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Maryland Academy of Family Physicians
Report on the 2022 General Assembly Session

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INTRODUCTION

The Maryland General Assembly wrapped up its annual 90-day Session last night, the last one of this four-year term, and the election season of 2022 now begins in earnest for all Delegates, Senators, and statewide office holders. In fact, one of the biggest issues of the Session was the drawing of district maps, both for State legislators and Members of Congress, a process that occurs every 10 years following the U.S. Census. While the congressional map was resolved through litigation and a new map being drawn by the General Assembly, the districts of State legislators remain the subject of a court case pending before the State's highest court. Legislators leave town still not knowing-for certain-what their districts look like, with the primary election currently set for July 19, 2022.

Even with redistricting in play, the Legislature acted on a number of high-profile issues. First, the only legislation required to pass each year is a Budget, and that job was made easier than ever this year with a surplus larger than the State has seen in its history, thanks to federal funds sent down through COVID relief legislation and federal infrastructure monies. The Assembly also passed legislation addressing climate change, abortion access, tax relief for retirees, and sent the legalization of marijuana to the ballot.

Health care issues were also the focus of a tremendous amount of attention. MDAFP identified four priorities prior to the Session, and by any measure our efforts were beyond successful. These priority issues are discussed below along with some other legislative matters that are of interest to primary care practices.

PRIORITY ISSUES[1]

1. **Maryland Loan Assistance Repayment Program for Physicians and Physician Assistants (LARP)**. There were two aspects to MDAFP's legislative efforts on LARP. The program was

[1] Keep in mind that bills passed by the Legislature are presented to the Governor for his signature. References in this report to bills that have passed do not mean they have become law; that does not occur until the Governor either signs the legislation or allows it to become law without his signature.

ripe for legislative action because of a LARP Workgroup established in 2020 by legislation which was charged with making recommendations on improving LARP. First, we sought temporary funding for the program while a permanent funding source can be found, as recommended by the Workgroup. Governor Hogan provided a great assist by including $1.4 million in the Budget he submitted to the General Assembly early in the Session, but the General Assembly then **added an additional $3 million**. This total of $4.4 million will be by far the largest amount ever provided for LARP and is due in large part to the extraordinary funds available to the State this year by way of federal funding. Second, **Senate Bill 626: Maryland Loan Assistance Repayment Program for Physicians and Physician Assistants – Alterations** was adopted. This bill contains a recommendation of the Workgroup that stems directly from a request made by MDAFP to allow part-time physicians and physician assistants to obtain loan assistance in pro-rated amounts. The bill also establishes an Advisory Council for the Program.

The combination of record funding and the adoption of these policy changes puts LARP on its best footing yet. The mission now becomes one of awareness for young physicians who are interested and willing to practice in underserved areas.

2. **Medicaid Payment Parity**. MDAFP and other organizations like MedChi have advocated to make Medicaid reimbursement rates for E&M codes equal to Medicare rates for some time. This effort begins each year with a letter from MDAFP and other provider organizations to the Budget Secretary, asking that funding be included for this important item in the Budget bill submitted to the General Assembly. For the first time since 2010, the FY 2023 Budget submitted by Governor Hogan to the General Assembly contained this funding, and the General Assembly left it intact. As we state in our letters, parity must be achieved if the State is to maintain the success it has had in recruiting and retaining physicians and other health care providers to participate with Medicaid.

   To be fair, this result is due partly to the State's current financial largesse. But the continued advocacy on this issue was the foundation on which this year's record funding stands, and a precedent is now set for future years.

3. **CareFirst Bill**. During the 2021 Session of the General Assembly, legislation was introduced that allowed health insurers to risk-share with providers, meaning enter contracts that allow for bonus payments to practitioners as well as the authority for insurance carriers to recoup funds if contract terms are not met. That legislation was withdrawn, but on the condition that MedChi coordinate with all specialty providers, including MDAFP, and work with CareFirst on this legislation. On behalf of MDAFP, Dr. Ariel Warden-Jarrett participated in the workgroup, which met over 20 times throughout the summer and fall of 2021. The result was draft legislation that solved most but not all of the concerns of the provider community.

   When the 2022 Session began, several issues were outstanding when **House Bill 1148/Senate Bill 834: Health Insurance – Two-Sided Incentive Arrangements and Capitated Payments – Authorization** were introduced. Through further negotiations, amendments were adopted to address the remaining provider concerns, namely protections for both those

physicians that decide to participate in these arrangements and those that do not. The end product is one that carries more protections for providers than any other law in the country, according to the insurers.

4. **Primary Care Reform Commission**. Though not an issue that MDAFP prioritized prior to Session, legislation was introduced late in the Session (Senate Bill 734), and without notice at the request of Dr. Howard Haft in the Department of Health, that would establish a Primary Care Workgroup within the MD Health Care Commission.

