



Government Affairs Committee Report on 2018 Maryland General Assembly

The Maryland General Assembly concluded on Monday April 9, 2018. The General Assembly was very active in the number of bills introduced this year. The session began with a vote to override the governor's veto of HB01 (Maryland Healthy Working Families Act) of 2017 requiring employers to provide paid sick leave. Much of the focus in this session included in-session workgroups to address protecting the individual health insurance market and to sort through over 40 bills designed to address the opioid crisis in the state. In addition, an election year lobbying battle took place between the health care industry and the plaintiffs bar over malpractice law changes. Despite the election year politics, the session was considered a bi-partisan success.

The Government Affairs Committee reviewed over 30 healthcare related bills for this session. The committee selected 6 of those bills to highlight during Maryland MGMA Legislative Day in Annapolis. Legislative Day was held on February 22, 2018. With many new MGMA members getting involved for the first time, we were able to meet face to face with members of the Senate Finance Committee and the House Health and Government Operations Committee to explain who we were, what we represent, and the issues effecting healthcare in Maryland. During the session, testimony was provided on several priority bills.

Outlined below is a brief summary of the outcome of some of the more significant issues:

2018 MGMA Priority Bills:

Disclosure of Medical Records Timeline:

SB230 (Disclosure of Medical Records – Compulsory Process – Timeline) attempts to require healthcare providers to respond to medical record requests within a statutory 30-day timeline as part of the discovery process in a court proceeding. There is already a statute to respond to patient requests for medical records within 21 days. Maryland MGMA opposed the bill in 2017 but testified to support the bill with amendments this session. The bill passed with an amendment for a 30-day extension when requested by the provider.

Interstate Medical Licensure Compact

SB234 (Interstate Medical Licensure Compact) allows Maryland to join 22 other states for a single process of medical licensure. The bill passed with amendments. In order to accommodate the PBQA, the effective date was pushed back to July 1, 2019 and provides for a 3-year sunset

provision. In addition, an amendment was made to allow for licensure without having to maintain specialty board certification. Maryland MGMA testified in favor of the bill.

Retroactive Denial of Reimbursement

HB 1070 (Health Insurance – Retroactive denial of Reimbursement to Health Care Providers)
This bill was introduced by Delegate Platt, Saab, and Sample-Hughes. The bill required a written notice of the retroactive denial at least 30 days to respond to the notice, and the option to pay the denied amount in lieu retention by the carrier. This is the first time the bill has been introduced. As this process is handled differently by all carriers, we would like to see this standardized process extended to all third-party payors including public payors. The bill received an unfavorable report from HGO. There was an agreement to send it to summer study for next year which Maryland MGMA will have an opportunity to participate.

Prescription Drug Monitoring Program Revisions

HB88 (Public Health – Prescription Drug Monitoring Program- Revisions) failed in the final hours with different amendments by the House and Senate in the final day of the session. Maryland MGMA opposed the original bill which required a mandatory referral of suspicious data to law enforcement without an appropriate medical peer review process. The amendments deleted the language of an automatic referral to law enforcement in favor of a referral to the Office of Controlled Substances Administration in the House and to the professional board after review by the technical advisory Committee in the Senate.

Prescription Drug Monitoring Program Disclosure

SB1007 (Prescription Drug Monitoring Program – Opioid Data – Disclosure) was similar to HB88. The bill was voted unfavorable by the Finance Committee.

Provider Credentialing Practices

HB1310 (Health Insurance – Provider Panels – Procedures and Credentialing Practices) reduces the statutory time period to process and notify providers during the carrier's credentialing process. The bill reduces from 30 to 15 the number of days to notify if the carrier rejects the provider for participation. If the carrier provides notice to the provider of its intent to continue the process the application to obtain necessary credentialing information, the carrier has 60 days instead of the current 120 days to complete the process. This is the first time this bill has been introduced in the general assembly. The bill was amended to simply state that a provider panel may not limit the number of behavioral health providers on the panel. The amended bill passed.

The Virginia legislature passed a bill this year that allows for retroactive payment to a provider who has applied for credentials but has not yet completed the process. This is similar to the

process already allowed under Medicare and Medicaid. Maryland MGMA will be looking to propose similar legislation for next year's session.

