BOARD OF PODIATRIC MEDICAL EXAMINERS

OPEN SESSION MEETING VIA GOOGLE MEET

AGENDA

February 10, 2022

Location Google Meet: http://meet.google.com/hwh-ajtv-sif

Join by phone: (US) +1 414-909-7557 PIN: 350 725 762#

A. ORDER of BUSINESS

1. **Call to Order- Roll Call**
2. **COMAR 10.01.14.02.B: Except in instances when a public body expressly invites public testimony, questions, comments, or other forms of public participation, or when public participation is otherwise authorized by law, a member of the public attending an open session may not participate in the session.**
3. **Approval of minutes from the January 13, 2022 meeting** **Tab A**

B. BOARD PRESIDENT'S REPORT

C. EXECUTIVE DIRECTOR'S REPORT-Eva Schwartz

1. **MLDSC Procedures**

D. OLD BUSINESS:

1. **SB 311/HB 790 -Podiatric Physician** **Tab B**

E. NEW BUSINESS:

1. **Proposed Legislation – Health Occupations Boards – Authority Over Staffing and Infrastructure Operations**
2. **HB 407- Health Occupations- Health Care Staffing Shortage Emergency- Declaration and Licensing and Practice Requirements** **Tab C**
3. **Topics Quarterly Newsletter Volume 36/No. 4 Winter 2021 from Gordon, Feinblatt, Rothman, Hoffberger & Hollander, LLC** **Tab D**
4. **SB 385 Health - Disclosure of Medical Records - Penalty**
5. **SB 159 Health Occupations - Authorized Prescribers - Reporting of Financial Gratuities or Incentives**
6. **SB 440/HB 625- Commission to Study the Health Care Workforce Crisis in Maryland- Establishment** **Tab E**
7. **Review eligibility for issuance of Full Active Podiatric License:**
   a. **Hesam Naenifard, DPM**

F. ADJOURNMENT

BOARD OF PODIATRIC MEDICAL EXAMINERS

OPEN SESSION MEETING VIA GOOGLE MEET

MINUTES

January 13, 2022

Location Google Meet: https://meet.google.com/zqx-pgzi-wuo?hs=224

Join by phone: (US) +1 904-900-0521 (PIN: 288495278)

The Public Meeting commenced at 1:04 PM, opened by the Board President, Dr. Adam Silverman.

Roll call was initiated by the Executive Director.

Board members present: Drs. Gottlieb, Umezurike, Silverman, and Fox. Dr. Aparna Duggirala was absent.

Consumer Members present: Ms. Frona Kroopnick and Ms. Lynne Brecker, RN

Board staff present: Eva Schwartz, Executive Director, and Elizabeth Kohlhepp, Deputy Executive Director

Office of the Attorney General: Rhonda Edwards, AAG, Board Counsel

Representing MPMA: Dr. Jay LeBow, MPMA member

Representing MDH: Kim Link, Secretary's Liaison to the Boards and Commissions, and Lillian Reese, Legislation

Dr. Silverman cited COMAR 10.01.14.02.B: "Except in instances when a public body expressly invites public testimony,questions, comments, or other forms of public participation, or when public participation is otherwise authorized by law, a member of the public attending an open session may not participate in the session."

A. MINUTES

1. **Approval of minutes from the November 18, 2021 meeting**

   The minutes from the November 18, 2021 meeting were approved unanimously, as submitted.

B. BOARD PRESIDENT'S REPORT

Dr. Silverman addressed some inquires relating to Hyperbaric Oxygen Therapy. He referred to the Board's website which states the following:

HYPERBARIC OXYGEN THERAPY BY PODIATRIC PHYSICIANS : It is the Board's opinion that the LCD by CMS of 5/1/2011 represents the current delineation of Hyperbaric Oxygen Therapy by Podiatric physicians.

Podiatric physicians may supervise hyperbaric oxygen therapy if such a service is within their State scope of practice. However, such supervision is only covered/reimbursed when the body area or condition being treated by the hyperbaric oxygen is also within the scope of practice (e.g., a diabetic wound of the leg distal to the mid calf).

Physicians supervising hyperbaric oxygen therapy should be certified in Undersea and Hyperbaric Medicine by the American Board of Emergency Medicine (ABEM) or the American Board of Preventive Medicine (APBM) or must haw completed additional training in hyperbaric medicine, such as the 40-hour training required by the ABPM Advanced Cardiac Life Support (ACLS) training and certification of supervising physicians (and NPPs) is required in physician offices and off-campus hospital sites; and in on-campus provider-based departments for which provider-response time to the chamber can be expected to exceed five minutes.

C. EXECUTIVE DIRECTOR'S REPORT-Eva Schwartz

Ms. Schwartz discussed with the Board the effects of a recent cyber security incident that occurred within MDH. The incident caused a delay in renewal of licenses being issued, however, Board staff worked and continues to work diligently to make sure that any verifications that could help to prevent credentialing issues at hospitals were issued. Ms. Schwartz also stated that DMV and PDMP and Medicaid will receive up to date rosters to prevent any credentialing issues with providers.

D. OLD BUSINESS:

1. MPMA Bill -Podiatric Physician

The Board discussed the upcoming session regarding the Podiatric Physician Bill. The House is currently hosting all sessions virtually, however the Senate will be moving to in person on February 14th. The MPMA will meet January 19, 2022 to discuss the Bill and request volunteers to testify. The Board voted to support the Bill.

E. NEW BUSINESS:

1. FPMB 2021 Q4 Newsletter

The Board reviewed the Federation of Podiatric Medical Boards Newsletter for informational purposes.

2. NPDB- Is It Reportable?

The Board was given a copy of the National Practitioner Data Bank Insights Newsletter for informational purposes.

3. Electronic Prescribing Mandate

The Board discussed the new electronic prescribing mandate which states that effective January 1, 2022, Senate Bill 0166 (CH0299)/House Bill 0512 (CH0230) (2020) Drugs and Devices – Electronic Prescriptions – Controlled Dangerous Substances requires licensed health care providers to electronically prescribe prescriptions for controlled dangerous substances and allows for waivers to be granted under certain circumstances. To apply for a waiver, visit the Office of Controlled Substances website, Quick Links, Electronic Prescribing Waiver Request. https://health.maryland.gov/ocsa/Pages/Electronic-Prescribing-Waiver-Request-form.aspx. Additional information is posted on the Board's website at:

Chromeextension://efaidnbmnnnibpcajpcglclefindmkaj/viewer.html?pdfurl=https%3A%2F%2Fhealth.maryland.gov%2mbpme%2FDocuments%2Fcdspodnotice.pdf&clen=132773&chunk=true.

4. HB 55- Health Occupations- Nurse Anesthetists- Drug Authority and Collaboration

The Board reviewed HB 55- Health Occupations- Nurse Anesthetists- Drug Authority and Collaboration. After discussion, the Board voted to take no position on the Bill. One Board member was opposed.

