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MDAAP Final Report

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The 427th Session of the Maryland General Assembly adjourned *Sine Die* at midnight on April 12th. It was a session dominated by election year rhetoric and challenging fiscal issues. Few policy issues of major importance were tackled. However, for the physician community, it turned out to be a very good year. Following is a summary of initiatives that were of specific importance to the pediatric community and/or were of general importance to the physician community as a whole.

MDAAP Initiated Legislation

Obesity Visits and Developmental Screening

House Bill 1017/Senate Bill 700 (*Health Insurance – Child Wellness Benefits*) – This legislation clarifies that the existing child wellness mandated benefit includes coverage for developmental screening and obesity evaluation and management visits. While some carriers had been appropriately covering developmental screening, CareFirst, the dominant carrier in the market, refused to reimburse for screenings. With respect to obesity visits, few carriers recognized the ICD-9 diagnosis code for obesity, forcing physicians to identify other diagnoses for these visits. Passage of this legislation should result in enhanced identification of children at risk for obesity related health issues and enhance the ability and willingness of pediatricians to conduct the recommended developmental screenings.

Statewide Advisory Commission on Immunization

House Bill 411 (*Statewide Advisory Commission on Immunizations – Membership, Duties, and Sunset Repeal*) – The Statewide Advisory Commission on Immunizations becomes a permanent Commission as a result of passage of this legislation. In addition to removing the sunset, the bill adds a consumer and pharmacist member, creates three-year terms for all Commission members, specifies that the Commission Chair shall be appointed by the Secretary of DHMH and adds several important charges to the tasks of the Commission.

The new charges include a review of: Potential provider reimbursement barriers to increasing immunizations; relative effectiveness of outreach programs that educate the public about the benefits of immunizations; potential cost-shifting of immunization expenses for privately insured patients who receive immunizations at public health departments; and the potential administrative burdens associated with State purchasing of vaccines. The Commission

is also required to make recommendations on how to increase immunizations, including catch-up immunizations among adults, adolescents and children.

The enactment of this legislation enhances the strength and relevance of the Commission and helps to ensure that it becomes a more effective tool for policy makers in shaping initiatives relevant to immunization policy in the State.

Other Primary Care Specific Legislation

There were a number of initiatives enacted that specifically address issues related to primary care services and physicians. The General Assembly is cognizant of the increasing shortage of primary care physicians and the access challenges that arise as a result of those shortages. The legislation passed this year demonstrates recognition by the General Assembly that it must "fix" the challenges facing primary care if the State is ever to be successful in improving quality and controlling costs. The bills particularly germane to primary care are:

Patient Centered Medical Home

House Bill 929/Senate Bill 855 (*Patient Centered Medical Home*) – Enactment of this legislation will enable the Maryland Health Care Commission to establish the Patient Centered Medical Home Demonstration Project that was approved by the Governor's Cost and Quality Council in December of 2009. The demonstration project will seek to involve a diverse cross section of the primary care physician community, including diversity of practice size, demographics and geography.

The Commission will develop regulations that address payment mechanisms, evaluation tools and other aspects of the program. It reflects the culmination of a two-year process that involved a broad range of stakeholders including the active participate of primary care physician specialties. The project has a five-year sunset but it is anticipated that data from the project will provide useful insights far in advance of the completion of the project.

After Hours Care Reimbursement

House Bill 435 (*Health Insurance – Reimbursement of Primary Care Providers – Bonus Payments*) – As originally introduced, House Bill 435 proposed to require reimbursement for "visits" provided via email or telephonic communication. In addition, it required reimbursement for after hours care. The provisions reflected issues incorporated into Recommendation No. 6 of the final report of the Governor's Task Force on Health Care Reimbursement. The Maryland Health Care Commission and the insurers raised questions regarding the email and telephone service part of the bill and these provisions were deleted. Given the uncertainty of telemedicine regulation by the Board of Physicians, there was no objection to the deletion of these provisions.

