SCHWARTZ, METZ & WISE, P.A.
ATTORNEYS
20 WEST STREET
TEL: 410-244-7000 ANNAPOLIS, MARYLAND 21401 FAX: 410-269-5443

MedChi Final Report

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INTRODUCTION

The 432nd Session of the Maryland General Assembly concluded at midnight on Monday, April 7, with its usual confetti release in both the Senate and House Chambers. In this Session, the General Assembly considered 2,693 legislative bills and resolutions and the MedChi Legislative Committee reviewed 252 bills, taking positions on many of those.

Since this was an election year session, there was often political posturing but relatively few controversial issues. Governor O'Malley was successful in passing his minimum wage proposal; possession of small quantities of marijuana was decriminalized and medical marijuana dispensing was strengthened; there was a reduction of estate tax rates but, in the main, as noted by Senate President Miller in the Baltimore Sun yesterday, there were very few "bombshell" issues as in past years.

The story line at the beginning of the Session was the complete failure of the Maryland Health Benefit Exchange which resulted in repeated finger-pointing in the upcoming gubernatorial race featuring – on the Democratic side – Lieutenant Governor Anthony Brown, Attorney General Doug Gansler and Delegate Heather Mizeur. The Maryland Exchange turned out to be so broken that, within the last week, it has been decided to abandon the Maryland software altogether and to import new software which has been used in Connecticut. While Lt. Governor Brown was the point man for the rollout of the Maryland Exchange, recent opinion polls indicate he has suffered relatively little political fallout as a result of the Exchange's meltdown.

All members of the Maryland General Assembly are up for reelection and the statewide offices of Governor, Lt. Governor, Attorney General and Comptroller will be decided as well. The Primaries will be held in June of 2014 with the General Election in November. In most cases, the winners of the Primary Election for the General Assembly will determine the actual Delegates and Senators who will be sworn in for their 4-year terms in January of 2015. This is so because – in most cases – the winner of a particular primary is likely to be the winner of the general election because districts are drawn so they "tend" Democratic or Republican, as the case may be.

MEDCHI MAJOR ISSUES: AN EXCELLENT YEAR

Naturopaths: The ongoing campaign of so called "naturopathic" doctors resulted in the passage of House Bill 402/Senate Bill 314 (*Health Occupations − State Board of Physicians − Naturopathic Doctors*) but only after MedChi amendments were added to the bill which resulted

in MedChi withdrawing its objection to the bill and taking "no position." From the perspective of the "naturopaths," one observer said, their success in passing the bill was really a defeat. Over the objections of the naturopaths, they will be regulated by the Maryland Board of Physicians and will have the most restricted scope of practice of any State in the nation. They must also attest to having a collaborative agreement with a physician. Moreover, they will be disallowed from calling themselves "physicians."

This has been an ongoing dispute for a number of years and it is now behind us with a result that addressed the major objections of organized medicine.

Step Therapy: Senate Bill 622/House Bill 1233 (*Health Insurance − Step Therapy or Fail-First Protocol*) was MedChi's major legislative initiative in 2014. Both bills now sit on the Governor's Desk awaiting his signature. In its final form, the legislation provides for three things. First, there is a 180-day "Grandfather Provision" which disallows any insurer from requiring a patient who has been successfully treated with a medicine in the last 180 days to undergo "Step Therapy" in order to continue on that medicine. This will help untold numbers of patients who have been forced into "Step Therapy" when their insurance changes.

The second provision of the bill forbids an insurer or PBM from requiring the use of a medicine in its step therapy protocol which is not FDA approved for the specific condition. In enacting this provision, Maryland becomes the first State in the nation to insist upon this requirement and, remarkably enough, many of the step therapy protocols imposed by insurers and PBMs require the use of non-FDA approved medicines.

Finally, the legislation provides that doctors will have a step therapy override process available to them in the online preauthorization programs which are to become effective in July of 2015.

The regulation of "Step Therapy" has been a MedChi project for two years. While the Step Therapy legislation was unsuccessful in 2013, the tide turned when MedChi was able to engage the Maryland Health Care Commission (MHCC) and its staff in a study of the issue during the summer and fall of 2013. The MHCC Report to the Legislature concerning step therapy reforms was key in crafting the final version of Senate Bill 622/House Bill 1233. MHCC Executive Director Ben Steffen was particularly helpful during legislative deliberations on the legislation.