Other Areas of Interest:

Stabilizing the Individual Health Insurance Market

After years of large premium increases, the reduction of insurance carriers in the individual health insurance market and the loss of the federal tax incentives, the General Assembly formed a special workgroup to address the stabilization of the marketplace. CareFirst and Kaiser Permanente are the only two carriers providing individual coverage. Kaiser's testimony conceded that while they have enrolled a relatively healthy population, CareFirst has suffered from adverse selection in this segment of the market. *House Bill 1782/Senate Bill 387: Health Insurance – Individual Market Stabilization (Maryland Health Care Access Act of 2018)* (passed) and *House Bill 1795/Senate Bill 1267: Maryland Health Benefit Exchange – Establishment of a Reinsurance Program* (passed) seek to stabilize the individual health insurance market. The bills authorize the State to apply to the federal government to develop a Section 1332 reinsurance program under the Affordable Care Act (ACA), which would be primarily funded through the recoupment of the 2.75% health insurance carrier fee that would have otherwise been assessed under the ACA but was suspended earlier this year, which is estimated to be approximately \$375 million. Additional monies will be available from the federal government under an approved 1332 waiver program. The reinsurance funding would be used to forestall projected rate increases in 2019. To expedite the process needed to file the application with the federal government, the Governor signed House Bill 1795/Senate Bill 1267 into law on April 5, 2018.

The bills also will require the current Maryland Health Insurance Coverage Protection Commission to study and make recommendations for individual and group health insurance market stability, including: (i) the components of one or more waivers under § 1332 of the ACA to ensure market stability that may be submitted by the State; (ii) whether to pursue a standard plan design that limits cost sharing; (iii) whether to merge the individual and small group health insurance markets for rating purposes; (iv) whether to pursue a basic health program; (v) whether to pursue a Medicaid buy-in program for the individual market; (vi) whether to provide subsidies that supplement premium tax credits or cost-sharing reductions described in § 1402(c) of the ACA; and (vii) whether to adopt a State-based individual health insurance mandate and how to use payments collected from individuals who do not maintain minimum essential coverage, including use of the payments to assist individuals in purchasing health insurance.

Medical Liability:

After 20+ years of a relatively stable medical liability market with several legal challenges upholding the current law, the election year environment set the stage for a major push in tort reform by the plaintiff attorneys. *Senate Bill 30/House Bill 1581: Health Care Malpractice Qualified Expert – Limitation on Testimony in Personal Injury Claims* (failed). As introduced, this bill proposed to repeal the “20% Rule”, which limited standard of care experts who sign the certificate of qualified expert or testify at trial to using no more than 20% of their time testifying as expert witnesses. This longstanding rule prevented the use of “professional witnesses”. The Senate passed the bill as introduced by a vote of 29-16. The House amended both the Senate and House bills to address the problem raised by the plaintiff’s lawyers—that an expert could become disqualified under the 20% Rule during the pendency of the case due to retirement, illness, or changes in his/her practice. As amended by the House, once the expert qualifies, he/she remains qualified for the entire case. The Senate refused to accept these amendments, and a conference committee was appointed in the closing days of the Session. The conference committee met and recommended returning the bill to its original form—a full repeal of the 20% Rule. Under intense lobbying by MedChi, the bill passed by only 1 vote in the Senate. However, the House voted it unfavorable on the floor (41-89).

Other bills that failed included: *House Bill 289/Senate Bill 36: Civil Actions – Noneconomic Damages* (failed), which would have tripled noneconomic damages; *Senate Bill 5: Civil Actions – Punitive Damage Awards* (failed), which would have allowed certain civil cases to be subject to punitive damages; and *House Bill 909/Senate Bill 862: Maryland No-Fault Birth Injury Fund* (failed), which would have created a birth injury fund in Maryland

Maryland’s Opioid Crisis:

The Governor and the General Assembly have made fighting Maryland’s opioid crisis a top public health priority. Over 40 bills were introduced to address the problem. Maryland MGMA did not participate in the public policy debate except for the priority bills mentioned above.