5. SB 77- Health Occupations Boards – Investigations – Right to Counsel

The Board reviewed SB 77- Health Occupations Boards – Investigations- Right to Counsel. There are many Boards collaborating to submit a Letter of Concern on the Bill due to the lack of clarification and definitions within it. The Board voted to also join the Letter of Concern.

6.SB- 111- Occupational Licenses or Certificates – Pre–application Determinations –

Criminal Convictions

The Board reviewed SB- 111- Occupational Licenses or Certificates- Pre-application Determinations-Criminal Convictions. The Bill would allow for Boards to issue a written and binding letter denying a license to an applicant prior to receiving their license application. The Bill is silent on whether a Board can request documents from the license applicant prior to receiving the application and gives no timeframe for the determination. The Board voted to join in on a Letter of Concern from additional Boards.

7. Review eligibility for issuance of Full Active Podiatric License:

a. Tobias Glister, DPM

b. Mperera Simango-Yiadom, DPM

The above identified licensure candidates were approved unanimously for the issuance of a full Maryland license.

F. ADJOURNMENT

With no further business, the Public Session of the Board meeting concluded at 2:08 PM.

Respectfully submitted by Eva Schwartz, Executive Director, Signature and date_____

and Elizabeth Kohlhepp, Deputy Executive Director, Signature and date_____

Signature by Frona Kroopnick, Board Secretary/Treasurer: _____

Maryland
DEPARTMENT OF HEALTH

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Acting Secretary

B

Board of Podiatric Medical Examiners
4201 Patterson Avenue
Baltimore, MD 21215
Phone: 410-764-4785

2022 SESSION
POSITION PAPER

BILL NO: SB 311
COMMITTEE: EHE
POSITION: SUPPORT

TITLE: Health Occupations – Podiatric Physicians

BILL ANALYSIS:

This bill would authorize the use of the name "Podiatric Physician" as an update to the present nomenclature of Podiatrist, in order to be aligned with the educational requirements for licensure that are in place and mandatory, as indicated in the Practice Act of the Board of Podiatric Medical Examiners and the respective COMAR.

POSITION AND RATIONALE:

The Board of Podiatric Medical Examiners supports SB311. The term "Podiatric Physician" is defined when analyzing the verbiage and context. The definition of "Physician" means someone who can practice medicine, while the definition of "medicine" is the practice of the diagnosis, treatment and prevention of disease. Therefore, a "Podiatric Physician" is someone who can practice medicine in relation to the foot and ankle. By definition, a Podiatrist is a doctor who diagnoses and treats disorders of the foot and ankle, while also providing preventative care to patients.

To become a Podiatrist, an applicant has to complete a four-year college degree and then is required by majority of the schools to shadow a Podiatrist before they can even apply to a Podiatric Medical School. During the four intense years of Podiatric Medical School, the first two years of training are the same courses that other medical school students are required to take, like pathology, anatomy, histology, microbiology, etc. The only difference is that Podiatry students are actually required to take ADDITIONAL courses such as biomechanics and lower anatomy. After finishing comprehensive science courses in the first two years of Podiatric Medical School, the remaining two years are clinical rotations and scrubbing into a very large variety of surgical cases. Once the four-year Podiatric Medical School is complete, the graduates

are awarded the degree of Doctor in Podiatric Medicine (DPM), and they must match into a hospital-based residency Program, and complete the mandatory 3 years residency in podiatric medicine and surgery. Some residents continue in a fourth and fifth year advanced and specialized fellowship programs.

The Maryland licensed podiatrists with delineated hospital and Ambulatory Surgical Centers'(ASC) privileges, perform surgical cases in their OHCQ licensed ASC's well as in the operating room. Podiatrists are surgically trained to do amputations, bunion removal, hammertoe correction, cyst/mass excisions, ulcer treatments, lateral ankle stability, etc. Podiatrists are surgically trained to fix any foot and ankle pathology. There are some medical doctors who are not trained to do any type of surgery, yet they are classified as physicians.

Adding the term "Physician" to Podiatry, brings Maryland in line with the 36 other states which classify their Podiatrists as "Podiatric Physicians". The rigorous and **extensive training**, the grit, the hard work applies to the term "Podiatric Physician.

By passing SB 311, Maryland will become the 37th state to recognize its Podiatrists with the appropriate title that they deserve and have earned, through coursework and clinical training, as well as their everyday clinical and surgical practice.

Thank you for considering this testimony. The Board of Podiatric Medical Examiners is respectfully requesting a favorable report on SB 311. If you require additional information, please contact Eva Schwartz, Executive Director of the Maryland Board of Podiatric Medical Examiners at (410) 764-4785 or at eva.schwartz@maryland.gov.

The opinion of the Board expressed in this document does not necessarily reflect that of the Department of Health or the Administration.

HOUSE BILL 407

J1, J2 EMERGENCY BILL 2lr0153
CF 2lr0152

By: **The Speaker (By Request – Administration) and Delegates Anderton, Boteler, Buckel, Chisholm, Ghrist, Griffith, Hartman, Hornberger, Howard, Jacobs, Kipke, Kittleman, Krebs, Long, Mangione, McComas, McKay, Metzgar, Morgan, Munoz, Novotny, Otto, Parrott, Reilly, Saab, Shoemaker, Szeliga, Thiam, and Wivell**
Introduced and read first time: January 19, 2022
Assigned to: Health and Government Operations

A BILL ENTITLED

AN ACT concerning

Health Occupations – Health Care Staffing Shortage Emergency – Declaration and Licensing and Practice Requirements
(Health Care Heroes Act of 2022)

FOR the purpose of authorizing the Secretary of Health to declare a health care staffing shortage emergency in the State; requiring each health occupations board to establish processes for the issuance of initial licenses, temporary licenses, and temporary practice letters on an expedited basis during a health care staffing shortage emergency; providing that certain health care practitioners qualify for initial or temporary health occupation licenses or temporary practice letters or to be practicing a certain health occupation at a health care facility without a license or temporary practice letter under certain circumstances; and generally relating to a health care staffing shortage emergency and health occupational licensing and practice.

BY adding to
Article – Health – General
Section 2–109
Annotated Code of Maryland
(2019 Replacement Volume and 2021 Supplement)

BY adding to
Article – Health Occupations
Section 1–227
Annotated Code of Maryland
(2021 Replacement Volume)

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**
[Brackets] indicate matter deleted from existing law.

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Health – General

2–109.