Workers' Compensation Dispensing: Perhaps the most lobbied issue of the Session, from a MedChi perspective, was the on-going battle over the dispensing of medicines by doctors to workers' compensation patients. This dispute started in 2011 when the Workers' Compensation Commission (WCC) proposed a regulation imposing a rate ceiling on the amount that doctors could charge for medicines which they dispensed in their offices. That rate ceiling would have meant that most doctors would be reimbursed less than they actually paid for the medicine. That rate schedule was voted down by the General Assembly's AELR Committee by a vote of 14-1.

After that defeat, the workers' compensation insurers, including self-insured entities and several governments such as Baltimore City, Baltimore County and Montgomery County, concentrated their efforts on stopping physician dispensing altogether. This year's entries into that battle from the insurers' side was Senate Bill 215/House Bill 280 (*Workers' Compensation – Payment for Physician-Dispensed Prescriptions – Limitations*) and Senate Bill 217/House Bill

281 (*Workers' Compensation – Payment for Controlled Dangerous Substances Prescribed by Physicians – Limitations*). The principal thrust came behind House Bill 280 which would have limited a doctor to dispensing in the first 30 days of treating a workers' compensation patient but forbid it after that. That bill had multiple hearings before a subcommittee in the House of Delegates and appeared to be on the verge of passage until a coalition formed by MedChi, which included doctors, workers' compensation plaintiff lawyers, the Minority Contractors Association and organized labor, went to work.

The MedChi entry into this fight was Senate Bill 507/House Bill 1342 (*Workers' Compensation – Reimbursement for Repackaged and Relabeled Drugs – Fee Schedule and Requirements*). These bills would have established a fair fee schedule for doctors to dispense medicine but the insurance industry adamantly opposed these initiatives even though it meant a $5.5 million savings per year to the industry. It became obvious that the lobbying strategy of the industry was to seek an effective ban on doctor-dispensing rather than agree to allow it to continue with reasonable pricing.

In the end, MedChi's most lobbied bill of the Session ended up with no vote actually being taken. The proponents of House Bill 280, who had confidently predicted victory in the middle of the Session, were unable to obtain the necessary majorities in either the House HGO Committee or the House Economic Matters Committee to report the bill favorably and so House Bill 280 died − not with a bang but with a whimper – without a vote ever being taken. Late last night, the House HGO Committee reported to the full House of Delegates that House Bill 280 had been "withdrawn."

The issue will surely be back next year and MedChi will continue to rally support in the Legislature for a reasonable fee schedule. In the meantime, Maryland doctors who treat workers' compensation patients may continue to dispense medicines from their offices.

Trial Lawyer Initiatives: The principal initiative of the Maryland Association for Justice (once known as the Maryland Trial Lawyers Association) was Senate Bill 789/House Bill 1009 (*Civil Actions – Noneconomic Damages – Catastrophic Injury*). This bill would have tripled (3x) the current Maryland cap on noneconomic damages. The current cap in any case involving "catastrophic injury" is $745,000 (25% more in a wrongful death case) and would have been moved to over $2 million in a case which could be defined as a "catastrophic injury." An analysis of the definition of "catastrophic injury" in the bill indicated that almost all medical malpractice cases filed in Maryland would fit that definition.

Since the cap on noneconomic damages applies in all cases, not just medical malpractice, most of the injured people who appeared before the Senate and House Committees testifying on these bills had suffered injury in non medical situations. In most cases the victims made very compelling witnesses. At the end of the day, however, the testimony of the medical community (including MedChi's President, Dr. Russell Wright, in the Senate and Incoming President, Dr. Tyler Cymet, in the House) and the business community was able to thwart any favorable actions on these bills.

