MedChi General Assembly Sine Die Report
April 8, 2024

This Sine Die report is sent to designated leaders at MedChi, all of whom have signed a Conflict-of-Interest statement and have agreed to keep matters – such as those contained in this Sine Die Report – confidential.

The Maryland General Assembly began its 446th Session at noon on Wednesday, January 10th and concluded its legislative work at midnight on Monday, April 8th. In addition to the budget issues, this Session was particularly challenging due to the unusually large volume of bills. As opposed to the typical introduction of 2200-2300 bills, there were 2,714 bills introduced this Session. As a result, committees were forced to take the atypical step of holding hearings on Fridays and Mondays. Some bills were not passed this year due simply to a lack of time.

Despite these challenges, MedChi had another successful Session, with a number of key legislative victories. These wins included passing priority legislation and fighting off any reductions in the Fiscal Year (FY) 2025 budget.

Fiscal Year 2025 Budget

The House Appropriations (APP) Committee and the Senate Budget and Taxation (B&T) Committee concluded the budget negotiations on April 5th after Governor Moore granted the General Assembly a 10-day budget extension. From the beginning of Session, the two chambers were at odds on addressing both Maryland's current operating budget deficit of $761 million as well as a $3 billion projected future deficit, much of it driven by the cost of the education funding plan, known as the Blueprint for Maryland's Future. Several factors then complicated this already trying budget situation. First, the Maryland Department of Health (MDH) announced a $236 million budget shortfall in Medicaid. Second, the Comptroller's Office announced a revenue decrease of $255 million (combined current and next FY). Third, the Francis Scott Key Bridge tragically collapsed. To address these issues, the House supported new and modified taxes whereas the Senate opposed tax increases out of concern over the impact on the economy. These differing approaches dominated the final days of Session. In the end, the General Assembly came to agreement and sent the $63 billion budget to Governor Moore using a combination of tactics.

Despite these obstacles, MedChi successfully maintained Medicaid E&M codes for physician payment at 100% of Medicare, a long-standing advocacy goal of MedChi. Given that the federal government recently increased Medicare rates, MedChi will be working to ensure that this increase is applied to Maryland's rate as well. In addition, MedChi received $3 million for the Physician Assistance Repayment Program. Following the end of Session, the Chairs of the Senate B&T Committee and the House APP Committee will release the Joint Chairmen's Report, which is a compilation of all budgetary actions taken this Session, including any reports required by State agencies. In addition, after Session, many committees will send separate letters to the State agencies requesting reports on priority issues. MedChi will review these documents and send out an addendum to this report.

As far as the overall FY 2025 budget is concerned, almost $105 million of new revenue will be dedicated to emergency medical services, consisting of about $46 million being used to eliminate a projected structural deficit for the Emergency Medical Systems Operations Fund, which supports the State police aviation command and coordination of the State's emergency medical system. In addition, $41 million will be allocated to shock trauma, and $18 million will be dedicated to expanding reimbursements from the Maryland Trauma Services Fund. The budget also raises an additional $91 million for education expenses through a new $1.25 tax on each pack of cigarettes; increasing the sales tax on e-cigarettes and vapes from 12% to 20%; and for other tobacco products (not cigars), increasing the tax from 53% to 60% of the wholesale price. Lastly, in order to increase funding for local road maintenance, public transit, and other transportation projects, the General Assembly, among other measures, increased fines for speeding in a work zone; increased surcharges on plug-in electric and hybrid vehicles ($62.50 surcharge on zero-emission electric vehicles and $50 on plug-in electric vehicles); and added a ride-hauling surcharge (75 cents per trip).

Boards and Commissions

House Bill 1388: Labor and Employment: Noncompete and Conflict of Interest Clauses for Veterinary and Health Care Professionals and Study of the Health Care Market (passed) MedChi adopted a Resolution in the fall of 2023 supporting the elimination of non-compete clauses in physician contracts and limiting their scope, the result of years of work by the Restrictive Covenant Task Force within MedChi. As introduced by Delegate/Dr. Terri Hill, this bill prohibited such clauses and was retroactive. MedChi and other health care professions strongly supported the bill. The House of Delegates removed the retroactivity clause because of constitutional concerns (the US Constitution prohibits the impairment of existing contracts) but passed the bill overwhelmingly, despite the objections of MedStar and the Maryland Hospital Association. In the Senate, the same entities pushed for amendments that banned non-compete clauses for those earning compensation less than $300,000 per year, but allowed them above that threshold, so long as the clause did not exceed 1-year and a 10-mile radius. Their amendments also sought a study of the effect of private equity firms buying physician practices and to delay implementation of the bill until July of 2025.

MedChi worked with Senate Finance (FIN) Committee Chair Pamela Beidle to modify the proposed amendments. Through our modifications, the bill measures the 10-mile radius from the primary place of employment, increases the salary threshold to $350,000, and expands the study to include all types of acquisitions of physician practices, including by hospitals. The bill's effective date remains July of 2025.

