

SCHWARTZ, METZ & WISE, P.A.

ATTORNEYS

20 WEST STREET
ANNAPOLIS, MARYLAND 21401

TEL: 410-244-7000

FAX: 410-269-5443

MedChi Final 2016 Session Report

April 11, 2016

The 436th Session of the Maryland General Assembly concluded at midnight on Monday, April 11th when it adjourned “Sine Die” with the traditional confetti release in both the Senate and House chambers. In this Session, the General Assembly considered 2,832 legislative bills and resolutions plus the proposed Fiscal Year 2017 budget, 584 more bills than last Session. The MedChi Legislative Council reviewed 235 bills, taking positions on many of these.

Achieving MedChi’s 2016 Legislative and Regulatory Agenda

This Session, MedChi successfully advocated for the issues outlined in MedChi’s 2016 Legislative and Regulatory Agenda. Specifically, MedChi worked on behalf of our members to:

Protect Medicaid: Medicaid E&M codes were increased from 92% of Medicare to 96% of Medicare. Please note that this increase will only occur if Governor Hogan agrees to fund the increase through the State’s Revenue Stabilization Fund. Similar to last Session, the General Assembly “fenced off” almost \$80 million to be used to fund eleven General Assembly priorities, including E&M codes for primary and specialty physicians and psychiatry. Governor Hogan has the right (or not) to fund these priorities. To the extent that these programs are not funded by the Governor, the monies will remain unspent.

Ensure Insurer Network Adequacy: For the first time, the Maryland Insurance Commissioner will have authority to determine the adequacy of an insurer’s network under Senate Bill 929/House Bill 1318 (*Health Benefit Plans – Network Access Standards and Provider Network Directories*). The Commissioner will be adopting regulations to establish quantitative and, if appropriate, non-quantitative criteria to evaluate the network. In addition to network adequacy, the Commissioner will also have authority to determine the accuracy of an insurer’s provider directory and can fine an insurer for inaccuracies. An insurer can avoid a fine if it can demonstrate that the insurer contacted the provider, but the provider failed to submit accurate information to the insurer. While MedChi successfully eliminated language in the bill that would have penalized providers for not updating their contact information, it is in the best interest of providers to periodically update this information given that it will be closely monitored by the Commissioner.

Defend Physician Rights: Senate Bill 217 (*State Board of Physicians – Distribution of Fees by Comptroller – Loan Assistance Repayment for Physicians and Physician Assistants*), a MedChi initiative, ceases the redirection of physician license fees to the Health Personnel Shortage

Incentive Grant Program (HPSIG) while maintaining the Loan Assistance Repayment Program (LARP), which helps physicians and physician assistants who agree to practice in underserved areas. The HPSIG has a tenuous relationship to physicians at best and is a fund that is often raided for the General Fund when the State is experiencing a deficit. Physician fees will now remain with the Board or be used for loan assistance for physicians. Additionally, remaining funds already transferred to HPSIG will be utilized for another incentive program passed this Session, also designed to incentivize physicians to work in underserved areas: Senate Bill 411/House Bill 1494 (*Income Tax – Credit for Preceptors in Areas with Health Care Workforce Shortages*) establishes a “preceptor” program. Under this program, physician practices in underserved areas can receive a tax credit for utilizing medical students in those areas.

Pursuant to the legislation passed in 2014 licensing naturopaths, Senate Bill 806 (*State Board of Physicians – Naturopathic Doctors – Establishment of Naturopathic Doctors Formulary Council and Naturopathic Formulary*) is the result of a workgroup on which MedChi served that recommended a formulary for naturopaths. The formulary limits naturopaths to prescribing “non-legend” drugs, administering epinephrine in the same manner as other non-physicians, and sets up a body to review the formulary annually, which includes a physician member.

Consistent with MedChi’s longstanding policy against mandates for continuing medical education, House Bill 185 (*State Board of Physicians – Licensed Physicians – Continuing Education Requirements*), a bill sponsored by Delegate Dan Morhaim, prohibits the State Board of Physicians from requiring a licensed physician to complete continuing education requirements in a specified subject matter as a condition of license renewal.