Also heard on the same day before the House Judiciary Committee was House Bill 996 (*Admissibility of Writings or Records of Health Care Providers*). This bill would have allowed a doctor's records to be introduced in a medical malpractice case without the doctor testifying. It would only have applied to medical malpractice cases in the District Court of Maryland which

has jurisdiction up to $30,000 but, nevertheless, a doctor's own records could have become the "expert witness" against the doctor in such a District Court case. MedChi was the only party which expressed opposition to the bill which was championed by the Maryland Association for Justice. The MedChi opposition testimony was sufficient and the bill was withdrawn.

Redesign of Maryland's All-Payer Model Contract − Transparency, Process and Funding: On the heels of the Centers for Medicare and Medicaid Services approving Maryland's modernization of the all-payer model contract on January 10, 2014, the General Assembly enacted two bills to ensure greater transparency and accountability during the transition and to provide additional funding to community providers. Senate Bill 172 (*Budget Reconciliation and Financing Act of 2014*) (BRFA) provides an additional $15 million in funding for FY 2015 for the purpose of assisting hospitals in covering costs associated with the implementation of the waiver and for funding statewide and regional proposals that support the implementation of the waiver. The Commission and DHMH will establish a stakeholder committee to review these proposals and make recommendations for funding. The proposals are to be developed in accordance with guidelines set by the Health Care Delivery Reform Subcommittee of the Health Care Reform Coordinating Council. This committee has several physician community representatives. The program, as adopted, creates tremendous opportunity for the physician community to partner with hospitals to receive funding to advance mutually beneficial objectives.

Wanting to avoid a similar situation that has occurred with the Maryland Health Benefit Exchange, the General Assembly made the determination that it needs regular status reports from the HSCRC on the changes being implemented under the all-payer model contract. Therefore, House Bill 298 (*Health Services Cost Review Commission – Powers and Duties, Regulation of Facilities, and Maryland All-Payer Model Contract*) requires, beginning October 1, 2014 and every six months thereafter, the HSCRC to update the General Assembly on the status of the State's compliance with the provisions of the model contract; a summary of the work conducted and any of the recommendations made by the HSCRC workgroups and any actions approved and considered by the HSCRC to promote alternative methods of rate determinations and any HSCRC action on recommendations made by the workgroups. The HSCRC must also provide written notice to the Governor and the General Assembly if CMS issues a warning notice related to a "triggering event" as described in the model contract. MedChi Executive Director Gene Ransom testified in support of these requirements during the legislative process. MedChi will continue to work closely on the implementation of the model contract.

OTHER ISSUES

Sterile Compounding: In 2013, Maryland passed stricter provisions relating to sterile compounding resulting from the scandal created by the Massachusetts manufacturing facility which had shipped contaminated drugs resulting in 64 deaths and multiple nonfatal injuries. While Maryland was enacting its sterile compounding law, the Federal Congress was also working on the issue and passed federal legislation in November 2013.

It became clear, however, that the Maryland law was so broad that it affected routine and highly appropriate medical procedures. Even though the Maryland law included a "waiver" provision which was designed to take care of situations raised by health professionals, the interpretation of the waiver provision by the Maryland Board of Pharmacy effectively eliminated the waiver provision as an avenue for redress. Accordingly, the dentists had to file two bills to

get relief from the sterile compounding law and the physician community also filed two bills. House Bill 1088 (*Health Occupations – Compound Drugs – Provision to Ophthalmologists for Office Use*) was initiated by the Maryland Society of Eye Physicians and Surgeons (MSEPS) so that ophthalmologists would be able to receive an emergency supply of a compounded medicine such as Avastin without first specifying the name of the patient. Opposed by both the State Health Department (DHMH) and the State Board of Pharmacy, the bill nevertheless now awaits the Governor's signature. The bill will allow ophthalmologists to store emergency supplies of the medicine which – in the case of diseased retinas – must be applied virtually immediately in an emergency case.

Senate Bill 1108 (*Sterile Compounding Permits – Definition of "Compounding"*) was a late filed bill on behalf of oncologists and hematologists to change the definition of compounding to exclude the "mixing" and "reconstituting" which is done with respect to the administration of chemotherapy. Once again, this legislation was opposed by the State Health Department and the Maryland Board of Pharmacy and, once again, the Legislature disagreed and – at MedChi's request – also added rheumatologists to the bill. Senate Bill 1108 is also awaiting the Governor's signature.