The importance of this legislation to physicians cannot be overstated. While we would have preferred the bill as adopted by the House, not taking what is still a significant improvement over the current law posed unknown risks and would have allowed the opposition to mobilize their considerable resources heading into 2025. With this result, physicians earning less than $350,000 cannot be subject to non-compete clauses at all, and those above that amount are protected from terms that are geographically overbroad (for example, when a hospital system measures the distance from ANY of its facilities in the State) and longer than 1-year. Effective Date: June 1, 2024.

- **Medical Malpractice and Tort Issues**

House Bill 83/Senate Bill 538: Civil Actions – Noneconomic Damages – Personal Injury and Wrongful Death (failed) would have repealed the cap on non-economic damages, i.e. those damages awarded in

negligence cases for pain and suffering. After a spirited debate on the Senate floor, Senate Bill 538 passed with amendments that would have increased the cap on noneconomic damages to $1,750,000 for personal injury and $2,625,000 for wrongful death of 2 or more claimants with an annual increase of $20,000. The cap addressed by this bill applies to all cases *other than* health care claims. Still, while physicians were not directly affected by this legislation, a repeal of this statute would set a bad precedent for the future repeal or increase of the noneconomic cap that applies to medical malpractices cases and, therefore, MedChi opposed it.

House Bill 1361: Task Force to Study Various Aspects of Changing Contributory Negligence to Comparative Negligence Act (failed) is a great illustration of our members having personal relationships with legislators. The bill would have studied a change in negligence law from the current standard of contributory negligence, which prohibits a plaintiff from recovering damages if they are at all responsible for their injuries, to that of comparative negligence, which requires a judge or jury to weigh the relative fault of both the plaintiff and defendant. MedChi favors the current standard of contributory negligence. Dr. Jeffrey Chung, a MedChi member and ophthalmologist who knows the bill sponsor, reached out and explained our position, and the legislation was withdrawn. This would not have happened without Dr. Chung having an established relationship with the sponsor, and it shows the importance of developing them.

House Bill 149: Medical Records – Destruction – Notice and Retrieval (passed) extends the period that a provider must keep medical records for adults from the current 5-year period to 7 years, consistent with the current Medicare requirement. The timeline for minors is extended from the current requirement of age 18 plus 3 years to age 18 plus 7 years. Providers may destroy records in less time than this, but proper notice must be provided. The amendments will allow such notice to be provided by email and letter, rather than the current law, which is outdated and requires publication in a newspaper "of general circulation." Effective Date: October 1, 2024.

- **Board of Physicians**

Senate Bill 506: State Board of Physicians – Discipline – Administrative Expungement (failed) would have allowed the Board to administratively expunge minor offenses, such as failure to maintain adequate CME credits, once 3 years have passed from the date of the offense. Regulations to this effect were approved by the Board over 3 years ago but have never been adopted, despite repeated letters from MedChi and the bill sponsor, Senator Chris West. The Board testified that the regulations will finally be adopted in the near future.

Following some significant amendments recommended by MedChi in 2023, MedChi supported ***House Bill 757: State Board of Physicians – Supervised Medical Graduates and Cardiovascular Invasive Specialists (Bridge to Medical Residency Act) (passed)***. The bill provides a home for medical graduates who have not matched for residency. These graduates would be regulated by the Board of Physicians and allowed to work under the supervision of a licensed physician for up to 2 years only. Effective Date: Emergency – Upon Enactment.

- **Scope of Practice**

See the full-page summary of ***House Bill 806/Senate Bill 167: Physician Assistants – Revisions (Physician Assistant Modernization Act of 2024)***, which is attached.

House Bill 464/Senate Bill 795: Health Occupations – Practice Audiology – Definition (passed with amendments) expands the scope of practice of audiologists to include evaluation, diagnosis, and treatment of any auditory or vestibular condition of the ear, and allows them to conduct health screenings, remove foreign bodies from the external auditory canal, and order cultures and bloodwork testing. MedChi followed the lead of the Maryland Society of Otolaryngology (MSO) and also opposed the measure. Despite MSO's objections, the bill passed with minor amendments. Effective Date: October 1, 2024.

Senate Bill 995: Health – Laser Hair Removal – Requirements (Laser Hair Removal Act) (failed) would have allowed Licensed Practical Nurses (LPNs) and others to perform laser hair removal, altering extensive regulations which already exist governing who can perform such cosmetic procedures. The Maryland Dermatological Society opposed the bill, and MedChi followed suit. After negotiating the removal of LPNs from the bill, MedChi later agreed to work with Milan, the company sponsoring the bill, over the summer to further discuss their goals. In exchange, the bill was withdrawn.

House Bill 425/Senate Bill 359: Advance Practice Registered Nurse Compact (failed) would have created a Compact for Advanced Practice Registered Nurses (APRN), which include Certified Registered Nurse Anesthetists, Nurse Midwives, Certified Nurse Specialists, and Nurse Practitioners (NPs). Maryland would have been one of the first five states to adopt it.