(A) IN THIS SECTION, "HEALTH CARE FACILITY" MEANS:

(1) A HOSPITAL AS DEFINED IN § 19–301 OF THIS ARTICLE;

(2) A HEALTH MAINTENANCE ORGANIZATION AS DEFINED IN § 19–701(G) OF THIS ARTICLE;

(3) A FREESTANDING AMBULATORY CARE FACILITY AS DEFINED IN § 19–3B–01 OF THIS ARTICLE;

(4) AN ASSISTED LIVING FACILITY AS DEFINED IN § 19–1801 OF THIS ARTICLE;

(5) A LABORATORY AS DEFINED IN § 17–201 OF THIS ARTICLE;

(6) A HOME HEALTH AGENCY AS DEFINED IN § 19–401 OF THIS ARTICLE;

(7) A RESIDENTIAL TREATMENT CENTER AS DEFINED IN § 19–301 OF THIS ARTICLE;

(8) A COMPREHENSIVE REHABILITATION FACILITY AS DEFINED IN § 19–1201 OF THIS ARTICLE;

(9) A FORENSIC LABORATORY AS DEFINED IN § 17–2A–01 OF THIS ARTICLE;

(10) A SUBSTANCE–RELATED DISORDER PROGRAM AS DEFINED IN § 7.5–101 OF THIS ARTICLE;

(11) A MENTAL HEALTH PROGRAM AS DEFINED IN § 7.5–101 OF THIS ARTICLE;

(12) A NURSING HOME AS DEFINED IN § 19–401 OF THIS ARTICLE;

(13) A PHARMACY; OR

(14) ANY OTHER FACILITY AS DETERMINED BY THE SECRETARY.

(B) IF THE SECRETARY FINDS THAT AN EMERGENCY HAS DEVELOPED REGARDING THE ABILITY OF HEALTH CARE FACILITIES IN THE STATE TO APPROPRIATELY RESPOND TO THE CLINICAL NEEDS OF PATIENTS BECAUSE OF INSUFFICIENT STAFF AND THAT THE STAFFING SHORTAGE ENDANGERS THE PUBLIC HEALTH IN THE STATE, THE SECRETARY MAY DECLARE A HEALTH CARE STAFFING SHORTAGE EMERGENCY.

(C) THE SECRETARY SHALL ESTABLISH THE CRITERIA FOR DETERMINING THE EMERGENCY CONDITIONS THAT WOULD REQUIRE THE DECLARATION OF A HEALTH CARE STAFFING SHORTAGE EMERGENCY.

(D) THE CRITERIA ESTABLISHED UNDER SUBSECTION (C) OF THIS SECTION SHALL INCLUDE CONSIDERATION OF THE FOLLOWING FACTORS:

(1) STAFFED BED OCCUPANCY RATE;

(2) STAFF VACANCY RATE FOR THE SPECIFIC CATEGORY OF HEALTH CARE PRACTITIONER INCLUDED IN THE STAFFING SHORTAGE;

(3) AVERAGE EMERGENCY DEPARTMENT WAIT TIMES;

(4) DURATION OF VACANCY RATE FOR THE SPECIFIC CATEGORY OF HEALTH CARE PRACTITIONER INCLUDED IN THE STAFFING SHORTAGE;

(5) AVERAGE STAFF VACANCY RATE FOR THE IMMEDIATELY PRECEDING 12 MONTHS FOR THE SPECIFIC CATEGORY OF HEALTH CARE PRACTITIONER INCLUDED IN THE STAFFING SHORTAGE; AND

(6) ANY OTHER FACTOR DETERMINED RELEVANT BY THE SECRETARY.

(E) ON THE DECLARATION OF A HEALTH CARE STAFFING SHORTAGE EMERGENCY, THE SECRETARY MAY DIRECT THE HEALTH OCCUPATIONS BOARDS THAT REGULATE THE CATEGORIES OF HEALTH CARE PRACTITIONERS INCLUDED IN THE IDENTIFIED STAFFING SHORTAGE TO IMPLEMENT THE EXPEDITED LICENSING PROCESSES UNDER § 1–227 OF THE HEALTH OCCUPATIONS ARTICLE.

(F) A DECLARED HEALTH CARE STAFFING SHORTAGE EMERGENCY MAY NOT EXCEED 180 DAYS.

(G) THE SECRETARY SHALL ADOPT REGULATIONS TO CARRY OUT THIS SECTION.

Article – Health Occupations

1–227.

(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(2) "HEALTH OCCUPATION LICENSE" MEANS A LICENSE OR CERTIFICATE ISSUED BY A HEALTH OCCUPATIONS BOARD TO PRACTICE A HEALTH OCCUPATION IN THE STATE.

(3) "INACTIVE LICENSEE" MEANS A LICENSEE WHO HOLDS A HEALTH OCCUPATION LICENSE ISSUED BY A HEALTH OCCUPATIONS BOARD THAT HAS BEEN PLACED ON INACTIVE STATUS WITHIN THE PAST 8 YEARS.

(4) "NURSING GRADUATE" MEANS AN INDIVIDUAL WHO HAS SATISFACTORILY COMPLETED ALL THE REQUIREMENTS FOR A DIPLOMA OR DEGREE FROM:

(I) A REGISTERED NURSING EDUCATION PROGRAM APPROVED BY THE STATE BOARD OF NURSING; OR

(II) AN OUT–OF–STATE NURSING EDUCATION PROGRAM DETERMINED TO BE EQUIVALENT TO A PROGRAM UNDER ITEM (I) OF THIS PARAGRAPH BY THE STATE BOARD OF NURSING.

(5) "RETIRED HEALTH CARE PRACTITIONER" MEANS AN INDIVIDUAL WHO HELD A VALID HEALTH OCCUPATION LICENSE ISSUED BY A HEALTH OCCUPATIONS BOARD WITHIN THE PAST 8 YEARS THAT IS NOT ACTIVE AND HAS NOT BEEN PLACED ON INACTIVE STATUS.

(6) "TEMPORARY HEALTH OCCUPATION LICENSE" AND "TEMPORARY PRACTICE LETTER" MEANS A HEALTH OCCUPATION LICENSE OR PRACTICE LETTER ISSUED BY A HEALTH OCCUPATIONS BOARD AUTHORIZING THE HOLDER TO PRACTICE A SPECIFIED HEALTH OCCUPATION IN THE STATE FOR A TEMPORARY PERIOD OF TIME.

(B) EACH HEALTH OCCUPATIONS BOARD SHALL ESTABLISH PROCESSES FOR THE ISSUANCE OF AN INITIAL HEALTH OCCUPATION LICENSE, A TEMPORARY HEALTH OCCUPATION LICENSE, AND A TEMPORARY PRACTICE LETTER ON AN EXPEDITED BASIS DURING A HEALTH CARE STAFFING SHORTAGE EMERGENCY

DECLARED BY THE SECRETARY UNDER § 2–109 OF THE HEALTH – GENERAL ARTICLE.

(C) THE FOLLOWING INDIVIDUALS QUALIFY FOR A HEALTH OCCUPATION LICENSE ISSUED ON AN EXPEDITED BASIS UNDER SUBSECTION (B) OF THIS SECTION DURING A HEALTH CARE STAFFING SHORTAGE EMERGENCY:

(1) AN APPLICANT FOR AN INITIAL HEALTH OCCUPATION LICENSE;

(2) AN INDIVIDUAL WHO HOLDS A VALID, UNEXPIRED HEALTH OCCUPATION LICENSE ISSUED IN ANOTHER STATE;

(3) AN INACTIVE LICENSEE;

(4) A RETIRED HEALTH CARE PRACTITIONER; AND

(5) A NURSING GRADUATE.

