

SCHWARTZ, METZ & WISE, P.A.

ATTORNEYS

20 WEST STREET
ANNAPOLIS, MARYLAND 21401

TEL: 410-244-7000

FAX: 410-269-5443

MedChi Final Report

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Introduction

The 430th Session of the Maryland General Assembly concluded at midnight on Monday, April 9th. In its 430th Session, the General Assembly considered 2,605 legislative bills and resolutions.

For its part, the MedChi Legislative Committee reviewed 222 of these proposals.

In a scenario not seen since 1992, the General Assembly waited until late on its 90th and last day to approve the state budget. There is a single constitutional requirement for the General Assembly which is to enact a balanced budget. If the 90th day concludes without a budget, the Session is extended for the sole purpose of completing work on the budget and all other bills die at midnight on the 90th day referred to as Sine Die. **The budget which passed was the “doomsday budget” which means that certain increases could not occur unless related revenue bills were enacted. However, none of the related revenue bills were enacted. It is now predicted that a Special Session will be called by the Governor for the purposes of enacting these related revenue proposals.**

The MedChi Agenda was ambitious as is usually the case and, in almost every instance, was accomplished. The following is a highlight of the Session from a MedChi perspective.

Preauthorization: Senate Bill 540 (Senator Astle)/House Bill 470 (Delegate Tarrant) (*Maryland Health Care Commission – Preauthorization of Medical Services and Pharmaceuticals – Standards*) is on the Governor’s desk with both bills having passed both chambers in identical form.

The legislation was amended from its original introduction. The amended version codifies the salient provisions of the Report prepared by the Maryland Health Care Commission (MHCC) in December 2011. Essentially, the Report provided that insurance intermediaries will simplify preauthorization procedures by adopting electronic preauthorization systems which will allow a physician to access insurance websites to determine the preauthorization requirements and make preauthorization requests in electronic form complete with unique tracking numbers. The goal of the Report is to allow for real-time preauthorization of most drugs by July 2013.

The insurance industry agreed in 2011 to the provisions of the MHCC Report but objected to legislation saying that their agreement was “voluntary”. MedChi believed that there needed to be a legal mechanism to enforce the “voluntary” agreement if a company elected not to follow through. Senate Bill 540/House Bill 470 grants the MHCC regulatory authority to enforce the voluntary agreement announced in the December 2011 Report.

In its amended form, Senate Bill 540/House Bill 470 also requires the MHCC to report to the General Assembly on five different occasions between now and December 2016 on the progress in obtaining the benchmarks for standardizing and automating the process for preauthorization. The first report is due on March 31, 2013, followed by annual reports on December 31, 2013, 2014, 2015 and 2016. Moreover, by October 1, 2012, the MHCC is directed to reconvene the multi-stakeholder workgroup whose collaboration resulted in the 2011 Report to review the progress made in attaining the benchmarks described in that Report. Many of the concerns of the insurance/payer industry were addressed by codifying the provisions of the December Report. The bill, however, accomplished MedChi's goal that there be legally enforceable regulatory power in the MHCC.

Medicaid Budget – Physician Reimbursement: The issue of Medicaid physician rates was decided on the last day. The Senate had voted to retain the increase in reimbursement for evaluation and management codes to Medicare levels for all physicians as it was included in the Governor's Medicaid budget. The House amended the Senate version to recommend the increase only apply to primary care physicians. In the end, the Senate position prevailed so that **all physicians** will be the beneficiary of the E&M code rate increases. **These fee increases, even though passed, will not occur unless there is a Special Session which enacts the related revenue measures necessary to fully fund the Budget.**

Scope of Practice: There were numerous scope of practice bills considered and, in every case, rejected by the General Assembly including the following:

A. Senate Bill 866/House Bill 758 (*Health Occupations Boards – Regulations – Scope of Practice Advisory Committees*) FAILED.

These bills would have given the Secretary of DHMH the authority to promulgate regulations to resolve scope of practice issues among the various licensing boards. MedChi opposed this bill as it would have given the Secretary broad and unrestricted authority to "resolve" these disputes when, in MedChi's view, the ultimate authority should remain with the General Assembly. MedChi believes that the Secretary's involvement in resolving disputes may be constructive but the authority to resolve them is another matter. Senate Bill 866 was turned down by the Senate EHE Committee and the companion House legislation was later withdrawn.

