BOARD OF PODIATRIC MEDICAL EXAMINERS

OPEN SESSION MEETING VIA GOOGLE MEET

AGENDA

July 8, 2021

Location Google Meet: https://meet.google.com/izq-gyee-ysy?hs=224

Join by phone: (US) +1 518-732-6181 PIN: 661 255 062#

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 June 11, 2021 meeting** **Tab A**

B. BOARD PRESIDENT'S REPORT -Dr. Umezurike

C. EXECUTIVE DIRECTOR'S REPORT-Eva Schwartz

D. OLD BUSINESS:

1. **COMAR 10.40.12.01-.06 Telehealth Regulations -BOARD OF PODIATRIC MEDICAL EXAMINERS**

E. NEW BUSINESS:

1. **FPMB - 2021 Q2 Newsletter** **Tab B**
2. **FYI- Topics Quarterly Newsletter Volume 36/No.2 Summer 2021 from Gordon, Feinblatt, Rothman, Hoffberger & Hollander, LLC.** **Tab C**

H. ADJOURNMENT

BOARD OF PODIATRIC MEDICAL EXAMINERS

OPEN SESSION MEETING VIA GOOGLE MEET

MINUTES

June 10, 2021

Location Google Meet: meet.google.com/sze-pyrw-rnx

Join by phone: (US) +1 240-903-4217 PIN: 541 211 403#

The Public Meeting commenced at 1:08 PM, opened by the Board President, Dr. Yvonne Umezurike.

Roll call was initiated by the Executive Director. By acclamation, all Board members were in attendance.

Board members present: Drs. Umezurike, Silverman, Gottlieb, Fox, and Duggirala

Consumer Members present: Ms. Sharon Bunch and Ms. Frona Kroopnick

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: Lillian Reese, Legislation and Regulations Coordinator for select Boards and Commissions

Dr. Umezurike 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 May 13, 2021 meeting**

   The minutes from the May 13, 2021 meeting were approved unanimously, as submitted.

B. BOARD PRESIDENT'S REPORT -Dr. Umezurike

Dr. Umezurike welcomed new Board member, Dr. Aparna Duggirala.

C. EXECUTIVE DIRECTOR'S REPORT-Eva Schwartz

Ms. Schwartz informed the Board that new Board member orientation will be presented virtually and the dates should be released soon for September or October of 2021.

Ms. Schwartz also discussed the newly proposed APMA White Paper.
The American Podiatric Medical Association (APMA) has a web page regarding the White Paper with additional links devoted to Frequently Asked Questions (FAQ) and
an Explainer: https://www.apma.org/News/NewsDetail.cfm?ItemNumber=45158

Dr Lebow explained some of the salient points regarding this endeavor, stating that there was a lack of consensus among the four organizations as to whether DPMs should currently be considered to be physicians.

Furthermore, it was clarified that all four organizations agree that irrespective of their differences with respect to the current definition of the term physician, that DPMs, similar to MDs, and DOs, should not be restricted in their ability to appropriately take care of patients within their respective scope of practice, nor in their access to patients based upon type of insurance. Nevertheless, each State would be required to legislate new licensing laws to address this proposal, if it were to pass.

D. OLD BUSINESS:

1. COMAR 10.40.12.01-.06 Telehealth Regulations -BOARD OF PODIATRIC MEDICAL EXAMINERS

The Board was made aware that the Governor's office has expressed some concerns relating to the proposed telehealth regulations, therefore holding up the approval process. The department is working with the Attorney General's Office as well as the Governor's Office to rectify the verbiage issues. The Board would not be able to vote on the regulation change until the final draft is received.

E. NEW BUSINESS:

1. Topics Quarterly Newsletter Volume 36/No. 1 Spring 2021 from Gordon, Feinblatt, Rothman & Hollander

The Board received a copy of the Topics Quarterly Newsletter Volume 36/No. 1 Spring 2021 from Gordan, Feinblatt, Rothman, & Hollander, for informational purposes.

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

a. Gurvikram Boparai, DPM

The above individually identified licensure candidate was approved for the issuance of a Full Maryland License.

H. ADJOURNMENT

With no further business, the Public Session of the Board meeting concluded at 1:28 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: _____

Federation of Podiatric Medical Boards
12116 Flag Harbor Drive ◆ Germantown, MD 20874 ◆ 202-810-3762 ◆ www.fpmb.org

Member Podiatric Medical Boards Newsletter – Q2 2021

PRESIDENT'S MESSAGE

Barbara A. Campbell, DPM
Cave Creek, Arizona

I am most honored and excited as I begin my year as President of the FPMB. I am quite fortunate and blessed to be surrounded by engaged fellow board members and an excellent executive director. I wish to thank them for the confidence they have placed in me. I am looking forward to a productive year as we move forward with the goals of the FPMB.

I would like to take the opportunity to welcome the College of Physicians and Surgeons of British Columbia *(CPSBC)* as an Affiliate Member. The FPMB looks forward to their participation. Please take the opportunity to read about the CPSBC in the Affiliate Member Board Spotlight section of this newsletter.

The FPMB continues its current Date Initiative Project. I encourage Member Boards to provide their continued assistance in this endeavor. The FPMB appreciates your strong support as we request information. As the FPMB moves forward and builds on the data initiative, the project will become an even greater source of beneficial information for Member Boards, the podiatry profession, and other valued stakeholders.

(Continued on page 4)

EXEC'S MESSAGE

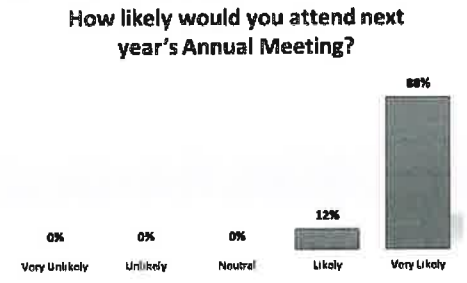
Russell J. Stoner
Germantown, Maryland

2021 Annual Meeting

The FPMB conducted a well-attended and very engaging Annual Meeting in April 2021. Meeting participants commented on the "collaborative energy" of the meeting due to the "opportunities to engage with the other states" and the "good participation levels."

The meeting focused on: 1) Announcements & Updates; 2) Strategic Plan Updates; 3) COVID-19 Pandemic Updates; and 4) Member Boards Round Robin.

Post-meeting feedback was very positive:



(Continued on page 4)

IN THIS ISSUE

MISSION STATEMENT:
To be a leader in improving the **quality**, **safety**, and **integrity** of podiatric medical health care by promoting high standards for podiatric physician **licensure**, **regulation**, and **practice**.

MEMBER BOARD BENEFITS

BENEFITS

REPRESENTATION

The FPMB provides representation to:

- American Podiatric Medical Association **(APMA)***
- American Society of Podiatric Executives **(ASPE)**
- Federation of State Medical Boards **(FSMB)**
- National Board of Podiatric Medical Examiners **(NBPME)**
- Professional Licensing Coalition **(PLC)**

**Continuing Education Committee (CEC) of the Council on Podiatric Medical Education*

PUBLIC POLICY & ADVOCACY

The FPMB supports its Member Boards by:

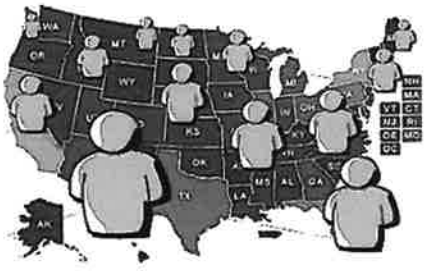
- Advocating for the restoration of antitrust immunity
- Monitoring and reporting on the increased focus on occupational licensing reform
- Increasing license portability *(model law, licensure compact, etc.)*

PRIMARY SOURCE VERIFICATION (LICENSURE)

The FPMB provides primary source verification of:

- APMLE Part I/II/III Score Reports
- Disciplinary Action Reports

UNDER 1 BUSINESS DAY: Median turnaround time from order placed to downloaded by Member Board



COLLABORATION & COMMUNICATION

The FPMB is a catalyst for its Member Boards by:

- Collecting and disseminating information that results in changes to requirements, regulatory structure, etc.
- Publishing key contact, general, licensure, and regulatory information to be viewed and compared
- Publishing a quarterly newsletter

AFFILIATE MEMBER BOARD SPOTLIGHT

College of Physicians and Surgeons of British Columbia

The mission of the College of Physicians and Surgeons of British Columbia *(the College)* is to serve the public by regulating physicians and surgeons in the province of British Columbia, Canada.

