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MedChi Final 2017 Session Report

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The 437th Session of the Maryland General Assembly concluded at midnight on Monday, April 10th when it adjourned “Sine Die” with the traditional confetti release in both the Senate and House chambers. In this Session, the General Assembly considered 2,876 legislative bills and resolutions plus the proposed Fiscal Year 2018 budget, 44 more bills than last Session.

While each session has its own rhythm and tempo, this Session was strongly influenced by the election of President Trump and the Republican Congress. This was evident in the introduction of many bills and/or resolutions that sought to address actions taken on the federal level, such as the passage of **Senate Joint Resolution 5: Attorney General – Powers – Maryland Defense Act of 2017 (passed)**, which directs the Attorney General to investigate, commence, and prosecute or defend any civil or criminal suit or action that is based on the federal government’s action or inaction that threatens the public interest and welfare of the State’s residents, with only notice provided to the Governor rather than the Governor’s approval. Other examples include legislation to provide State funding for Planned Parenthood if Congress moves to defund the organization – **House Bill 1083: Health – Family Planning Services – Continuity of Care (passed)** – and another joint resolution expressing the General Assembly’s opposition to proposed federal budget cuts to the Chesapeake Bay Program – **Senate Joint Resolution 8: Chesapeake Bay Restoration – Federal Budget Blueprint Funding Reductions – Rescission Request (passed)**.

The MedChi Legislative Council reviewed approximately 237 bills this Session, taking positions on many of these. Overall, MedChi successfully advocated on behalf of our profession and our patients to protect Medicaid and enhance physician payments, to defend the scope of medical practice and physician rights and to protect the public health needs of the residents of Maryland.

Below is a comprehensive review of the issues advocated on by MedChi this Session.

Fiscal Year 2018 Budget and Physician Payments

Realizing the need to ensure access to physicians who will participate in the Medicaid program, the FY2018 budget maintains Medicaid E&M codes at 94% of Medicare. MedChi successfully maintained this level of funding despite a report by the Department of Legislative Services that Medicaid is underfunded by \$100.6 million for FY2018, which is not addressed in this budget. Complicating this issue remains the uncertainty of the State budget due to potential federal action. Federal funding provided under the Affordable Care Act (ACA) supports over \$1.4 billion in services in the FY2018 budget, and the State anticipates over \$7.7 billion in ACA funding through

FY2022. Outside of the direct budget connections between Maryland and the ACA, Maryland's health care policy is supported by other provisions allowed under the ACA. Most notably is the fact that Maryland's All-Payer Model Contract was approved through a federal agency established by the ACA. The State continues negotiations with the Center for Medicare and Medicaid Innovation on the All-Payer Model Contract.

While the GOP withdrew the proposal to change the ACA, there is still strong speculation that changes may occur in the future. It is for this reason that the General Assembly passed **Senate Bill 571: Maryland Health Insurance Coverage Protection Act**, which creates a Maryland Health Insurance Coverage Protection Commission to examine the affect that changes on the federal level to the ACA, Medicare, Medicaid or the All-Payer Model Contract could have on the State and to make recommendations. MedChi is a named participant on the Commission. On a similar note, the General Assembly added budget language to require the Maryland Health Benefit Exchange (MHBE) to submit a report 60-days after the enactment of any legislation at the federal level that impacts the operation of MHBE or qualified health plans.

The General Assembly also included language in the budget bill to require the Department of Human Resources (DHR) and the Department of Information Technology to submit quarterly progress reports (beginning August 15, 2017 and ending May 15, 2018) on the Maryland Total Human Services Information Network (MD THINK). DHR recently received over \$195 million in federal funding to build a new technology platform to assist the State's ability to deliver vital human services to Marylanders. MD THINK, is a cloud-based data repository that is focusing on breaking down traditional silos and data barriers between State agencies and provide integrated access to programs administered by agencies including DHR, the Department of Health and Mental Hygiene (DHMH), the Department of Juvenile Services and the Department of Labor, Licensing, and Regulation. The Administration dedicated nearly \$14 million in funding for this effort in the FY2017 budget. When fully implemented, this system will replace both CARES and MMIS.

Lastly, the budget bill authorizes DHMH to implement an opioid risk reduction pilot program in the Medicaid program to improve Medicaid patient safety and clinical outcomes for individuals being prescribed long-term opioid therapy for chronic pain. Participation in the program would be voluntary for physicians. Prior to the implementation of this program, the State would need to receive a waiver from the federal government, given that it is only a pilot program and would not be available to all Medicaid recipients.

One additional bill passed related to physician payments. While MedChi typically does not take a position on legislation that would alter Maryland's self-referral law, MedChi did support **House Bill 403/Senate Bill 369: Maryland Patient Referral Law – Compensation Arrangements Under Federally Approved Programs and Models (passed)**. This bill exempts a health care practitioner from Maryland's current self-referral law who has a compensation arrangement with a health care entity if the compensation arrangement is funded by or paid for under certain federal programs or initiatives. With the passage of this legislation, Maryland's All-Payer Model Contract will be able to more easily advance to the second phase and physicians will have greater opportunities to comply with federal MACRA requirements.