B. Senate Bill 180/House Bill 620 (*Health Occupations – State Board of Naturopathic Medicine*). FAILED.

These bills would have created a new licensing board for "naturopathic doctors" and allowed them to practice "naturopathic medicine" independently of physicians. The proposed scope of practice included prescribing, doing "minor surgery" and numerous other interventions. There are currently 24 naturopaths in Maryland; 5 would have served on the board and another 3 on the "formulary council," meaning that one-third of all naturopaths would be serving in a regulatory capacity.

When it became clear that the legislation had the support of a majority of the Senate EHE Committee and that a "floor fight" was imminent in the Senate, MedChi issued a "call to arms" that resulted in numerous physicians visiting on the evening of

Monday, March 19th, to lobby their legislators. Significant delegations from Montgomery, Prince George's, Anne Arundel and Baltimore Counties and Baltimore City appeared (many in white coats) and went door to door in the Senate office buildings prior to the Monday night session. MedChi CEO Gene Ransom was a constant presence in Annapolis on the bill. As a result of this outpouring and countless e-mails and phone calls, the tide turned on the Senate floor. Although the bill was comfortably reported by out by the committee on a vote of 9-2, it became clear that the bill could not muster the necessary votes in the full Senate.

In the end, the Senate bill was "recommitted" to Committee prior to a vote on the floor, with the Committee Chair indicating she knew the "fate of the bill" and did not care to take up the Senate's time. The House did not act on the crossfiled bill, though it held numerous subcommittee meetings where the bill was discussed, right up until the Senate "killed" the bill.

C. Senate Bill 598/House Bill 323 (*Health Occupations – Licensed Podiatrists – Scope of Practice*). FAILED.

Senate Bill 598/House Bill 323 would have allowed podiatrists to do surgery on "acute ankle fractures." It was vigorously opposed by the orthopedic community but the podiatrists argued that their scope of practice has evolved since the prohibition was enacted and that their training now prepares them to conduct such surgeries, with 40 states allowing them to do so. In spite of these arguments, MedChi and the orthopedic community remained opposed and the legislation was withdrawn although there may be discussion of this issue during the upcoming interim

D. Senate Bill 408/ House Bill 56 (*Pharmacists – Administration of Vaccines – Expanded Authority*). FAILED

The pharmacists have very aggressive in advancing scope of practice expansion over the last few years. This legislation proposed to expand their authority to administer vaccines to include all CDC recommended vaccines as well as all travel vaccines to anyone over the age of 9. The proposed expansion of authority did not include requirements for a physician prescription, communication with an individual's primary care physician, record keeping requirements or any other provisions to ensure continuity of care or protect patient safety.

Current law limits pharmacists' authority to the administration of the flu vaccine to individuals age 9 and older and the administration to adults of vaccines for pneumococcal pneumonia, herpes zoster, and any other vaccine found to be in the public interest as determined by the collective approval of the Board of Physicians, Board of Nursing and Board of Pharmacy provided the patient has a physician's prescription, the pharmacist reports back to the prescribing physician and if the prescribing physician is not the patient's primary care physician that the pharmacist make a good faith effort to contact the patient's primary care physician.

The expansive, all-inclusive approach of the bill as proposed was not well received and the bills did not advance. However, there was significant favorable sentiment

expressed by members of both the House and Senate Committees regarding the need for expanded access to vaccines with the proper patient protections. Consequently, there will undoubtedly be a summer workgroup convened to discuss the issue in a more deliberative context. It will be critical that MedChi continue to advocate for physician prescriptions and reporting requirements attached with any contemplated expansion of prescribing authority.

E. House Bill 1056 (*Health Occupations – Licensed Midwives*). FAILED

Legislation introduced to license certified midwives generated significant discussion in the House Health & Government Operations Committee. The day of the bill hearing hundreds of proponents of “home birth” allied in Annapolis including a large representation from Maryland’s Amish and Mennonite communities. While the legislation itself would have licensed certified midwives who would not be required to have more than a high school diploma and limited experience, the bill hearing became a forum for discussion on access to home birth – not on the professionals seeking certification.