Lastly, Senate Bill 1020/House Bill 998 (*State Board of Physicians - Physician Licensing Reciprocity*), a bill sponsored by Delegate Terri Hill, allows the Board of Physicians to enter into licensing reciprocity agreements with other jurisdictions. This legislation should result in a more expedited licensure process for physicians already licensed in such other states who want to practice in Maryland, and likewise for physicians licensed in Maryland who want to become licensed in the reciprocating state. In light of this bill, Senate Bill 446 (*Interstate Medical Licensure Compact*), which MedChi had concerns with, was withdrawn.

Strengthen Medical Liability Measures: Several bills were introduced this Session by both the trial lawyers and provider groups on medical liability. Senate Bill 450/House Bill 1487 (*Health Care Provider Malpractice Insurance – Scope of Coverage*) is the only bill that passed this Session and finally allows physicians to purchase one policy for both medical liability and coverage for the defense of a health care provider in a disciplinary hearing arising out of the practice of the health care provider’s profession.

While no other liability-related bills eventually passed, MedChi did ward off an effort to pass House Bill 869/Senate Bill 574 (*Civil Actions – Noneconomic Damages – Catastrophic Injury*), which would have eviscerated the current cap by tripling the maximum amount of noneconomic damages that may be recovered in a health care malpractice case. Other bills introduced but not passed on the issue of medical liability include House Bill 606 (*Patient Safety Early Intervention Programs*) (the apology bill); House Bill 814/Senate Bill 849 (*Task Force to Study the Establishment of Health Courts*); House Bill 992 (*Health Care Malpractice Claims – Health*

Care Alternative Dispute Resolution Office – Repeal); and Senate Bill 513/House Bill 377 (*Maryland No-Fault Birth Injury Fund*).

Enhance Physician Payment and Insurance Reform: MedChi successfully worked to limit the authority of insurers to reduce payments to physicians by using virtual credit cards as a method of payment to physicians. House Bill 639 (*Health Insurance – Provider Claims – Payment by Credit Card or Electronic Funds Transfer Payment Method*) requires an insurer to provide advance notice to a provider that fees are attached to a payment being made using a credit card or electronic funds transfer by the insurer, and requires insurers to offer an alternative payment that does not carry any fees. This initiative was led by Dr. Stephen Rockower who testified on the bill in both the House Health and Government Operations Committee and the Senate Finance Committee.

MedChi also successfully defeated two bills that would have unfairly penalized providers in worker's compensation cases. Senate Bill 258/House Bill 710 (*Workers' Compensation – Medical Benefits – Payment of Medical Services and Treatment*) would have established a 45-day time limit for a provider to submit a bill to an employer or its insurer under workers' compensation. Senate Bill 441/House Bill 1160 (*State Board of Physicians – Admissibility of Board Records – Workers' Compensation Commission*) would have made the proceedings, records, files, and orders of the State Board of Physicians discoverable and admissible in evidence before the Workers' Compensation Commission.

For the second consecutive Session, MedChi defeated legislation that would have changed the State's assignment of benefits (AOB) law. Under the State's current AOB law, a non-preferred hospital-based or on-call physician may accept an AOB, entitling the physician to be paid directly paid by the insurer pursuant to a statutory formula but prohibiting the physician from balance billing the patient. If the physician does not accept the AOB, the physician will not be paid directly by the insurer but can still balance bill the patient. Senate Bill 335/House Bill 1505 (*Health Insurance – Assignment of Benefits and Reimbursement of Nonpreferred Providers – Modifications*) would have altered this law by removing the ability of the physician to accept an AOB and instead would have had all non-preferred hospital-based or on call physicians paid pursuant to the AOB formula and would have prohibited balance billing.