Formed in 1886, the College regulates the practice of medicine under the authority of provincial law. All physicians, including podiatric surgeons, who wish to practice in the province must be registrants of the College.

The primary function of the College is to ensure that physicians and surgeons are qualified, competent, and fit to practice. The College administers processes for responding to complaints from patients and for taking action if a physician or surgeon is practicing in a manner that is incompetent, unethical, or illegal. The College also administers quality assurance and accreditation programs to ensure that every physician and surgeon in the province is practicing according to professional standards and that all of British Columbia's diagnostic and private medical and surgical facilities are accredited.

The role of the College and its authority and powers are set out in legislation. A Board of 10 peer-elected registrants and six members of the public appointed by the Ministry of Health govern the College. Under the legislation, the College has many committees made up of board members, medical professionals, and public representatives who review issues and provide guidance and direction to the Board and College staff. The daily operations of the College are administered by the registrar and CEO, Dr. Heidi Oetter, and other medical and professional staff.

A top priority for the College is to work collaboratively with government, universities, hospitals, and other organizations to address provincial and national issues, one of which is pledging to make British Columbia's health system more culturally safe and effective for Indigenous people. Over 2,000 College registrants recently reported completing Indigenous cultural competency training.

At the conclusion of the 2019/20 licensing year, the College reported 14,007 independently practicing registrants of which 13,257 were professionally active. 6,720 were recognized as family physicians and 6,537 were recognized as specialists. In addition, the College recorded 1,291 postgraduate resident and 1,237 medical student educational registrants.

Following the amalgamation in August 2020, the College has registered 77 podiatric surgeons.

Following recommendations from the British Columbia provincial government, the College of Physicians and Surgeons of British Columbia and the College of Podiatric Surgeons of British Columbia amalgamated on August 31, 2020. Following the amalgamation, the College Bylaws were amended to include four classes of registration for the practice of podiatric medicine and 77 podiatric surgeons were added to the register.

The College has since become an Affiliate Member of the Federation of Podiatric Medical Boards and was warmly welcomed at the recently held 2021 Annual Meeting. The College would like to acknowledge the assistance kindly provided by the staff at the Oregon Medical Board who graciously took time to guide College staff through the amalgamation process.

For further information, please visit the College website at www.cpsbc.ca.

Contact the FPMB now to be featured in the next Member Board Spotlight!

President's Message continued from page 1)

The annual meeting of the FPMB was held on April 30, 2021. The round robin discussion proved to be most productive as Member Boards in attendance discussed issues of importance. The engagement was outstanding and well received by participants.

Prior to the meeting, Member Boards were asked to present information regarding their current board activities that they believed to be of interest to others. Member Boards were also asked to present topics and questions that they wished to have addressed in the round robin discussion.

This resulted in 25 topics available for discussion, and participants were able to rank topics for discussion through a voting process. Participants shared their experiences and offered solutions to help other Member Boards.

The FPMB has recently participated, along with other stakeholders, in discussions regarding the White Paper presented by the Joint Task Force of the American Academy of Orthopaedic Surgeons *(AAOS)*, American College of Foot and Ankle Surgeons *(ACFAS)*, American Orthopaedic Foot & Ankle Society *(AOFAS)*, and the American Podiatric Medical Association *(APMA)* as well as the associated American Medical Association *(AMA)* Resolution. The FPMB will continue to monitor the situation and, as always, will continue to be a source of information to our Member Boards and others.

The FPMB will strive to continue its pursuit of excellence and will endeavor to be a strong participant in the national podiatric community.

Executive Director's Message continued from page 1)

The FPMB thanked Bruce R. Saferin, DPM for his exemplary service as FPMB President over the past year and welcomed Barbara A. Campbell, DPM as the incoming FPMB President.

The FPMB is in excellent hands with the leadership of Dr. Campbell, and I join her in welcoming the College of Physicians and Surgeons of British Columbia *(CPSBC)* as an Affiliate Member.

Data Initiative

The FPMB is increasing the data collected and reported to support its Member Boards, and other stakeholders. This data will create knowledge to power well-informed decision making. Member Board engagement and responsiveness is critical to the success of this initiative.

In the meantime, I am pleased to inform you that the FPMB has expanded the data it collects from licensure applicants. We are seeking greater insight into interstate licensure and will be able to identify if the license being sought is "primary" versus "secondary." Additionally, we are seeking greater insight into how the license will be utilized for each applicant (i.e., residency, fellowship, self-employed solo practice, self-employed group practice, employed group practice, employed hospital , etc.).

This new data collection started on June 1, 2021, and the FPMB looks forward to providing an update in our next newsletter.

Joint Task Force of Orthopaedic and Podiatric Surgeons

"Res. 303 – Improving the Standardization Process for Assessment of Podiatric Medical Students and Residents by Initiating a Process Enabling Them to Take the USMLE" was not considered at the Special Meeting of the American Medical Association (AMA) House of Delegates this month. The Joint Task Force may submit a revised resolution for the 2021 Interim Meeting of the AMA House of Delegates in November.

In the meantime, the FPMB and other stakeholder organizations are meeting with American Podiatric Medical Association (APMA) Executive Director/ CEO James R. Christina, DPM at the end of July to discuss the white paper and resolution. Member Boards are strongly encouraged to contact the FPMB Executive Office with any questions and/or comments for consideration at this meeting.

AMERICAN BOARD OF FOOT AND ANKLE SURGERY

Katherine Kreiter, Executive Director

"Ensuring the Highest Surgical Standards since 1975"

In the six years I have served in my role at the American Board of Foot and Ankle Surgery *(ABFAS)*, I have been proud to help carry out the ABFAS mission: **to protect and improve the health and welfare of the public by advancing the art and science of foot and ankle surgery**.

Please let me take this opportunity to introduce you to *(or remind you of)* ABFAS, its goals, and its methods. If this article intrigues you, I hope you will explore abfas.org to learn more.

What ABFAS Does

ABFAS accomplishes its mission of protecting public health by granting either foot surgery or foot and reconstructive rearfoot and ankle *(RRA)* surgery certification status to candidates who demonstrate a cognitive knowledge in either foot surgery or foot and ankle surgery, including the diagnosis of general medical problems and surgical management of pathologic foot *(and ankle for those holding RRA certification)* conditions, deformities, and/or trauma, and related structures that affect the foot and ankle *(and leg for those holding RRA certification)*. Those who attain the credential(s) receive the status of ABFAS Diplomates. Board Certification in Foot Surgery is a prerequisite for Board Certification in RRA Surgery.

ABFAS formed in 1975 as the American Board of Podiatric Surgery. Today, more than 7,500 foot and ankle surgeons rely on their ABFAS status to help **ensure rigorous standards for competency in their profession**. The Joint Committee on the Recognition of Specialty Boards *(JCRSB)* of the Council on Podiatric Medical Education *(CPME)*, under the authority of the American Podiatric Medical Association *(APMA)*, recognizes ABFAS—and ABFAS alone—as the **only foot and ankle surgical certification board**.

How We Do It

ABFAS gauges certification readiness through a series of examinations. ABFAS develops all exams following the rigorous standards of professional testing. An independent testing consultant—an expert in psychometrics, the study of the theory and technique of psychological measurement—oversees development and scoring.

The ABFAS pathway to certification begins at the resident level. In the Fall, residents can take In-training exams *(ITEs)* to assess strengths and weaknesses. The ITEs consist of both a didactic *(multiple choice)* component and a computer-based patient simulation *(CBPS)* component. ABFAS offers two sets of ITEs: one for postgraduate years 1 and 2 *(and 3 in four-year programs)*; and a second for final-year residents. Candidates may use any passed Final-year ITE to fulfill board qualification examination requirements.