House Bill 934/Senate Bill 830: State Board of Physicians – Performance of X-Ray Duties Without a License (passed with amendments) alters the circumstances under which an individual may perform x-ray duties without a license. A physician's office that employs an unlicensed individual to perform x-ray duties is responsible for ensuring that all requirements are met for each x-ray examination performed. The Maryland Radiologic Society was heavily involved in the bill, which was ultimately agreed to by all parties. The biggest issue was the training and education requirements, which are:

1. Completion of a limited scope X-ray educational program consisting of at least 115 hours of didactic training delivered by a radiologic technologist certified by the American Registry of Radiologic Technologists.
2. Completion of at least 480 hours of clinical training under the direct supervision of a radiologic technologist certified by the American Registry of Radiologic Technologists.
3. Successful completion of a minimum of five competencies in each body part listed in the subsection, which includes the upper and lower extremities, under the direct supervision of a radiologic technologist certified by the American Registry of Radiologic Technologists.
4. Achieving a passing score on the American Registry of Radiologic Technologists examination for limited scope of practice in radiography or an alternative examination approved by the Board.
5. Registration with the Board, attesting to the completion of the educational and clinical requirements, as well as completing at least 24 hours of approved continuing education credits every two years.

The start date of the bill is Jan 1, 2025; it's effective for 5 years and has a sunset date of December 31, 2030.

Health Insurance

After almost two years of advocacy and negotiations, ***Senate Bill 791/House Bill 932: Health Insurance – Utilization Review – Revisions*** passed the General Assembly. Passage of this bill represent a major policy win for MedChi, despite some challenges and last-minute bumps in the road. After a successful interim workgroup involving physicians, health care practitioners, payors, pharmacy benefit managers (PBMs), and other advocacy organizations, Vice Chair of the Senate FIN Committee Kathy Klausmeier and Vice Chair of the House Health and Government Operations (HGO) Committee Bonnie Cullison introduced the bill as "consensus legislation," with all parties agreeing to support. However, a few weeks into Session, CareFirst broke from its support and raised an issue with the reauthorization provision of the legislation. This provision would prohibit an insurer from issuing a denial upon a request for renewal of a prior authorization when the insurer previously approved the prescription drug, the patient had been treated with the prescription drug without interruption, and the prescriber attested that the drug continued to be necessary to effectively treat the patient's condition. Equally frustrating and more importantly, the Maryland Department of Budget and Management sent a letter to the committees stating that the legislation would cost the State, through the State Employee Health Benefit Plan, approximately $91 million. Right or wrong, the General Assembly could not ignore this cost, especially given the budget situation. As such, committees dealt with the fiscal note by limiting the reauthorization clause to a prescription drug to treat a patient's mental health disorder or a prescription drug that is an immune globulin. All other protections remain fully in the bill. ***A comprehensive summary is attached to this report***. MedChi will continue to examine the issues surrounding the fiscal note to determine how to expand the reauthorization provision. Effective Date: January 1, 2025 (reports due prior to the 2025 Session).

Unfortunately, for the second consecutive year, ***Senate Bill 990/House Bill 1423: Maryland Medical Assistance Program and Health Insurance – Step Therapy, Fail-First Protocols, and Prior Authorization – Prescription Drugs to Treat Serious Mental Illness*** failed to pass. However, with the reauthorization provision in the utilization review bill applying to prescription drugs that treat mental health disorders, prescribers and patients will be assured that medications which are effectively treating their condition will not be denied upon a renewal of the prior authorization.

Similarly, ***House Bill 1337: Health Insurance – Appeals and Grievances Process – Reporting Requirements (passed)*** expands the required contents for the quarterly report each carrier must submit to the Insurance Commissioner regarding appeals and grievances. Each carrier must include in a quarterly report to the Commissioner (1) the number of members entitled to health care benefits under a policy, plan, or certificate issued or delivered in the State by the carrier and (2) the number of clean claims for reimbursement processed by the carrier. Effective Date: July 1, 2024.

Furthering the protections for those with a mental health or substance use disorder, ***Senate Bill 684/House Bill 1074: Health Insurance – Mental Health and Substance Use Disorder Benefits – Sunset Repeal and Modification of Reporting Requirements (passed)*** alters and expands reporting requirements for carriers to demonstrate compliance with the federal Mental Health Parity and Addiction Equity Act (Parity Act). The bill requires a carrier to submit a biennial compliance report beginning July 1, 2024, that includes specified information, including information on select nonquantitative treatment limitations (NQTLs), results from a comparative analysis conducted by the carrier, and authorizes the Insurance Commissioner to take additional actions to enforce compliance with reporting requirements. Effective Date: Emergency Bill – Upon Enactment.

Regarding benefits, coverage, and reimbursement, ***House Bill 1259: Health Insurance – Breast and Lung Cancer Screening – Coverage Requirements (passed)*** adds image-guided breast biopsy to the definition of "supplemental breast examination" and clarifies that follow-up diagnostic imaging applies to lung cancer screening. The bill affirms that prior authorization for the procedures is prohibited. Effective Date: January 1, 2025.

