LIFEBRIDGE HEALTH®

Date: March 5, 2026
House Health Committee
HB1051 Public Health - Patient Access to Medication
Position: Unfavorable
Dear Chair, Bagnall and Health Committee Members,

On behalf of LifeBridge Health, we respectfully request an unfavorable report on House Bill 1015. LifeBridge Health shares the sponsor's goal of improving medication access and adherence following hospital discharge. Ensuring patients leave the hospital with a clear and actionable care plan including prescriptions is critical to preventing readmissions and promoting positive health outcomes. However, mandating a comprehensive Meds-to-Beds program at every hospital presents significant operational, financial, and patient-centered concerns.

A Meds-to-Beds program requires a licensed outpatient pharmacy operation, which is distinct from an inpatient acute care pharmacy license. Not all LifeBridge Health hospitals currently maintain outpatient pharmacy infrastructure on campus. Establishing and operating compliant outpatient pharmacy services systemwide would require substantial capital investment, staffing, workflow redesign, and regulatory approvals.

We estimate that implementation across all LifeBridge Health facilities would cost more than $2 million at the lower end, exclusive of ongoing operational expenses. Importantly, there is no corresponding consideration within the rate-setting framework of the Health Services Cost Review Commission (HSCRC) to account for the establishment or maintenance of this type of program. Absent reimbursement adjustments, this mandate would impose an unfunded financial burden on hospitals already operating under global budget constraints.

Requiring delivery of discharge medications prior to a patient leaving the hospital could delay discharges, particularly during evenings, weekends, and peak census periods. Discharge delays directly affect bed availability, emergency department boarding, and overall hospital throughput. Any policy that unintentionally increases length of stay or emergency department wait times must be carefully evaluated within Maryland's highly regulated all-payer system.

LifeBridge Health has direct experience in this area. Both Sinai Hospital and Carroll Hospital piloted a similar Meds-to-Beds program. Despite focused implementation efforts, patient adoption rates were below 25 percent. This demonstrates that while the service may benefit certain patients, it is not universally desired. Patient choice remains important. Many individuals have established relationships with trusted community pharmacies, including independently owned local businesses. Forcing a hospital-based dispensing model could inadvertently disrupt continuity with community pharmacists who often provide ongoing counseling, medication synchronization, and long-term support.

This legislation raises additional unanswered questions regarding how discharge medications would be billed and reimbursed. If medications are bundled into the inpatient stay under HSCRC-regulated

rates, hospitals would need clarity on implications for drug acquisition pricing, contract compliance, and programs such as 340B. Differences between inpatient and outpatient drug pricing structures could inadvertently increase overall system costs.

Additionally, for uninsured or underinsured patients, hospitals frequently absorb medication costs or provide vouchers to ensure access. Expanding a mandatory dispensing obligation without a defined reimbursement mechanism would further strain hospital resources.

LifeBridge Health supports targeted strategies to improve medication access, particularly for high-risk populations. However, HB1015 imposes a broad, unfunded mandate that creates operational disruption, financial strain, potential discharge delays, and reduced patient choice without evidence of widespread patient demand based on our own pilot experience. For these reasons, LifeBridge Health respectfully requests an unfavorable report on House Bill 1015.

Respectfully,

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