Financing

The Hogan Administration proposed additional money for the Opioid Crisis Fund (OCF), raising the appropriation from \$10 million in fiscal year 2018 to \$13 million for fiscal year 2019. However, the Administration advised that \$5.3 million of these fiscal year 2019 funds have already been designated to support the 2% rate increase for providers, in response to both the HOPE and Treatment Act as well as budget language that prioritized new initiatives within the HOPE Act when it came to making decisions on OCF funding. Given the slow, bureaucratic release of OCF funding by the Opioid Operational Command Center (OOCC) to the Opioid Intervention Teams in fiscal year 2018, the budget now requires the OOCC to provide quarterly reports on OCF spending.

In addition, the General Assembly statutorily mandated additional funds to fight the opioid crisis through *House Bill 1092/Senate Bill 703: Behavioral Health Crisis Response Grant Program – Establishment* (passed), which provides funds to local jurisdictions to establish and expand community behavioral health crisis response systems. The Governor must include the following appropriations in the State operating budget for the program: (1) \$3 million for fiscal 2020; (2) \$4 million for fiscal 2021; and (3) \$5 million for fiscal 2022.

Opioid Initiatives

House Bill 922: Maryland Department of Health – “Pill Mill” Tip Line and Overdose Report (passed) establishes a hotline allowing citizens to report suspected over-prescribing by licensed health professionals, and those reports are forwarded to the professional licensing board with jurisdiction. The bill was amended to require a multi-departmental analysis of the prescription and treatment history, including court-ordered treatment or treatment provided through the criminal justice system, of individuals who have suffered fatal overdoses involving opiates and other controlled dangerous substances in the preceding 4 calendar years. The additional language is based on a Massachusetts initiative referred to as the Chapter 55 Project. The bill also includes a study of the “Hub and Spoke” model of behavioral health care service delivery, which has been implemented in Vermont.

House Bill 359: Health – Reporting of Overdose Information (passed) enables EMS personnel and law enforcement to enter information related to the location of overdoses into a multijurisdictional database. The information in the database does not contain individualized data and is to be used to better focus resources for prevention, intervention, and enforcement. A law enforcement agency may not publish the exact location of an overdose unless there is a valid public safety concern. The bill also requires the OOC to provide a comprehensive report regarding the reporting of overdoses to the multijurisdictional database.

House Bill 653/Senate Bill 522: Health Care Providers – Opioid Prescriptions – Advice Regarding Benefits and Risks (passed) deleted all the originally proposed language. As amended, the bill essentially restates existing direction for patient communication that is already incorporated in all evidenced-based guidelines for prescribing, which is to advise the patient of the benefits and risks associated with the opioid. The bill also addresses patient communication related to co-prescribing of opioids and benzodiazepines.

House Bill 1452/Senate Bill 1223: Controlled Dangerous Substances Registration – Authorized Providers – Continuing Education (passed) requires a provider to attest to having taken 2 hours of continuing education related to prescribing or dispensing opioids at the time a provider registers for a Controlled Dangerous Substance (CDS) certificate, or at the first renewal of the registration after the implementation of the law. It is a one-time requirement that is linked to the provider’s CDS registration and not to their medical license.

House Bill 517: Prescription Drug Monitoring Program – Data Request Exemption – Surgical Procedures (passed) strengthens and clarifies the current exemption for surgical procedures from the requirement to query the Prescription Drug Monitoring Program (PDMP). Under current law a prescriber is not required to request data from PDMP when prescribing or dispensing an opioid or benzodiazepine to treat or prevent acute pain, for a period of up to 14 days, following a surgical procedure in which general anesthesia was used. The bill removes the reference to general anesthesia in recognition of the fact that the type of anesthesia associated with a surgical procedure is not indicative of the need to address acute pain.

House Bill 1716: Prescription Drug Monitoring Program – Prescription Monitoring Data – Insurance Carriers (failed) would have required the PDMP to disclose prescription drug monitoring data to insurance carriers for determining the medical necessity of a prescription drug claim, enhancing or coordinating patient care, or assisting the treating provider's clinical decision making.