(D) (1) TO APPLY FOR AN INITIAL HEALTH OCCUPATION LICENSE, A TEMPORARY HEALTH OCCUPATION LICENSE, OR A TEMPORARY PRACTICE LETTER UNDER SUBSECTION (B) OF THIS SECTION, AN APPLICANT SHALL SUBMIT TO THE APPROPRIATE HEALTH OCCUPATIONS BOARD:

(I) AN APPLICATION;

(II) ANY DOCUMENTATION REQUIRED BY THE BOARD;

(III) IF A CRIMINAL HISTORY RECORDS CHECK IS REQUIRED BY THE BOARD FOR LICENSURE, PROOF OF APPLICATION FOR A CRIMINAL HISTORY RECORDS CHECK;

(IV) ANY APPLICATION FEE; AND

(V) ANY OTHER INFORMATION REQUIRED BY THE BOARD.

(2) EXCEPT AS PROVIDED IN PARAGRAPH (3) OF THIS SUBSECTION, A HEALTH OCCUPATIONS BOARD SHALL PROCESS AND ISSUE A LICENSE OR TEMPORARY PRACTICE LETTER TO AN APPLICANT WHO MEETS THE REQUIREMENTS OF THIS SUBSECTION USING THE EXPEDITED PROCESS ESTABLISHED UNDER SUBSECTION (B) OF THIS SECTION.

(3) A HEALTH OCCUPATIONS BOARD MAY NOT ISSUE A LICENSE OR TEMPORARY PRACTICE LETTER UNDER THIS SECTION IF THE ISSUANCE OF THE

LICENSE OR TEMPORARY PRACTICE LETTER WOULD POSE A RISK TO PUBLIC HEALTH, WELFARE, OR SAFETY.

(E) (1) A TEMPORARY HEALTH OCCUPATION LICENSE OR TEMPORARY PRACTICE LETTER ISSUED UNDER THIS SECTION AUTHORIZES THE HEALTH CARE PRACTITIONER TO PRACTICE THE SPECIFIED HEALTH OCCUPATION FOR A LIMITED PERIOD OF TIME, AS DETERMINED BY THE HEALTH OCCUPATIONS BOARD AND SUBJECT TO THE DURATION OF THE HEALTH CARE STAFFING SHORTAGE EMERGENCY.

(2) A HEALTH OCCUPATION LICENSE ISSUED UNDER THIS SECTION AUTHORIZES THE LICENSEE TO PRACTICE THE SPECIFIED HEALTH OCCUPATION FOR A LIMITED PERIOD OF TIME, AS DETERMINED BY THE HEALTH OCCUPATIONS BOARD, WHILE THE LICENSEE COMPLETES ADDITIONAL REQUIREMENTS FOR LICENSURE IN THE STATE, IF REQUIRED.

(F) (1) DURING A HEALTH CARE STAFFING SHORTAGE EMERGENCY, A HEALTH CARE PRACTITIONER MAY PRACTICE THE SPECIFIED HEALTH OCCUPATION THAT IS INCLUDED IN THE STAFFING SHORTAGE IN A HEALTH CARE FACILITY IN THE STATE WITHOUT FIRST OBTAINING A LICENSE OR PRACTICE LETTER FROM THE RELEVANT HEALTH OCCUPATIONS BOARD ONLY IN ACCORDANCE WITH THE REQUIREMENTS OF THIS SUBSECTION.

(2) A HEALTH CARE PRACTITIONER WHO HOLDS A VALID, UNEXPIRED HEALTH OCCUPATION LICENSE ISSUED IN ANOTHER STATE MAY PRACTICE THE SPECIFIED HEALTH OCCUPATION IN A HEALTH CARE FACILITY UNDER PARAGRAPH (1) OF THIS SUBSECTION IF:

(I) DOING SO IS NECESSARY TO ALLOW THE HEALTH CARE FACILITY TO MEET REQUIRED STAFFING RATIOS OR OTHERWISE ENSURE THE CONTINUED AND SAFE DELIVERY OF HEALTH CARE SERVICES TO PATIENTS IN THE FACILITY;

(II) THE HEALTH CARE PRACTITIONER REASONABLY BELIEVES A TEMPORARY HEALTH OCCUPATION LICENSE OR TEMPORARY PRACTICE LETTER COULD NOT BE OBTAINED IN SUFFICIENT TIME TO MEET THE IMMINENT NEEDS OF THE HEALTH CARE FACILITY; AND

(III) THE HEALTH CARE PRACTITIONER SUBMITS AN APPLICATION FOR A TEMPORARY HEALTH OCCUPATION LICENSE OR TEMPORARY PRACTICE LETTER WITHIN 10 DAYS OF THE DAY THE HEALTH CARE PRACTITIONER BEGINS WORKING AT A HEALTH CARE FACILITY.

(3) AN INACTIVE LICENSEE OR A RETIRED HEALTH CARE PRACTITIONER MAY PRACTICE A SPECIFIED HEALTH OCCUPATION IN A HEALTH CARE FACILITY UNDER PARAGRAPH (1) OF THIS SUBSECTION IF:

(I) QUALIFIED SUPERVISORY PERSONNEL AT THE HEALTH CARE FACILITY REASONABLY CONCLUDE THAT THE INACTIVE LICENSEE OR RETIRED HEALTH CARE PRACTITIONER CAN COMPETENTLY PRACTICE THE HEALTH OCCUPATION;

(II) DOING SO IS NECESSARY TO ALLOW THE HEALTH CARE FACILITY TO MEET REQUIRED STAFFING RATIOS OR OTHERWISE ENSURE THE CONTINUED AND SAFE DELIVERY OF HEALTH CARE SERVICES TO PATIENTS IN THE FACILITY;

(III) THE HEALTH CARE PRACTITIONER REASONABLY BELIEVES THE INACTIVE LICENSE COULD NOT BE REACTIVATED OR A TEMPORARY HEALTH OCCUPATION LICENSE OR TEMPORARY PRACTICE LETTER COULD NOT BE OBTAINED IN SUFFICIENT TIME TO MEET THE IMMINENT NEEDS OF THE HEALTH CARE FACILITY; AND

(IV) THE INACTIVE LICENSEE OR RETIRED HEALTH CARE PRACTITIONER SUBMITS AN APPLICATION TO THE HEALTH OCCUPATIONS BOARD WITHIN 10 DAYS OF THE DAY THE HEALTH CARE PRACTITIONER BEGINS WORKING AT A HEALTH CARE FACILITY:

1. TO REACTIVATE AN INACTIVE LICENSE; OR

2. FOR A TEMPORARY HEALTH OCCUPATION LICENSE OR TEMPORARY PRACTICE LETTER.

(4) A NURSING GRADUATE MAY PRACTICE REGISTERED NURSING, AS DEFINED IN § 8–101(O) OF THIS ARTICLE, IN A HEALTH CARE FACILITY UNDER PARAGRAPH (1) OF THIS SUBSECTION IF:

(I) DOING SO IS NECESSARY TO ALLOW THE HEALTH CARE FACILITY TO MEET REQUIRED STAFFING RATIOS OR OTHERWISE ENSURE THE CONTINUED AND SAFE DELIVERY OF HEALTH CARE SERVICES TO PATIENTS IN THE FACILITY;

(II) QUALIFIED SUPERVISORY PERSONNEL AT THE HEALTH CARE FACILITY:

1. REASONABLY CONCLUDE THAT THE NURSING GRADUATE CAN COMPETENTLY PRACTICE REGISTERED NURSING; AND

2. ACTIVELY SUPERVISE THE NURSING GRADUATE WHILE PRACTICING REGISTERED NURSING AT THE HEALTH CARE FACILITY; AND

(III) THE NURSING GRADUATE SUBMITS AN APPLICATION TO THE STATE BOARD OF NURSING WITHIN 10 DAYS OF THE DAY THE NURSING GRADUATE BEGINS WORKING AT THE HEALTH CARE FACILITY.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act is an emergency measure, is necessary for the immediate preservation of the public health or safety, has been passed by a yea and nay vote supported by three–fifths of all the members elected to each of the two Houses of the General Assembly, and shall take effect from the date it is enacted.