In addition to the physician community, the bill was opposed by the Physician and Nursing Boards as well as the certified nurse midwives with whom physicians have well-defined collaborative relationship. The legislation did not advance but a letter from the Committee will be sent to the Department of Health & Mental Hygiene to look at the issues associated with home birth, why few certified nurse midwives are performing home births and what, if any, regulatory structure is appropriate for certified midwives. Nationally, there has been a significant push to recognize certified midwives. It is an issue that will require concerted attention given the apparent interest expressed by Committee members in providing access to home birth services.

F. Senate Bill 603 (*Health Care Practitioners – Licensed Dentists, Physicians, and Podiatrists – Personally Preparing and Dispensing Prescription Drugs and Devices*) was enacted in the final hours of the Session. MedChi was successful in its efforts to defeat amendments offered by the Board of Pharmacy which would have placed regulatory authority under the Pharmacy Board as opposed to the Board of Physicians and would have created a prohibition on physician dispensing within 10 miles of a pharmacy. As enacted, the bill retains regulatory control for physician dispensing under the Board of Physicians. It does provide for inspections and specific CME requirements related to dispensing activities for those who hold dispensing permits but the provisions are consistent with current practices for dispensing physicians. The bill as enacted will preserve an appropriate regulatory structure for physician dispensing and will remove this issue from the pharmacist’s efforts to expand their scope of practice and limit the scope of physician services.

Truth in Advertising: Senate Bill 395 (Senator Jennings)/House Bill 957 (Delegate Cullison) (*Health Occupations – Public Disclosure of Professional Credentials*). PASSED. The MedChi House of Delegates adopted a Resolution in the fall of 2011 calling for the introduction of model AMA legislation on ‘Truth in Advertising’, which is a national effort to place statutory

restrictions on advertising by health professionals. In addition to prohibiting health professionals from misrepresenting their licensure or certification, it also requires professionals to wear name badges during patient encounters plainly stating the license they hold, and establishes who within the physician community can claim to be “board certified.”

While some health care professions supported the measure, the nurses, dentists, psychologists and audiologists either opposed or sought amendments to it, and the hospitals and nursing homes asked to be exempted from it, citing current law which already requires identification badges in those settings. Additional concerns were raised from within MedChi by psychiatrists who sought to carve out small practices from the legislation.

The bill faced possible defeat in the Senate EHE Committee, so MedChi prepared amendments preserving the “board certified” aspect of the bill and inserting language requiring all health occupations boards to submit information by the end of 2012 on exactly what regulations or policies currently exist as to advertising.

After the bill passed the Senate, an intramural fight broke out between medical specialties when the emergency room doctors objected to the wording of the board certification section of the bill and sought changes. Initially, the proposals of the American College of Emergency Physicians (ACEP) were not welcomed by the various groups which had been working on the agreed amendments. Steve Wise worked at length with the various medical specialties to develop further amendments that would achieve the goals of all involved and, in the end, those amendments were incorporated into the legislation. Senator Jennings and Delegate Cullison worked very hard on behalf of MedChi and were very patient with the physician community while it developed the very complex amendments to the bill, and are to be commended for their efforts in passing this legislation.

Telemedicine: Senate Bill 781/House Bill 1149 (*Health Insurance – Coverage for Telemedicine Services*) was successfully enacted. The prime sponsor of the Senate bill was Senator Catherine Pugh of Baltimore City and the lead in the House was Delegate Susan Lee of Montgomery County. The bill requires covered insurers to reimburse telemedicine when medical services are delivered in that modality. These efforts with respect to telemedicine have been championed by the MedChi Legislative Committee Member Dr. Neil Reynolds, a critical care physician at the University of Maryland, who has been using telemedicine in his practice for a number of years. It was also championed by groups supporting therapies for heart and stroke victims. Two other telemedicine bills, however, were not acted on favorably. House Bill 1399 (*Hospitals – Credentialing and Privileging Process – Telemedicine*) and House Bill 1400 (*State Board of Physicians – Exceptions from Licensing – Physicians Authorize to Practice Medicine by Another State*) would have changed existing requirements for credentialing and licensure. These proposals raised a variety of complex issues and will best be addressed next year after appropriate discussion by various stakeholders.