The 2014 legislation on sterile compounding indicates that last year's bill went too far without an adequate consideration of its implications for actual patient care. There may be other specialties who were also adversely affected and need to be addressed in subsequent sessions of the General Assembly.

Birth Injury Fund: Senate Bill 798/House Bill 1337 (*Maryland No-Fault Birth Injury Fund*) was an initiative started by Mercy Hospital in Baltimore which sought to create a birth injury fund in order to take birth injuries out of the normal medical malpractice court system. The proposal was modeled on similar funds in Florida and Virginia and was to be funded by assessments on hospitals and doctors and would work more like a workers' compensation system where any child injured at birth – whether there was negligence or not – would be entitled to receive economic relief from the fund. This was very complicated legislation with a variety of competing viewpoints even among proponents and, of course, opposed by the plaintiff malpractice lawyers. Both bills were unsuccessful although language was added to the Maryland budget directing the Health Department to study access to OB-GYN services in both rural and urban Maryland. The principal headline case which prompted discussion of such a fund was a Baltimore City verdict against Johns Hopkins Hospital for $55 million. Although the verdict was later reduced, that verdict and other multi-million dollar verdicts caught the attention of a number of hospitals.

Health Insurance Bonuses for Doctors: Senate Bill 884/House Bill 1127 (*Health Insurance – Incentives for Health Care Practitioners*) was an initiative of the health insurance industry and particularly United Healthcare. It changed the Maryland "bonus" law which regulates the types of incentives that health insurance carriers may build into a doctor's contract. MedChi adamantly opposed the bill in its original iteration as it would have allowed the payment of medically inappropriate bonuses which had occasioned the passage of the Maryland law in the late 1990's. At that time, for example, health insurers were incentivizing OB doctors to encourage mothers and babies to leave the hospital 24 hours after birth rather than 48 hours or later.

While MedChi opposed the bill, it was clear that the existing Maryland bonus law was worded in such a way that perfectly acceptable bonuses might be forbidden as well. Hence, MedChi engaged in meetings with the proponents of the bill and the result was a heavily amended bill which specifically stated that any bonus could not be a "disincentive" for medically appropriate care and that any bonus arrangement between a health insurer and a doctor was to be in writing and have a clear description of the bonus rules. Moreover, a doctor could not be forced, in his or her contract, to agree to such a bonus and a doctor would have the right to file a complaint with the Maryland Insurance Administration if the bonus was medically inappropriate. As amended, the bill received the support of MedChi and now awaits the Governor's signature.

Patient Provider Workgroup: House Bill 779 (*Maryland Health Care Commission – Health Provider-Carrier Workgroup*) was a pet project of the Chair of the House HGO Committee, Delegate Peter Hammen. The bill, which was enacted, provides that the Maryland Health Care Commission shall convene, on a regular basis, meetings between representatives of health insurance carriers and providers. The goal of such meetings would be to "iron out" issues that may otherwise become bills in the Legislature. Delegate Hammen believes that such regular meetings may result in more agreements between the parties and less disagreements. While he may well be right, only time will tell whether his belief is correct.

Tanning Prohibition: Senate Bill 410/House Bill 310 (*Tanning Devices – Use by Minors – Prohibition*) failed to win the approval of the Senate Finance Committee and was subsequently given an unfavorable report by the House HGO Committee. The bill would have prohibited minors from using commercial tanning salons and was a public health initiative supported by the dermatological community and the American Cancer Society. It was modeled on a local bill in Howard County, Maryland and similar to that prohibition passed last year in California. This legislation has been filed for the last number of years in the General Assembly and has not been successful. One of the principal reasons for its lack of success this year is the current requirement for the execution of an extremely strong parental consent form (which was beefed up just before the start of this year's Session). The consent must be executed by a parent in the tanning salon prior to a minor child being allowed to tan.

