MDAAP Final Report

April 8, 2014

The 432nd Session of the Maryland General Assembly adjourned *Sine Die* at midnight on Monday, April 7th. In this Session, the General Assembly considered 2,693 legislative bills and resolutions. The last Session of a four year election cycle is typically absent major legislative initiatives but full of proposals that reflect the interests of those running for reelection. For the Governor, who has successfully enacted a number of major policy initiatives, his major focus this year was the enactment of a significant increase in Maryland's minimum wage which was passed in the waning hours of the final day. This report summarizes the major issues of interest to MDAAP. A full list of bills identified by MDAAP and monitored throughout the Session is provided as a separate attachment. Further information can be provided on any of the bills tracked on MDAAP's behalf if requested.

Child Maltreatment: MDAAP was successful in passing its initiative to improve communication between health care providers, DHR and local DSS offices with respect to information relevant to the provision of health care services for children who were the subject of a report of potential child abuse or neglect. House Bill 1284/Senate Bill 685 (*Family Law – Child Abuse and Neglect – Provision of Information to Health Care Providers)* as enacted will require that treating health care providers, upon their request, be provided information relevant to the provision of health care services to the child. The bill originally would also have established requirements of DHR to communicate affirmatively under certain circumstances, but those issues are more complex due to federal confidentiality restrictions. Consequently, the bill was amended to establish a stakeholder workgroup to work through the more complex communication issues and report back to the relevant committees by December 1, 2014. It is a positive step forward with more work to be done.

The balance of the child abuse and neglect initiatives were unsuccessful as they have been in previous years except for the passage of Senate Bill 460 (*Criminal Law – Person in a Position of Authority - Sexual Offenses with a Minor*) which broadens the current prohibition on sexual activity with minors by "persons in authority." Senate Bill 460 extends the prohibition to include all persons 21 years and older who are employed by, or under contract with, a public or private school. The bill also includes "coach" in the list of positions specifically delineated in the law. Strengthening this prohibition has been the subject of legislative activity for a number of years and raised many controversial issues such "age gap" concerns. Its passage is notable and should provide important expanded protection to our school age youth.

No progress was made on issues relative to failure to report, education of providers on the prevention and identification of abuse and neglect, system responsiveness and accountability when reports are made, etc. There remain significant differences of opinion on the problems, solutions, etc. associated with the child protection system as a whole. Until a more comprehensive review and assessment of the system and its deficiencies is undertaken, the piecemeal approach to specific issues is likely to remain unsuccessful.

Health Insurance: There were a number of bills that were enacted that impact the practice of medicine and the physician's interaction with the commercial insurance marketplace. These include:

Step Therapy: Senate Bill 622/House Bill 1233 (*Health Insurance − Step Therapy or Fail-First Protocol*) which, in its final form, 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.

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. (MedChi referenced as they were the face of the physician community on this initiative).

Patient Provider Workgroup: House Bill 779 (*Maryland Health Care Commission – Health Provider-Carrier Workgroup*), 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, the Chair of the House Health and Government Operations Committee and sponsor of the bill, 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.

Confidentiality of Sensitive Health Information: Senate Bill 790 (*Health Insurance – Communications Between Carriers and Enrollees – Conformity with HIPAA*) was enacted. It is the beginning of what is expected to be an extended effort to protect the confidentiality of sensitive health information. With the number of individuals remaining on their parents' insurance policies until age 26, coupled with existing concerns about services that minors can access without parental consent and individuals who are victims of domestic violence, there is a growing awareness that action needs to be taken to ensure that there is a mechanism to request that health information remain confidential. Accomplishing that objective is complex but HIPAA provides a mechanism for those who are in danger – essentially domestic violence – to request privacy protections. Senate Bill 790 reaffirms HIPAA's provisions in State law. AAP, at the national level, has been very active on this issue. It is anticipated that broader protections, beyond those provided to victims of domestic violence, will be proposed next Session.

Medicaid: Significant activity occurred relative to the Medicaid program both through the passage of legislation and in the budget deliberations. The actions of note included:

Independent Review Organization Program: Narrative language in the budget was adopted 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 MDAAP, MedChi and other primary care provider specialty organizations' 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 the physician community 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 attention will now turn 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. 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 the 2015 Session.

Telemedicine: House Bill 802/Senate Bill 198 (*Maryland Medical Assistance Program – Telemedicine)* brings the Medicaid program into conformity with commercial carriers with respect to reimbursement for telemedicine. Previously Medicaid was only required to reimburse for limited services in rural areas. Now, Medicaid will be required to reimburse for telemedicine in the same manner they reimburse for "in-person" services under defined circumstances. Its

passage should advance the ability to utilize telemedicine services in areas with significant access to care challenges.