   MDAFP identified a number of concerns with the legislation as introduced and asked for amendments to address these. For example, we asked that 'primary care investment' be used instead of 'primary care spending', that the definition of defining 'primary care' include 'family medicine' and not 'family practice', and that in the first year, the workgroup must first develop a plan for analyzing the State's primary care investment before it begins the actual task of doing so, and report that plan to the General Assembly by December 1, 2023.

   For an issue that arose late, the final product is a good one and the upcoming effort promises to provide needed focus on primary care, as it has in other states where the same analysis has been conducted.

5. **Interstate Medical Licensure Compact**. House Bill 180/Senate Bill 386 extends through 2030 Maryland's membership in the Compact and were introduced because membership was set to expire later in 2022. The Compact allows physicians to practice in multiple member states but importantly retains the requirement that they become licensed in each state and subject to disciplinary requirements in each state.

OTHER LEGISLATION

Senate Bill 808/House Bill 961: Health Occupations – Physician Assistants – Revisions (withdrawn). This legislation made a wide range of changes to the physician assistant (PA) statute, most significantly in the relationship between the physician and the PA, removing the "supervision" requirement and making it a collaborative relationship. Before consideration of the bills got underway in earnest, the bill was withdrawn on the condition that interested parties work together this interim to achieve a compromise.

House Bill 421/Senate Bill 398: Out-of-State Health Care Practitioners – Provision of Behavioral Health Services via Telehealth – Authorization (failed). This legislation would have allowed a practitioner who is not licensed in Maryland to provide behavioral telehealth services to a patient located here. The person practicing telehealth here must hold a valid license in another state and consent to the jurisdiction of the relevant Maryland health occupations board, but not be fully licensed here. The bill failed.

Senate Bill 77: Health Occupations Boards – Investigations – Right to Counsel ( ). This legislation would have codified existing practice which allows a licensee to have counsel present

during an investigation. The boards raised questions about whether the language of the bill allowed a licensee to demand that their counsel be present before an office or facility inspection, and asked for amendments that allowed them to exclude counsel if they are interfering or acting inappropriately during an investigation or interview. The Senate adopted these amendments and passed the bill, but it encountered further difficulties in the House.

Senate Bill 159/House Bill 462: Health Occupations – Authorized Prescribers – Financial Reporting ( ). This bill would have required every prescriber in the State to report to their respective professional board anything of value received from a drug manufacturer. This information is already provided under the federal Sunshine Law and the "Open Payments" database, so there is no need to report this same information at the State level. MedChi offered to amend the bill to require the Board of Physicians to provide on its website a link to the open payment system in each physician's existing profile, a solution the Senate adopted. However, the Senate sponsor, Sen. Delores Kelley, did not like this approach and asked the House to restore the bill to its original form. Further amendments were proposed by the Board of Physicians and by the House sponsor, all of which resulted in significant confusion. The bill died.

House Bill 1073/Senate Bill 824 Health – Accessibility of Advance Care Planning Documents (passed). This legislation requires the adoption of a number of measures designed to increase public awareness of the importance of and facilitate access to advance care planning documents, such as advanced directives. The Maryland Health Care Commission is charged with coordinating the implementation of advance care planning programs, including developing an electronic system for health care facilities to use to verify the existence of or assist in creating planning documents. For providers, the primary requirement in the bill is that an information sheet adopted by the Department of Health be provided to patients at the appropriate time during a scheduled visit.

House Bill 260/Senate Bill 305: State Board of Physicians – Dispensing Permits (failed). This legislation would have transferred the regulatory oversight for conducting inspections of physician offices with dispensing permits from the Office of Controlled Substance Administration (OCSA) to the Board of Physicians. While the bill passed the House, it was held in the Senate. The Attorney General's Office raised a concern that the bill would weaken the authority of OCSA to investigate claims related to opioid prescribing. While this would not be the case, the argument stuck.

The main labor and employment bill passed by the General Assembly this Session was **Senate Bill 275: Labor and Employment – Family and Medical Leave Insurance (FAMLI) Program – Establishment (Time To Care Act of 2022) (passed)**. This was a hotly contested bill, with labor and advocacy groups supporting and business groups opposing. In a maneuver often invoked during the fourth year of a term, the General Assembly passed and presented the bill to the Governor during the 2021 Session, forcing him to sign or veto it during the Session. As expected, Governor Hogan vetoed it, and the General Assembly easily overrode the veto.

Therefore, Senate Bill 275 requires, beginning October 1, 2023, employers (15 or more employees) and employees to make annual contributions to the FAMLI Fund as determined through a cost analysis performed every two years. Beginning January 1, 2025, the program generally provides up to 12 weeks of benefits to a covered individual who is taking leave from employment due to caring for specified family members, the individual's own serious health

condition, or a qualifying exigency arising out of a family member's military deployment. A "covered individual" is an employee who has worked at least 680 hours over a 12-month period immediately preceding the date on which leave is to begin or a self-employed individual who has opted to participate in the program. The weekly benefit, which is based on an individual's average weekly wage, ranges from $50 to a $1,000 cap that is indexed to inflation.