Prescription Drug Monitoring Program: In December 2013, the Maryland Prescription Drug Monitoring Program (PDMP) became operational. The PDMP will allow doctors, law enforcement and regulatory officials to monitor prescription drug use (and abuse) throughout the state. One of the unique features of the Maryland PDMP law is the Technical Advisory Committee (TAC). The Maryland PDMP mimics the laws of other states with the exception of TAC which was a MedChi amendment when the original law was passed. The purpose of TAC is to act as a "clinical buffer" between law enforcement and regulatory officials seeking information about a particular doctor's practice. The TAC will review all such requests and provide a viewpoint to the Secretary before a subpoena is honored. However, it appears that the TAC is not a favorite of the State Health Department. That became clear with respect to two bills dealing with the Maryland PDMP.

House Bill 1296 (*Prescription Drug Monitoring Program – Review and Reporting of Possible Misuse or Abuse of Monitored Prescription Drugs*) awaits the Governor's signature. This legislation will allow the Administrator of the Maryland PDMP to advise doctors of problem issues that are seen with respect to prescriptions to certain patients. Prior to advising the doctor of such problems, the PDMP will be required to present the information to the TAC to receive clinical input. The State Health Department requested that the presentation of the

information to the TAC be deleted from the bill. MedChi opposed this amendment and the House HGO Committee rejected it.

Even though the PDMP law just became operational, it was subject to sunset review and was reauthorized by Senate Bill 296/House Bill 255 (*Prescription Drug Monitoring Program – Sunset Extension and Program Evaluation*). That legislation, as originally drafted, diminished the role of the TAC in responding to requests for information and, while it was argued by the State Health Department that such was necessary so out-of-state doctors could use the PDMP, the way the legislation was drafted would have allowed out of state law enforcement personnel to use the PDMP without TAC input. MedChi objected vigorously to this change and both the Senate and House committees agreed with MedChi.

Sunset Bills Related to Physician Payment: A MedChi initiated bill, now awaiting the Governor's signature, was Senate Bill 416/House Bill 437 (*Health Maintenance Organizations – Payments to Nonparticipating Providers – Repeal of Termination Date*). The current Maryland law was passed in 2009 with a 5 year sunset. It regulated the payments to nonparticipating doctors who treat HMO patients and essentially requires HMOs to pay the nonparticipating doctor at 125% of the amount paid to network doctors for the same medical service. The passage of the bill means that the "sunset" was removed and the current law is now a permanent Maryland law.

A similar bill was Senate Bill 642/House Bill 709 (*Health Insurance – Assignment of Benefits and Reimbursement of Nonpreferred Providers – Repeal of Reporting Requirement and Termination Date*). This would have removed the "sunset" from the 2010 legislation dealing with Assignment of Benefits (AOB). The bill was unsuccessful principally because the "sunset" on the AOB law does not come due until 2015 so the repeal of this sunset will have to wait until the next General Assembly Session.

Privileged Communications: Senate Bill 803/House Bill 641 (*Courts and Judicial Proceedings − Communications Between Patient or Client and Health Care Professional – Exceptions to Privilege*) was legislation designed to allow a psychiatrist to waive the psychiatric privilege in a case where the psychiatrist's testimony was necessary in a case against a patient who was threatening the psychiatrist. Supported by the psychiatric community and MedChi, the legislation now awaits the Governor's signature.

Medical Marijuana: Senate Bill 923/House Bill 881 (*Medical Marijuana – Natalie M. LaPrade Medical Marijuana Commission*) is also awaiting the Governor's signature. This legislation would allow "certified doctors" to give recommendations (not a prescription) for medical marijuana to patients that the doctor believes would benefit. The current Maryland law allows medical marijuana to be distributed at teaching hospitals such as the University of Maryland and Johns Hopkins. However, since that law was passed, the hospitals have not elected to engage in providing medical marijuana. This bill is an attempt to allow a broader physician community to make such "recommendations" since actual prescriptions are prohibited by federal law.

Payments for Physician Office Visits: House Bill 279 **(***Health Occupations − Physicians − Payments for Office Visits*) was a proposal to forbid a doctor for charging for an office visit where the visit occurred more than 30 minutes after the appointment time. It was initiated by a Delegate who had to wait for a considerable period in a doctor's office. Opposed by MedChi

and the Maryland Medical Group Management Association (MGMA), the bill was voted down by the House HGO Committee.