Cancer Chemotherapy: Senate Bill 179/House Bill 243 (*Kathleen A. Mathias Chemotherapy Parity Act of 2012*) was enacted into law and will be signed by the Governor on Tuesday, April 10th. The legislation provided that covered insurance companies must treat patients’ expenses for different modalities for chemotherapy in the same manner. Traditional chemotherapy has relied upon intravenous application while newer therapies often rely on orally

administered drugs. For covered insurance plans, this bill will ensure the patient is not charged any more for the oral brand of chemotherapy than he or she would be charged for the intravenous method.

Board of Physicians: Senate Bill 629/House Bill 824 (*State Board of Physicians and Allied Health Advisory Committees – Sunset Extension and Program Evaluation*). AMENDED/PASSED. These bills were “Sunset” legislation to extend the existence of the Board of Physicians for another 10 years and to enact various changes recommended in the Sunset Report. However, action on the substantive portion of the bills will be delayed until next year when the results of a consultant’s review of the Board ordered by Secretary of Health Joshua Sharfstein, M.D. and supported by MedChi are complete. Dr. Perman of the University of Maryland will be preparing the consultant’s report.

Pending the consultant’s report, the legislation was rewritten to take out the original provisions of the bill and insert a single provision to give the Governor appointing authority over the Chair of the Board of Physicians. This change was desired by Secretary Sharfstein to make the Chair a gubernatorial appointment as it was just over ten years ago. In recent years, the Chair has been “elected” from among other Board members. Pete Hammen, Chair of the House HGO Committee, was extremely vocal during committee consideration of this bill about his concern over the operation of the Board of Physicians. Board representatives opposed the change but it was passed in spite of that opposition. The Senate concurred in this approach. The substantive issues with the Board will be front and center in the 2013 Session.

Safe Driving Practices: MedChi was successful in its efforts to strengthen Maryland’s child safety seat requirements. A primary focus of MedChi’s Public Health Legislative Agenda, House Bill 313/Senate Bill 185 (*Motor Vehicles – Child Safety Seats – Requirements*) (Delegate Stein/Senator Forehand) proposed to clarify and strengthen Maryland’s child safety seat requirements based on new recommendations from the National Highway Traffic Safety Administration (NHTSA) and the American Academy of Pediatrics. The most important provision of MedChi’s legislation was the removal of weight as a factor in determining whether a child is required to be restrained in a child safety seat. In 2008, when the General Assembly last addressed safety seat requirements, a weight factor was added to the law in contradiction to federal recommendations. The placement of the seat-belt across the body is the critical component of determining what seat restraint is appropriate. The use of weight could actually lead to inappropriate restraint, and therefore reduced protection for those youth who may be short but very heavy. Passage of this legislation removes the weight restriction and better aligns Maryland’s law with national recommendations. A second provision of the national recommendations – restraint of children in rear-facing seats until age 2 – did not require a change in statute as Maryland’s current language requires parents to use child safety seats in accordance with the manufacturer’s instructions. NHTSA is in the process of revising its manufacturer requirements. When that is complete, Maryland’s law will require compliance with those requirements as reflected in the manufacturers’ instructions.

Maryland has been a national leader in addressing distracted driving. This year, the General Assembly strengthened the prohibition against the use of wireless communications for young drivers and clarified that the ban on text messaging applied to all drivers. House Bill

55/Senate Bill 529 (*Motor Vehicles – Use of Text Messaging While Driving*) (Delegate Malone/Senator Robey) applies the current prohibition on the use of wireless communication devices to all young drivers under the age of 18, not just those with learner’s permits or provisional licenses. The prohibition is a secondary offense but applies to all wireless communication devices – not just handheld devices. The bill also clarifies that the current ban on text messaging, which is a primary offense, applies to all drivers and includes administrative penalties for young drivers under that age of 18. These penalties include suspension or restriction of their driving privileges.

Health Disparities: The Administration’s initiative to address Maryland’s high incidence of health disparities in communities across the State was successfully enacted. Spearheaded by Lt. Governor Anthony Brown, House Bill 439/Senate Bill 234 (*Maryland Health Improvement and Disparities Reduction Act of 2012*) establishes a process for designation of “Health Enterprise Zones” (HEZs) to target State resources to reduce health disparities, improve health outcomes, and reduce health costs and hospital admissions and readmissions in specific areas of the State. \$4 million annually has been identified for incentive awards under the program.