Residents can participate in either Podiatric Medicine and Surgery Residency *(PMSR)* programs which address foot surgery, or PMSR/RRA programs which have additional focus on reconstructive rearfoot and ankle surgery. The ABFAS ITEs address foot surgery and RRA surgery.

Upon residency completion, candidates who pass both the Part I didactic and CBPS exam components receive ABFAS Board Qualified status. And candidates who successfully passed their Final-year ITEs can convert those results to serve as their Part I *(Board Qualification)* examinations. There are separate examinations/pathways for foot surgery and RRA surgery.

Candidates then have seven years to successfully complete the Part II certification examination, Case Review, in which a team of case reviewers *(ABFAS Diplomates)* thoroughly evaluate all aspects of a randomly selected list of candidates' surgical cases. Reviewers review case documentation to see if the candidate has formulated an accurate diagnosis and treatment plan, performed the procedure with excellent or adequate patient outcomes, has identified and managed any complications in a timely manner, and provided safe, effective, and compassionate patient care.

(Continued on page 6)

(American Board of Foot and Ankle Surgery continued from page 5)

Once ABFAS certifies them as Diplomates, surgeons must demonstrate they have kept their skills sharp and their knowledge fresh. Starting in 2022, they will accomplish this through the LEAD program, a new process of Continuous Certification in which Diplomates will answer a set number of questions each quarter using a digital interface. We are in the process of crafting the LEAD program to fit into the lives and demanding schedules of busy surgeons. You can find more information at abfas.org/lead.

Why We Do It

The full process of qualifying, achieving certification, and demonstrating mastery each year may sound like a lot, but we like to think of it as exhaustive rather than exhausting.

ABFAS engages with DPMs, podiatric students, colleges of podiatric medicine, and residency program directors with patients' wellbeing in mind. The ABFAS certification process protects the public by ensuring that standards in the field of foot and ankle surgery are rigorous and thorough.

Thanks to ABFAS certification, patients can rest assured they are receiving high-quality care, and fellow practitioners can refer their patients to ABFAS Diplomates with confidence.

How It Helps Surgeons

So, that covers the patient's perspective, but what do surgeons gain through certification as ABFAS Diplomates?

Beyond the level of training required to successfully complete medical school and residency, ABFAS Diplomate status communicates that the surgeon has made the effort to be better, that they can perform at a more advanced level of surgical excellence.

The ABFAS requirement that Diplomates maintain their certification by continuing to demonstrate competence throughout their careers through the LEAD program of Continuous Certification showcases their willingness to continue learning and growing throughout their careers.

Finally, ABFAS does offer more tangible benefits. Many hospitals require qualification and/or certification as a prerequisite for surgical privileges; some require board certification within five years of residency. In addition, many insurance companies require that physicians carry specialty board certification. As ABFAS is the only surgical board recognized by the JCRSB, hospital and insurance companies can trust that ABFAS Diplomates have demonstrated the knowledge, skills, and professionalism to provide safe, high-quality patient care.

Prestige accompanies Diplomate status, and the ABFAS website includes advertising guidelines to help foot and ankle surgeons professionally display their credential. And patients can find ABFAS certified DPMs through the ABFAS website "Find a Surgeon" function, located at my.abfas.org/Find-a-Surgeon.

We invite surgeons, residents, and students to contact us at ABFAS to discuss the process.

RESIDENCY APPLICANTS: Class of 2021

Placed in Residencies	530	(100.0%)
To Be Placed	0	(0.0%)
TOTAL	530	(100.0%)

RESIDENCY POSITIONS:

CPME Approved Positions at March 31, 2021	625
Positions not filling for this training year	45
Total Active Positions Available for this year	580

Prior Year Applicants:	**Class of 2020**	**Class of 2019**	**Prior Years**
Placed in Residencies	10 (100.0%)	0 (100.0%)	2 (100.0%)
To Be Placed	0 (0.0%)	0 (0.0%)	0 (0.0%)
TOTAL	10 (100.0%)	0 (100.0%)	2 (100.0%)

MEMBER BOARDS INFORMATION / COMPENDIUM

The FPMB's data visualization page provides **general**, **contact**, **licensure**, and **regulatory** information about its Member Boards. The page contains the following sections:

MEMBER BOARDS INFO

Enables visitors to open an "information card" for an in-depth view of the **contact**, **general**, **licensure**, and **regulatory** information for any Member Board.

DATA POINTS

Enables visitors to compare 15+ **general** and **licensure** data points across all Member Boards. The data can be viewed in both map and table format.

COMPENDIUM

Enables visitors to compare all 15+ **general** and **licensure** data points across all, or a subset of, Member Boards.

YOUR Accurate, Complete, and Current Data is CRITICAL!

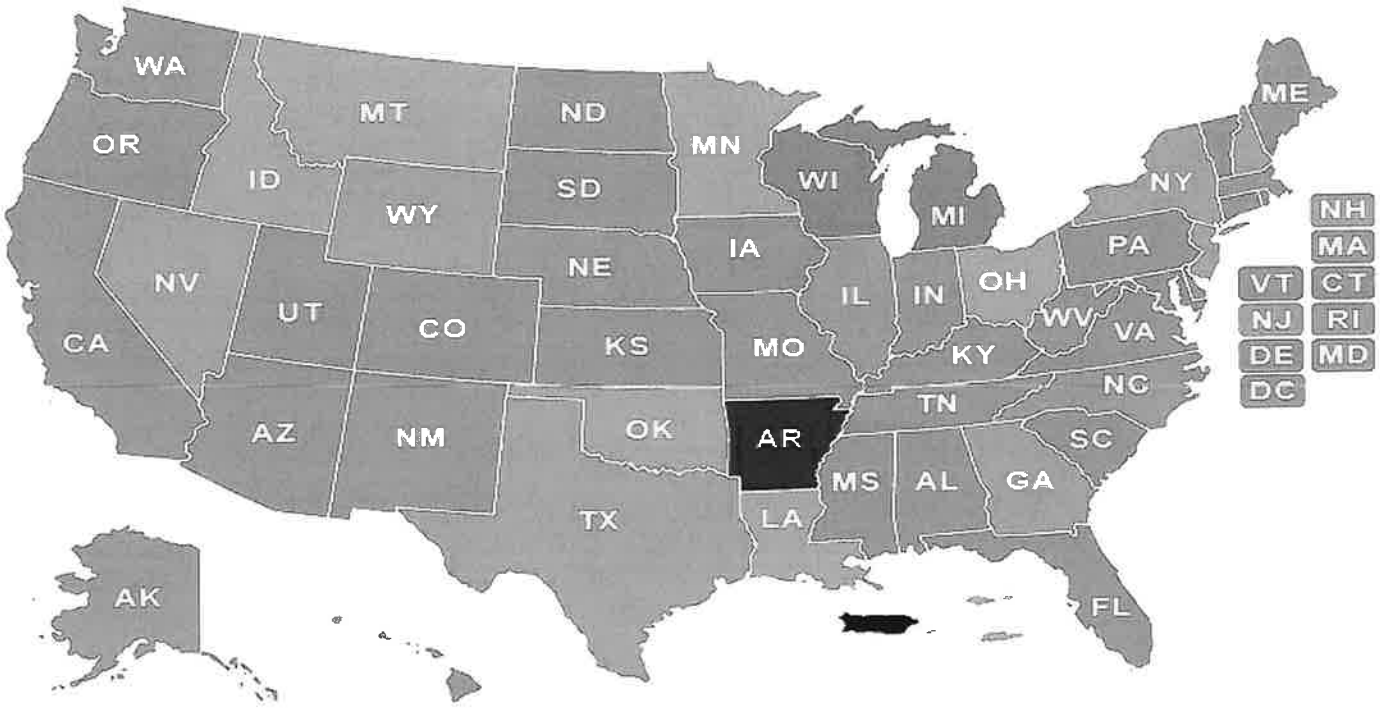
Member Board Update Forms were distributed on August 31, 2020 with a response due date of September 30, 2020. Blue states *(see map below)* have not responded yet and should respond as soon as possible.