Fighting Opioid Abuse and Addressing Substance Use and Mental Health Disorders

The General Assembly and the Governor made Maryland's opioid crisis a top priority this Session. Over forty bills were introduced on topics ranging from limitations on prescribing, education in schools, access to community supports and removing restrictions on insurance. MedChi worked hard to partner with the State to fight this crisis while at the same time ensuring that physicians had the needed flexibility to treat each patient's health care needs. In the end, that balance was achieved through three major initiatives.

House Bill 1432: *Health Care Providers – Prescription Opioids – Limits on Prescribing (The Prescriber Limits Act of 2017) (passed)*. As introduced, this bill would have limited an initial prescription of an opioid to seven days. MedChi worked tirelessly to remove the limitation and ensure that the bill did not legislate clinical practice. In the end, MedChi successfully negotiated with DHMH to require a health care provider, based on his/her clinical judgment, to prescribe the lowest effective dose of an opioid and a quantity that is no greater than the quantity needed for the expected duration of pain based on evidence-based clinical guidelines that is appropriate for the health care service delivery setting for the patient, the type of health care services required by the patient, and the age and health status of the patient. The bill does not apply to an opioid being prescribed for a substance-related disorder, pain associated with a cancer diagnosis, pain experienced while the patient is receiving end-of-life, hospice or palliative care services, or chronic pain.

Senate Bill 967/House Bill 1329: *Heroin and Opioid Prevention Effort (HOPE) and Treatment Act of 2017 (passed)* focuses on expanding treatment options. Many of the provisions contained in this legislation were also introduced as separate legislation. This bill requires the State Court Administrator to assess drug court programs in circuit courts, juvenile courts, and district courts to determine how to increase these programs in a manner sufficient to meet each county's needs. The bill also: (1) requires the Behavioral Health Administration in DHMH to establish crisis treatment centers for individuals experiencing a mental health or substance use disorder crisis; (2) requires DHMH to establish a toll-free health crisis hotline and maintain certain information on behavioral health programs; (3) requires each health care facility that is not part of a health care system and each health care system to make available the services of health care providers who are trained and authorized to prescribe opioid addiction treatment medications, including buprenorphine-containing formulations; (4) requires DHMH to develop written information about opioid use disorders and distribute the information to health care facilities and health care providers that treat opioid use disorders so they can make it available to patients; (5) expands access to naloxone by removing the need to be a certificate holder; (6) requires DHMH to establish guidelines for the co-prescribing of opioid overdose reversal drugs that are applicable to all licensed health care providers in the State; (7) provides a mandatory appropriation for community providers that serve mental disorders, substance-related disorders or a combination of these disorders; (8) requires hospitals to develop a discharge protocol for individuals treated for a drug overdose; and (9) prohibits an insurance carrier from applying a prior authorization requirement for a prescription drug used for treatment of an opioid use disorder and that contains methadone, buprenorphine or naltrexone. An insurance carrier can apply a prior authorization for an opioid antagonist (naloxone or other similarly acting and equally safe drug approved by the FDA) if the

entity provides coverage for at least one formulation of the opioid antagonist without a prior authorization requirement.

Senate Bill 1060/House Bill 1082: *Heroin and Opioid Education and Community Action Act of 2017 (Start Talking Maryland Act) (passed)* focuses on education. This bill: (1) requires the Maryland State Board of Education (MSDE) to expand an existing program to encompass drug addiction and prevention education in public schools that specifically includes heroin and opioid addiction and prevention; (2) requires each local board of education to establish a policy requiring each public school to store naloxone and authorize a trained school nurse or other school personnel to administer it; (3) requires each local board of education to hire a sufficient number of either county or regional community action officials; (4) requires the Governor to include a general fund appropriation of at least \$3.0 million in the FY2019 budget for MSDE to award grants to local boards of education to implement the bill's policy and training requirements; (5) requires each institution of higher education in Maryland that receives State funding to establish a policy that addresses heroin and opioid addiction and prevention, including awareness training for incoming students, obtaining and storing naloxone, and campus police training; and (6) requires MSDE to convene a workgroup to evaluate programs that provide behavioral and substance abuse disorder services in the public schools in the State and develop proposals to expand the programs.

In addition to these bills, the Governor allocated approximately \$23.5 million in the FY2018 budget to combat opioid and substance use disorders. The budget bill also included language expressing the intent of the General Assembly that the Governor assign an individual in the Executive Branch on a permanent basis who will be designated to administer the Governor's authority to operationally address the heroin, opioid, and fentanyl overdoses crisis, until such a time that the crisis can be satisfactorily controlled and eliminated.

Other bills that passed this Session on this topic include:

- **House Bill 1093/Senate Bill 433: *Substance Use Treatment – Inpatient and Intensive Outpatient Programs – Consent by Minor (passed)*** specifies that a parent or guardian of a minor may apply, on behalf of the minor, for the minor's admission to a certified intensive outpatient alcohol and drug abuse program and makes a series of conforming changes.
- **Senate Bill 968/House Bill 1127: *Health Insurance – Coverage Requirements for Behavioral Health Disorders – Modifications (passed)*** updates terminology – replacing the terms alcohol abuse and drug abuse with alcohol misuse and drug misuse – and alters the services that an insurer must provide for the diagnosis and treatment of a mental illness, emotional disorder, drug use disorder, or alcohol use disorder to include residential treatment center benefits and intensive outpatient benefits, including diagnostic evaluation, opioid treatment services, and medication evaluation and management for both outpatient and intensive outpatient benefits.
- **House Bill 887: *Health Insurance – Prior Authorization for Drug Products to Treat an Opioid Use Disorder – Prohibition (passed)*** prohibits carriers that provide coverage for prescription drugs, including coverage through a pharmacy benefits manager, from applying a preauthorization requirement for a prescription drug when used for treatment of an opioid use disorder and that contains methadone, buprenorphine, or naltrexone. This bill was also contained in the HOPE Act.