A HEZ, which will be designated as such by the Secretary of DHMH in conjunction with the Maryland Community Health Resource Commission, is defined as a contiguous geographic area that demonstrates measurable and documented health disparities and poor health outcomes and is small enough to allow for the incentives offered under the bill to have a significant impact on improving health outcomes and reducing racial, ethnic, and geographic health disparities. HEZ designations will be made upon application of local jurisdictions and/or nonprofit community based organizations and will take into account assuring geographic diversity across the State.

HEZ physicians that practice in a designated HEZ will be eligible for State income tax credits; loan repayment assistance; priority to enter the Maryland Patient Centered Medical Home (PCMH) Program; and priority for receipt of any State funding available for electronic health records. HEZ physicians may also apply to the Secretary for a grant to defray the cost of capital or leasehold improvements to, or medical or dental equipment to be used in, a HEZ.

Further, a HEZ physician who practices in a HEZ may be eligible for a State income tax credit if the individual demonstrates competency in cultural, linguistic, and health literacy in a manner determined by the Department of Health and Mental Hygiene (DHMH); accepts and provides care for Medicaid and uninsured patients; and meets any other criteria established by DHMH. The legislation also contains provisions for a hiring tax credit to recognize efforts to expand employment in HEZs.

As part of the legislation’s effort to evaluate the effectiveness of addressing health disparities, the Maryland Health Care Commission (MHCC), as part of its system of comparative evaluation of the quality of care and performance of health benefit plans, is charged with the implementation of a standard set of measures regarding racial and ethnic variations in quality and outcomes and provide information on carriers’ actions to track and reduce health disparities.

Uncodified language requires the Health Services Cost Review Commission and the Maryland Health Care Commission to study the feasibility of including racial and ethnic performance data tracking in quality incentive programs and, in coordination with the evaluation of the PCMH program, measure the impact of the program on eliminating disparities in health outcomes. The commissions must report to the General Assembly, by January 1, 2013, data by race and ethnicity in quality incentive programs, if feasible, and recommendations for criteria and standards to measure the impact of the PCMH program on the elimination of disparities in health care outcomes.

In addition, the Maryland Health Quality and Cost Council (MHQCC) must convene a workgroup to examine appropriate standards for cultural and linguistic competency for medical and behavioral health treatment and the feasibility and desirability of incorporating these standards into reporting by health care providers and tiering of reimbursement rates by payers; assess the feasibility of and develop recommendations for criteria and standards establishing multicultural health care; and recommend criteria for health care providers in the State to receive continuing education in multicultural health care. The workgroup must submit its findings and recommendations to MHQCC by December 1, 2013.

Trial Lawyer Bills: The Maryland Association for Justice (aka the Maryland Trial Lawyers Association) supported the filing of two bills in the General Assembly, both of which drew MedChi's opposition. Senate Bill 857/House Bill 506 (*Health Care Malpractice Claims – Expert Witnesses – Admissibility of Insurance Coverage*) would have allowed a doctor's expert witness to be cross examined if the expert witness had malpractice insurance in the same company as the defendant doctor. The argument was that the expert doctor may "slant" his testimony in favor of the accused doctor if they were both insured by the same insurance company and the expert was trying to protect that company's assets. In reality, this was just an excuse to advise the jury that there were insurance proceeds available in the case. The other Trial Lawyer initiative was Senate Bill 924/House Bill 507 (*Health Care Malpractice Claims – Expert Witnesses – Limitations*) which would limit the number of expert witnesses a doctor could call to two per specialty per case.

Senate Bill 857/House Bill 506 were withdrawn the day of the hearing before the House Judiciary and Senate Judicial Proceedings Committees. House Bill 507 was given an unfavorable report by the House Judiciary Committee which resulted in its being unsuccessful in the Senate committee as well.

Health Benefit Exchange: Senate Bill 238/House Bill 443 (*Maryland Health Benefit Exchange Act of 2012*) was enacted. This legislation creates marketplace rules for the operation of the Maryland "Exchange" which will be the marketplace for uninsured individuals seeking health insurance, including the federal subsidies provided under the Federal Affordable Care Act. However, in light of the just completed Supreme Court hearings, it appears that the federal law, or portions of it, are in danger of being declared unconstitutional. Maryland will be the first state to establish the Exchange required by federal law although it remains to be seen how the Exchange would operate if the Supreme Court declares portions of the federal law unconstitutional.

