapter 243 of 2008 renamed the Board of Chiropractic Examiners as the Board of Chiropractic and Massage Therapy Examiners and repealed the Massage Therapy Advisory Committee. Three licensed massage therapists and one chiropractor were added to the board’s membership, which previously had no massage therapist members. While the Massage Therapy Advisory Committee was repealed with the bill’s October 1, 2008 effective date, the terms of the massage therapy board members do not begin until July 1, 2009. <b>Senate Bill 789/House Bill 1460 (both passed)</b> authorize the massage therapy members of the board to begin their terms two months earlier on May 1, 2009.”</p>	
HB 1468		<p><b><i>Public Health Surveillance – Confidentiality</i></b></p> <p><b>Official Synopsis:</b> Expanding requirements for confidentiality relating to specified reports on specified conditions or diseases by physicians, institutions, and specified medical laboratories so as to require that all information collected in connection with a report, the subject of the report, or other</p>	Maureen Dove	<p><b>Sponsored by:</b> Chair, Health and Government Operations Committee (By Request - Departmental - Health and Mental Hygiene)</p> <p><b>Status:</b> <b>PASSED CHAPTER 470</b></p> <p><b>Summary / Analysis:</b> <b>Maureen Dove’s Comments:</b> Current law mandates that patients with a condition or infection or contagious disease that endangers public health and has been designated by DHMH as reportable must be reported to DHMH by (1) physicians, (2) institutions (including hospitals and lodging facilities) and (3) a medical laboratories. The information is confidential and</p>	

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		individuals who might be affected by the condition or disease in the report are subject to the requirements; making specified exceptions; etc.		not open to public inspection. This bill strengthens the confidentiality protections and mandates that the information reported is: <ol style="list-style-type: none"> <li>1. confidential</li> <li>2. not a medical record</li> <li>3. not open to public inspection; and</li> <li>4. not discoverable or admissible in evidence in any civil or criminal matter except in accordance with a court order sealing the court record.</li> </ol>	
HB 1472		<p><b>Health Insurance – Senior Prescription Drug Assistance Program – Funding</b></p> <p><b>Official Synopsis:</b> Clarifying that the transfer of funds that a specified nonprofit health service plan is required to make to the Senior Prescription Drug Assistance Program is in addition to the subsidy a nonprofit health service plan is required to provide to the Program; clarifying that the transfer of funds is not subject to specified limitations imposed on the amount of the subsidy a nonprofit health service plan is required to provide to the Program; etc.</p>		<p><b>Sponsored by:</b> Chair, Health and Government Operations Committee (By Request - Departmental - Health Insurance Plan)</p> <p><b>Status:</b> <b>PASSED CHAPTER 734</b></p> <p><b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative</i>: “<b>House Bill 1472 (passed)</b> makes clarifying changes to the Senior Prescription Drug Assistance Program (SPDAP) and specifies how CareFirst must provide a subsidy for assistance with the Medicare Part D coverage gap for individuals enrolled in SPDAP.</p> <p>The bill clarifies that there are two subsidies provided to SPDAP: (1) a subsidy under § 14-106 of the Insurance Article, which funds the SPDAP premium subsidy and is capped at \$14.0 million in fiscal 2010; and (2) a subsidy under § 14-106.2 of the Insurance Article, which provides assistance with the Medicare Part D coverage gap and is provided in an amount of \$4.0 million in years in which CareFirst incurs a specified surplus.</p> <p>The bill also alters the timing of the second subsidy to simplify administration of SPDAP. Beginning with calendar 2009, CareFirst must transfer \$4.0 million to SPDAP if it has a surplus that exceeds 800% of specified consolidated risk-based capital (RBC) requirements. CareFirst is not required to make the transfer if its surplus does not exceed the specified level. The RBC threshold for determining the transfer is based on the corporation’s annual March 1 filing with the Maryland Insurance Administration. By September 1 of each year, CareFirst must notify SPDAP whether it will transfer the \$4.0 million subsidy during the next calendar year. CareFirst must pay the \$4.0 million subsidy to SPDAP in quarterly installments of \$1.0 million beginning October 1 for the next calendar year.”</p>	