Medical Liability Reform Legislation

As expected, all legislation failed that would have altered Maryland's medical liability environment. One thing is certain – the lines are clearly drawn and we can expect these bills to surface again next Session.

The trial bar requested introduction of several bills, all opposed by MedChi, Medical Mutual and other health care providers. Early in Session, **Senate Bill 225: *Civil Actions – Noneconomic Damages – Catastrophic Injury (failed)***, which would have increased the cap for catastrophic injuries, was withdrawn and **Senate Bill 682: *Civil Actions – Noneconomic Damages (failed)*** took its place which would have raised the cap for non-economic damages in wrongful death cases from 150% to 450% of the cap in personal injury cases. **Senate Bill 836: *Civil Actions – Punitive Damage Awards (failed)*** would have lowered the standard for awarding punitive damages from “actual malice” to “reckless indifference.” Lastly, **Senate Bill 1037: *Health Care Malpractice Qualified Expert – Limitation on Testimony in Personal Injury Claims – Repeal (failed)*** would have repealed the “20 Percent Rule” related to expert witnesses.

For the providers and their counsel, three bills were introduced which were supported by MedChi and other health care providers. **House Bill 604: *Courts and Judicial Proceedings – Venue – Health Care (failed)*** would have required that the venue for specified health care proceedings is in the county where an alleged negligent act or omission occurred. This bill was essentially trying to prohibit “forum shopping” by plaintiff attorneys. For the first time, the Senate Judicial Proceedings Committee voted **House Bill 777/Senate Bill 783: *Patient Early Intervention Programs (failed)*** favorable with amendments, but it was recommitted back to the Committee from the Senate floor at the request of a certain influential Senator. Lastly, **Senate Bill 877/House Bill 1347: *Maryland No-Fault Birth Injury Fund*** failed to pass for the third consecutive year.

There was one medical professional liability bill that did pass. As introduced, **House Bill 957/Senate Bill 195: *State Board of Physicians – Medical Professional Liability Insurance Coverage – Verification, Publication, and Notification Requirements (Janet's Law) (passed)*** would have mandated medical liability insurance for every physician licensee. After hours of meetings and numerous amendments, the bill now requires disclosure only by those physicians who do not carry liability insurance. Also, beginning October 1, 2017, each physician's profile on the Board of Physician's website will state whether the physician has medical professional liability coverage, as indicated by the physician during the renewal process. Where the physician does not carry medical professional liability coverage, that person must provide a written notice to a patient stating that the physician does not maintain medical professional coverage. The written notification provided to the patient must be (1) signed by the patient at the time of the patient's visit; and (2) retained by the licensee as part of the licensee's patient records. A physician who does not have medical professional liability coverage must also post this information in a conspicuous location in the physician's place of practice.

Scope of Practice and Physician Licensure

After a “not enough time” hiatus, the optometrists returned requesting broad expansion of their scope of practice. **House Bill 807/Senate Bill 611: *Health Occupations – Requirements for the***

Practice of Optometry – Miscellaneous Revisions (failed – referred to interim study). Despite the title, this bill contained anything but “miscellaneous revisions.” It was a broad expansion of optometric scope which would have authorized the prescribing of all medications and devices, the ordering of all tests, the independent practice of glaucoma and questionable surgical procedures. The Maryland Society of Eye Physicians and Surgeons and MedChi aggressively opposed this expansion due to strong patient safety concerns. After contentious hearings in both the House Health and Government Operations Committee and the Senate Education, Health, and Environmental Affairs Committee, both committees voted the bill unfavorable and instead moved the bill to interim study. The move to interim study ensures that the bill will be back next Session, with legislators pushing for a compromise between the two professions.

House Bill 1124: *Health Occupations – Physician Assistants – Preparing and Dispensing Prescriptions (failed)* and **Senate Bill 848: *Health Occupations – Physician Assistants – Dispensing Authority (failed)*** both would have allowed physician assistants to dispense medications subject to the delegation agreement with a physician. During the hearing in the House Health and Government Operations Committee, committee members raised questions regarding the dispensing of opioids by physician assistants. Shortly thereafter, the sponsor withdrew the bill.

A MedChi initiative, **House Bill 1054/Senate Bill 989: *State Board of Physicians – Physician Licensure – Prohibition on Requiring Specialty Certification***, passed without controversy. This bill prohibits the State Board of Physicians from requiring, as a qualification for initial licensure or a condition of license renewal, (1) certification by a nationally recognized accrediting organization that specializes in a specific area of medicine; or (2) maintenance of such certification that includes continuous reexamination to measure core competencies as a requirement for maintaining certification. This bill responds to the national anger among physicians over the increasing cost and time commitments necessary to maintain board certification.