The Maryland Exchange was created by legislation in 2011 but that legislation provided that the rules for the operation of the Exchange would be decided in 2012. Senate Bill 238/House Bill 443 is the legislation promised last year.

Tanning: Senate Bill 213 (Senator Raskin)/House Bill 207 (Delegates Reznik and Love) (*Tanning Devices – Use by Minors – Prohibition*) was a principal item in the MedChi Public Health Agenda. It would have changed Maryland law to disallow minors (under 18) from frequenting a commercial tanning salon. Present Maryland law is to allow minors to attend such salons if they receive a parent's written consent. The bills would have expanded a law which presently exists in Howard County, Maryland to the entire state (California has recently passed a similar ban).

This legislation has failed for a number of years and one of its principal stumbling blocks is the Senate Finance Committee. It appeared that there was a reasonably good chance that an amended version of the bill (a ban for children 16 and under with written consent for 16 to 18) might emerge from the Senate Finance Committee but the amendment died on a 5-5 tie vote. One senator was not in the voting session because of a medical emergency and would have likely have provided the necessary 6th vote. As with many things in Annapolis, a single vote can tip or determine an entire issue. Hence, the tanning prohibition legislation failed much to the disappointment of the physician, and particularly the dermatological, community. It is well documented that indoor tanning is a major cause of melanoma and particularly dangerous for young women.

Tobacco Tax: In the closing minutes of the Legislative Session, the Senate and the House agreed on an increase in tobacco tax. **However, this agreement could not be enacted before the 12 midnight deadline. This will be an item for any Special Session.** The agreement provided that the tax on premium cigars would remain at 15% of the wholesale price. The tax on other tobacco products was raised. The most significant increase was on "little cigars," raising that tax from 15% of wholesale price to 70%. Smokeless tobacco products such as snuff and chewing tobacco had their tax increased from 15% of the wholesale price to 30%. The increase in tobacco tax on "other tobacco products" (OTPs) has been a long standing position of MedChi as a participating member of the Healthy Maryland Initiative.

Other Public Health Issues: House Bill 497/Senate Bill 621 (*Public Schools – Epinephrine Availability and Use – Policy Requirements*) supported by MedChi's Alliance, was successfully enacted. The legislation requires local school boards to establish a policy to authorize the school nurse and other school personnel to administer auto-injectable epinephrine, if available, to a student who is determined to be or perceived to be in anaphylaxis, regardless of whether the student has been identified as having an anaphylactic allergy or has a prescription for epinephrine. The policy must also include training for school personnel on how to recognize the symptoms of anaphylaxis; procedures for the emergency administration of auto-injectable epinephrine; proper follow-up emergency procedures; and a provision authorizing a school nurse to obtain and store auto-injectable epinephrine to be used in an emergency situation.

At the urging of the MedChi's Public Health Committee, MedChi supported legislation that bans the use of certain arsenic containing chemicals in poultry feed. House Bill 167/Senate

Bill 207 (*Agriculture – Commercial Feed – Arsenic Prohibition*) prohibits the use of Roxarsone and other arsenic containing feed unless approved for use by the U.S. Food and Drug Administration. Proponents argued that arsenic in poultry feed not only causes risk to the environment from water pollution caused by excrement of the poultry but also raises health risks for humans who ingest the meat of poultry which ingested feed that contained arsenic.

Consent by Minors to Health and Dental Care Services: MedChi played a key role in shaping Senate Bill 72 (*Medical and Dental Treatment – Consent by Minors and Protections for Licensed Health Care Practitioners*) which addresses a narrow but significant access issue that has been before the General Assembly for the last few years. There is a small but significant number of minors who find themselves completely and legitimately without an adult in their life to consent to health care services. While current law provides for consent authority in life-threatening circumstances, there is no mechanism for these youth to consent to a broader range of services that enable them to access preventative services as well as receive care for chronic conditions, minor injuries and other basic health care needs.

Delegate Rosenberg, who has championed this issue in prior years, and Senator Kelley advanced legislation that initially MedChi opposed as it broadened consent access for all minors and included a broad range of practitioners. However, working in conjunction with the bill's proponents, the Senate crafted compromise language that limited the expansion of consent rights to those minors who were self-supporting and lived separate from adults who could consent. Further, the bill clarified and strengthened immunity language that applies to physicians and other practitioners who provide care to minors under the belief they meet the definitions provided in the statute. Delegate Morhaim managed the amended bill on the floor of the House to ensure that "minor consent" concerns often raised by various House members did not derail the effort to ensure access to these vulnerable and disadvantaged youth.

