MDAAP Final Report

April 9, 2012

The 430th Maryland General Assembly adjourned *Sine Die* at midnight on Monday, April 9th. It was a Session dominated by fiscal issues, gay marriage, gambling and a host of controversial environmental initiatives. In what may be the first time in history, the Session adjourned *Sine Die* without fully completing the revenue package necessary to balance the budget. While a budget was passed, the revenue package required to avoid more than $500 million in spending cuts was not enacted. At the writing of this report it is unclear what will occur next but it is almost certain that the Governor will need to call a "Special Session" to resolve the unfinished fiscal issues.

Despite the uncertainty of an inevitable "Special Session," there was notable action in the health care arena this year. The tenor was more positive and collaborative than in previous years and a number of significant issues were addressed. The one policy area of exception is "scope of practice" disputes where there remain significant unresolved issues of expanded authority for a variety of professionals that will either be the subject of further deliberation over the interim or will return next year. This report is not an exhaustive review of all issues followed by the Chapter as more than 130 bills were reviewed. Rather it reflects as summary of the primary issues of interest and/or concern that directly impact the practice of pediatrics and the health and well-being of the patients you serve. Please note the issues are not listed in order of priority.

<u>Federal Health Care Reform Implementation</u>

Senate Bill 238/House Bill 443 ***Maryland Health Benefit Exchange Act of 2012*** was enacted. This legislation creates marketplace rules for the operation of the Maryland "Exchange" which will be the marketplace for uninsured individuals seeking health insurance, including the federal subsidies provided under the Federal Affordable Care Act. However, in light of the just completed Supreme Court hearings, it appears that the federal law, or portions of it, is in danger of being declared unconstitutional. Maryland will be the first state to establish the Exchange required by federal law, although it remains to be seen how the Exchange would operate if the Supreme Court declares portions of the federal law unconstitutional. The Exchange was created by legislation in 2011 but that legislation provided that the rules for the operation of the Exchange would be decided in 2012. Senate Bill 238/House Bill 443 is the legislation promised last year. The next phase of Maryland's implementation of federal reform should it survive the Court challenge will be to address benefit and plan design issues. That will be the focus of activity over the interim.

<u>Health Insurance Reform</u>

Senate Bill 540/House Bill 470 – *Maryland Health Care Commission – Preauthorization of Medical Services and Pharmaceuticals – Standards* passed in an amended form. The amended version codifies the provisions of a Report prepared by the Maryland Health Care Commission (MHCC) in December 2011. Essentially, the Report provided that insurance intermediaries will simplify preauthorization procedures by adopting electronic preauthorization systems which will allow a physician to access insurance websites to determine the preauthorization requirements and make preauthorization requests in electronic form complete with unique tracking numbers. The goal of the Report is to allow for real-time preauthorization of most drugs by July 2013.

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

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

The Chapter has long been concerned about the failure of commercial insurers to provide appropriate access to **habilitative** services. Current law mandates coverage for these services to age 19, however, many insurers create tremendous barriers to access and the benefit often seems illusory. **House Bill 1055/Senate Bill 744 – Health Insurance – Habilitative Services – Required Coverage, Workgroup, and Technical Advisory Group,** as originally introduced, would have extended the coverage to individuals up to age 19. As amended, the age remains as 19 but the bill establishes two important workgroups to more comprehensively address issues relative to the provision of habilitative services. The bill requires the Maryland Insurance Commissioner to establish a workgroup on access to habilitative services benefits. The workgroup includes a broad range of stakeholders including pediatricians and is charged with a number of tasks evaluating whether individuals entitled to benefits are receiving them and what the costs would be for extending benefits to individuals up to the age of 26. The Department of Health and Mental Hygiene, in consultation with the Commissioner, must also establish a technical advisory group on the use of habilitative services to treat autism and autism spectrum disorders (ASDs). Beginning November 1, 2013, a determination by a carrier on whether habilitative services are medically necessary and appropriate to treat autism and ASDs must be made in accordance with regulations adopted by the Commissioner.

Senate Bill 781/House Bill 1149 − *Health Insurance – Coverage for Telemedicine Services* was successfully enacted. The bill requires covered insurers to reimburse telemedicine when medical services are delivered in that modality. Two other telemedicine bills, however, were not acted on favorably. House Bill 1399 (*Hospitals – Credentialing and Privileging Process – Telemedicine*) and House Bill 1400 (*State Board of Physicians – Exceptions from Licensing – Physicians Authorize to Practice Medicine by Another State*) would have changed existing requirements for credentialing and licensure. These proposals raised a variety of complex issues and will best be addressed next year after appropriate discussion by various stakeholders.