VOL. 36/NO.4 WINTER 2021

GORDON·FEINBLATT LLC
ATTORNEYS AT LAW

Topics

A quarterly newsletter published in the interests of the health care industry in the Mid-Atlantic region

No Loss of Years Under Maryland Wrongful Death Law

When a victim dies due to negligence, the law generally affords those left behind the right to sue by way of two distinct statutory options: wrongful death claims and survival actions.

A wrongful death claim is a statutory claim brought by the relatives of the victim against the person or entity who negligently caused the victim's death. In a wrongful death claim, damages are generally measured by the harm caused to the family members who suffer the loss of the victim. Notably, this cause of action only allows compensation where the survivors can show that the victim would not have died, but for negligence.

Conversely, in a survival action, the deceased's estate seeks compensation for the injuries suffered by the deceased victim prior to their death. Survival actions are brought by the personal representative

continued on page 2

for the estate of the deceased. Generally, survival actions permit compensation to the victim's estate for the conscious pain and suffering suffered by the victim, endured up to the moment of the victim's death, as well as other damages, such as medical expenses incurred by the victim prior to death.

Unlike wrongful death claims, in a survival action, it is not necessary for the estate to prove that the victim's death was caused by negligence. Rather, the estate must prove that negligence resulted in harm to the victim while they were still alive.

Recently, in the matter of *Wadsworth v. Sharma*, Maryland's intermediate appellate court held that a doctor's failure to diagnose Stephanie Wadsworth's incurable terminal cancer was not the cause of her death. Consequently, her family could not recover damages for the shortening of her life.

A. The Facts

In 2006, Mrs. Wadsworth was diagnosed with metastatic breast cancer. She quickly underwent a mastectomy followed by radiation therapy. During the next seven years, Mrs. Wadsworth's treating oncologist, Dr. Sharma, believed she was in remission as her periodic PET/CT scans returned negative for cancer.

However, a diagnostic scan was ordered in April 2013, and a radiologist allegedly observed a cancerous lesion not detected on prior imaging studies. It would ultimately become an undisputed fact that the lesion appearing on the April 2013 scan was representative of incurable and terminal metastatic cancer. Nevertheless, Mrs. Wadsworth did not become aware of the resurging cancer until several years later.

In February 2016, Mrs. Wadsworth suffered an accidental fall, injuring her right shoulder, and sought medical treatment in a hospital. In assessing her shoulder injury, the hospital performed a diagnostic bone scan on her clavicle and the scan revealed a lesion. Soon thereafter, she was diagnosed with terminal cancer, and she died in June of the following year.

The aggrieved family members filed a combined wrongful death and survival action against the treating oncologist, alleging that Mrs. Wadsworth's life had been shortened because of the missed diagnosis. Specifically, the family argued that had Mrs. Wadsworth received the proper diagnosis in April 2013, she would have received more aggressive treatments and would have lived approximately 30 months longer.

The oncologist argued that Mrs. Wadsworth's cancer was both incurable and terminal by April 2013. Therefore, Mrs. Wadworth's death was not *caused* by a missed or incorrect diagnosis. In short, she would have nevertheless rapidly died from the aggressive cancer regardless of whether she had received a timelier diagnosis.

B. The Holding

While Mrs. Wadsworth's surviving family members argued that they should be able to recover for her shortened life expectancy as part of a wrongful death claim, Maryland's intermediate appellate court plainly rejected this notion. The court held that Maryland's wrongful death statute is strictly construed to provide that an action for wrongful death may only "be maintained against a person whose wrongful act *causes* the death of another."

The court reasoned that the alleged failure of Mrs. Wadsworth's doctor to diagnose her terminal illness did not *cause* her death. Rather, any such missed diagnosis would have only served to shorten Mrs. Wadsworth's life. Thus, the court concluded, a timelier diagnosis would *not* have resulted in Mrs. Wadsworth's survival.

Further elaborating, the court reasoned that Maryland's wrongful death statute has been

Topics is published by the Health Care Department of the law firm of **Gordon Feinblatt LLC**, a multidisciplinary team of lawyers with experience in areas of law affecting health care services.

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Please address letters and comments to the Editor:

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codified to reflect Maryland's common law, which has historically held that in a wrongful death claim, "death is the only injury for which a Plaintiff may sue." Therefore, the court indicated, "[t]he relatives of Mrs. Wadsworth were not entitled to recover solatium type damages, or any other type of damages because they were deprived of the decedent's company, love and affection for 30 months."

Finally, the court said its decision would not necessarily preclude a survival claim by Mrs. Wadsworth's estate. The court noted that Mrs. Wadsworth's estate could potentially pursue a recovery for Mrs. Wadsworth's shortened life expectancy, as part of a survival claim, if the estate could prove that Stephanie knew of her shortened life expectancy and suffered mental or physical anguish because of it prior to her death.

C. Everybody Dies

In its analysis of Maryland's wrongful death law, the court noted that as *everyone* ultimately dies, every claim for wrongful death is essentially at its core a claim for shortened life expectancy. In other words, death is the ultimate shortening of life expectancy. However, in this case, the wrongful death claim was not barred because eventually everyone will die. It was barred because the family could not prove that Dr. Sharma caused the death of Mrs. Wadsworth.

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No-Poach Provisions

No-poach provisions are agreements that prohibit one company from hiring another company's employees. This article addresses whether no-poach provisions violate applicable antitrust laws, and more specifically, the conditions under which no-poach provisions are legal.

A. The Law

No-poach provisions are often horizontal restraints; that is, they constitute an agreement between or among competitors restricting the way in which they will compete with one another. Horizontal restraints are often unreasonable per se under federal antitrust principles, meaning they are deemed illegal without any inquiry into their anti- or pro-competitive effects.

However, if a horizontal restraint qualifies as an "ancillary" restraint, it is analyzed under the rule of reason, to determine if it is or is not legal. To qualify as an ancillary restraint, the restraint must be subordinate and collateral to a separate, legitimate transaction.