The form can be submitted electronically [link] *(user account required)*. To **reduce** the amount of data entry needed, the form is pre-filled and only requires edits to information that has changed.

As part of the FPMB's Data Initiative, the data the FPMB collects and reports will be expanding. The need and value of this initiative has only increased during the COVID-19 pandemic, as evidenced by the information requests the FPMB has received from Member Boards, podiatric organizations, podiatrists, and other impacted stakeholders.

Member Boards Data - Last Updated

(States in green are current with their data.)



Data Point Range

6/2/2014 — 2/3/2017 — 10/7/2019

PRIMARY SOURCE VERIFICATION (LICENSURE) — ❖Q1 2021❖

Reports Ordered via Online System

100.00%

FPMB - Median Report Processing Time

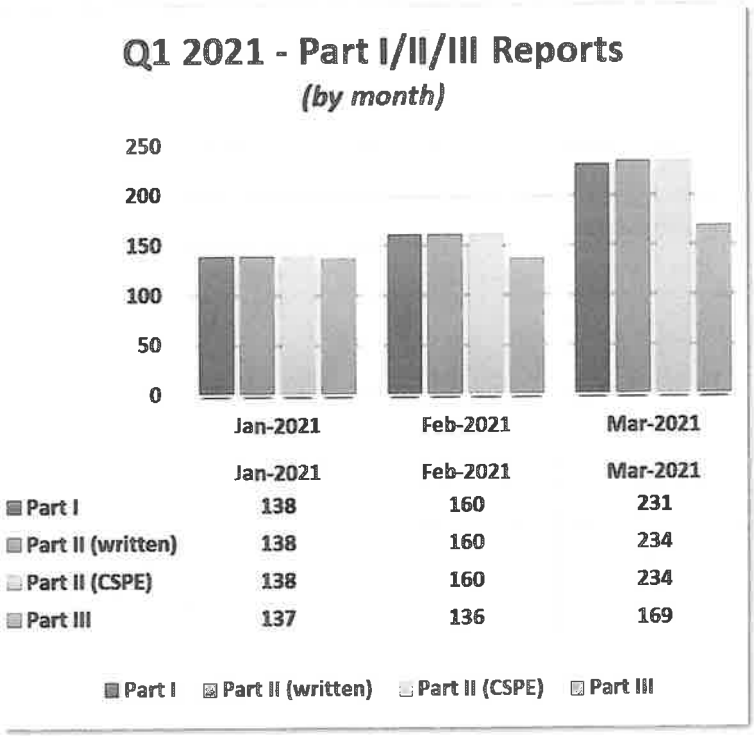
< 1 business hour

Member Boards - Electronic Delivery

52

Member Boards - Median Download Time

3.92 business hours

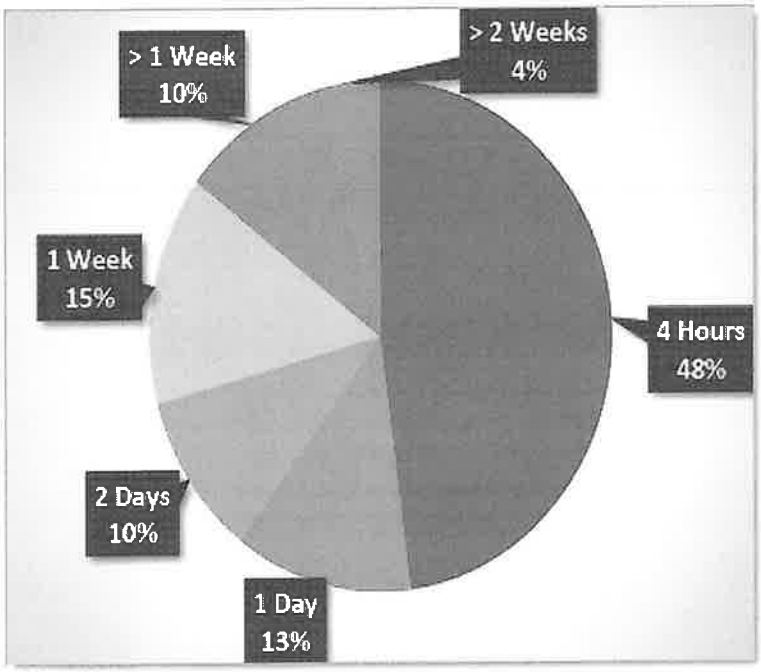


	Jan-2021	Feb-2021	Mar-2021
Part I	138	160	231
Part II (written)	138	160	234
Part II (CSPE)	138	160	234
Part III	137	136	169

EFFICIENCY IN LICENSURE — ❖Q1 2021❖

The FPMB is committed to its role in efficient licensure and has a median Part I/II/III and Disciplinary report processing time of **under one business hour**.

Member Boards also have an opportunity to demonstrate efficiency via the timely download of these reports:



The FPMB recognizes the following Member Boards for their timely download of reports sent in **Q1 2021**:

Within 4 Hours

Alabama
British Columbia
Colorado
California
District of Columbia
Florida
Hawaii
Idaho
Indiana
Kansas
Louisiana
Missouri
Montana
New Hampshire
New Jersey
New Mexico
New York
North Carolina
Ohio
Oregon
Rhode Island
Virginia
Washington

Within 1 Day

Connecticut
Massachusetts
Nevada
Pennsylvania
Texas
Utah

Within 2 Days

Kentucky
Maryland
Michigan
Oklahoma
South Carolina

NOTE: The 34 Member Boards listed above downloaded reports within 2 business days (median). 14 Member Boards were longer than 2 business days (median), and 7 of these were more than 1 business week (median).

Occupational licensure reform seeks efficiency in licensure, especially for military spouses. Timely downloads of reports enables the FPMB to demonstrate efficiency by its Member Boards.

LEGISLATIVE NEWS

Advocacy Network News from the Federation of State Medical Boards (FSMB)

❖ FEDERAL LEGISLATIVE NEWS ❖

COVID-19 Pandemic

The Biden Administration's COVID relief bill, the American Rescue Plan Act of 2021 (H.R. 1319), was signed into law on March 11, 2021. The Act contains several grant and pilot opportunities that would fund delivery of healthcare via telehealth or expand telehealth infrastructure, including:

- **Emergency Grants for Rural Health Care** – Creates a pilot program under the Secretary of Agriculture to help facilities increase telehealth capabilities, including underlying health care information systems (among other items).
- **Funding for Indian Health** – Provides $140,000,000 for information technology, telehealth infrastructure and the Indian Health Services electronic health record system.
- **Funding for Community-Based Funding for Local Behavioral Health Needs** – Funds can be used to provide mental and behavioral health services to individuals with mental health needs as delivered by behavioral and mental health professionals utilizing telehealth services.
- **Emergency Assistance to Families through Home Visiting Programs** – Entities can use funds to serve families with home visits or with virtual visits that may be conducted by the use of electronic information and telecommunications technology, in a service delivery model described in 511(d)(3)(A).

The Act contains several sections regarding mental health and substance use disorder training for health professionals:

- **Sec. 2703:** $80 million in funding to plan, develop, operate, or participate in training activities for healthcare students, professionals, and other related occupations, regarding evidence-informed strategies for reducing and addressing suicide, burnout, mental health conditions, and substance use disorders among healthcare professionals.
- **Sec. 2704:** $20 million in funding to carry out a national evidence-based education and awareness campaign directed at healthcare professionals and first responders to encourage the prevention of mental health conditions and substance use disorders and identify risk factors in themselves and others.
- **Sec. 2705:** $40 million in funding to establish, enhance, or expand evidence-informed programs or protocols to promote mental health for individuals providing healthcare in rural and medically underserved communities.

The COVID-19 Testing, Reaching And Contacting Everyone (TRACE) Act (H.R. 726) was introduced by **Rep. Bobby Rush (D-IL)** and would direct the Centers for Disease Control and Prevention (CDC) to establish a grant program to create robust testing and contact tracing infrastructure through mobile health units and, as necessary, at individuals' residences. Eligible entities for these grants would include Community Health Centers, academic medical centers, School-Based Health Centers, nonprofits, and other organizations.