Senate Bill 549/House Bill 1265: *State Board of Physicians and Allied Health Advisory Committees – Sunset Extension and Program Evaluation (passed)* incorporates the recommendations of the Department of Legislative Services’ (DLS) December 2016 full sunset evaluation. This emergency bill extends the termination date of the State Board of Physicians and its related allied health advisory committees by five years to July 1, 2023 and requires DLS to conduct a direct full evaluation of the Board by December 1, 2021. The bill limits the scope of the next sunset evaluation to: (1) the implementation of DLS’ recommendations from the December 2016 sunset evaluation; (2) the efficacy of the two-panel disciplinary system; and (3) the impact of criminal history records checks on the Board and its licensees.

Following two years of debate that resulted from a decision by the United States Supreme Court, known as NC Dental, the General Assembly passed **House Bill 628/Senate Bill 517: *Secretaries of Principal Departments – Supervision and Review of Decisions and Actions by Units Within Departments***. In general, this bill requires that the Secretary of each principal department to supervise the boards and commissions within that department to: (1) prevent unreasonable anticompetitive actions by the unit; and (2) determine whether the decisions and actions of the unit further a clearly articulated State policy to displace competition in the regulated market. For the boards and commissions within DHMH, the Office of Administrative Hearings (OAH) must review a decision or action, in accordance with regulations adopted by DHMH. This avoids the

scenario where the Secretary of DHMH is performing a review of a disciplinary matter, something Med Chi fought hard to avoid, and it restricts the circumstances of any review to only those cases where there may be anticompetitive actions involved, not routine disciplinary matters. DHMH and OAH must convene at least two stakeholder meetings at least six months before proposing the required regulations and must submit the proposed regulations by June 1, 2018.

Senate Bill 194/House Bill 1484: *Workers' Compensation – Medical Benefits – Payment of Medical Services and Treatment (passed)*. As introduced, this bill would have required health care providers to submit a bill for medical treatment within 45-days of providing medical services or treatment. MedChi initially opposed and then worked with the sponsors to amend the bill to require health care providers to submit the bill within 12-months from the later of the date – providing medical services or treatment, the employer or the employer’s insurer accepts the claim or when the worker’s compensation commission determines the claim is compensable. This one-year is consistent with the requirement under Medicare and Medicaid for submitting bills. Commercial carriers require bills to be submitted within 180-days.

MedChi weighed in on several child abuse and neglect bills. All bills were resolved in accordance with MedChi’s position. **Senate Bill 679: *Child Abuse and Neglect – Training (failed)*** would have required each health practitioner, police officer, educator, and human service worker in the State to receive periodic training on the obligation to report suspected child abuse and neglect and the identification of abused and neglected children. **House Bill 1263/Senate Bill 996: *Family Law – Child Abuse and Neglect – Definitions (passed)*** alters the definition of “abuse,” in provisions of law relating to the reporting and investigation of suspected child abuse and neglect, to include acts by a person who, because of the person’s position or occupation, exercises authority over the child. **Senate Bill 135: *Crimes – Child Abuse and Neglect – Failure to Report (failed)*** would have made it a misdemeanor for a health practitioner, police officer, educator, or human service worker to knowingly fail to provide a required notice or make a required report of suspected child abuse or neglect if the person: (1) has actual knowledge of the abuse or neglect or (2) witnesses the act of the abuse or neglect. MedChi continues to oppose any effort to impose criminal penalties for failure to report.

Related to child abuse and neglect, **Senate Bill 27: *Child Abuse and Neglect – Substance-Exposed Newborns – Reporting (failed)*** was a Departmental bill triggered by a change in the federal CAPTA law (Child Abuse Prevention and Treatment Act) that requires states to incorporate prescribed controlled dangerous substances in their reporting requirements or face potential loss of federal funding for child abuse and neglect related services. Maryland’s current CAPTA funding is approximately \$400,000 annually. Maryland’s current CAPTA language explicitly states that reporting under the specific section does not create a presumption of abuse and neglect. The legislation would have repealed a provision that exempts health care practitioners from making a required report regarding a substance-exposed newborn if the health care practitioner has verified that, at the time of delivery if: (1) the mother was using a controlled substance as currently prescribed for the mother by a licensed health care practitioner or (2) the presence of the controlled substance was consistent with a prescribed medical or drug treatment administered to the mother of the newborn. Concerns were raised about the creation of disincentives for pregnant woman to seek prenatal care and the further stigmatization of women in drug treatment. Efforts to address those concerns were unsuccessful and despite potential loss of funding the bill failed. DHR

will work over the interim to address the concerns raised and it is expected the dialogue will continue in the 2018 Session.

Public Health

House Bill 269/Senate Bill 531: *Housing Navigator and Aftercare Program (passed)* is an initiative successfully worked on by MedChi's medical students and residents. This bill codifies the Housing Counselor and Aftercare Program in DHR as the Housing Navigator and Aftercare Program. The stated purpose of the program is to assist families and individuals who are experiencing, or who are in imminent danger of, a housing crisis in obtaining and maintaining permanent housing. Beginning in FY2019, the program is funded with an annual appropriation of \$516,828, subject to the limitations of the State budget.