Sugar Free Kids: Sugar Free Kids, a coalition between the Horizon Foundation, MedChi, NAACP and the American Heart Association, advocated for two bills this Session to address the twin epidemics of childhood obesity and diabetes. Senate Bill 716/House Bill 1276 (*Child Care Centers – Healthy Eating and Physical Activity Act*) passed and will require the Maryland State Department of Education to develop rules and regulations to promote proper nutrition and developmentally appropriate practices in licensed childcare centers by establishing training and policies to promote breast-feeding; requiring compliance with the United States FDA Child and Adult Care Food Program standards for beverages served to children, except milk that is not nonfat or low fat may be ordered by a health care practitioner or requested by a parent or guardian; prohibiting beverages, other than infant formula, that contain added sweetener or caffeine; and setting limits on screen time. House Bill 1255/Senate Bill 750 (*Food Service Facilities – Meals for Children*) failed but would have required food service establishments that offer a children's menu that includes a beverage to only include water or low-fat milk. A food service facility could have offered any nonalcoholic beverage for an additional charge.

Oral Chemotherapy: Senate Bill 641/House Bill 625 (*Kathleen A. Mathias Oral Chemotherapy Improvement Act 2014*) was enacted. Two years ago, legislation was passed to provide that insurance companies should apply the same co-pay and deductibles to oral chemotherapy agents as were being applied to conventional chemotherapy administration. However, the proponents of that legislation agreed to an amendment at that time which effectively exempted 95% of the insurance policies issued in Maryland by exempting policies that were to be offered on the Maryland Health Benefit Exchange. Senate Bill 622/House Bill 1233 deletes that exemption so that all insurance policies covered by Maryland law will now apply to the same co-pay/deductible to oral medicine as apply to the more conventional chemotherapy.

Senate Bill 162/House Bill 272 (*Health Occupations – Licensed Podiatrists – Scope of Practice and Hospital Privileges*) deleted the 20+ year old Maryland law which precluded podiatrists from surgery on an "acute ankle fracture." The bill also instructed hospitals to grant privilege to podiatrists on the basis of their training, education and experience. This legislation had previously been defeated by the orthopaedic community but its time had come. One of the difficulties with the existing Maryland law was there was no definition of what constituted an "acute ankle fracture."

Workers' Compensation Oversight of Doctor's Prescription of Narcotics: Senate Bill 217/House Bill 281 (*Workers' Compensation – Payment for Controlled Dangerous Substances Prescribed by a Physician – Limitations*) was another entry into the workers' compensation "dispensing" war mentioned earlier in this report. This legislation would have required a doctor to get prior authorization from a workers' compensation adjuster before he or she could dispense a narcotic to a workers' compensation patient. The hearing in the House HGO Committee was so embarrassing to the proponents that the Senate companion bill was withdrawn before its hearing. The notion that an adjuster should determine whether a doctor should provide a medicine or not is almost laughable but it shows the resolve of the workers' compensation insurers to drive doctors out of the business of dispensing to workers' compensation patients.

Apology Bill: House Bill 635 (*Health Care Malpractice – Expression of Regret or Apology − Inadmissibility*) received a frosty reception in the House Judiciary Committee and an unfavorable report. This legislation sought to correct an exemption in Maryland's existing Apology Law which has the effect of negating the practical ability of a doctor to apologize for a poor outcome without fear that his or her statement would be used in a later proceeding.

Malpractice Coverage: Senate Bill 832/House Bill 1363 (*Health Care Provider Malpractice Insurance – Scope of Coverage*) was legislation which would have allowed a malpractice carrier to include − within a doctor's coverage − payment for attorneys' fees not only for the defense of a malpractice case but for a defense of the doctor before the Board of Physicians. At the present time, a Maryland malpractice insurer may not automatically include coverage for defense before the licensing Board. Senate Bill 832 passed the Senate without significant dissent but was given an unfavorable report in the House Economic Matters committee, largely as a result of the Trial Lawyers' opposition.