The Biden Administration's infrastructure bill, the American Jobs Plan, is still being discussed and will not reach its final form for a few weeks, however, one of the aspects of the plan is to invest $100 billion to build high-speed broadband infrastructure for all Americans, which 30% of the country currently lacks.

Licensure

The Improving Access to Health Care in Rural and Underserved Areas Act (S. 201) was re-introduced by **Sen. Jacky Rosen (D-NV)** and **Sen. Lisa Murkowski (R-AK)**, and would create a five-year pilot program that provides a funding opportunity for up to 100 Federally Qualified Health Centers (FQHCs) and Rural Health Clinics to ensure access to continuing medical education in specific areas of medical need within their communities, enhancing skills in these areas and expanding access to care.

(Continued on page 10)

(Legislative News continued from page 9)

The Protecting Job Opportunities for Borrowers (Protecting "JOBs") Act (H.R. 1372/S. 210) was introduced by **Rep. Deborah Ross (D-NC)** in the House and **Sen. Marco Rubio (R-FL)** in the Senate and would prohibit a state from suspending, revoking, or denying a state-issued driver's license, teaching license, or professional license based solely on an individual's default or delinquency on a federal student loan or health education loan. Further, an aggrieved individual may bring a civil action against a state for violating this legislation.

Pain Management

The Veterans Cannabis Use for Safe Healing Act (H.R. 430) was introduced by **Rep. Gregory Steube (R-FL)** and would prohibit the VA Secretary from denying veterans benefits due to a veteran participating in a State-approved marijuana program. The bill ensures that VHA physicians discuss marijuana use with the veteran, adjust medical treatment plans accordingly, and record use in their medical records.

Telehealth

The Telehealth Improvement for Kids' Essential Services (TIKES) Act (H.R. 1397) was introduced by **Rep. Michael Burgess (R-TX)** and **Rep. Lisa Rochester (D-DE)** and would require the Government Accountability Office and the Medicaid and CHIP payment and Access Commission to help states integrate telehealth, while building off of the State Medicaid and CHIP Telehealth Toolkit CMS developed in April 2020.

The More Opportunities for Rural Economies (MORE) Grants Act (S. 649) was introduced by **Sen. Catherine Cortez Masto (D-NV)** and **Sen. Steve Daines (R-MT)** and would create "High-Density Public Land Counties" – areas that are small, rural, and under-resourced – and increase their access to the USDA's Telemedicine and Distance Learning Services grant program, Community Connect Grant Program, and Rural eConnectivity Pilot Program to improve broadband access and connectivity.

The KEEP Telehealth Options Act (H.R. 1677/S. 620) was re-introduced by **Rep. Troy Balderson (R-OH)** and **Rep. Cindy Axne (D-IA)** in the House and **Sen. Deb Fischer (R-NE)** and **Sen. Jacky Rosen (D-NV)** in the Senate and would require HHS and the GAO to report on the availability and effects of expanded telehealth services under Medicare, Medicaid, and CHIP during the COVID-19 public health emergency.

The Tele-Mental Health Improvement Act (S. 660) was introduced by **Senators Tina Smith (D-MN)** and **Lisa Murkowski (R-AK)** to improve access to tele-mental health during the COVID-19 emergency by creating certain coverage requirements and requiring the Department of Health and Human Services (HHS) to issue a report on the impact of telehealth parity measures on the use of telehealth and in-person services. A summary of the legislation is available here.

The Tech to Save Moms Act (H.R. 937) was introduced by **Rep. Eddie Bernice Johnson (D-TX)** in the House and **Sen. Bob Menendez (D-NJ)** in the Senate and would make investments to promote the integration and development of telehealth and other digital tools to reduce maternal mortality and severe maternal morbidity, and close racial and ethnic gaps in maternal health outcomes.

The Telehealth Response for E-prescribing Addiction Therapy Services (TREATS) Act (S. 340) was introduced by **Sen. Rob Portman (R-OH)** and would make permanent waivers instituted in light of the COVID-19 pandemic, including the ability to prescribe Medication Assisted Therapies (MAT) and other necessary drugs without needing a prior in-person visit and the ability to bill Medicare for audio-only telehealth services.

The Telehealth Modernization Act (S. 368) was reintroduced by **Sen. Tim Scott (R-SC)** and **Sen. Brian Schatz (D-HI)** and would make permanent the temporary waivers that removed Medicare's geographic and originating site restrictions, which required both that the patient live in a rural area and use telehealth at a doctor's office or certain other clinical sites, and ensure that telehealth services at federally qualified health centers (FQHCs) and rural health clinics (RHCs) are covered by Medicare.

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Further, it gives the HHS Secretary authority to permanently expand the types of telehealth services covered by Medicare (including hospice and home dialysis) and the types of care providers who able to deliver those services (including physical therapists, speech language pathologists, and others).

The COVID-19 Emergency Telehealth Impact Reporting Act (H.R. 1406) was introduced by **Rep. John Curtis (R-UT)** and would study the impacts of telehealth during the COVID-19 Public Health Emergency and require HHS to assess key health care metrics, including utilization rates and hospital readmission rates, for patients who received their health care through expanded telehealth programs during the COVID-19 pandemic.

The Black Maternal Health Momnibus Act of 2021 (H.R. 959/S. 346) was introduced by **Rep. Lauren Underwood (D-IL)** in the House and **Sen. Cory Booker (D-NJ)** in the Senate and would, among many other things, invest in digital tools like telehealth to improve maternal health outcomes in underserved areas and improve data collection processes and quality measures to better understand the causes of the maternal health crisis and inform solutions to address it.

The Connected Maternal Online Monitoring Services (MOM) Act (S. 801) was re-introduced by **Sens. Bill Cassidy (R-LA), Maggie Hassan (D-NH), Tom Carper (D-DE), Todd Young (R-IN)** and **Jacky Rosen (D-NV)** and would require the Centers for Medicare and Medicaid (CMS) to provide coverage recommendations for remote devices such as those that check for irregularities in blood pressure, blood glucose and pulse rates which can be indicators of potential pregnancy complications. It also requires CMS to update state resources, such as state Medicaid telehealth toolkits, to correspond with the recommendations provided. The goal is to improve maternal and infant outcomes for pregnant and postpartum women.

The Expanded Telehealth Access Act (H.R. 2168) was re-introduced by **Rep. Mikie Sherrill (D-NJ)** and **Rep. David McKinley (R-WV)** and would permanently expand the list of the providers eligible for Medicare reimbursement for providing care via telehealth to include physical therapists, audiologists, occupational therapists, and speech language pathologists, among others. CMS has been reimbursing these providers, however, that is currently time-limited to the public health emergency.

The Ensuring Parity in MA and PACE for Audio-Only Telehealth Act (H.R. 2166) was re-introduced by **Rep. Terri Sewell (D-AL)** and **Rep. Gus Bilirakis (R-FL)** and would help ensure Medicare Advantage enrollees who cannot access audio-video technologies during telehealth visits are able to access care through audio-only modalities, time-limited to the COVID-19 pandemic.

The Rural Behavioral Health Access Act (H.R. 2228) was introduced by **Rep. Dan Kildee (D-MI)** and **Rep. Brad Wenstrup (R-OH)** and would augment rural Critical Access Hospitals (CAHs) by allowing Medicare to provide payment for outpatient behavioral therapy services rendered via telehealth, allowing the initiation of a new patient-physician relationship via telehealth, and allowing audio-only behavioral therapy telemedicine services, if audio-visual capability is not available.