House Bill 775/Senate Bill 600: *Public Health – Maternal Mental Health (passed)* reflects recommendations issued by the Task Force on Maternal Mental Health, created through legislation enacted in 2015. The bill requires DHMH, in consultation with stakeholders, to identify up-to-date, evidence-based, written information about perinatal mood and anxiety disorders and to disseminate the information to health care facilities and providers and to post the information on the DHMH website. The legislation also requires DHMH, in conjunction with MedChi and other stakeholders to identify and develop training and education programs for providers that enhance the early identification of postpartum depression and perinatal mood disorders. The educational programs developed are required to include CMEs developed in conjunction with an organization that is ACCME accredited. Finally, the legislation requires DHMH, in conjunction with stakeholders to develop a strategic plan for the expansion of the Maryland's Behavioral Health Integration in Pediatric Primary Care Program to assist obstetric, primary care, pediatric and other providers in addressing emotional and mental health needs of pregnant and postpartum women. A report on the strategic plan is due by December 1, 2017.

Several bills that MedChi originally opposed as introduced because they legislated clinical practice were successfully amended to address MedChi's objections.

- **House Bill 184: *Public Health – Treatment of Attention-Deficit/Hyperactivity Disorder – Identification and Posting of Information (passed)*** charges DHMH to work with stakeholders to identify evidence-based information and other resources and information regarding Attention-Deficit/Hyperactivity Disorder and to post the information on the DHMH website for use by both providers and patients. The amendments are based on a similar approach undertaken in 2014 relative to Down Syndrome.
- **House Bill 190: *Mammography Centers – Dense Breast Tissue – Notification of Breast Cancer Screening Options (passed)*** clarifies that a woman should discuss with her physician whether 'additional' screening may be appropriate rather than specifying additional treatment options.
- **House Bill 518: *Public Health – Prenatal HIV Testing (passed)*** requires DHMH, in consultation with stakeholders, to adopt regulations for prenatal HIV testing. The legislation is in response to concerns about the statutory mandate for third trimester HIV testing of pregnant woman that was enacted in statute in 2016. The bill requires the Department to develop regulations that address existing statutory requirements. Once adopted in regulations,

the current statutory requirements will be null and void. During the development and promulgation of regulations that reflect current statutory requirements, the statute will stay in effect.

Efforts to address perceived health care access limitations by expanding access through pharmacies continued to be the focus of debate as it has in previous Sessions. **House Bill 613/Senate Bill 363 – Pharmacists – Contraceptives – Prescribing and Dispensing (passed)** authorizes pharmacists to prescribe and dispense contraceptives. The bill, while supported by the pharmacists, was advanced by proponents of contraceptive access such as Planned Parenthood to reduce the number of unplanned pregnancies. Consequently, it has never been perceived as a scope of practice bill. Further strengthening the proponent’s arguments was a recent article in the Baltimore Sun discussing Hopkins research that indicates oral contraception should be authorized for sale over the counter. This legislation as enacted included several critical amendments including a requirement for the Board of Pharmacy to work with stakeholders in the development of the regulations that will define implementation of the law. Additionally, specific requirements for referral to a health care provider and provision of documentation to the patient were also added. Finally, the bill specifies that pharmacists are prohibited from prescribing and dispensing contraceptives before January 1, 2019 to provide sufficient time for regulation development.

The General Assembly decided not to act on another bill that would have expanded the ability of pharmacist to administer flu vaccines. **House Bill 1262/Senate Bill 1168 – Pharmacists – Administration of the Influenza Vaccination – Age Requirement (failed)** would have lowered the age limit from 9-years old to 5-years old for administration of the flu vaccine. For that age cohort, two doses of the vaccine are recommended the first time the vaccine is administered. Consequently, there was a concern that access through a pharmacy would make tracking the need for a second dose difficult. The debate over expanded access versus second dose tracking resulted in the legislation being referred for further consideration over the interim.

Senate Bill 38: Department of Health and Mental Hygiene – Updating Advisory Boards and Councils (passed) consolidates three State advisory councils into a newly created State Advisory Council on Health and Wellness in DHMH. MedChi has a seat on the new Council. The bill also expands the membership of the Advisory Board on Prescription Drug Monitoring by adding the President of the Maryland Association of County Health Officers, President of the State Board of Podiatric Medical Examiners, President of the State Board of Dental Examiners, Secretary of Police, and an academic or research professional. Finally, the bill makes a number of technical changes to the appointment process or composition of various other Boards and Councils that do not directly impact MedChi.

Senate Bill 110: Public Health – Expedited Partner Therapy – Trichomoniasis and Pharmacist Dispensing (passed) clarifies certain provisions of Maryland’s Expedited Partner Therapy program that was authorized statewide in 2014. The bill clarifies concerns about whether licensed pharmacists could dispense antibiotic therapy prescribed to a sexual partner of a patient diagnosed with chlamydia or gonorrhea that had not been seen by the provider writing the prescription. The bill explicitly authorizes a licensed pharmacist to dispense the prescribed medication, thereby removing a barrier to full implementation of the program. The bill also adds trichomoniasis to the

sexually transmitted infections covered under the State's expedited partner therapy protocols. Trichomoniasis is the most common sexually transmitted infection and its addition will expand the effectiveness of the program in addressing the spread of sexually transmitted infection and disease.