Ancillary restraints are then determined to be permissible or impermissible, depending upon: (1) whether the challenged restraint has a substantial anticompetitive effect that harms consumers in the relevant market; (2) the pro-competitive rationale for the restraint; and (3) whether procompetitive efficiencies could be reasonably achieved through less anticompetitive means.

B. The Facts

In August of 2021, a federal appellate court, in *Aya Healthcare Services, Inc. v. AMN Healthcare, Inc.*, issued an opinion regarding a no-poach provision in a contract between a provider of travel nursing services and a health care staffing agency. The court began by finding that the restraint was ancillary to an otherwise legitimate relationship of one company using the staff of another company.

To respond to rapidly growing demand for travel nurses, which demand AMN was itself unable to supply, AMN contracted with Aya and other staffing agencies to provide additional nurses to meet that demand. However, in exchange for the spillover assignments, Aya agreed, among other things, not to solicit AMN's employees. Therefore, the restraint allowed competitors to give spillover assignments to other competitors without risking their established networks of traveling nurses.

Accordingly, the court found the no-poach provision legal because the restraint was reasonably necessary to the parties' pro-competitive collaboration and resulted in greater productivity.

Also, the court found no substantial anti-competitive effects that harmed consumers in the market, such as an increase in prices resulting from the no-poach provision.

continued on page 4

Although the court refused to find antitrust liability resulting from the no-poach provision in *Aya Healthcare Services*, public opinion against no-poach provisions and other non-competition agreements is growing, and, therefore, one should expect more litigation in this area.

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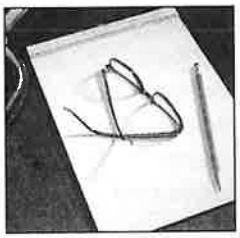

Maryland Regulatory News

1. In October, the Maryland Department of Health launched the Maryland Commission on Health Equity (MCHE), a new multiagency commission that will develop a statewide plan to equitably improve health outcomes. The MCHE, created pursuant to legislation passed by the Maryland General Assembly earlier in the year, will consist of two subcommittees, one on data collection and quality assurance and one to advise on implementing framework to reduce disparities based on race, ethnicity, culture or socioeconomic status.

2. As part of the Maryland Total Cost of Care Model, the Health Services Cost Review Commission (HSCRC) identified maternal and child health as a population health priority and will provide $10 million annually for the next four years to support new and existing programs that aim to reduce severe maternal morbidity and pediatric asthma-related emergency department visits for minors. These funds will be combined with matching federal funds. Some of the programs receiving funding include a new initiative to provide Medicaid reimbursement for doula services, an expanded support program for pregnant and postpartum individuals with opioid use disorders, and a home visit programs to help caregivers identify asthma triggers and implement asthma action plans developed by health care providers.

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HERCs

In February 2022, the Community Health Resources Commission (CHRC), an independent commission within the Maryland Department of Health, will distribute $13 million to entities in the Pathways for Health Equity Program (Pathway Program), which lays the foundation for addressing disparities in Health Equity Resource Communities (HERCs).

A HERC is a small geographic area with poor health outcomes that consists of at least 5,000 residents and where racial, ethnic and disability-related disparities have a large impact on the overall health of the area.

A. Background

HERCs build conceptually on a prior initiative that identified Health Enterprise Zones (Zones) in five areas where residents had little access to health care. Concentrating resources and services on these areas had a major impact, including one provider, Johns Hopkins, reporting a decrease in 18,000 inpatient stays and more than $100 million in health care savings because of the Zone pilot.

The success of that pilot prompted new Maryland legislation in 2021 that authorized the CHRC to launch the HERC program. In fact, proposals benefiting areas previously identified as Zones are given "special consideration" in the Pathway Program.

B. 2022 Grants

Nonprofits, hospitals, higher education institutions, federally qualified health centers and local government agencies had until December 7, 2021, to apply to the Pathway Program, and were encouraged to present proposals addressing diabetes, heart disease, hypertension, asthma, maternal-infant mortality and substance abuse disorders.

While the CHRC identified those issues as particular priorities for funding, applicants were free to address other problems that data indicated could be tackled with targeted interventions.

The CHRC announced that it was looking for applicants who received community buy-in, and whose proposals could not only improve outcomes and reduce disparities, but also improve access to primary care, promote preventative services, and ultimately reduce

health care costs and hospital admission and re-admissions.

C. Future Grants

The Pathway Program will provide funding for a two-year period allowing applicants to collect data and demonstrate the efficacy of their proposals in practice. At the conclusion of the two-year pilot window, successful applicants will be encouraged to apply for HERC designation and additional grant funding.

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Health Care Employer Vaccine Mandates Survive Legal Challenges

Health care workplaces have led the way implementing COVID-19 vaccine mandates. For example, in June 2021, Maryland's largest hospitals and health care systems announced that employees would be required to be vaccinated as a condition of employment.

In September 2021, President Biden also announced a multipronged federal vaccination mandate, including one directed to approximately 17 million health care workers at Medicare- and Medicaid-certified facilities.

Several states, including Maryland, Maine and New York, have also required most health care workers to be vaccinated.

Given the politically charged nature of this issue, it is not surprising that vaccine mandates for health care employees have led to lawsuits across the country. Despite these challenges, most health care vaccine mandates have been upheld by federal courts. Two recent federal cases provide good examples of the arguments employees have made in their attempt to defeat the mandates as well as the judiciary's generally skeptical response to these suits.

A. *Bridges v. Houston Methodist Hospital*

In June 2021, a Texas federal court issued the first reported decision examining a COVID-19 vaccine mandate in a health care setting. In *Bridges v. Houston Methodist Hospital*, 117 employees sued to block Houston Methodist Hospital's requirement that its employees be vaccinated. The employees raised various claims based on federal, state and international law, all of which were rejected by the court.

In particular, the employees argued that the federal law governing the administration of drugs issued under an emergency use authorization (EUA) prohibited the hospital's mandate. The court rejected this argument, finding that the law governing EUAs only requires the government to ensure that recipients understand the potential risks and benefits of the drug, and that it does not restrict the action of private employers.

The Texas court also noted that more than a century ago the U.S. Supreme Court decided, in *Jacobson v. Massachusetts*, that a compulsory smallpox vaccination law did not violate the 14th Amendment right to due process. The *Jacobson* decision, which held that the "common good" sometimes outweighs individual liberties, has been repeatedly cited by courts during the COVID-19 era to validate the imposition of mandated vaccine programs.

The Texas court also lambasted as "reprehensible," the employees' claim that the mandate violated the Nuremberg Code, a set of ethical research principles developed in response to the horrors of Nazi-era medical experiments during the Holocaust.

Summarizing the employees' situation, the Texas court held that "Bridges can freely choose to accept or refuse a COVID-19 vaccine; however, if she refuses, she will simply need to work somewhere else."

Although the employees have filed an appeal, they face an uphill battle as subsequent events have undercut some of their primary arguments.

First, on July 6, 2021, the U.S. Department of Justice issued a memorandum opinion that the federal Food, Drug and Cosmetic Act does not prohibit public or private entities from imposing vaccination requirements for a vaccine that is subject to an EUA. Further, on August 23, 2021, the Food and Drug Administration gave full approval to the Pfizer COVID-19 vaccine, so it is now possible to obtain a vaccine not subject to EUA status.