The legislation as amended requires that an insurer must specifically address bonus payments for primary care physicians when they provide services to insureds between the hours of 6 p.m. and 8 a.m., weekends and holidays. The amount of the bonus payment is subject to negotiation with the insurer but must be specifically addressed in the contract. It reflects a desire

by the General Assembly to incentivize behavior that will reduce the inappropriate use of emergency department services and to enhance the compensation of primary care physicians.

Annual Preventive Care Visits

House Bill 878/Senate Bill 313 (*Health Insurance – Annual Preventive Care*) – In an effort to facilitate the scheduling of routine and preventive care, the passage of this legislation specifies that an insured can receive their annual preventive care visits at anytime during their plan year. The legislation's enactment will provide physician offices and their patients, flexibility in scheduling annual preventive services. Annual preventive services include annual child wellness visits; routine gynecological visits; screening or exams for colorectal cancer, Chlamydia, HPV, prostate cancer, or breast cancer; and annual vision examinations.

Scope of Practice

Nurse Practitioners

The Nurse Practitioners (NP's) introduced legislation (House Bill 319/Senate Bill 484 (*State Board of Nursing – Nurse Practitioners – Certification Requirements and Authority to Practice*) that would have abolished the requirement that the NP have a collaborative agreement with a physician. The physician community strongly opposed this measure. After the hearings, HGO Chairman Peter Hammen made clear to the NP's that the measure as introduced would not pass, while the Senate seemed more inclined to pass something close to what was introduced. After numerous meetings and amendments, the parties reached an agreement which preserves the requirement of collaboration between an NP and a physician. An NP must file an attestation with the Nursing Board that the NP has an agreement which sets forth a plan for collaborating and consulting with a physician, and for referrals. The regulations which will follow require the NP to identify the physician. This approach mirrors the approach adopted for Nurse Midwives in late 2009. The legislation also codifies the NP's scope of practice, which previously was only set forth in regulation, and allows the Board of Physicians to access an NP's attestation as needed.

Pharmacists

House Bill 1089/Senate Bill 1053 (*Health Occupations – Pharmacists – Laboratory Tests*) proposed to make CLIA waivered laboratory tests a recognized "scope of practice" of licensed pharmacists. The physician community, the Board of Physicians and the DHMH Laboratories Administration opposed the bill on a number of grounds including that passage of this legislation would further fragment continuity of care and was counter to the goal encompassed in the patient centered medical home legislation. The legislation was ultimately withdrawn, with an agreement that the Laboratories Advisory Committee would review the list of Maryland excepted tests and make a recommendation on how to proceed.

Child Abuse and Neglect

The focus of the Governor's Office and the General Assembly with respect to child abuse and maltreatment focused almost exclusively on child sexual predators and the criminal justice system. Much of that focus was a result of the death of the young girl on the Eastern Shore in early January. Several of the Governor's initiatives were enacted including requirements for lifetime supervision under certain circumstances and the loss of diminution credits. The Chapter has historically not weighed in on the criminal penalty component of child abuse and maltreatment issues – focusing instead on issues relative to the identification, intervention and treatment of child abuse and neglect.

The Chapter again supported efforts to recognize "neglect" in its child abuse statutes and to define what is NOT reasonable corporal punishment. Unfortunately, the General Assembly remains reticent to address either issue, often citing the fear of criminalizing poverty and intrusion on parental rights. The legislation on these issues failed. They will continue to be advanced in future years and hopefully will continue to gain support. It remains a fight worth continued focus. There were, however, other issues of lesser import that were enacted this year that move the ball forward.

House Bill 1043/Senate Bill 796 – *Criminal Procedure – Child Advocacy Centers* – defines child advocacy centers in statute. The bill also allows CACs to continue to apply to the State Victims of Crime Fund without creating a specific funding set aside. The legislation requires the Board of Victim Services to view support of CACs as a purpose area and permits funding for the development and operation of CACs.