Senate Bill 778/House Bill 1339: Health Insurance – Hearing Aids for Adults – Coverage (passed) requires carriers to provide coverage for all medically appropriate and necessary hearing aids for an adult covered under a policy or contract. Carriers may limit the benefit to $1,400 per hearing aid for each hearing-impaired ear every 36 months. The bill does not prohibit carriers from providing coverage that is greater or more favorable or from an insured in paying the difference if a hearing aid is chosen that is more costly. Effective Date: January 1, 2025.

Senate Bill 614/House Bill 865: Maryland Medical Assistance Program and Health Insurance – Coverage for Prostheses (So Every Body Can Move Act) (passed) applies to both the Medicaid Program and the full commercial market and expands coverage of prosthetic devices to coverage for prostheses and replacement for prostheses. The covered benefits include prostheses if the treating physician determines that the prostheses is determined by a treating health care provider to be medically necessary for: (i) completing activities of daily living; (ii) essential job-related activities; or (iii) performing physical activities, including running, biking, swimming, strength training, and other activities to maximize the whole-body health and lower or upper limb function of the insured or enrollee. The bill also requires the carriers and Medicaid managed care organizations to report to the Maryland Insurance Administration claims data for dates of coverage between 2025-2028. Effective Date: January 1, 2025.

Due to a large fiscal note, ***Senate Bill 594/House Bill 986: Maryland Medical Assistance Program – Coverage for the Treatment of Obesity – Required Study (passed)*** was converted into a study, rather than requiring the Medicaid program (not the commercial market) to provide comprehensive coverage for the treatment of obesity. The study requires the MDH and other stakeholders to (1) identify and compare the coverage for the treatment of obesity under Medicaid and other public health programs in other states; and (2) examine and estimate any potential savings that may result from requiring comprehensive coverage for the treatment of obesity, due to reductions in the use of medications and services currently covered under Medicaid. Effective Date: Study results due to the General Assembly by December 31, 2024.

Opposed by MedChi, ***Senate Bill 1104/House Bill 1148: Health Care Facilities – Notice to Consumers – Out-of-Network Status (Health Care Provider Out-of-Network Information Act) (failed)***, a bill requested by the Attorney General (AG), would have required a health care facility to provide notice of out-of-network status to a consumer, including a written estimate of the costs for receiving services at the out-of-network facility. As drafted, it was unclear how a physician or health care practitioner's office would have been affected, given the definitions and the use of "health care facility" and "provider." MedChi had several discussions with representatives from the AG's Office regarding our concerns. In the end, based on the concerns raised, the AG's Office withdrew the bill.

Senate Bill 487/House Bill570: Health Maintenance Organizations – Payments to Nonparticipating Providers – Reimbursement Rate (failed) would have altered Maryland's law governing payments for non-participating providers (otherwise referred to as out-of-network) by providing a date certain (January 31, 2019) from which the carrier must base calculations for payment to providers. Concerns on whether imposing a date may disadvantage certain specialties, while benefiting others caused the House HGO

Committee not to move the bill forward. However, the Committee has stated that it will study this issue over the interim to determine how a bill could be designed for introduction next Session.

Senate Bill 526/House Bill 876: Health Insurance – Pharmacy Benefits Managers – Specialty Drugs Dispensed by a Physician (failed), as introduced, would have prohibited a PBM from requiring a beneficiary to use a specific pharmacy or entity for a specialty drug. As a first step, the committees decided to limit it to oncology services. Therefore, the bill was amended to state that a PBM or a carrier may not exclude coverage for a covered specialty drug administered or dispensed by a provider if: (1) the provider that administers or dispenses the covered specialty drug: (i) is an in-network provider of covered medical oncology services; and (ii) complies with state regulations for the administering and dispensing of specialty medication. In addition, the covered specialty drug must be: (i) infused, auto injected, or an oral targeted immune modulator; or (ii) an oral medication that requires complex dosing based on clinical presentation or is used concomitantly with other infusion or radiation therapies. In the last week of Session, the bill hit a snag when the advocates and PBMs/insurers could not agree on language regarding reimbursement. It is likely a version of this bill will be introduced next Session.

Bills affecting coverage and benefits that did not pass and where the committees did not indicate an intention to further study the issue include ***Senate Bill 535: Health Insurance – Labor and Delivery Services – Cost-Sharing Requirements (failed)***, which would have prohibited carriers that provide coverage for labor and delivery services from imposing a deductible, coinsurance, copayment, or other cost-sharing requirement for such services; ***House Bill 400/Senate Bill 124: Maryland Medical Assistance Program and Health Insurance – Annual Behavioral Health Wellness Visits – Coverage and Reimbursement (failed)***, which would have required carriers to provide coverage for an annual behavioral health wellness visit, regardless of the assessment resulting in a behavioral health diagnosis; ***House Bill 939/Senate Bill 989: Health Insurance – Epinephrine Injectors – Limits on Cost Sharing (Epinephrine Cost Reduction Act of 2024) (failed)***, which would have required carriers to limit the total amount a patient is required to pay in copayments, coinsurance, and deductibles for a twin-pack of medically necessary prescription epinephrine injectors to not more than $60, regardless of the type of epinephrine injector needed to fill the covered individual's prescription; ***House Bill 1137: Maryland Medical Assistance Program and Health Insurance – Required Coverage for Calcium Score Testing (failed)***, which would have required carriers and the Medicaid program to provide coverage for calcium score testing to individuals who have certain risk factors; and ***Senate Bill 876/House Bill 1040: Maryland Medical Assistance Program – Limited Behavioral Health Services (failed)***, which would have required the Medicaid Program to provide limited behavioral health services to individuals under the age of 18 years regardless of whether the individual has a behavioral health diagnosis.