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HB 1475		<p><b>Maryland Veterans Behavioral Health – Expansion</b></p> <p><b>Official Synopsis:</b> Expanding behavioral health coordination to specified additional veterans who served on active duty in the uniformed services of the United States; and requiring that specified behavioral health services be provided in additional areas of the State.</p>		<p><b>Sponsored by:</b> Chair, Health and Government Operations Committee (By Request - Departmental - Health and Mental Hygiene)</p> <p><b>Status: PASSED CHAPTER 736</b></p> <p><b>Summary / Analysis: :</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative</i>: “Chapters 555 and 556 of 2008 established a new program for behavioral health services for Maryland veterans of the Afghanistan and Iraq conflicts. Although the program’s call center has received 267 calls since its inception, very few veterans have actually been provided program-funded behavioral health services through the Mental Hygiene Administration. Instead, veterans have been connected to services through the U.S Department of Veterans Affairs (VA) or through other available, pro-bono services outside of the program.</p> <p><i>House Bill 1475 (passed)</i> extends behavioral health services benefits to <i>all</i> Maryland veterans of foreign wars who have been discharged or released from service under conditions other than dishonorable and are not receiving services from the VA, rather than to veterans only of the Iraq and Afghanistan conflicts. In addition, the bill broadens the geographic coverage area for short-term behavioral services provided to these veterans, where existing federal and State services are determined by DHMH to be inadequate, from rural areas to any area in the State.”</p>	
HB 1486	SB 1039	<p><b>Prince George’s County Hospital Authority</b></p> <p><b>Official Synopsis:</b> Altering the scope of the Prince George’s County Hospital Authority’s bidding process; clarifying the duration of a specified funding commitment of the State and Prince George’s County; requiring the Authority to make specified assessments and take specified actions regarding bids for the Prince George’s County health care system; and requiring the Authority to develop a plan for the transfer of the component assets of the Prince George’s County health care system.</p>	Maureen Dove	<p><b>Sponsored by:</b> Delegates Hubbard, Barnes, Davis, Frush, Gaines, Griffith, Healey, Holmes, Howard, Ivey, Levi, Niemann, Pena-Melnyk, Proctor, Ramirez, Ross, V. Turner, Valderrama, Vallario, Vaughn, and Walker</p> <p><b>Status: PASSED CHAPTER 117</b></p> <p><b>Summary / Analysis:</b> As stated in the Maryland General Assembly’s <i>The 90-Day Report-A Review of 2009 Legislative</i>: “The Prince George’s County Health System, which includes Prince George’s Hospital Center, has been faced with financial difficulties for the past several years, experiencing lost market share, revenue losses, low liquidity, significant deferred capital needs, poor bond ratings, and a disadvantageous payor mix. Both the State and Prince George’s County have provided significant financial support to help the hospital meet its financial needs.</p> <p>Chapter 680 of 2008 established the Prince George’s County Hospital Authority to implement a competitive bidding process for transferring the system to new ownership. Under Chapter 680, an agreement to transfer the system was to be reached prior to the beginning of the 2009 session. This did not occur. To support ongoing efforts to transfer the system, <i>Senate Bill</i></p>	

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				<p><b>1039/House Bill 1486 (Chs. 116 and 117)</b> alter the scope of the authority, including authorizing an extension of the bidding process, clarifying the duration of State and county funding commitments, and authorizing MHCC to issue an exemption from the certificate of need process and waive requirements of the State Health Plan. The authority must complete its obligations prior to the expiration of the authority on May 22, 2010, and certain State agencies have to designate consultants to advise the authority.</p> <p>The fiscal 2010 budget includes \$12.0 million in operating support for the authority. The State has also committed to provide long-term financial support of \$75.0 million in operating funds (\$15.0 million in fiscal 2011 through 2015) and \$24.0 million in capital funds (\$4.0 million in fiscal 2012 and \$10.0 million in fiscal 2013 and 2014). Under <b>Senate Bill 1039/House Bill 1486 (Chs. 116 and 117)</b>, the State and Prince George’s County must be relieved of some or all of their long-term funding obligations to support the system only to the extent that any fund balance remains after the transfer of all of the system’s components to a new owner(s), or after the authority has expired without agreement on the transfer of all of the system’s components to a new owner(s).”</p> <p><b>Maureen Dove’s Comments:</b> The PG County Hospital Authority was created during the 2008 session (Chapter 680) to establish a bidding process for transfer of the PG County Health Care System to new financially viable owners. The bidding process did not produce a viable bid prior to the 2009 session, and SB 1039 extends the time for bidding to be implemented. The State and County have made funding obligations, which will not be relieved unless either (1) there is a fund balance remaining after transfer, or (2) the Authority expires without an agreement on transfer.</p> <p>The Maryland Health Care Commission is authorized to issue an exemption from a Certificate of Need and waive requirements of the State Health Plan to facilitate relocation of beds recommended by the Authority.</p> <p>Eleven state agencies are instructed to designate individuals to serve as advisors to the Authority</p>	