House Bill 811/Senate Bill 559 – *Child Protection – Reporting of Children Living with or in the Regular Presence of Registered Child Sexual Offenders* was significantly amended from its original version. As enacted, it enable a person to make a report to a local social services agency or law enforcement agency if the person believes a child is living with or in the regular presence of a registered sexual offender. It also provides a framework for the DSS and law enforcement to respond to such reports. The legislation does NOT change or affect current reporting requirements for physicians or others now required to report abuse. The bill only enables reporting, it does not compel it.

House Bill 1141/Senate Bill 948 – *Child Abuse and Neglect – Disclosure of Information,* will lessen the restrictions on the disclosure of information with respect to a child who has suffered a fatality or near fatality as a result of abuse. The bill makes State law more consistent with the federal Child Abuse Prevention and Treatment Act (CAPTA). While the law still provides certain protections regarding the release of information, it will enable greater information sharing and thus more effective intervention.

Assignment of Benefits

Assignment of Benefits (AOB) legislation has foundered for the last 5 years and although, always supported by MedChi, it became its number one priority when MedChi

lobbyists – on the last day of the 2009 Session – persuaded Senate Finance Chair Thomas "Mac" Middleton and House HGO Chair Pete Hammen to send the issue for study by the Joint Committee on Health Care Delivery and Financing. The Joint Committee, after studying the issue over the summer and fall of 2009, produced Senate Bill 314.

Senate Bill 314 was adamantly opposed by CareFirst CEO Chet Burrell, the rest of the health insurance industry including United, Cigna, Aetna and Coventry as well as by the Maryland State AFL-CIO. The legislation had been mired in the House HGO Committee for over one month and it was assumed that the bill would either not be voted on or, if voted on, would be defeated in that Committee. While the opposition was supremely confident in their ultimate victory, and while the MedChi lobbyists were publicly not optimistic, they remained at work on the bill. Their great allies turned out to be House Speaker Michael E. Busch and Insurance Commissioner Elizabeth Sammis. The intervention of these two individuals resulted in a compromise being affected that was hammered out in 24 hours from Friday until Saturday afternoon and which was presented to the House HGO Committee on Monday morning for approval. The Committee unanimously approved, the full House of Delegates consented and the Senate concurred all within a matter of 12 hours.

The opposition was shell-shocked by the HGO Committee turnaround and found an ally in the Maryland Health Care Commission. On Sunday night, Rex Cowdry, the Executive Director of the Maryland Health Care Commission, sent an "over the top" letter blasting the House compromise. This letter became the insurance industry's last minute sword against the bill but it was unavailing.

The contribution of Acting Insurance Commissioner Elizabeth Sammis was particularly critical as she constructed a method of compromise which pleased hospital-based doctors as well as legislative opponents who were concerned that "balance billing" would occur more frequently if network doctors left the networks once they could continue to receive insurance reimbursement directly. The provisions of the compromise which apply to hospital-based doctors and on-call specialists were essentially the same: a "hospital-based" doctor or a "on-call" specialist who accepted an assignment of benefits would not be allowed to "balance bill" the patient but would be guaranteed to receive from the insurance company **the greater of** (1) 140% of the average contracted amount paid for the same service or, (2) the amount that the doctor had received on January 1, 2010. The practical effect of this language was to guarantee hospital-based and on-call doctors an increase in reimbursement from CareFirst and disallow higher paying insurers from lowering their reimbursements over what they were paying on January 1, 2010. In addition, the reimbursements will increase over time with a built in yearly inflation rider.

Approximately 10 years ago, a similar formula had been devised for the payment of non-par doctors by Maryland HMOs. The proponent of that 10-year old compromise was Speaker Michael E. Busch, then Chair of the House Economic Matters Committee. Ten years later, Acting Commissioner Sammis found a similar pathway to compromise.