Several bills aimed at prescription drug costs failed to move forward this Session. ***House Bill 340/Senate Bill 388: Prescription Drug Affordability Board – Authority for Upper Payment Limits and Funding (The Lowering Prescription Drug Costs for All Marylanders Now Act) (failed)*** would have authorized the Prescription Drug Affordability Board to establish a process to set upper payment limits for all purchases and payor reimbursements of prescription drug products in the State rather than only State payors. With the failure of the bill, the Board will continue as scheduled with the study to examine expansion of the Board's authority to all payors in the State. Similar to measures taken in other states, ***House Bill 1270/Senate Bill 1019: Health Benefit Plans – Prescription Drugs – Rebates and Calculation of Cost Sharing Requirements (failed)*** would have required PBMS to "pass through" at least 85% of the rebates received by pharmaceutical manufacturers to offset costs to patients.

Perhaps the most disappointing patient protection that failed to move forward this Session was ***Senate Bill 595/House Bill 879: Health Benefit Plans – Calculation of Cost Sharing Contribution – Requirements and Prohibitions (failed)***. This bill, known as the copay accumulator bill, would have prohibited an insurer or PBM from denying the ability for a patient to use copay assistance coupons. Copay assistance coupons help limit patients' out-of-pocket costs in two ways: by reducing the amount a patient pays at the pharmacy counter when they fill their prescription and by allowing the value of the coupon to also be applied to a patient's annual cost-sharing requirement, like deductibles. The Senate FIN Committee and the House HGO Committee each passed the bill with differing amendments, and neither committee agreed to recede from its original position. The advocates for the bill, including MedChi, supported the Senate version. It is expected that the bill will be reintroduced next Session.

A few other notable health insurance bills that seek to increase access to health insurance include ***House Bill 728/Senate Bill 705: Health Insurance – Qualified Resident Enrollment Program (Access to Care Act) (passed)***. This bill requires the Maryland Health Benefit Exchange to submit a federal State Innovation Waiver application by July 1, 2025, to establish a Qualified Resident Enrollment Program and seek, if available, federal pass-through funding to allow qualified residents to obtain coverage through the Exchange. Effective Date: October 1, 2024. ***Senate Bill 701/House Bill 953: Maryland Health Benefit Exchange – State-Based Young Adult Health Insurance Subsidies Pilot Program – Amount of Annual Subsidies (passed)*** allows unspent funds from the current Pilot Program to remain in the fund designated for subsidies for young adults rather than being diverted to the General Fund to continue to offset the costs for young adults obtaining insurance through the Exchange. Effective Date: Emergency Bill – Upon Enactment.

Public Health

House Bill 119/Senate Bill 211: Public Health – Giving Infants a Future Without Transmission (GIFT) Act (passed) was advanced by the MDH to address the increasing incidences of HIV in pregnant women and their newborn infants. Current law requires physicians to test during the first trimester. The bill expands the testing and reporting requirements from physicians to any health care provider who has diagnosed an individual with HIV while under their care and expands the reporting requirements to include the pregnancy status of an individual, if applicable. In addition, the bill requires testing of a pregnant woman in the third trimester as well as at the time of delivery, including stillborn births under certain circumstances. The bill also requires a hospital to determine the syphilis serologic status of a mother before discharging the newborn for purposes of neonatal evaluation and treatment. Finally, the bill was amended to strengthen the current privacy protections that prevent the information from being discoverable or admissible as evidence in any civil, criminal, or administrative action and if not protected, the release of information is subject to civil penalties. Effective Date: October 1, 2024.

House Bill 238/Senate Bill 244: Public Health – Clean Indoor Air Act – Revisions (passed) is an MDH bill. It extends the ban on smoking in public indoor areas and on specified mass transit systems under the Clean Indoor Air Act (CIAA) to include "vaping." Signage that states "No Smoking or Vaping" must be conspicuously posted and properly maintained in each indoor area open to the public (including each public entrance to an indoor area) where smoking or vaping is prohibited under CIAA. Effective Date: July 1, 2024.

House Bill 522/Senate Bill 492: Public Schools – Student Telehealth Appointments – Policy and Access (passed) was heavily amended to address several issues raised by Maryland public schools. As enacted,

the bill requires the Maryland State Department of Education (MSDE) and MDH, by December 31, 2024, to develop State guidelines regarding the availability for student participation in telehealth appointments during the school day on the premises of public middle and high schools. In developing the guidelines, MSDE and MDH must consult with a broad range of stakeholders and consider operational, legal, and financial issues. The State Board of Education must adopt the State guidelines as developed by MSDE and MDH, and, before the start of the 2025-2026 school year, each local board of education must adopt and implement a policy in accordance with the State guidelines. Each local board must ensure that the local school system publishes the student telehealth policy in the student handbook and makes school personnel aware of student telehealth policy objectives and requirements. Effective Date: July 1, 2024.