Independent Review Organization Program – Medicaid: The General Assembly adopted narrative language in the budget that requires the Department of Health and Mental Hygiene to work with stakeholders to develop an appeals and grievance process analogous to that of the MIA for Medicaid. The budget language was developed in response to MedChi's concerns regarding an IRO program proposed in regulation in November 2013 that had several deficiencies that made it virtually without value to the majority of the physician community. The regulations were put on hold by the AELR Committee and MedChi and other specialty organizations worked collaboratively on the language with Medicaid Director Chuck Milligan. He is to be commended for his commitment and follow through. The original regulations, supported by the hospitals were released to be finalized and MedChi will turn its attention to working with DHMH this interim to create a more responsive program.

Medicaid Funding: The Medicaid program reaffirmed its commitment to retain the E&M Code reimbursement rate increases in the coming fiscal year, despite the loss of enhanced federal matching funds. Medicaid had previously increased E&M code reimbursement to Medicare rates for all physicians, not just the specialties required by federal law − a $75 million commitment by the state that MedChi worked in conjunction with DHMH to secure. The enhanced federal reimbursement for certain specialties will end January 1, 2015 but the budget that was recently enacted maintains the enhanced reimbursement through the entire fiscal year – requiring an additional $15 million in state funding. It is an issue we will need to address again in 2015.

Medicaid also increased the reimbursement rates for anesthesia for reconstructive dental surgery following a study that was required as a result of budget language adopted in 2013. The enhanced rates are believed to be a key factor in enhancing access to medically necessary dental surgical procedures where access barriers have been a challenge due to inadequate reimbursement. Further study on the issue will continue under the auspices of the Medicaid program.

Community Integrated Medical Home Program (CIMH): Late in the Session, DHMH introduced House Bill 1235 (*Community Integrated Medical Home Program*) to create a Community Integrated Medical Home Program and an Advisory Board. CIMH is a concept that is designed to expand the patient centered medical home concept across all payers and to incorporate "community health workers" and other community based services into the model to

assist patients with access and compliance. The bill was purportedly the outcome of the extended stakeholder process held over the interim that occurred as a result of a CIMH planning grant DHMH received from the federal government. However, the bill, as introduced, proposed a program design that was not previously vetted by the stakeholders and it raised as many questions as it answered and was opposed by virtually all interest groups. Consequently, DHMH significantly amended the bill to reflect only the creation of an advisory board to work with the Department on the development of the program. While stakeholders did not object to the advisory board concept, there remain many questions about the development of this program going forward. DHMH has recently submitted a program application to the federal government for funding consideration. Public comment was not requested prior to its submittal but DHMH has assured stakeholders that it is a dynamic proposal that can be amended based on public input. It remains a work in progress for which MedChi will continue to be an active participant.

Midwives and Home Birth: There continues to be growing pressure to enact legislation to recognize certified professional midwives (CPMs). While this year's legislation never gained significant momentum, a number of meetings were held with stakeholders and the legislative leadership of the House HGO Committee to further discuss essential elements of an acceptable regulatory structure. DHMH, as well as the Boards of Physicians and Nursing, appear to support regulatory requirements that are similar to those that Maryland ACOG and the physician community have consistently expressed. These include, but are not limited to, education and training, scope of practice, communication, transfer protocols, and collaboration requirements. The main change in the dialogue this year was the willingness of the CPMs to compromise. While there remain significant differences in position, the dialogue is more fluid than it has been in the past. Given the growing political strength of the "home birth" community, it is inevitable that some form of regulatory structure will ultimately be enacted. Furthermore, given the direction of the House Committee leadership, it is likely that there will be a focused effort this interim to construct an approach that has political credibility, not only in the House where the issue has been gaining traction for a few years, but also in the Senate, which has not addressed the issue to date. It is a work in progress but the ability to just say "no" will not likely prevail in the future.

Tobacco Taxes: House Bill 443/Senate Bill 589 (*Tobacco Taxes – Healthy Maryland Initiative*) was introduced this Session with expectations that it would be a multi-year effort. The bill proposed to raise the current tax on cigarettes by $1.00 and a comparable increase for other tobacco products. The momentum in support was greater than expected and the coalition of interests, of which MedChi is a member, will continue its effort to get pledges from both legislators and candidates with the goal of passage in the 2015 Session.