Protect the Integrity of the Prescription Drug Monitoring Program (PDMP): Addressing Maryland's heroin and opioid overdose epidemic has remained a priority for this Administration as well as key legislative leaders. As a result, the Administration introduced Senate Bill 382/House Bill 456 (*Prescription Drug Monitoring Program – Revisions*) and Senator Katherine Klausmeier and Delegate Erik Barron, introduced Senate Bill 537/House Bill 437 (*Department of Health and Mental Hygiene – Prescription Drug Monitoring Program – Modifications*). Both sets of bills proposed mandatory PDMP registration by all controlled dangerous substance (CDS) prescribers as well as broad mandatory PDMP query requirements for prescribers and pharmacists prior to prescribing or dispensing a CDS. The bills, as introduced, also included authority for the PDMP to directly refer cases to law enforcement and the licensing boards. The bills quickly became one of the most hotly debated health issues of the Session.

After many weeks of workgroup meetings, the bills introduced by Senator Klausmeier and Delegate Barron (Senate Bill 537/House Bill 437) became the vehicle and were amended to address many of MedChi's concerns. As amended, the bills now require:

- Mandatory registration of all CDS registrants by 2017. The registration process remains linked to the CDS license registration process, however, the Secretary of Health and Mental Hygiene has authority to delink it if issues arise with timely issuance of CDS licenses.
- Mandatory query but only under very limited circumstances with a number of exceptions, which may be expanded by the Secretary by regulation. The mandated query provisions become effective on July 1, 2018. Again, the Secretary has the authority to delay the mandate's implementation if the PDMP technical capacity and "ease of access" will not support the increased system demand of the mandate.

With regard to the use of the data by law enforcement, MedChi opined that direct referral authority to law enforcement completely undermines the current construct of the PDMP which was purposefully structured to be a health care "tool" for providers and not a "tool" for law enforcement. Fortunately, after significant debate amongst the stakeholders and aggressive advocacy by MedChi, all provisions related to direct referral to law enforcement or licensure boards were deleted from the legislation. A full analysis of the legislation will be sent out under separate cover.

Advance Public Health Initiatives: The General Assembly passed and the Governor has already signed into law House Bill 610 (*Greenhouse Gas Emissions Reduction Act – Reauthorization*) repealing the termination date of the current requirement to reduce greenhouse gas (GHG) emissions by 25% from 2006 levels by 2020 and requires the State to develop plans, adopt regulations, and implement programs to reduce GHG emissions by 40% from 2006 levels by 2030.

DHMH proposed two successful initiatives supported by MedChi. The first initiative, Senate Bill 97/House Bill 468 (*Public Health – Opioid-Associated Disease Prevention and Outreach Programs*) expands statewide the current sterile needle exchange pilot programs operating in Baltimore City and Prince Georges County. The legislation enhances the provisions of the current programs to include requirements that local health departments or community-based organizations authorized to establish an opioid-associated disease prevention and outreach program must provide for substance use outreach, education, and linkage to treatment services, including exchange of hypodermic needles and syringes. Under the legislation, DHMH is required to establish a Standing Advisory Committee to provide assistance and make recommendations on program protocols and procedures. The House cross-file (House Bill 468) was sponsored by Delegate Clarence Lam.

DHMH's second initiative, Senate Bill 91 (*Public – State-Identified HIV Priorities*) requires rebates received by DHMH from the Maryland AIDS Drug Assistance Program to be deposited in a special fund and used only for State-identified priorities for HIV prevention, surveillance, and care services in a more flexible manner. There is strong evidence to suggest that, absent a concerted effort to reinvigorate public awareness, prevention and support services, there could be

an increase in the incidence of HIV and AIDS with a significant portion of that increase occurring in young adults and adolescents who do not have the historical awareness of risks associated with HIV and AIDS.

A few public health initiatives that were strongly supported by MedChi failed to gain traction this Session. House Bill 1467 (*Department of Human Resources – Housing Counselor and Aftercare Program*) would have established a Housing Counselor and Aftercare Program in DHR to assist clients in obtaining and maintaining permanent affordable housing. Several jurisdictions have implemented these programs and the legislation would have mandated the expansion of the program to all jurisdictions. While the legislation failed due to fiscal issues, DHR and relevant stakeholders have pledged to continue to work to expand these programs going forward. It will remain a focus of MedChi's attention in that it is consistent with MedChi's Resolution to address homelessness and housing issues.