House Bill 657: Public Institutions of Higher Education – Pregnant and Parenting Students – Policy (failed) and ***House Bill 771/Senate Bill 741: Public Senior Higher Education Institutions – Pregnant and Parenting Students – Plan Requirements (Pregnant and Parenting Support Act)(failed)*** would have required higher education institutions to adopt policies related to pregnant and parenting students consistent with Title IX of the Education Amendments of 1972. House Bill 771/Senate Bill 741 also required the policy to include requirements for referrals to on-campus and off-campus services and the provision of information regarding the availability of or eligibility for government assistance programs. The House passed House Bill 771, but no action was taken in the Senate. In part, the failure to advance the legislation is based on evidence that Maryland Public Higher Education Institutions are already complying with Title IX.

House Bill 691/Senate Bill 119: Legally Protected Health Care – Gender-Affirming Treatment (passed) expands the definition of "legally protected health care" to include all gender-affirming treatment, including medications and supplies related to the direct provision or support of the provision of care related to gender-affirming treatment. Thus, the bill applies the additional protections and prohibitions established for reproductive health care services to all gender-affirming treatment that is lawful in the State. Effective Date: October 1, 2024.

House Bill 1048/Senate Bill 212: Behavioral Health Advisory Council and Commission on Behavioral Health Care Treatment and Access – Alterations (passed) is a MDH bill, which alters the membership of both the Behavioral Health Advisory Council and the Commission on Behavioral Health Care Treatment and Access and provides specific requirements for collaboration and meeting timeframes. Effective Date: July 1, 2024.

House Bill 1078: Maryland Medical Assistance Program – Remote Ultrasound Procedures and Remote Fetal Nonstress Tests (passed) requires Medicaid to provide coverage for remote ultrasound and fetal nonstress tests if the patient is in a residence or location other than the office of the patient's provider and the provider follows the same standard of care that would be followed if the services were provided on-site. Because the bill requires the same standard of care, coverage for remote ultrasound and fetal nonstress testing is consistent with Medicaid coverage for many other services that are now authorized to be provided via telehealth. Medicaid currently covers these services, and the bill is essentially a codification of existing policy. Effective Date: October 1, 2024.

House Bill 1096/Senate Bill 427: Public Health – Overdose and Infectious Disease Prevention Services Program (failed) is the reintroduction of legislation that reflects the policy adopted in a Resolution of the MedChi House of Delegates. The legislation provides that a community-based organization may establish an Overdose and Infectious Disease Prevention Services Program in one or more counties with the

approval of MDH, in consultation with the local health department. The legislation limits the program to approval of six programs, two in urban areas, two in suburban areas, and two in rural areas. Unfortunately, this bill has not gained traction in the House or Senate but will undoubtedly continue to be the subject of consideration in coming Sessions.

House Bill 1180/Senate Bill 1056: Cigarettes, Other Tobacco Products, and Electronic Smoking Devices – Revisions (Tobacco Retail Modernization Act) (passed) limits the sale of electronic smoking devices (ESD) to licensed vape shop vendors and restricts such vendors to selling only ESD and their component parts and accessories. The bill repeals the ESD retailer license and provisions allowing ESD manufacturers to sell ESD directly to consumers. The bill prohibits the display of cigarettes, other tobacco products, or ESD, unless the products are behind a counter. MDH is required to conduct at least one unannounced inspection of licensed retailers/vape shop vendors annually. The bill also prohibits a pharmacy from selling tobacco products or ESD and eliminates the exception that allows those in the military to purchase tobacco products or ESD down to age 18. Members of the military will now be subject to the age 21 requirement for purchase of tobacco products or ESD. Effective Dates: October 1, 2024, and October 1, 2025.

House Bill 1293/Senate Bill 938: Maryland Department of Health – Public Education Campaign on Prostate, Lung, and Breast Cancer Prevention (passed) requires MDH to develop and implement a three-year public education campaign on prostate, lung, and breast cancer prevention that targets communities disproportionately impacted by those cancers. The campaign must provide educational information, promote cancer screenings; and provide information on avenues to reduce cost barriers to prevention services. In developing the public education campaign, MDH must work with health care providers, hospitals, and health care associations that focus on prostate, lung, and breast cancer. In implementing the public education campaign, MDH must use communications tools and messaging; post all materials on its website in a conspicuous manner and in an accessible format; and develop partnerships with health agencies, nonprofit organizations, and private entities that work with communities disproportionately impacted by prostate, lung, and breast cancer. MDH must develop the public education campaign by December 1, 2026, and implement the campaign by January 1, 2027. The bill also establishes the public education campaign as a required use of Cigarette Restitution Funds monies. Effective Date: July 1, 2025.