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B. *Beckerich v. St. Elizabeth Medical Center*

In *Beckerich v. St. Elizabeth Medical Center*, a federal court in Kentucky denied the request of a group of health care workers to prohibit their hospital employer from enforcing its mandatory COVID-19 vaccination. The employees focused their attack on the hospital's supposed failure to properly handle requests for religious exemptions from the vaccine mandate.

Title VII of the Civil Rights Act of 1964 may require an employer to provide a reasonable accommodation where being vaccinated would violate an employee's sincerely held religious belief. Far from demonstrating their assertion that the hospital's accommodation process was "corrupt," the court found that the hospital had appropriately considered accommodation requests. In fact, many employees had received exemptions.

The court also rejected claims that the mandate violated the employees' "right to bodily integrity" and rejected hyperbolic comparisons to cases involving inmates being forcibly injected with antipsychotic drugs, and the residents of Flint, Michigan being exposed to lead-contaminated water.

Ultimately, the court found the employees' position came down to elevating their individual liberties over the greater good. Rejecting that position, the court held, similarly to the *Bridges* court: "If an employee believes his or her individual liberties are more important than legally permissible conditions on his or her employment, that employee can and should choose to exercise another individual liberty, no less significant—the right to seek other employment."

C. Conclusion

COVID-19 vaccine mandates in the health care workplace have fared very well thus far in the courts. Nevertheless, employers should pay close attention to legal developments in this area.

Already, the attorneys general of at least 10 states have filed suits seeking to block various aspects of the federal mandates. Whether any of these suits will ultimately succeed and what impact, if any, the litigation will have on the enforcement of mandates in health care facilities, remains to be seen.

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No Surprises Act's Transparency Rules for Health Plans

The No Surprises Act (NSA) generally protects patients from receiving large unanticipated bills for out-of-network care. To implement the NSA, transparency rules have been issued that require health plans to include deductibles and out-of-pocket maximums on physical or electronic health insurance ID cards. These transparency rules also try to provide health plan participants with enough information to help lower the risk of receiving surprise medical bills.

The transparency requirements were originally anticipated to apply to all health plans for plan years beginning after December 31, 2021. However, because so little guidance has been issued to date, the Secretaries of Labor, Health and Human Services, and the Treasury (Departments) have chosen to delay or scale back enforcement on most of the new transparency requirements until new guidance is published.

Brief explanations of each new transparency requirement and the anticipated extent of compliance and enforcement can be found below.

A. Annual Reporting of Pharmacy Benefits and Drug Costs

The NSA requires plans to report annually the following information to the Departments:

1. Each plan year's beginning and end date;
2. Each plan's participant/beneficiary count;
3. Each state where a plan or coverage is offered;
4. The 50 brand name prescription drugs pharmacies most frequently dispensed for claims for each plan and the number of claims paid per drug;
5. The 50 most costly prescription drugs per plan by total annual spending and annual amount spent per drug;
6. Total spending on prescription drugs and types of costs (*e.g.*, hospital, primary, specialty care, etc.);

7. The average monthly employer-paid premium and participant-paid premium; and

8. The impact rebates, fees and other remuneration drug manufacturers paid to a plan, its administrators or service providers had on premiums for prescribed drugs.

No regulations have been issued and enforcement will be deferred until then. However, plan sponsors should comply by December 27, 2022, for reporting years 2020 and 2021.

B. Price-Comparison Tool

The NSA requires plans to offer participants health care price comparisons over the phone and online. No regulations have been issued and compliance has been deferred until 2023.

C. Advanced Explanations of Benefits (AEB)

The NSA requires plans to provide participants an AEB once a participant receives a "good faith" cost estimate for an item or service from a health care provider/facility. The AEB must show, with respect to an item or service the following:

1. The provider's/facility's network status;

2. If in-network, the contracted rate for the item or service; if out-of-network, information on how the participant can learn more about in-network providers/facilities offering the same item or service;

3. The good faith estimate from the provider/facility, the amount the plan must pay, and any cost-sharing the participant must pay;

4. A disclaimer regarding whether the coverage for the item or service is subject to medical management techniques; and

5. A disclaimer that the information in the AEB is an estimate only.

No regulations have been issued and compliance has been deferred until further notice.

D. Gag Clause Prohibition

The NSA prohibits plan sponsors from entering an agreement with a provider, provider network, third-party administrator or other service providers that could restrict the plan from:

1. Furnishing provider-specific cost or quality of care information;

2. Accessing redacted claims and encounter data for participants; and

3. Sharing care or encounter information consistent with privacy rules.

Likely, beginning in 2022, plans will have to attest annually on compliance with the Gag Clause prohibition, but no regulations have been issued and, until then, plans should comply using good faith reasonable interpretation of the law.

E. Provider Directory Requirements

The NSA requires plan sponsors to establish, verify and timely update its provider/facility directory and establish a protocol for timely responses to inquiries about a provider's/facility's network status.

Should a participant elect care based on inaccurate directory information, the plan may not impose a cost-sharing amount greater than the care received in-network. Moreover, payments must be applied against the participant's deductible or out-of-pocket maximum as if the provider/facility was in-network.

No regulations have been issued; for now, a plan will be deemed compliant if it applies the NSA's cost-sharing, deductible and out-of-pocket rules described in C above.

F. Continuity of Care Requirements

The NSA requires plans to offer participants continuity of care for certain treatments if, during treatment, a provider's/facility's contract with the plan is terminated or changed in a way that eliminates the covered treatment. Treatments subject to this requirement include treatments for any "serious and complex condition," inpatient care, scheduled nonelective surgery, terminal illness, or pregnancy.

No regulations have been issued; until then, plan sponsors should comply using a good faith reasonable interpretation of the law.

G. Protections Against Balance Billing

The NSA requires plan sponsors to make publicly available, post on a public website and include in each Explanation of Benefits with respect to an item or service, information in plain language on the prohibitions of balance billing, among other things.

No regulations have been issued; until then, plan sponsors should comply using good faith reasonable interpretation of the law. To assist with compliance, a model disclosure notice may be found on the CMS website

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Did You Know?

Publishing Hospital Prices: Did you know that the Centers for Medicare and Medicaid Services (CMS) is considering raising the fines for hospitals that fail to comply with price transparency requirements? By January 1, 2021, hospitals were required to publish price data about their services online, either in a machine-readable file or a list of services in a consumer-friendly format. By the midpoint of the year, one study indicated that only 60% of hospitals had attempted to post the required information, and the quality and the usability of the data provided varied wildly among that group. While CMS has the authority to fine hospitals that have not complied, so far CMS has only issued warning letters. As some hospital executives have hinted that paying fines would be more cost effective than compiling and sharing the data, CMS is considering increasing the amount of the fines to up to $5,500 per day for large hospitals to dissuade hospitals from ignoring the requirements.