The Telehealth Modernization Act (H.R. 1332) was re-introduced by **Rep. Earl "Buddy" Carter (R-GA)** and would make permanent the temporary waivers that removed Medicare's geographic and originating site restrictions, which required both that the patient live in a rural area and use telehealth at a doctor's office or certain other clinical sites, and ensure that telehealth services at federally qualified health centers (FQHCs) and rural health clinics (RHCs) are covered by Medicare. Further, it gives the HHS Secretary authority to permanently expand the types of telehealth services covered by Medicare (including hospice and home dialysis) and the types of care providers who able to deliver those services (including physical therapists, speech language pathologists, and others). The Senate companion bill, S. 368, was introduced in February by **Sen. Tim Scott (R-SC)** and **Sen. Brian Schatz (D-HI)**.

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Substance Abuse Disorder Treatment

The Emergency Support for Substance Use Disorders Act (H.R. 706/S. 660) was introduced by **Rep. Ann Kuster (D-NH)** in the House and **Sen. Tina Smith (D-MN)** in the Senate and would authorize $50 million in federal grant funding for States, Tribes, Tribal organizations, and community-based entities to address substance use disorders through harm reduction services. The CDC would help administer these grants and prioritize funding for areas with higher drug overdose death rates, telemedicine and workforce needs, prevention and recovery supports, and efforts to reduce stigma.

The Bipartisan Mainstreaming Addiction Treatment Act (MAT) (H.R. 1384/S. 445) was introduced by **Rep. Paul Tonko (D-NY)** and **Rep. Michael Turner (R-OH)** in the House and **Sen. Lisa Murkowski (R-AK)** and **Sen. Maggie Hassan (D-NH)** in the Senate and would eliminate a requirement - referred to as the "x-waiver" - that currently limits health care professions from prescribing, Buprenorphine, to treat patients with opioid addiction.

The Tele-Mental Health Improvement Act (H.R. 2264) was introduced by **Rep. David Trone (R-MD)** and **Rep. Brian Fitzpatrick (R-PA)** and seeks to improve access to tele-mental health by requiring ERISA plans to cover mental health and substance use disorder services provided through telehealth at the in-person rate, prohibiting health plans from imposing additional barriers to accessing tele-mental health services, informing enrollees how they can access tele-mental health and substance use disorder services and requiring HHS to issue a report on the impact of telehealth parity measures on the use of telehealth and in-person services. The Senate companion bill, S. 660, was introduced in March.

The Behavioral Health Coordination and Communication Act of 2021 (H.R. 1385) was re-introduced by **Reps. Tom Emmer (R-MN), David Trone (D-MD), Doris Matsui (D-CA), Paul Tonko (D-NY), Tony Cárdenas (D-CA)** and **Brian Fitzpatrick (R-PA)** and would create an Interagency Coordinator for Behavioral Health to streamline federal programming and to develop a strategy for coordination across agencies to address mental health and substance use disorders, establish a publicly available knowledge center on mental health and SUD, including insurance information, tools, and other public education efforts; and promote efforts to destigmatize mental health and SUD and incorporate screenings as a vital sign.

Mental Health

The Dr. Lorna Breen Health Care Provider Protection Act (S. 610/H.R. 1667) was reintroduced by **Senators Kaine (D-VA), Cassidy (R-LA), Reed (D-RI)** and **Todd Young (R-IN)** and cosponsors in the Senate and Representatives **Susan Wild (D-PA), Raja Krishnamoorthi (D-IL), Judy Chu (D-CA), David McKinley (R-WV)** and cosponsors in the House. The bill was previously introduced during the 116th Congress in response to high levels of mental and physical stress and burnout in the healthcare workforce and would provide grants for training healthcare professionals in evidence-informed strategies to reduce and prevent suicide, burnout, mental health conditions, and substance use disorders, and encourage those at risk to seek support and treatment. The bill also requires a comprehensive study on health care professional mental and behavioral health and burnout. For bill text click here. The FSMB endorsed this legislation.

The Coronavirus Mental Health and Addiction Assistance Act of 2021 (H.R. 593/S. 135) was introduced by **Rep. Tim Ryan (D-OH)** in the House and **Sen. Amy Klobuchar (D-MN)** in the Senate and would authorize $100 million to initiate or expand programs offering mental health and substance use disorder services in response to the pandemic, including support groups, telephone helplines and websites, training programs, telehealth services, and outreach services.

The Stopping the Mental Health Pandemic Act (H.R. 588/S. 165) was introduced by **Rep. Katie**

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Porter (D-CA) in the House and **Sen. Tina Smith (D-MN)** in the Senate and would authorize $150 million in federal grant funding for States, Tribes, Tribal organizations, and community-based entities to address behavioral health needs during the COVID-19 pandemic. The bill empowers the Substance Abuse and Mental Health Services Administration (SAMHSA) to administer the grants for training, technology upgrades, surge capacity needs, emergency crisis intervention, suicide prevention, and outreach to underserved communities.

Graduate Medical Education

The Expanding Teaching Health Centers Act of 2021 (H.R. 949) was introduced by **Rep. Raul Ruiz (D-CA)** and would provide $331 million for the Teaching Health Center Program, administered by the Health Resources & Services Administration, which helps support primary care medical and dental residency programs.

Opioids

The Guarantee Health by Targeting (FIGHT) Fentanyl Act (S. 339) was introduced by **Sen. Rob Portman (R-OH)** and **Sen. Joe Manchin (D-WV)** and would permanently schedule illicitly manufactured fentanyl, which has been temporarily scheduled by the DEA since February 2018, to help bring criminal actions against individuals who manufacture, distribute, or handle fentanyl-related substances.

The Opioid Patients' Right to Know Act of 2021 (H.R. 1185) was introduced by **Rep. David Trone (D-MD)** and would incentivize states, via a grant program, to require health care providers who prescribe opioids to discuss the risks and addictive qualities of opioids with patients, as well as non-opioid alternatives before issuing a new prescription for acute, not chronic, pain.

Prescription Drug Monitoring Programs (PDMPs)

The Prescription Drug Monitoring Act (S. 889/H.R. 2344) was re-introduced by **Sen. Amy Klobuchar (D-MN)** and **Sen. Rob Portman (R-OH)** in the Senate and **Rep. Tim Ryan (D-OH)** and **Rep. Troy Balderson (R-OH)** in the House and would strengthen PDMPs by requiring their use in all states in order to receive federal funding to combat opioid abuse, and making their data accessible to other states. Specifically, the bill would require drug dispensers to report each opioid prescription they dispense within 24 hours, require practitioners to consult the PDMP before prescribing opioids, and require states to actively notify practitioners when the PDMP shows a patient exhibiting patterns indicative of opioid misuse.

Broadband / Infrastructure

The Accessible, Affordable Internet for All Act (S. 745/H.R. 1783) was re-introduced by **Sen. Amy Klobuchar (D-MN)** in the Senate and **Rep. James Clyburn (D-SC)** in the House and would, among other things, appropriate $2 billion for the Telehealth Connectivity Fund to carry out the Rural Health Care Program which provides funding to eligible health care providers for telecommunications and broadband services necessary to provide care.

The American Broadband Buildout (ABBA) Act (S. 436) was introduced by **Sen. Susan Collins (R-ME)** and **Sen. Jacky Rosen (D-NV)** and would help close the "digital divide" between urban and rural America by providing up to $15 billion in matching grants to assist states and state-approved entities in building the "last-mile" infrastructure to bring high-speed broadband directly to homes and businesses in areas that lack it in order to bolster telehealth, distance learning, and remote work capabilities.

The Leading Infrastructure For Tomorrow's ("LIFT") America Act (H.R. 1848) was introduced by **Rep. Frank Pallone (D-NJ)** and would, among other things, expand broadband internet access nationwide with $80 billion of funding to achieve 100% deployment, $7 billion towards State, local, Tribal, and territorial health departments and the CDC to enhance workforce capacity, testing capacity, health information, disease surveillance, and other critical core public health needs; and $10 billion in funding for community health center capital project grants for the construction and modernization of community health centers.

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The Public Health Infrastructure Saves Lives Act ("PHISLA") (S. 674) was re-introduced by **Sen. Patty Murray (D-WA)** in the Senate and **Rep. Chris Van Hollen (D-MD)** in the House and would establish a Core Public Health Infrastructure Program at the CDC with $4.5 billion in annual funding to award grants to state, local, tribal and territorial health departments to ensure they have the tools, workforce and systems in place to address existing and emerging health threats and reduce health disparities.