House Bill 602/Senate Bill 422: *Keep Antibiotics Effective Act of 2017 (passed)* prohibits the administration of a medically important antimicrobial drug to cattle, swine, or poultry solely to promote weight gain or improve feed efficiency. Beginning January 1, 2018, a medically important antimicrobial drug may be administered to cattle, swine, or poultry if, in the professional judgment of a licensed veterinarian, the drug is necessary: (1) to treat, or control the spread of, a disease or infection; (2) for a surgery or medical procedure; or (3) provided the drug is not administered in a regular pattern, for prophylaxis to address an elevated risk of contraction of a particular disease or infection. In addition, the Maryland Department of Agriculture must annually collect, and report on, specified publicly available data on the use in the State of medically important antimicrobial drugs in cattle, swine and poultry. The Secretary of Agriculture can impose an administrative penalty for a violation of the bill's provisions.

House Bill 1325: *Oil and Natural Gas – Hydraulic Fracturing – Prohibition (passed)*. Governor Hogan has already signed this bill into law, which prohibits a person from engaging in the hydraulic fracturing of a well for the exploration or production of oil or natural gas in the State.

Senate Bill 570/House Bill 658: *Maryland Medical Assistance Program – Telehealth – Requirements (failed)* was introduced this year to remove service and provider restrictions in the Medicaid telehealth program. Rather than pass the bill, Chairman Middleton and Chairwoman Pendergrass sent a joint letter to Secretary Schrader of DHMH requesting a commitment by DHMH to undertake certain actions to expand the telehealth program. The Secretary responded shortly thereafter highlighting current and planned expansion efforts. While DHMH's response does not reflect as vibrant a telehealth program as anticipated in the original legislation, the effort is moving forward. There will be continued opportunity to urge expansion of telehealth during the interim as some of DHMH's identified initiatives for expansion will require the development of regulations that will include stakeholder input.

Another bill, **House Bill 352/Senate Bill 1106: *Health Care Practitioners – Use of Teletherapy***, related to teletherapy did pass. This bill authorizes health care practitioners who provide behavioral health services and are licensed by the State boards of Nursing, Physicians, Professional Counselors and Therapists, Psychologists, and Social Workers to use teletherapy if they comply with specified requirements. By April 1, 2018, the boards must adopt regulations that, to the extent practicable, are uniform and nonclinical, for the use of teletherapy by health care practitioners in accordance with the bill.

Pharmaceuticals and Pharmacies

Concerns about the high cost of prescription drugs, including some significant price increases for generic drugs, prompted calls for action to lower prescription drug costs. Consequently, two bills were introduced – **House Bill 631: *Public Health – Essential Off-Patent or Generic Drugs – Price Gouging – Prohibition (passed)*** and **House Bill 666/Senate Bill 437: *Public Health –***

Expensive Drugs – Manufacturer Reporting and Drug Price Transparency Advisory Committee (failed).

Hotly contested by the pharmaceutical industry, **House Bill 631** prohibits a manufacturer or wholesale distributor from engaging in “price gouging” in the sale of an “essential off-patent or generic drug” and authorizes the Maryland Attorney General to bring an action against the manufacturer. On petition of the Attorney General, a circuit court may issue specified orders, including compelling a manufacturer or wholesale distributor to provide certain statements or records, restraining or enjoining a violation, requiring restitution, and imposing a civil penalty of up to \$10,000 for each violation. Maryland is the first state to pass this type of law.

House Bill 666/Senate Bill 437 would have required drug companies to give notice and explain price increases under certain circumstances. Due to the complexity surrounding reporting requirements for drug manufacturers, the Senate did not pass the bill and instead referred the issue to the Maryland Health Insurance Coverage Protection Commission (created by House Bill 909/Senate Bill 571) for further study. However, the House failed to act upon it, and the bill failed.

The General Assembly considered several bills regarding pharmacy dispensing, of which only two passed. After several failed attempts in past Sessions, **Senate Bill 997/House Bill 1273: Pharmacists – Substitution and Dispensing of Biological Products** finally passed. This bill authorizes a pharmacist to substitute an interchangeable biological product, of the same dosage form and strength, for any brand name drug if: (1) the authorized prescriber does not expressly state that the prescription must be dispensed only as directed; (2) the substitution is recognized as specified; and (3) the consumer is charged less for the interchangeable biological product than the brand name drug. Specific notifications after dispensing is required, which is strongly supported by MedChi.

In addition, **House Bill 1147/Senate Bill 898: Health Insurance – Prescription Drugs – Dispensing Synchronization (passed)** requires carriers and PBMs that provide coverage for prescription drugs, to allow and apply a prorated daily copayment or coinsurance amount for a partial supply of a prescription drug dispensed by an in-network pharmacy. However, this requirement only applies if: (1) the prescriber or pharmacist determines dispensing a partial supply to be in the best interest of the member; (2) the prescription is anticipated to be required for more than three months; (3) the member requests or agrees to a partial supply to synchronize the dispensing of the member’s prescription drugs; (4) the prescription is not a Schedule II controlled dangerous substance; and (5) the supply and dispensing of the drug meet specified prior authorization and utilization management requirements. Medication synchronization has been demonstrated to increase a patient’s medication adherence.

Several other pharmacy dispensing bills failed to advance.