The final version of the bill (particularly its formulas) are somewhat complicated and will require insurance companies to make calculations to establish the actual rates that they were

paying doctors as of January 1, 2010. The legislation will have a delayed effective date and not take effect until July 1, 2011. Senate Bill 314 contains a provision indicating that it is the "intent of the General Assembly" that the reimbursement for doctors not be decreased as a result of the legislation.

False Claims

Senate Bill 279 - *Maryland False Health Claims Act of 2010* passed the House of Delegates in the concluding week of the General Assembly but not without a fight. The passage of this legislation has been a foregone conclusion since the Maryland hospitals agreed to a "compromise" which enabled the bill to move through the Senate where it had been killed in fierce floor fights in each of the last two years. These amendments limited the qui tam provisions so that a whistleblower lawsuit could not go forward without the state taking over the case. In its amended form, the new Maryland law is not "DRA compliant" (the federal Deficit Reduction Act) and thus Maryland will not be entitled to additional monetary reimbursement from federal fraud lawsuits. Nevertheless, the enacted legislation provides for whistleblower involvement in the imposition of extremely punitive remedies for any hospital, clinic, doctor or pharmaceutical company accused of making a "false health claim."

Other Issues

House Bill 269/Senate Bill 540 – *Child with a Disability – Individualized Education Program* as enacted will require schools to provide parents with a copy of information, reports, draft IEPs or other documents at least 5 days before a scheduled meeting between the school and the parents to discuss the proposed IEP. The bill provides the school a waiver for extenuating circumstances but those circumstances must be documented. Hopefully, parents will be better able to advocate on behalf of their children when provided with the requisite information prior to meeting with the school.

House Bill 1036/Senate Bill 718 (*Tanning Devices – Use by Minors – Prohibition*) – MedChi sponsored an initiative in 2008 which successfully limited access to tanning devices by minors. Current law requires that minors have parental consent before they access tanning services. Since the enactment of the original legislation, Howard County has instituted a complete ban on minor's access to tanning services. This legislation proposed to eliminate the parental consent provisions and implement a ban statewide. The bill was defeated in both Houses.

House Bill 1391/Senate Bill 865 (*Education – Student-Athletes – Concussions*) – This legislation, which was introduced fairly late in the session, imposed various training and educational requirements for schools and recreation and parks programs related to student-athletes and concussions. The original bill also provided for various immunity provisions for those programs. The Senate passed the bill with amendments which deleted the immunity provisions and narrowed certain aspects of the training and educational requirements. The House Ways and Means Committee did not take the amended version of the Senate bill and thus the legislation failed. Successful passage of the Senate bill does provide a framework for consideration in 2011.

House Bill 1375 - *Kids First Express Lane Eligibility Act* expands upon a successful initiative enacted in 2008 that required the Comptroller's office to provide Medicaid and MCHP eligibility information to families whose incomes fell within the eligibility range and for which the families indicated the children did not have health care coverage. The new legislation will enable the Comptroller's office to share the tax information with DHMH if the families "opt in" and DHMH will then forward enrollment applications and other programmatic information to the families. It is hoped this will further enhance the State's efforts to enroll those children and their families who are not eligible have not enrolled in the programs.

House Bill 1358/Senate Bill 521 - *Family Planning Works Act* would have provided family planning services to all women with incomes under 250% of poverty. Based on the experience in other states with such programs, it is projected that adopting the proposed policy would generate significant savings over time. The challenge for passage of this legislation this year was the projected need for approximately $2 million in revenue to implement the program. While savings would accrue quickly, the State lacks the resources to begin the program. The House sponsor of the legislation, Delegate Heather Mizeur was investigating the potential to secure private funding and/or leverage federal funding. Unfortunately, a source of revenues for program implementation was not identified and the bills remained in their respective committees without a vote. It is an issue that will undoubtedly be revisited again next year.

House Bill 334/Senate Bill 256 – *Public Schools – Physical Education Facilities* requires all new school construction and or major renovations to include facilities for physical education.