Likewise, the Governor's current "anti-tax" stance, as well as the General Assembly's focus on other funding and tax issues, deterred any increase in the tobacco tax this Session. MedChi will continue to push for an increase in future Sessions but the successful advancement of the issue is difficult to predict.

Other Legislation Considered by MedChi

Public Health

House Bill 6 (*Criminal Law – Improper Prescription of Controlled Dangerous Substance Resulting in Death*) (failed) would have increased criminal penalties on a provider if the provider prescribes, administers, distributes, or dispenses a CDS to a person in nonconformity with State law and the use or ingestion of the CDS is a contributing cause of the person's death.

Senate Bill 289/House Bill 216 (*Public Health – Preventive Medical Care – Consent by Minors*) (failed) would have provided an important clarification to Maryland's minor consent law related to sexually transmitted disease. These bills would have ensured that health care providers can treat the full range of sexually transmitted diseases and infections, including the provision of preventative services and counseling that is the standard of care in addressing sexually transmitted disease and infection. Opposition to the bill arose from individuals opposed to the HPV vaccine. Their opposition diverted attention from the primary objective of the legislation but created enough controversy that the sponsors decided to withdraw the legislation without action.

House Bill 394 (*Public Health – Hydraulic Fracturing Chemicals – Information and Fund*) (failed) would have required a permit applicant to submit to DHMH certain information relating to each chemical constituent that will be used in the hydraulic fracturing of the well, including specified information about each chemical. While the bill was not successful, MedChi continues to monitor all initiatives that address the use of chemicals in hydraulic fracturing including any effort to limit information available to health care providers.

Senate Bill 926/House Bill 399 (*Lyme Disease – Laboratory Test – Required Notice*) (passed) was significantly amended to require providers and/or laboratories to provide a notice to patients at the time blood is drawn for the purpose of performing a lab test for Lyme disease. The exact wording of the notice is included in the bill. The notice advises the patient that the test is unreliable and if symptoms persist, to discuss the issue with their provider and/or consider additional testing. The bill includes language that will allow the Secretary to change the notice by regulation if the Secretary finds that it does not reflect current medical evidence on Lyme disease testing. It also contains immunity language that specifies the provision of the notice cannot be the basis for a cause of action.

House Bill 682/Senate Bill 551 (*Behavioral Health Advisory Council – Clinical Crisis Walk-In Services and Mobile Crisis Teams – Strategic Plan*) (passed) requires the Behavioral Health Advisory Council, in consultation with local core service agencies, community behavioral health providers, and interested stakeholders, to develop a strategic plan for ensuring that clinical crisis walk-in services and mobile crisis teams are available statewide and operating 24 hours a day and 7 days a week.

Senate Bill 398/House Bill 820 (*Reducing Environmental Degradation for the Underserved Through Community Engagement*) (failed), a bill sponsored by Delegate Lam, would have required a specified applicant for an air quality permit to construct to: (1) estimate and report specified information related to diesel vehicle trips and emissions to the Maryland Department of the Environment and, (2) solicit specified information from an “affected community” located around a source or proposed source. Several issues were raised during the hearings, which continue to be under consideration by the Maryland Department of the Environment’s Cumulative Impact Workgroup. The Workgroup’s deliberations will continue during the 2016 interim, which MedChi will be monitoring.

House Bill 886/Senate Bill 242 (*Maryland Medical Assistance Program – Telemedicine – Modifications*) (passed) clarifies that primary care providers are authorized to provide telemedicine services; reflects changes made by DHMH that simplify the provider registration form and requires DHMH, in consultation with the Maryland Health Care Commission, to submit a report by October 1, 2016 on Medicaid telehealth assessing the policies of select Medicaid programs in other states, including reimbursement for telehealth services provided in a home setting; and details planned enhancements to Maryland Medicaid telehealth.