- **House Bill 1159/Senate Bill 814: Pharmacists – Dispensing of Prescription Drugs – Single Dispensing of Dosage Units (failed)** would have allowed pharmacists, under certain circumstances, to “single dose” several units of medicine at one time, e.g., prescription plus two refills at once. While the bill was on track to pass, the bill ultimately failed when the chain

drug stores failed to agree to an amendment put forth by the Maryland Psychiatric Society that would have allowed a prescriber to prohibit single dose.

- **House Bill 316/Senate Bill 428: *State Board of Pharmacy – Dispensing of Drugs Containing Controlled Dangerous Substances – Requirements (failed)*** would have required a pharmacist to dispense a drug that contains a substance listed in Schedules II through V in a lockable vial.
- **House Bill 582: *Pharmacies – Availability of Generically Equivalent Drugs (failed)*** would have required a pharmacy that stocks a brand name drug to stock at least one generically equivalent drug or, on the request of the patient or prescriber, order the generically equivalent drug for delivery to the pharmacy within a reasonable period of time to treat a patient’s illness or condition.

Likewise, the General Assembly (by way of the House Health and Government Operations Committee) sent four bills related to pharmacies and pharmacy benefit managers to summer study, most likely to be done by the Maryland Insurance Administration. These include: **House Bill 1103: *Health Insurance and Pharmacy Benefits Managers – Reimbursement for and Provision of Pharmacy Services*** would have allowed a pharmacy to refuse to dispense medication to a patient if the reimbursement by the carrier or PBM was less than its acquisition cost; **House Bill 1117: *Health Insurance – Specialty Drugs – Authority to Dispense*** would have expanded the type of pharmacies that can be used to acquire a specialty drug; **House Bill 1121: *Health Insurance – Freedom of Choice of Pharmacy Act*** would have prohibited carriers from putting certain restrictions on pharmacies; and **House Bill 1162: *Pharmacy Benefits – Processing and Adjudication of Claims – Restrictions on Fees*** would have prohibited a PBM from charging certain fees to a pharmacy.

Health Insurance

Given the uncertainty on the federal level with the continuation of the ACA, apart from the opioid issues, there were only a few bills affecting health insurance availability and accessibility this Session. **House Bill 740/Senate Bill 919: *President Jimmy Carter Cancer Treatment Access Act (passed)*** prohibits a step therapy protocol to be used if the: (1) drug is used to treat the insured’s or enrollee’s stage four advanced metastatic cancer; and (2) use of the drug is consistent with the U.S. Food and Drug Administration-approved indication or the National Comprehensive Cancer Network Drugs & Biologics Compendium Indication. Another mandated bill that passed was **House Bill 675/Senate Bill 61: *Health Insurance – Coverage for Digital Tomosynthesis***, which expands the health insurance mandate for coverage of breast cancer screenings to include coverage for “digital tomosynthesis” that the treating physician determines is medically appropriate and necessary. **House Bill 730: *Health Insurance – Coverage for Diabetes Test Strips – Prohibition on Deductible, Copayment, and Coinsurance*** prohibits carriers from imposing a deductible, copayment, or coinsurance requirement on diabetes test strips. However, a high-deductible health plan may subject diabetes test strips to the plan’s deductible requirement.

Other health insurance mandates that did not pass:

- **Senate Bill 768/House Bill 1128: *Health Insurance – Prescription Drugs – Formulary Changes (failed)*** would have prohibited carriers during a plan year and the preceding open

enrollment period, from: (1) removing a prescription drug from a formulary; (2) moving a prescription drug to a benefit tier that requires a higher deductible, copayment, or coinsurance; or (3) except at the time of enrollment or issuance of coverage, adding a “utilization management restriction” to a prescription drug in the formulary.

- **House Bill 876: *Health Insurance – Coverage of Fertility Preservation Procedures for Iatrogenic Infertility (failed)*** would have required carriers to provide coverage for “standard fertility preservation procedures” that are: (1) performed on a policyholder or subscriber or on the dependent spouse of a policyholder or subscriber; and (2) medically necessary to preserve fertility due to a need for medical treatment that may directly or indirectly cause “iatrogenic infertility.”
- **House Bill 667: *Health Insurance – Coverage for Lymphedema Diagnosis, Evaluation, and Treatment (failed)*** would have required carriers to provide coverage for the medically necessary diagnosis, evaluation, and treatment of lymphedema.

Other Bills of Interest

- **Senate Bill 82: *Department of Health and Mental Hygiene – Renaming (passed)*** renames the Department as the Department of Health.
- **House Bill 103: *Department of Human Resources and Child Support Enforcement Administration – Renaming (passed)*** renames the Department as the Maryland Department of Human Services and renames the Child Support Enforcement Administration as the Child Support Administration.
- **Senate Bill 354/House Bill 370: *Richard E. Israel and Roger ‘Pip’ Moyer End-of-Life Option Act (failed)*** would have created a process by which an individual may request and receive “aid in dying” from the individual’s attending physician.
- **House Bill 1053: *Integrated Community Oncology Reporting Program (failed)*** would have exempted a health care practitioner who has a beneficial interest in and practices medicine at an integrated community oncology center (defined in the bill) that participates in integrated community oncology reporting program (defined in the bill) from general prohibitions against self-referrals by health care practitioners.
- **House Bill 63: *Health Care Practitioners – Cost Estimate Notice – Required (failed)*** would have required a health care practitioner to provide information to an individual (or the parent or guardian of a minor) about the cost of the health care service that the practitioner will provide prior to performing the service for the individual.
- **House Bill 191: *Optometrists and Physicians – Prescriptions for Lenses – Expiration Dates (failed)*** would have required prescriptions for lenses to expire two years from the date written, similar with contact lenses.
- **House Bill 7: *Environment – Lead Hazards – Environmental Investigation, Reporting, and Risk Reduction (failed)*** as amended by the House would have required the Maryland Department of the Environment (MDE), by October 1, 2018, to adopt regulations establishing procedures for conducting environmental investigations beyond lead paint reduction assessments to determine lead hazards for children younger than age six and pregnant women with elevated blood lead levels greater than or equal to 10 micrograms per deciliter.