Failure to Report Child Abuse – Criminal Penalties: As a result of the Penn State incident, there were a number of bills introduced that proposed to criminalize the failure to report child abuse and neglect. This issue has been before the General Assembly for several years as Maryland is one of only three states that does not have a penalty for failure to report. However, in past years, and again this year, neither the Senate Judicial Proceedings Committee nor the House Judiciary Committee had much appetite for broadly criminalizing failure to report. In an effort to finally resolve this issue, members of the Senate Judicial Proceedings Committee amended Senate Bill 63 (*Child Abuse and Neglect – Failure to Report – Civil Liability and Criminal Penalty*) in a manner that was so narrow as to only apply to the most egregious failure to report circumstances.

As amended, the criminal penalties would only apply if a mandated reporter, only in the course of their professional duties, "knowingly and willfully" failed to report a case where they had actual and direct knowledge of abuse. Note, it is **not** actual and direct knowledge of injury, but actual and direct knowledge that abuse occurred. Further, one would have to know that the abuse is likely to cause or has caused serious physical injury or death. With respect to sexual abuse, you would also have to have actual and direct knowledge that the abuse occurred. Consequently, the language was so narrow that it was difficult to publicly object to someone not reporting under those circumstances. Senate Bill 63 passed the Senate as amended on Saturday

April 7th. With only the final day of the Session for consideration, the House Judiciary Committee did not take up the legislation and the bill failed. Therefore, the issue is likely to arise again in 2013 but hopefully the Senate Bill as amended will become the starting point for the discussion.

Miscellaneous: House Bill 634 (*Physician Assistants – Use of C-Arm Devices*) passed the House of Delegates but never was considered by the Senate and failed. If enacted, the bill would have allowed physician assistants to operate C-Arm devices and it pitted certain nighttime pediatric practices against radiologists. Senate Bill 505/House Bill 408 (*Health Occupations – Imaging and Radiation Therapy Services – Accreditation*) was another dispute between medical specialties seeking to overturn Maryland's laws which limit the use of imaging devices and radiation therapy services to radiologists. This on-going fight pits orthopods, urologists and others against radiology. Neither the House nor the Senate committee voted on the proposal and hence it was unsuccessful.

Senate Bill 954 (*Medical Records – HIPAA Consistency Act of 2012*) was an initiative of CareFirst. As originally proposed, the legislation would have changed Maryland's medical privacy laws to conform with the federal HIPAA law. In many respects, the Maryland law on medical privacy is more restrictive than the federal law and so the bill, as introduced, raised concern not only in MedChi but in the Attorney General's Office. MedChi's counsel Steve Johnson worked with the Attorney General's office and with CareFirst to fashion amendments to more appropriately focus the bill.

CareFirst desired to pass the legislation so that insurance companies could share medical information with treating doctors. This would be particularly important as insurers like CareFirst begin projects such as patient-centered medical homes and as accountable care organizations (ACOs) begin to form to operate under the new federal health care reform laws. In the end, CareFirst satisfied all stakeholders' concerns and MedChi became supportive of the amended legislation. Doctors will now be able to receive medical information on new patients that already exists in an insurer's file. This will assist in the proper treatment of patients where a doctor is able to receive complete information when, for example, a patient is assigned to his or her practice.

Workers' Compensation Regulation Aimed at Physician Dispensing: Midway through the General Assembly Session, MedChi convinced the AELR Committee to turn down proposed regulations of the Workers' Compensation Commission. The Commission was attempting to effectively end the practice of physician dispensing medicines in workers' compensation cases. Its method of doing so was to reduce prices which physicians could charge workers' compensation insurers for dispensed medicines. The regulations would have allowed a dispensing physician to charge 95% of the Average Wholesale Price (AWP) as set by the original manufacturer of the medication in question. However, physicians do not purchase their medicines from original manufacturers but rather from companies that repackage the medicines in smaller quantities. If the regulations had been successful, doctors would have been reimbursed less than they paid for the medicines in question. After an extended 4 hour hearing in the AELR Committee, the regulations received an overwhelming unfavorable vote (14 to 1).