<u>Medicaid Budget – Physician Reimbursement</u>

The issue of Medicaid physician rates was decided on the last day. The Federal Affordable Care Act (ACA) requires States, by 2013, to reimburse primary care physicians at Medicare rates for E&M codes for which the federal government will provide a 100% match for

2 years. The Administration's budget included an increase of E&M codes for all physicians even though the State would only receive a 50% match for specialist reimbursement. The Senate voted to retain the increase in reimbursement for evaluation and management codes to Medicare levels for all physicians as it was included in the Governor's Medicaid budget. The House amended the Senate version to recommend the increase only apply to primary care physicians. In the end, the budget committees agreed with the Senate position so that **all physicians** will be the beneficiary of the E&M code rate increases. This is a significant enhancement of physician reimbursement that is intended to help increase physician participation in the Medicaid program. However, because the General Assembly failed to complete its fiscal work before adjourning, the increase is abrogated unless restored when the General Assembly reconvenes for Special Session to complete its work. All revenue bills will require reintroduction and it is unknown whether the resolution of issues will remain as currently configured.

Home Visiting Funding and Legislation

The Governor's original budget did not include funding to maintain Maryland's home visiting programs that are administered through MSDE and DHMH. In part, the cut was based on a flawed premise that relied upon funding received by DHMH from the federal government to fund the continuation of the programs. What was not thoroughly understood was that money was neither sufficient nor available for use to maintain programs. Further, the "new" money is needed for targeted program expansion potential not for replacement of current funding. Through the leadership of members of both the House and Senate and the child advocacy community, the Governor's supplemental budget included funds to restore the funding that had been cut. As with the Medicaid funding issue, it is unclear how these programs will be impacted until the issue of revenue is addressed through a special session.

Concurrent with the funding issues associated with the home visiting programs, **House Bill 699/Senate Bill 566 – *Home Visiting Accountability Act of 2012*** was enacted. The legislation will help align Maryland's programs with federal guidelines and requirements calling for funding of "evidence-based" and "promising" program designs and thus enhance Maryland's competitiveness for available grant funds. It will also strengthen the effectiveness and accountability of our current programs thereby enhancing outcomes and increasing the State's return on its investment.

Health Disparities

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

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

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

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

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

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

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

Safe Driving Practices

The effort to strengthen Maryland's child safety seat requirements was successful. **House Bill 313/Senate Bill 185 – *Motor Vehicles – Child Safety Seats – Requirements*** (Delegate Dana Stein/Senator Jennie Forehand) proposed to clarify and strengthen Maryland's child safety seat requirements based on new recommendations from the National Highway Traffic Safety Administration (NHTSA) and the American Academy of Pediatrics. The most important provision of the legislation was the removal of weight as a factor in determining whether a child is required to be restrained in a child safety seat. In 2008, when the General Assembly last addressed safety seat requirements, a weight factor was added to the law in contradiction to federal recommendations. The placement of the seat-belt across the body is the critical component of determining what seat restraint is appropriate. The use of weight could actually lead to inappropriate restraint, and therefore reduced protection for those youth who may

be short but very heavy. Passage of this legislation removes the weight restriction and better aligns Maryland's law with national recommendations. A second provision of the national recommendations – restraint of children in rear-facing seats until age 2 – did not require a change in statute as Maryland's current language requires parents to use child safety seats in accordance with the manufacturer's instructions. NHTSA is in the process of revising its manufacturer requirements. When that is complete, Maryland's law will require compliance with those requirements as reflected in the manufacturer's instructions.

Maryland has been a national leader in addressing distracted driving. This year, the General Assembly strengthened the prohibition against the use of wireless communications for young drivers and clarified that the ban on text messaging applied to all drivers. **House Bill 55/Senate Bill 529 – *Motor Vehicles – Use of Text Messaging While Driving*** (Delegate James Malone/Senator James Robey) applies the current prohibition on the use of wireless communication devices to all young drivers under the age of 18, not just those with learner's permits or provisional licenses. The prohibition is a secondary offense but applies to all wireless communication devices – not just handheld devices. The bill also clarifies that the current ban on text messaging, which is a primary offense, applies to all drivers and includes administrative penalties for young drivers under that age of 18. These penalties include suspension or restriction of their driving privileges.