- **House Bill 1516/Senate Bill 750: *Public Health – Health Record and Payment Clearing House – Pilot Program (failed)*** would have required the Maryland Health Care Commission (MHCC), by December 31, 2017, to develop health record and payment clearing house payment pilot program.
- **House Bill 354/Senate Bill 624: *Clean Indoor Air Act – Use of Electronic Cigarette Devices – Prohibition (failed)*** would have revised the Clean Indoor Air Act to include any electronic cigarette device under the definition of smoking.
- **Senate Bill 669: *Tobacco Products – Minimum Age and Civil Fines (failed)*** would have raised the minimum age to purchase smoking devices from age 18 to 21, and it establishes civil fines for individuals ages 18 to 20 who purchase or possess tobacco products or paraphernalia in violation of the bill’s requirements.
- **Senate Bill 988/HB1113: *Health Occupations – Maryland Community Health Worker Act***, which, as introduced, would have created a State Board of Community Health Workers in DHMH and required them to be certified by October 1, 2018. The bill was amended to authorize community health workers to be certified rather than require them to be certified. The bill was on the path for passage when, what only could be described as the eleventh hour, a large medical system and representatives from the health occupation boards expressed concern that the bill would deter individuals from working as community health workers. Consequently, the legislation did not pass.
- **Senate Bill 1020: *Maryland Health Care Regulatory Reform Act of 2017 (failed)*** would have combined the Health Services Cost Review Commission and the Maryland Health Care Commission into one commission.
- **House Bill 1443: *Natalie M. LaPrade Medical Cannabis Commission Reform Act (failed)*** would have reconstituted the Commission and would have awarded additional grower licenses pending the results of a disparity study. The main issue being decided in this bill was whether to automatically grant the two grower applicants who were displaced from the rankings a license or whether any additional licenses should only go to minority businesses. After a few contentious days with the Senate wanting to give the two grower applicants’ licenses and the House wanting the licenses reserved for minority businesses, the House receded from its’ position in favor of the Senate position. HOWEVER, the final vote was not taken and the bill FAILED in the last few minutes before Sine Die.

Special Thanks

MedChi thanks those members who served on the MedChi Legislative Council this Session for their efforts in promoting the practice of medicine in Maryland and strengthening the role that MedChi plays in shaping public policy in Maryland. A special thanks to our subcommittee chairs: Dr. Clement S. Banda (Boards and Commissions), Dr. Sarah Merritt and Dr. Elizabeth Wiley (Public Health), and Dr. Anuradha Reddy (Health Insurance) and to our Legislative Council co-chairs, Dr. Gary Pushkin, Dr. Sarah Merritt, and Dr. Ben Lowentritt for pitch-hitting as Legislative Council for a couple of meetings as well.

MedChi also recognizes those physicians who came to Annapolis on behalf of MedChi to testify on various initiatives, including Dr. Elizabeth Wiley, Dr. Stephen Rockower, Dr. Richard Bruno (Resident), and Dr. David Myles.

Lastly, MedChi extends its appreciation to the physicians who volunteered their time to staff the State House First Aid Room this Session. Staffing the First Aid Room is an honor for MedChi and one that cannot be taken for granted. Physicians who staff the First Aid Room have access to the legislators and are looked at not only as a resource for medical care but also as a resource on policy issues. MedChi also would like to thank Colleen White, R.N. for her dedication in staffing the First Aid Room for the full 90-days of Session.

Doctors who staffed the First Aid Room this Session include:

Amit Bhargava, M.D.	Loralie Ma, M.D.
Richard Bruno, M.D. (Resident)	George Malouf Jr., M.D.
Brooke Buckley, M.D.	Sarah Merritt, M.D.
Jane Chew, M.D.	Mike Murphy, M.D.
Geoff Coleman, M.D.	Mike Niehoff, M.D.
Tyler Cymet, M.D.	Gary Pushkin, M.D.
Gwen DuBois, M.D.	Padmini Ranasinghe, M.D.
Willarda Edwards, M.D.	Anuradha Reddy, M.D.
Ramsay Farah, M.D.	Stephen Rockower, M.D.
Alan Gonzalez-Cota, M.D.	Joseph Snyder, M.D.
John Gordon, M.D.	Roger Stone, M.D.
Natasha Herz, M.D.	Joe Weidner, M.D.
Calvin Kagan, M.D. (Resident)	Russell Wright, M.D.
Ben Lowentritt, M.D.	Joseph Zebley, M.D.