Health Equity

The John Lewis NIMHD Research Endowment Revitalization Act of 2021 (H.R. 189) was introduced by **Rep. Nanette Barragan (D-CA)** and would increase investments in schools promoting minority health and health disparities research capacity and infrastructure, increasing the diversity of the scientific workforce, and enhancing the recruitment and retention of individuals from health disparity populations that are underrepresented in the scientific workforce.

Workplace Safety

The Workplace Violence Prevention for Health Care and Social Service Workers Act (H.R. 1195) was introduced by **Rep. Joe Courtney (D-CT)** and would provide health and social service workers the protection they deserve by compelling the Occupational Safety and Health Administration (OSHA) to issue a rule requiring healthcare and social service sectors to develop and implement a workplace violence prevention plan, identify risks, specify solutions, and require training, reporting, and incident investigations; provide protections from retaliation for reporting violent incidents, and protect healthcare and social service workers in the public sector in the 24 states not covered by OSHA protections.

Federal Regulatory News

Highlights

On February 10 and March 11, HHS announced the sixth and seventh amendments to the Public Readiness and Emergency Preparedness (PREP) Act, expanding the list of persons authorized to prescribe, administer, deliver, distribute, or dispense the Covered Countermeasure, preempting state laws that are more restrictive than the amendments. For additional information and a list of who is covered under the COVID-19 PREP Act Declaration, please click here.

On February 23, HHS issued a notice that it would exercise discretion enforcing HIPAA privacy requirements on doctors and other health providers who use scheduling tools in good faith. This is intended to help health providers – or their patients – schedule COVID-19 vaccine appointments on websites without having to take comprehensive safeguards to protect personal health information.

On March 11, it was reported that the Biden Administration would be directing $2.5 billion in funding to address the nation's worsening mental illness and addiction crisis. The funds will be broken down into two components by the Substance Abuse and Mental Health Services Administration (SAMHSA):

- $1.65 billion will go toward the Substance Abuse Prevention and Treatment Block Grant, which gives the receiving states and territories money to improve already-existing treatment infrastructure and create or better prevention and treatment programs.
- $825 million will be allocated through a Community Mental Health Services Block Grant program, which will be used by the states to deal specifically with mental health treatment services.

On April 1, the Biden Administration released its Statement of Drug Policy Priorities through the Office of National Drug Control Policy (ONDCP), which include:

- Expanding access to evidence-based treatment
- Advancing racial equity issues in our approach to drug policy
- Enhancing evidence-based harm reduction efforts

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- Supporting evidence-based prevention efforts to reduce youth substance use
- Reducing the supply of illicit substances
- Advancing recovery-ready workplaces and expanding the addiction workforce
- Expanding access to recovery support services.

Telehealth Updates

On February 25, the USDA announced that it will invest a total of $42 million in telemedicine infrastructure and distance learning to improve health and education outcomes for rural residents, $24 million of which was appropriated in last year's CARES Act.

On March 15, the Medicare Payment Advisory Commission (MedPAC) published recommendations to Congress on to continue some Medicare COVID-19 telehealth coverage expansions temporarily to allow more time for study before making any policies permanent. MedPAC recommended:

- Medicare continue covering telehealth services regardless of patient location for a "limited duration (e.g., one to two years)", including beneficiaries at home
- Medicare continue covering the over 140 telehealth services that were temporarily added to the Physician Fee Schedule, such as emergency department visits.
- Maintaining the allowance of audio-only interactions based on clinical assessment and potential for clinical benefit, for instance, audio-only evaluation and management visits with established patients.
- Medicare should return to paying lower facility-based rates post-public health emergency.
- Acknowledging additional upfront costs, MedPAC argues the cost of a telehealth service generally should be lower than that of an in-person service, raising concerns that payment parity policies could incentivize inappropriate favoring of telehealth services by providers.
- Advises CMS to establish additional safeguards against potential fraud, for instance flagging certain clinicians, such as those who work for direct-to-consumer telehealth vendors, as outliers in terms of volume of telehealth services compared to other providers within their specialty.

On March 30, the Federal Communications Commission (FCC) established Round 2 of the COVID-19 Telehealth Program, a $249.95 million federal initiative that builds on the $200 million program established as part of the CARES Act. This grant program supports the efforts of healthcare providers to continue serving their patients by providing telecommunications services, information services, and connected devices necessary to enable telehealth during the COVID-19 pandemic. Phase 2 strives to facilitate a more equitable funding window by evaluating applications collectively, and prioritizing hard-hit, low-income, and medically underserved areas.

❖ STATE LEGISLATION OF INTEREST ❖

[E] *Denotes enacted legislation*

Interstate Medical Licensure Compact

The Interstate Medical Licensure Compact is currently comprised of 32 Members (30 states, DC, and Guam). Legislation has been introduced in Missouri (HB 516 and SB 300), New Jersey (A 1112 and S 523), New York (A 5540 and S 5495), North Carolina (SB 380), Ohio (SB 6), Oregon (HB 2335), Rhode Island (HB 6122) and Texas (SB 517 and HB 1616). Other states are expected to introduce IMLC in the coming weeks and months.

Between April 2017 and February 2021, the Interstate Medical Licensure Compact Commission (IMLCC) has received a total of 12,265 license applications and through the IMLC process, 17,172 licenses have been issued by Compact member states.

The model Compact legislation and other resources can be found on the Interstate Medical Licensure Compact Commission's website at www.imlcc.org.

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Background Checks

Kansas HB 2370 - Prohibits licensing boards from barring applicants with criminal convictions, requires boards to consider the nature and seriousness of the crime, the age when the crime was committed, the amount of time since the crime, the circumstances of the offense, and evidence of rehabilitation before rendering a licensing decision. Further, if the Board rules against the applicant, they're required to give their reasoning and provide the earliest date to reapply for licensure.

West Virginia HB 3090 – Prohibits public employers, including licensing boards, from barring applicants with criminal convictions, requires boards to consider the nature and seriousness of the crime, the age when the crime was committed, the amount of time since the crime, the circumstances of the offense, and evidence of rehabilitation before rendering a licensing decision.

Board Structure and Function

Arkansas SB 152 - Increases Board members to 15 (from 14), with the extra member being a physician assistant (PA) who must remain in active practice for their entire term.

Delaware HB 33 [E] - Decreases the number of public members on the state medical board from seven to five, and adds two PAs (as recommended by the Regulatory Council for Physician Assistants).

Idaho S 1126 – Clarifies that Idaho holds jurisdictional rights for civil and administrative actions for Idaho patients receiving telemedicine services, even if the patient is temporarily located out of state.

Idaho S 1128 - Creates a board of naturopathic health care to regulate Naturopaths, separate from the Board of Medicine.

Iowa SF 487 - Mandates that an unregulated health profession can only be regulated for the purpose of protecting the public health or safety, not diminishing competition, and that proposed regulations shall be reviewed by the Assembly. The bill also creates a government efficiency review committee that would meet as necessary to review all boards.

Nevada AB 278 - Requires physicians to answer a questionnaire from the Department of Health as a condition of license renewal. Information collected includes whether the practitioner is employed by a hospital or independently, if they practice solo or with at least another physician, their specialty areas, and the number of locations at which they practice; responses will be kept confidential.

Nevada AB 369 - Creates sunset provisions, so that every six years each professional or occupational board must be renewed by the Legislature or else be disbanded. Requires the Sunset committee to review 10 boards per legislative term.

Nevada SB 90 – Clarifies protocol so that when a Board finds that there are no reasonable grounds to believe that the practitioner committed a violation, the investigation will be deemed a "review and evaluation" instead of an "investigation" for purposes related to employment, professional licensure or credentialing, education, liability, or health insurance.

Nevada SB 335 - Adds one member to the Board of Medical Examiners, specifying that it is a PA that has practiced and resided in the state for at least the last five years.

New Mexico SB 219 - Removes the requirement that physicians must be "in compliance with immigration laws" in order to become licensed.