The General Assembly also enacted legislation that requires persons operating mopeds and motor scooters to wear protective headgear and eyewear. **House Bill 149/Senate Bill 309 – *Mopeds and Motor Scooters – Titling, Insurance and Required Use of Protective Headgear*** addresses a number of issues relative to mopeds and motor scooters for which we took no position. The use of protective headgear and eyewear, however, has long been a position that MDAAP has supported and which the General Assembly has finally been persuaded to adopt.

<u>Child Abuse and Neglect</u>

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

As amended, the criminal penalties would only apply if a mandated reporter, only in the course of their professional duties, "knowingly and willfully" failed to report a case where they had actual and direct knowledge of abuse. Note, it is **not** actual and direct knowledge of injury but actual and direct knowledge that abuse occurred. Further, one would have to know that the abuse is likely to cause or has caused serious physical injury or death. With respect to sexual abuse, you would also have to have actual and direct knowledge that the abuse occurred. Consequently, the language was so narrow that it was difficult to publicly object to someone not reporting under those circumstances. Senate Bill 63 passed the Senate as amended on Saturday, April 7th. With only the final day of the Session for consideration, the House Judiciary Committee did not take up the legislation and the bill failed. Therefore, the issue is likely to arise again in 2013 but hopefully the Senate bill as amended will become the starting point for the discussion.

House Bill 834 – Child Abuse and Neglect – Alternative Response was passed on the final day of Session. The bill reflects the collaborative effort of a broad range of stakeholders that have met over the past year to craft the framework for a program that that is tailored toward those children who are found to be at low risk of harm. Rather than focusing most resources on investigation and identification of a perpetrator, the program focuses on engaging the family in the assessment of the child's safety, evaluating the family's strengths and needs, and providing referral for necessary services. The program's primary mission is to help parents become better at parenting and thereby increase the likelihood that children will grow up in safe, stable, and nurturing environments.

The Chapter strongly supported language in the bill that creates an advisory board to work with DHR in developing an implementation and evaluation plan. The bill identifies key stakeholder agencies and organizations who have the expertise to assist DHR and who have the experience to advocate for the best interest of children. The legislation also calls for data collection processes to assess the impact of the programs that will be developed through this initiative − a provision that the Chapter argued is essential for long-term program viability and to ensure adequate accountability for program outcomes.

Hopefully sufficient community resources will be available to meet the needs of families diverted to the alternative response system. The ultimate success of this promising program will undoubtedly depend upon access to adequate family support services. Hopefully there will be resources available to educate Maryland citizens about the alternative response system. Parents who are aware of this non-adversarial program may be more willing to cooperate with the Department, and more willing to accept services.

A growing number of States are reforming their front-end responses to child maltreatment referrals through differential response. States that have evaluated their systems have generally found that a less adversarial, more service-oriented front-end response to certain families has had positive outcomes without compromising child safety.

House Bill 860/Senate Bill 1082 – Children in Need of Assistance and Child Abuse and Neglect – Sexual Abuse – Definition also passed. This legislation expands the definition of sexual abuse to include allowing or encouraging a child to engage in obscene or pornographic photography, films or other similar activities; prostitution; and human trafficking.

Scope of Practice

House Bill 56/Senate Bill 408 – *Pharmacists – Administration of Vaccines – Expanded Authority* failed. The pharmacists have been very aggressive in advancing scope of practice expansion over the last few years. This legislation proposed to expand their authority to administer vaccines to include all CDC recommended vaccines as well as all travel vaccines to anyone over the age of 9. The proposed expansion of authority did not include requirements for a physician prescription, communication with an individual's primary care physician, record keeping requirements or any other provisions to ensure continuity of care or protect patient safety.

Current law limits pharmacists' authority to the administration of the flu vaccine to individuals age 9 and older and the administration to adults of vaccines for pneumococcal pneumonia, herpes zoster, and any other vaccine found to be in the public interest as determined by the collective approval of the Board of Physicians, Board of Nursing and Board of Pharmacy

provided the patient has a physician's prescription, the pharmacist reports back to the prescribing physician and if the prescribing physician is not the patient's primary care physician that the pharmacist make a good faith effort to contact the patient's primary care physician.

The expansive, all-inclusive approach of the bill as proposed was not well received and the bills did not advance. However, there was significant favorable sentiment expressed by members of both the House and Senate Committees regarding the need for expanded access to vaccines with the proper patient protections. Consequently, there will undoubtedly be a summer workgroup convened to discuss the issue in a more deliberative context. It will be critical that MedChi continue to advocate for physician prescriptions and reporting requirements attached with any contemplated expansion of prescribing authority.