House Bill 1498/Senate 602 (*Maryland Healthy Vending Machine Act*) (failed) would have required items in vending machines located on State owned or leased property to meet certain nutritional guidelines. This legislation was an initiative by Sugar Free Kids.

Health Insurance

Senate Bill 647/House Bill 752 (*Physicians – Prescriptions Written by Physician Assistants and Nurse Practitioners – Preparing and Dispensing*) (passed) clarifies the practice that physicians can dispense medications prescribed by physician assistants working under a delegation agreement with a physician or by a nurse practitioner working with a physician in the same office setting.

House Bill 1220 (*Department of Health and Mental Hygiene - Health Program Integrity and Recovery Activities*) (passed) sets forth a process to authorize DHMH to use extrapolation in a Medicaid audit to recover overpayments from providers. As introduced, the bill failed to adequately address provider protections. MedChi, along with other stakeholders, worked with DHMH to develop a clear process for when and how extrapolation could be used as well as an appeals process for providers. As passed, Maryland will have the most narrowly tailored law on extrapolation.

Senate Bill 857/House Bill 1265 (*Maryland Health Care Commission – Hospital and Physician Financial Arrangement Disclosure – Requirements*) (failed) would have required each hospital and physician with a “financial arrangement” with a pharmaceutical or surgical hardware manufacturer to file a financial disclosure form with the Maryland Health Care Commission within 90 days after the financial arrangement is finalized.

Boards and Commissions

Senate Bill 310/House Bill 245 (*Child Abuse and Neglect – Failure to Report*) (passed) requires an agency that is participating in a child abuse or neglect investigation and that has substantial grounds to believe that a person has knowingly failed to report suspected abuse or neglect to file a complaint with the appropriate licensing board (if the person is a health practitioner), law enforcement agency (if the person is a police officer), or the appropriate agency, institution, or licensed facility at which the person is employed (if the person is an educator or human service worker). For many years, legislation had been considered and defeated that would have criminalized “failure to report.” Passage of this bill will hopefully end the debate on criminalization and will minimize the potential of a physician referral for “failure to report” abuse and neglect since, under Senate Bill 310/House Bill 245, the failure must occur “knowingly.”

Senate Bill 462/House Bill 724 (*Public Health – Copies of Medical Records – Fees*) (passed) establishes that copies of electronic medical records will be subject to certain fee limits that are different from those which exist for hard copies.

Senate Bill 482/House Bill 1114 (*State Board of Physicians – License Renewal – Grace Periods*) (failed) would have established a 60-day grace period for licensees of the State Board of Physicians to retroactively renew licenses after license expiration if the licensee (1) otherwise meets the renewal requirements and (2) pays the renewal fee and any late fee set by the Board.

Other Bills of Interest

Aid in Dying

Several bills related to “aid in dying” were introduced but did not pass. On these bills, MedChi deferred to the AMA Policy governing the issue. The bills included:

- Senate Bill 418/House Bill 404 (*Richard E. Israel and Roger ‘Pip’ Moyer End-of-Life Option Act*) would have created a process by which an individual may request and receive “aid in dying” from the individual’s attending physician.
- Senate Bill 873/House Bill 416 (*Health Care Decisions Act – End-of-Life Decision-Making Informational Booklet*) would have required DHMH, in consultation with the State Advisory Council on Quality Care at the End of Life, to develop an end-of-life decision-making information booklet by October 1, 2017.
- House Bill 568 (*Health Occupations – Health Care Practitioners – Exemption from Participation in Aid in Dying*) would have prohibited a health care practitioner from being required to participate in aid in dying and would have prohibited a health care practitioner who refuses to participate in aid in dying from being held criminally or civilly liable for refusing to participate.