Special Thanks

MedChi thanks those members who served on the MedChi Council on Legislation 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. Lawrence J. Green (Boards and Commissions), Dr. Karen M. Dionesotes (Public Health), and Dr. Anuradha D. Reddy (Health Insurance), and to our Council on Legislation co-chairs Dr. Clement S. Banda and Dr. Kathleen D. Keeffe Hough. MedChi also recognizes those physicians who testified on behalf of MedChi for various initiatives, including Dr. Sonny Goel.

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, RN, and Megan Wobbe, BSN for their dedication in staffing the First Aid Room for the Session.

Doctors who staffed the First Aid Room this Session include:

Dr. Heidi Abdelhady
Dr. Marie-Alberte Boursiquot
Dr. Jill Allbritton
Dr. Deondra Asike
Dr. Omer Bajwa
Dr. Anne Banfield
Dr. Jeffrey Bernstein
Dr. Renee Bovelle
Dr. Jay Bronder
Dr. Tyler Cymet
Dr. Karen Dionesotes
Dr. Pascale Duroseau
Dr. Umar Farooq
Dr. Walter Giblin
Dr. John Gordon
Dr. Lawrence Green
Dr. Alan Gonzalez-Cota
Dr. Darryl Hill
Dr. Mona Kaleem
Dr. Laura Kaplan-Weisman
Dr. Benjamin Lowentritt
Dr. Loralie Ma
Dr. George Malouf
Dr. Erinn Maury
Dr. Casey McRoy
Dr. Leia Medlock
Dr. Sarah Merritt
Dr. Dan Morhaim
Dr. Michael Murphy
Dr. J. Michael Niehoff
Dr. Kalpana Prakasa
Dr. Gary Pushkin
Dr. Padmini Ranasinghe
Dr. Anuradha Reddy
Dr. Stephen Rockower
Dr. Frank Sparandero
Dr. Sadiq Syed
Dr. Bernita Taylor
Dr. Duane Taylor
Dr. James Williams
Dr. H. Russell Wright, Jr.
Dr. James York
Dr. Sammy Zakaria
Dr. Jiaying (Jayne) Zhang

Summary of Physician Assistant Legislation
House Bill 806/Senate Bill 167: Physician Assistants – Revisions (Physician Assistant Modernization Act of 2024)

After three long years of work, legislation reforming the Maryland Physician Assistant (PA) law was finally adopted in the 2024 Session. MedChi began discussions with the PA's during the 2022 Session, and those have continued since but took on more urgency in the recent interim given the directive from both House and Senate leaders that legislation would be adopted in the 2024 Session.

The bill embodies the principles set forth by the physician workgroup established in 2022, namely ensuring that physicians remain the leaders of the patient care team and retain control over the scope of practice and actions of PAs. This legislative resolution comes at a time when other states are allowing PAs to practice independently and forestalls that effort here, because the Legislature now considers the issue resolved for the foreseeable future. All the physicians who have worked on the bill, including Dr. Jim York (orthopedic surgeon), Dr. Mike Niehoff (family physician), Dr. Loralie Ma (radiologist), Dr. Doug Mithcell (internal medicine and CEO of Adfinitas Health), Dr. Mike Silverman (emergency physician), and Dr. Ben Lowentritt (urologist and MedChi President), should be thanked for the time and thought they put into the passage of this bill.

Bill Summary

- Requires a Collaboration Agreement rather than the current Delegation Agreement.
- Defines "Collaboration" as being a physician led team, the first reference to that concept in MD law.
- Allows the Collaboration Agreement to be entered into by a physician or group of physicians, but not an administrator of an entity, as was sought by the PAs initially.
- Sets forth the required contents of the Collaboration Agreement.
- Expressly prohibits independent practice by PAs.
- Specifically includes PAs in the non-economic damage cap statute, which already covers most other health occupations.
- Retains existing law providing that the scope of the PA practice must be:
    1. Appropriate to their education, training, and experience;
    2. Customary to the practice of the physician (versus the setting, which is what the PAs pressed for); and
    3. Consistent with the Collaboration Agreement.
    - NOTE: These limits were referred to within the physician workgroup as the "3 Guardrails."
- Revises the core duties that PAs can perform but preserves the current law governing a PA's review and interpretation of diagnostic and other patient data.
- Allows a physician to limit the PA's scope of practice and detail their practice in the Collaboration Agreement.
- Allows a physician to delegate acts to no more than 8 PAs while on duty. These limits do not apply in hospitals and certain other settings, as per current law.
- Allows certain PAs to delegate acts to other medical personnel.