House Bill 1056 –Health Occupations – Licensed Midwives introduced to license certified midwives generated significant discussion in the House Health & Government Operations Committee. The day of the bill hearing, hundreds of proponents of "home birth" allied in Annapolis including a large representation from Maryland's Amish and Mennonite communities. While the legislation itself would have licensed certified midwives who would not be required to have more than a high school diploma and limited experience, the bill hearing became a forum for discussion on access to home birth – not on the professionals seeking certification.

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

Senate Bill 180/House Bill 620 − *Health Occupations – State Board of Naturopathic Medicine* also failed. These bills would have created a new licensing board for "naturopathic doctors" and allowed them to practice "naturopathic medicine" independently of physicians. The proposed scope of practice included prescribing, doing "minor surgery" and numerous other interventions. There are currently 24 naturopaths in Maryland; 5 would have served on the board and another 3 on the "formulary council", meaning that one-third of all naturopaths would be serving in a regulatory capacity. The Senate Committee voted the bill favorably out of Committee but recommitted it to Committee when it became evident that a "floor fight" would ensue. The House did not vote on the initiative but held several workgroups up until the time the bill died in the Senate. It is an issue that will return next year.

<u>Consent by Minors to Health and Dental Care Services</u>

Senate Bill 72 *Medical and Dental Treatment – Consent by Minors and Protections for Licensed Health Care Practitioners* addresses a narrow but significant access issue that has been before the General Assembly for the last few years. There is a small but significant number of minors who find themselves completely and legitimately without an adult in their life to consent to health care services. While current law provides for consent authority in life-threatening circumstances, there is no mechanism for these youth to consent to a broader range of services

that enable them to access preventative services as well as receive care for chronic conditions, minor injuries and other basic health care needs.

Delegate Rosenberg, who has championed this issue in prior years, and Senator Kelley advanced legislation that initially was opposed as it broadened consent access for all minors and included a broad range of practitioners. However, working in conjunction with the bill's proponents, the Senate crafted compromise language that limits the expansion of consent rights to those minors who were self-supporting and lived separate from adults who could consent. Further, the bill clarifies and strengthens immunity language that applies to physicians and other practitioners who provide care to minors under the belief they meet the definitions provided in the statute. Passage of this legislation ensures access to some of Maryland's most vulnerable and disadvantaged youth.

Other Bills of Interest

As a result of the leadership of Dr. Amy Valasek, Maryland now has a requirement for school systems to adopt heat acclimatization policies. **House Bill 1080 – Education – Student Athletes – Heat Acclimatization Guidelines** was introduced by Delegate Jay Walker relatively late in the Session after Dr. Valasek brought to the Chapter's attention the fact that Maryland was one of only a few States that had no requirements for the adoption or adherence of heat acclimatization guidelines for student athletes. It often requires several years of work to gain the support of the local school boards on issues that impose mandates on their school systems. However, the compelling issue of injury and death associated with heat related illness and failure to properly acclimatize student athletes lead to their support of the legislation.

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

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

Increase in the tax for "other tobacco products"

In the closing hours of the Legislative Session, the Senate and the House agreed upon an increase in the tobacco tax that was included in the revenue bill that failed to be enacted in the final minutes of the Session. The agreement retained the current tax rate on premium cigars at 15% of the wholesale price, but the tax on other tobacco products was raised significantly. The largest was on "little cigars," raising that tax from 15% of wholesale price to 70%. Smokeless tobacco products such as snuff and chewing tobacco had their tax increased from 15% of the wholesale price to 30%. The need to increase the tax on "other tobacco products" (OTPs) has been a long standing position of the Chapter as a participating member of the Healthy Maryland Initiative. It is unclear whether this agreement will be retained when the Special Session is

convened although likely given the joint agreement of both Houses. It remains a work in progress.

SCID

DHMH, in conjunction with the State Advisory Council on Hereditary and Congenital Disorders, has been directed to report to the budget committees by December 31, 2012 on the feasibility of implementing severe combined immunodeficiency disease (SCID) screening of newborns in Maryland. The report is to address the impact of implementing SCID screening, including an analysis of screening costs, and start ups costs for the necessary equipment and staff that would be need to implement SCID screening. Insurance reimbursement, as it pertains to screening costs and the financial impact on Medicaid should a newborn fail to be diagnosed with SCID, should also be discussed. The report will advise the budget committees if and when DHMH plans on adding SCID screening, or other hereditary and congenital conditions, to the newborn screening program.