Community Integrated Medical Home:

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 MDAAP will continue to be an active participant.

Community Health Workers: Related to the CIMH program were various efforts to define/develop the community health worker concept and regulatory structure. House Bill 856/Senate Bill 592 (*Workgroup on Workforce Development for Community Health Workers*) was enacted. Initially introduced as different approaches to the same issue, the House and Senate amended the referenced legislation to require DHMH and the Maryland Insurance Administration to jointly establish a stakeholder workgroup to study and make recommendations regarding the training and credentialing required for community health workers to be certified as nonclinical health care providers and reimbursement and payment policies for community health workers through Medicaid and private insurers. The workgroup is to report its findings by December 1, 2014.

Public Health:

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 MDAAP is a member, will continue its effort to get pledges from both legislators and candidates with the goal of passage in the 2015 Session.

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.

Energy Drink Sale Prohibition: House Bill 1273/Senate Bill 986 (*Criminal Law – Energy Drinks – Sale to and Possession by Minors Prohibited*). mandated the protection of children and adolescents by prohibiting a person from distributing, selling, furnishing, or giving away an energy drink to a minor, as they are products linked to potential health risks. The bill would have criminalized the distribution of energy drinks to and consumption of energy drinks by minors. This is the first year for this initiative and, as expected, there was strong opposition from the manufacturers and retailers. Retailers argued that it would not be feasible for salespersons to distinguish which energy drinks are prohibited, and it would be unfair to criminalize a salesperson and persons for providing minors with energy drinks. The proponents did an excellent job educating the Committee. While the bills were defeated, the hearings created a strong basis for future action. AAP nationally has policy on this issue as well.

Newborn Screening: House Bill 1542/Senate Bill 433 (*Department of Health and Mental Hygiene-Newborn Screening Program Fund – Establishment)* was an issue that failed in the waning hours of the Session but holds promise for addressing funding issues related to the addition of disorders to the newborn screening panel when recommended by the State Commission on Hereditary and Congenital Disorders. The issue arose as a result of advocacy by a family that sought to have Krabbe A and other lysomal storage disorders added to the newborn screening panel. While MDAAP opposed their addition as they are not yet recommended for inclusion, the discussion broadened to recognition that funding had prevented other recommended disorders from being added, such as SCID. The bill, as proposed and passed by both House and Senate in slightly different versions (the reason it failed), would have created a special fund that captured the fees collected for newborn screening. Any revenues in excess of expenses could then be used for expansion of the program to included recommended tests. While the bill failed – it provides a framework for addressing the issue in 2015.

Medical Marijuana: Senate Bill 293/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.

The General Assembly also enacted legislation that decriminalizes marijuana but the decriminalization only applies to individuals over the age of 21.

Environmental Health: Legislation expanding current prohibitions on flame-retardant chemicals to include TDCPP was enacted with the support of MDAAP − House Bill 229 (*Public Health – Child Care Products Containing Flame-Retardant Chemicals – TDCPP – Prohibition).* Legislation was also passed that restructured and reaffirmed the obligation of employers that utilize hazardous chemicals to provide a list of those chemicals to the Maryland Department of the Environment as required under federal OSHA laws. The legislation also clarifies that the information is available to a number of individuals including health care providers treating individuals who may be exposed and community organizations − House Bill 189/Senate Bill 711 (*Maryland Occupational Safety and Health Act – Chemical Information List – Submission, Maintenance, and Accessibility).* Legislation that would have required companies "fracking" in Maryland to provide information on the chemicals utilized and to establish a fund for use by those affected was not enacted in large part because there is no fracking currently permitted in Maryland and the Governor's Commission that is studying the issue has not issued its final report.

Scope of Practice:

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.

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. The Department of Health and Mental Hygiene, as well as the Boards of Physicians and Nursing, have a mindset on necessary regulatory requirements that is similar to those MDACOG, MDAAP 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 continue to prevail.

Education Related:

Habilitative Services: House Bill 798/Senate Bill 701 (*Education – Children with Disabilities – Habilitative Services – Information)* was enacted which emanates from a technical advisory committee process under the auspices of the Maryland Insurance Administration on which MDAAP members served as experts. The bill requires local school systems to provide the parents or guardians of a child with a disability information about access to habilitative services that is produced by the Maryland Insurance Administration.

Safe and Healthy School Hours: House Bill 883/Senate Bill 14 (*Department of Health and Mental Hygiene – Study of Safe and Healthy School Hours for Maryland Public Schools)* was enacted. Originally proposed as a task force to be staffed jointly by MSDE and DHMH, it was amended to require DHMH to do a study of the health issues associated with school start times. This study is anticipated to be useful in the continued effort to address concerns about start times and their effect on students, particularly high school students.

Child Care Centers: 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.