- Revises the approval process required for PAs to perform advanced duties as follows:
  - "Advanced duties" are those duties requiring additional training beyond the basic PA education required for licensure.
  - Under current law, the general rule is that advanced duties require approval by the Board of Physicians ("Board"). However, there is an exemption from that requirement for hospitals and ambulatory surgery centers, recognizing that there are credible outside checks and balances like accreditation, risk management, and credentialing in those facilities to ensure that PAs are not given advanced duties for which they are not qualified.
  - The bill expands the list of exempt facilities to include federally qualified health centers (the PAs sought the inclusion of other places like school-based health centers and local health departments. However, we opposed those, and they were not included in the bill).
    - NOTE: Even in these exempt facilities, there must be an internal process for advanced duty approval.
  - Outside of exempt facilities, Board approval is still required for advanced duties unless:
    - The PA has previously been approved for that advanced duty by the Board but changes places of employment; or
    - The PA has over 7,000 hours (approx. 3.5 years) of clinical experience and the physician and PA document the training for the advanced duty.
    - Even here, the advanced duty must comply with the "3 Guardrails" stated above.
- Enhances the dispensing laws governing physicians and PAs. Under the bill, the PA will continue to be able to dispense under the physician's permit, thereby eliminating any extra expense that would have occurred if each PA were required to have their own permit. More importantly, the bill allows the physician to delegate ALL acts of dispensing to the PA, including the final check. The act of prescribing and dispensing remains under the terms of the Collaboration Agreement.
- **EFFECTIVE DATE: October 1, 2024**
  - Delegation agreements in effect on this date will be treated as the Collaboration Agreement required under this bill, until such time as a PA notifies the Board pursuant to the bill.

Summary of Prior Authorization Legislation
Senate Bill 791/House Bill 932: Health Insurance – Utilization Review – Revisions

The passage of Senate Bill 791/House Bill 932 provides Maryland with some of the most comprehensive laws in the country on prior authorization and utilization review protections. MedChi is working on a comprehensive document to better assist physicians on understanding these laws and how to file a complaint with the Maryland Insurance Administration (MIA) if a law is not being followed by an insurer or pharmacy benefit manager.

CAUTION: Maryland's laws can only apply to Maryland's fully insured market. To know if a patient is covered by these laws, the patient's insurance card will indicate "Maryland Insurance Administration" or "MIA" on the back of the card.

1. **Reduces/Streamlines the Volume of Prior Authorization Requirements – Effective January 1, 2025**

    a. Prohibits a carrier from issuing a denial of care when a patient requests a medication renewal for a prescription that is used to treat a mental health disorder or that is an immune globulin if the insurer previously approved the drug, the patient has been successfully treated on the prescription drug, and the prescriber attests that the patient continues to need the drug.
    b. Exempts prescription drugs from requiring a prior authorization for dosage changes provided that the change is consistent with federal U.S. Food and Drug Administration labeled dosages and is not an opioid. ***Maryland law already prohibits prior authorization for a prescription drug when used for treatment of an opioid use disorder and that contains methadone, buprenorphine, or naltrexone.*
    c. Requires a carrier to allow a patient who changes health insurance carriers to remain on the patient's medication for a period of the lesser of 90 days or the course of treatment during which time the new carrier can perform its own prior authorization review.
    d. Requires a carrier to provide 60 days' notice rather than the current 30 days' notice when it implements a new prior authorization requirement.
    e. Requires that a carrier, when approving a prior authorization request, to approve a course of treatment of a non-medication health care service for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, the patient's medical history, and the treating provider's recommendation (similar to the final Medicare Advantage rule).

2. **Increasing Transparency and Communication as Part of the Review Process – Effective January 1, 2025**

    a. Ensures that the decision of when a case requires an expedited review after a denial is by the health care provider and/or the patient or the patient's representative and not the carrier (i.e., expedited reviews must be conducted within 24 hours).

b. Requires that any communication from the carrier where there is a denial of health care services state in detail the factual bases for the decision, including explaining the reasoning why the health care provider's request was not medically necessary and why it did not meet the criteria and standards used in conducting the review, which must be specifically referenced and not simply referred to "as part of the member's policy or plan document."
c. Requires carriers to have a dedicated call line for denials or a dedicated and monitored email for scheduling calls so that health care providers can discuss the decision rather than having to go through the general customer call line.
d. Requires that, if any additional information is needed to make the determination, the carrier provide the specific information needed, including any lab or diagnostic test or other medical information, along with the criteria and standard used to support the need for the additional information.
e. Adds new reporting requirements by carriers for inclusion within the annual report on appeals and grievances by the MIA regarding how many patients requested a formulary or copay tier exception when changes have occurred to either.
f. Eliminates "homegrown" criteria in favor of requiring carriers to utilize criteria and standards that are developed by nonprofit medical or clinical specialty societies or organizations that work directly with health care providers in the same specialty and that satisfy other criteria.
g. Mandates that a "peer to peer" must occur if requested by the health care provider (currently – it is discretionary) and that the licensed physician or dentist making the decision participating in the peer to peer be board certified or eligible in the same specialty and knowledgeable about the requested health care service or treatment through actual clinical experience.
h. Mandates that if the carrier does not meet the required times for deciding the request, then the request is deemed approved.

3. **Future Studies and Changes**

a. Requires a study on whether to implement a "gold card" standard. The MHCC must report to the General Assembly on the results of the study by the 2025 Session.
b. Requires a study to determine whether to eliminate prior authorization requirements when a health care provider participates in a value-based arrangement. The MHCC must report to the General Assembly on the results of the study by the 2025 Session.
c. Imposes a future requirement that carriers' electronic processes must integrate with all electronic health records to provide real-time benefit information on a patient's coverage at no cost to the health care provider by 2026.