House Bill 601/Senate Bill 1255: Public Health – Opioids – Dispensing Requirement (failed). The bill would have required all prescribers when prescribing an opioid to also provide the patient with a product designed to deactivate the opioid for purposes of disposal. The Senate amended the bill to be permissive, not mandatory and to only apply to pharmacists, however the House took no action on the legislation.

House Bill 326/Senate Bill 288: Public Health – Overdose and Infectious Disease Prevention Supervised Drug Consumption Facility Program (failed), which proposed providing a place for the consumption of pre-obtained drugs with sterile needles, failed.

Pharmaceuticals and Pharmacy Related Bills:

House Bill 736/Senate Bill 576: Pharmacy Benefits Managers – Pharmacies and Pharmacists – Information on and Sales of Prescription Drugs (passed) which prohibits “gag clauses” and allows pharmacists to discuss the retail price of a prescription versus the patient’s cost. The bill maintains current law regarding the dispensing of generics and biologics.

House Bill 115/Senate Bill 13: Maryland Health Care Commission – Electronic Prescription Records System – Assessment and Report (passed) requires MHCC to convene interested stakeholders to assess the feasibility of developing an electronic system to allow health care providers to access a patient’s prescription medication history. By January 1, 2020, MHCC, in consultation with interested stakeholders, must report its findings and recommendations to the Governor and the General Assembly. The bill was originally opposed by MedChi because it would have required all prescriptions, not just controlled dangerous substances, to be transmitted through the PDMP. While MedChi could support the intent of the legislation, the larger concern was the use of the PDMP as the “pipes” before the PDMP is fully operational and the mandatory query (July 1, 2018) takes effect. MedChi supported the workgroup and subsequent report.

House Bill 1283: Health Insurance – Prescription Contraceptives – Coverage for Single Dispensing (passed) requires carriers that provides coverage for contraceptive drugs and devices to provide coverage for a single dispensing of up to a 12-month supply of prescription contraceptives. The bill may not be construed to require a provider to prescribe, furnish, or dispense 12 months of contraceptives at one time.

House Bill 1558: Pharmacists – Dispensing of Prescription Drugs – Single Dispensing of Dosage Units (passed) authorizes a pharmacist to dispense, in a single dispensing and exercising the professional judgment of the pharmacist, a quantity of a prescription drug that (1) is up to the total number of dosage units authorized by the original prescription and any refills and (2) does not exceed a 90-day supply of the drug. For a contraceptive dispensed on or after January 1, 2020, the single dispensing cannot exceed a 12-month supply of the drug. The authorization does not apply to a CDS or the first prescription or change in a prescription for a patient. A pharmacist may not dispense, in a single dose, a quantity of a prescription drug that exceeds the limit prescribed if the prescriber has indicated that the prescription be dispensed only as prescribed.

House Bill 1546: Pharmacy Benefits Managers – Requirements for Prior Authorization (failed), introduced by Delegate Terri Hill, M.D., would have made several exemptions to prior authorization laws, including no longer requiring prior authorizations for medications needed by patients for long-term or chronic conditions. MedChi believes that this bill could be amended to include physician services as well and will be back next session.

Scope of Practice

House Bill 591/Senate Bill 549: Health Occupations – Physician Assistants – Dispensing of Drugs Under a Delegation Agreement (passed) which allow a physician assistant to dispense drugs, if allowed by the physician under the delegation agreement. The physician thus retains control over whether a physician assistant can dispense at all, and if so, which drugs.

House Bill 857: Health Occupations – Physicians – Specialty Certifications (failed). This bill would have prohibited hospitals and insurers from requiring physicians to maintain their specialty certifications through the American Board of Medical Specialties. MedChi supported this bill, as many physicians have expressed frustration with the costs and time commitment required to maintain their certification. The hospitals and insurers all opposed it. However, MedChi did secure a letter from Chairman Shane Pendergrass of the House Health and Government Operations Committee, directing the Maryland Health Care Commission (MHCC) to study the issue over the interim, and MedChi will be involved in that study.

House Bill 863: State Board of Nursing – Advanced Practice Registered Nurses – Certification and Practice (passed). As introduced, this bill codified certain existing scope of practice functions of nurse anesthetists, but also altered their scope. MedChi opposed the bill. Through amendments, the bill was limited to codifying the scope as it currently exists in regulation.