Self-Referral

There were two bills considered by the General Assembly that failed to pass the last week of Session affecting Maryland’s self-referral law, one related to Maryland’s Hospital Waiver. Senate Bill 886/House Bill 1272 (*Health – Collaborations to Promote Provider Alignment*) (failed) would have exempted “collaborations to promote provider alignment” from general prohibitions against self-referrals by health care practitioners and required disclosures of beneficial interests to promote provider alignment to achieve the goals of Maryland’s Hospital Waiver. MedChi had been in negotiations with the Health Resources Cost Review Commission (HSCRC) and the Maryland Hospital Association (MHA) to include an amendment to the bill to allow the HSCRC to designate an entity to assist the State in implementing two programs under the Waiver – the Internal Cost Saving Program between hospitals and physicians, and the Pay for Outcomes Programs between hospitals and other community-based providers. While the language was believed to have been worked out, MHA subsequently withdrew its support for the language. MedChi will continue to work with the HSCRC and others to ensure that the intent of the Waiver can be achieved and that physicians have a fair playing field to participate with and enter into incentive programs.

Senate Bill 739/House Bill 1422 (*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.

Hospitals

Several bills were introduced this Session aimed at actions taken by hospitals to close or alter services -- hospitals have contended that the new Hospital Waiver requires hospitals to adjust their level of services to account for declining hospital inpatient stays. However, individuals (both consumers and providers) in the affected communities have expressed concern over patient safety and access to care. While the bills have statewide impact, the issues were mainly

highlighted this Session when the University of Maryland Shore Regional Health and Laurel Regional Hospital announced they would be closing inpatient services. As a result, bills were introduced by legislators to address these issues and to allow for greater community involvement.

- House Bill 1121/Senate Bill 12 (*Health Care Facilities – Closures of Hospitals – County Board of Health Approval*) (failed) would have prohibited an entity from closing or partially closing a hospital that receives State and county funding unless (1) the person notifies the county board of health in which the hospital is located at least 90 days prior to the proposed date of closure or partial closure and (2) the county board of health approves the closure or partial closure.
- Senate Bill 707 (*Freestanding Medical Facilities – Certificate of Need, Rates, and Definition*) (passed) exempts the conversion of a licensed general hospital to a freestanding medical facility (and any related capital expenditure) from the requirement to obtain a certificate of need (CON) and establishes the procedures for obtaining the exemption from the Maryland Health Care Commission. In direct response to the issue at Chester River Hospital, the bills prohibit a licensed general hospital located in Kent County from converting before July 1, 2020, and create a workgroup on rural health care delivery.
- Senate Bill 352 (*Maryland Health Care Commission – Certificate of Need Review – Interested Party*) (passed) allows a jurisdiction affected by a change in the CON to be considered an “interested party” in the review of a replacement acute general hospital project proposed by or on behalf of a regional health system that serves multiple contiguous jurisdictions within the region served by the regional health system, when the jurisdiction does not contain the proposed replacement acute general hospital project.

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 Banda (Boards and Commissions); Dr. Sarah Merritt (Public Health) and Dr. Anuradha Reddy (Health Insurance) and to our Legislative Council chairs, Dr. Gary Pushkin, and Dr. Sarah Merritt.

MedChi also recognizes those physicians who came to Annapolis on behalf of MedChi to testify on various initiatives, including Dr. Russell White, Dr. Tyler Cymet, Dr. Brooke Buckley, Dr. Frederico Ward and Dr. Michael Murphy.

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 has 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:

Reed Winston, M.D.
James Williams, M.D.
Tyler Cymet, D.O.
Sarah Merritt, M.D.
Jane Chew, M.D.
James Lacey, M.D.
John Gordon, M.D.
Walter Giblin, M.D.
Irfana Ali, M.D.
Gene Ashe, M.D.

Ramsay Farah, M.D.
George Malouf, Jr., M.D.
Gary Pushkin, M.D.
David Hexter, M.D.
Geoffrey Coleman, M.D.
Stanley Wisniewski, M.D.
Larry Green, M.D.
Gary Cohen, M.D.
Willarda Edwards, M.D.
H. Russell Wright, M.D.

Dr. James Chappell
Ning Hu, M.D.
Roger Stone, M.D.
Stephen Rockower, M.D.
Mark Plaster, M.D.
Tim Romanoski, M.D.
Stephen Rockower, M.D.
Ramsay J. Farah, M.D.