Remaining Telehealth Restrictions: Did you know that some restrictions remain in place for telehealth? While many requirements were relaxed during the COVID-19 pandemic, and additional flexibilities were permanently adopted by state legislatures, there are still requirements providers must meet before offering or continuing this service. For example, most states have ended emergency orders that allowed for widespread out-of-state practice and have resumed requiring an out-of-state provider to be licensed by the appropriate licensing board in the state where the patient is located prior to providing services via telehealth. Additionally, while some supervision of support staff could be conducted remotely, in-person supervision requirements still exist for some roles on a state-by-state basis. For example, there are currently no plans to allow for remote supervision of a physical therapy aid in Maryland. A physical therapist still must be present within the treatment area to provide supervision.

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Coming in Future Issues

- ***Judge Rotenberg v FDA***
- **Affiliate Trademark Licenses**

E

HOUSE BILL 625

J2, J1, J3

2lr0757
CF SB 440

By: **Delegate Kelly**
Introduced and read first time: January 31, 2022
Assigned to: Health and Government Operations

A BILL ENTITLED

AN ACT concerning

Commission to Study the Health Care Workforce Crisis in Maryland – Establishment

FOR the purpose of establishing the Commission to Study the Health Care Workforce Crisis in Maryland to examine certain areas related to health care workforce shortages in the State, including the extent of the workforce shortage, short–term solutions to the workforce shortage, future health care workforce needs, and the relationship between the Maryland Department of Health and the health occupations boards; and generally relating to the Commission to Study the Health Care Workforce Crisis in Maryland.

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That:

(a) There is a Commission to Study the Health Care Workforce Crisis in Maryland.

(b) The Commission consists of the following members:

(1) two members of the Senate of Maryland, appointed by the President of the Senate;

(2) two members of the House of Delegates, appointed by the Speaker of the House;

(3) the Secretary of Higher Education, or the Secretary's designee;

(4) the Secretary of Health, or the Secretary's designee;

(5) the State Superintendent of Schools, or the State Superintendent's designee;

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**
[Brackets] indicate matter deleted from existing law.

(6) the Secretary of Commerce, or the Secretary's designee;

(7) the Deputy Secretary of Developmental Disabilities, or the Deputy Secretary's designee;

(8) the Deputy Secretary of Public Health, or the Deputy Secretary's designee;

(9) the Chairman of the Maryland Health Care Commission or the Chairman's designee;

(10) the Assistant Secretary for Workforce Development and Adult Learning, or the Assistant Secretary's designee; and

(11) the executive director of each health occupations board established under the Health Occupations Article, or the executive director's designee.

(c) The Secretary of Health shall designate the chair of the Commission.

(d) The State agencies represented on the Commission jointly shall provide staff for the Commission.

(e) A member of the Commission or a member of an advisory committee or a stakeholder workgroup established under subsection (g) of this section:

(1) may not receive compensation as a member of the Commission, an advisory committee, or a stakeholder workgroup; but

(2) is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(f) (1) The Commission may establish advisory committees or stakeholder workgroups to assist the Commission in carrying out its duties.

(2) An advisory committee or a workgroup established under paragraph (1) of this subsection may include an individual who is not a member of the Commission.

(g) The Commission shall:

(1) determine the extent of the health care workforce shortage in the State, including the extent of shortages in:

(i) different settings including in–home care, hospitals, private practice, nursing homes, and hospice care;

(ii) different regions of the State;

(iii) care provided in different languages spoken in the State;

(iv) environmental services in hospitals and nursing homes; and

(v) different levels of care for health occupations including entry level direct care positions, professional extenders, primary care providers, and specialists;

(2) examine turnover rates and average length of tenure for the shortages identified in item (1) of this subsection and identify strategies to reduce turnover in the professions that are experiencing shortages;

(3) examine short–term solutions to address immediate needs for the shortages identified in item (1) of this subsection while ensuring the safety of Maryland patients by:

(i) determining which health occupations boards have backlogs of applicants for licensure and certification;

(ii) determining whether expediting or streamlining the licensing or certification process for specific health occupations is a viable option;

(iii) determining whether implementing additional temporary licensure or certification for specific health occupations is a viable option; and

(iv) determining whether the State has adequate State educational institutions and training programs, including by:

1. examining the capacity of State educational institutions to meet the demand for health occupations, including alternative degree models, access, cost, eligibility, length of time necessary to complete a program, and barriers posed by clinical requirements;

2. examining the cost of training programs, how the programs are paid for, and the role the State has or could have in paying for the programs, including the role the Maryland Department of Labor has in the process and whether it would be feasible to reimburse employees for training costs if they maintain employment in a profession for a certain number of years; and

3. comparing training programs for the direct health care workforce in nursing compared to programs in traditionally male industries;

(4) examine future health care workforce needs as populations age including by region and spoken language;

(5) examine what changes are needed to enhance incentives for individuals to enter and stay in the health care workforce in the State, including changes to high school

curricula, mid–career transition programs, State tax incentives, grant programs, enhanced benefits, tuition subsidies, and potential rate increases;

(6) examine ways to facilitate career advancement and retention by identifying and elevating career ladders and programs for on–the–job advancement, particularly for low–wage employees;

(7) examine the special needs of the rural health care system in the State and methods for recruiting and retaining workers in rural areas;

(8) examine the impact reimbursement has on workforce shortages, including in industries that are heavily reliant on Medicaid reimbursement; and

(9) examine the relationship between the health occupations boards and the Maryland Department of Health and determine:

(i) what authority the Secretary should have over the boards; and

(ii) what additional support the Department could provide the boards to assist with workloads, overhead, staffing, technology improvement, and other areas identified by the Commission.

(h) On or before December 31 each year, the Commission shall submit a report of its findings and recommendations to the Senate Education, Health, and Environmental Affairs Committee and the House Health and Government Operations Committee in accordance with § 2–1257 of the State Government Article.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2022. It shall remain effective for a period of 2 years and, at the end of June 30, 2024, this Act, with no further action required by the General Assembly, shall be abrogated and of no further force and effect.

SENATE BILL 440

J2, J1, J3

2lr2261
CF 2lr0757

By: **Senator Beidle**
Introduced and read first time: January 26, 2022
Assigned to: Finance

A BILL ENTITLED

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(iv) determining whether the State has adequate State educational institutions and training programs, including by:

1. examining the capacity of State educational institutions to meet the demand for health occupations, including alternative degree models, access, cost, eligibility, length of time necessary to complete a program, and barriers posed by clinical requirements;

2. examining the cost of training programs, how the programs are paid for, and the role the State has or could have in paying for the programs, including the role the Maryland Department of Labor has in the process and whether it would be feasible to reimburse employees for training costs if they maintain employment in a profession for a certain number of years; and

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(4) examine future health care workforce needs as populations age including by region and spoken language;

(5) examine what changes are needed to enhance incentives for individuals to enter and stay in the health care workforce in the State, including changes to high school

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(6) examine ways to facilitate career advancement and retention by identifying and elevating career ladders and programs for on–the–job advancement, particularly for low–wage employees;

(7) examine the special needs of the rural health care system in the State and methods for recruiting and retaining workers in rural areas;

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