New Mexico SB 279 [E] - Consolidates New Mexico's medical and osteopathic boards, effective July 1, 2022. The composition of the consolidated New Mexico Medical Board will include eleven members (from nine), adding two DOs, which will be selected by the Governor on the recommendation of the New Mexico Osteopathic Medical Association.

Ohio HB 196 - Implores the state medical board to develop standards, requirements and regulations for the licensing and actions of surgical assistants, maintain a registry, and develop licensing renewal procedures including CME.

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Oregon SB 705 - Changes the composition of the Oregon Medical Board by adding two additional PA members (currently practicing or retired). Currently, there is one PA on the Board.

Pennsylvania HB 19 - Adds behavioral health analyst to the list of disciplines, including nurse midwife, PA, NP, respiratory therapist, athletic trainer and perfusionist, eligible for one spot on the state's Medical Board.

Tennessee HB 1080 – Replaces the Board of Medical Examiners' Committee on Physician Assistants with the Board of Physician Assistants. The bill changes the composition of the Board of Physician Assistants to nine members (from five), including seven PAs, one physician and one public member.

Texas HB 2117 - Requires the Texas Medical Board to develop rules regarding the process by which a practitioner conducts the examination of a patient for which opioids may be prescribed. Requires the practitioner to review the patient's medical history and discuss the risk of addiction to opioids among other things.

Continuing Medical Education

Florida HB 603 - Excuses physicians with 120 or more hours of pro bono work from biennial CME requirements. The bill also authorizes the Board to issue restricted licenses to Canadian physicians who hold unencumbered licenses and agree to practice for 36 months in a federally funded community health center, migrant health center, or free clinic. Bill also allows retired physicians (who have practiced for at least three of the last five years) who have a license in good standing to provide free, volunteer medical services to indigent persons or medically underserved populations.

Illinois HB 309 – Requires health care professionals prior to license renewal to complete an evidence-based implicit bias training, including the promotion of bias-reducing strategies to address unintended biases regarding race, ethnicity, gender, identity, sexual orientation, socioeconomic status.

Nevada AB 327 - Requires psychiatrists and their PAs to complete six hours of CME pertaining to cultural competency and diversity, equity, and inclusion per renewal period.

New York A 5426 - Requires physicians to obtain two hours of training on diversity, inclusion, and elimination of bias as a condition of license renewal.

Pennsylvania SB 163 - Requires the state to incorporate social bias and cultural competence training into the CME requirements for Board of Medicine licensees.

Texas HB 2758 - Requires physicians to have at least one CME hour per renewal period regarding the identification and assistance of victims of human trafficking.

COVID-19 Waivers

Maine LD 1194 - Makes permanent the COVID-19 executive orders authorizing the licensing of out-of-state and recently retired doctors and PAs that have not been subject to a disciplinary or adverse action in the past 10 years to provide care either in-person or via telemedicine. Further, the bill expands the definition of telehealth to include for audio-only telephone. Lastly, the bill suspends the requirement that a PA licensed in good standing in another state needs mandatory supervision or a collaborative practice agreement.

Maine LD 1419 and Texas SB 6 - Gives physicians, as well as other healthcare providers, legal immunity for their treatment, or failure to provide treatment, that may have resulted in injury or death during the pandemic, except in cases of reckless, intentional misconduct.

New Jersey S 3175 - Allows, for the duration of the COVID-19 pandemic and future emergencies, unlicensed mental health professionals that have completed their Masters' degree to temporarily practice their profession under the supervision of mental health professionals.

Vermont S 117 [E] - Extended pandemic-related telemedicine waivers until March 31, 2022; including reimbursement parity for audio-only telephone, early prescription refill, authorization to prescribe buprenorphine, and allowing healthcare professionals licensed in other jurisdictions, as well as professionals with inactive licenses, to practice in the state.

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Immunizations

Georgia SB 46 - Grants EMTs the ability to administer vaccines during a PHE under the order of a licensed physician.

Texas HB 2968 - Requires the informed consent of the parent or guardian of a child before an immunization is administered.

International Medical Graduates

Arkansas HB 1667 and North Carolina SB 545 – Grants an occupational or professional license or certificate to a person who establishes residency in the state and has held a license for at least one year in another state, is in good standing, has not faced disciplinary action and has met the requirements of license-holders in the state.

Maine LD 1361 - The bill repeals the requirement that out-of-state physicians possessing an unrestricted license in another jurisdiction providing telehealth consulting services must be registered with the Board. The bill also changes the definition of telehealth to include remote patient monitoring and removes the exclusions on audio-only telephone, fax, email, and text.

Michigan HB 4355 - Allows a health professional licensed in another state to practice that health profession through telehealth in Michigan without obtaining a Michigan license, so long as they obtain consent beforehand and provide only the services they are qualified to render in the state(s) in which they are licensed.

Missouri HB 1283 - Allows healthcare professionals licensed in another jurisdiction to treat Missouri patients via telemedicine.

Nevada AB 439 - Requires the Medical Board to grant a license by endorsement to a licensee that holds a valid medical license in another jurisdiction, so long as they are certified by ABMS or AOA, have not been disciplined, have not been held liable in a malpractice case, and meet all requirements of licensed physicians in Nevada.

Texas HB 3499 - Allows practitioners licensed in another jurisdiction to establish the patient-physician relationship via telemedicine and provide services via telemedicine to Texas patients, with the same standard of care as if rendered in person.

Wisconsin SB 202 - Authorizes health care providers licensed in another jurisdiction to provide services for which they are licensed in Wisconsin or via telehealth under a temporary permit during a national emergency or if the practitioner has applied for a permanent license in the state.

Wisconsin AB 159 - Allows a physician 90 days per year of medical practice at a recreational or educational camp if they are licensed in good standing by another state or a foreign country with similar licensure standards, and the individual is not under active investigation by a licensing authority.

License Portability & Reciprocity

Arkansas HB 1667 and North Carolina SB 545 – Grants an occupational or professional license or certificate to a person who establishes residency in the state and has held a license for at least one year in another state, is in good standing, has not faced disciplinary action and has met the requirements of license-holders in the state.

Idaho H 179 - Allows a physician licensed and in good standing in one jurisdiction to provide telemedicine to in-state patients. Physicians must act in full compliance with ID laws and regulations including holding liability insurance. Disciplinary actions will be based in the patient's county of residence.

Kansas SB 207 - Allows out-of-state practitioners to practice telemedicine during the state of emergency with permission of the Board of Healing Arts, as well as during future emergencies.

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Maine LD 1361 - The bill repeals the requirement that out-of-state physicians possessing an unrestricted license in another jurisdiction providing telehealth consulting services must be registered with the Board. The bill also changes the definition of telehealth to include remote patient monitoring and removes the exclusions on audio-only telephone, fax, email, and text.

Massachusetts HD 2533 - Creates a Department of Health and Human Services taskforce on the Interstate Medical Licensure Compact and licensure reciprocity.

Michigan HB 4355 - Allows a health professional licensed in another state to practice that health profession through telehealth in Michigan without obtaining a Michigan license, so long as they obtain consent beforehand and provide only the services they are qualified to render in the state(s) in which they are licensed.

Missouri HB 1283 - Allows healthcare professionals licensed in another jurisdiction to treat Missouri patients via telemedicine.

Nevada AB 439 - Requires the Medical Board to grant a license by endorsement to a licensee that holds a valid medical license in another jurisdiction, so long as they are certified by ABMS or AOA, have not been disciplined, have not been held liable in a malpractice case, and meet all requirements of licensed physicians in Nevada.

South Carolina H 3867 - Allows healthcare professionals licensed out-of-state to practice telemedicine with in-state patients if registered with the Department of Labor, Licensing and Regulation, and provides services within the applicable scope of practice.

Tennessee HB 967 - Allows practitioners licensed out-of-state to practice telemedicine on Tennessee patients on a volunteer basis through a free clinic.

Texas HB 3499 - Allows practitioners licensed in another jurisdiction to establish the patient-physician relationship via telemedicine and provide services via telemedicine to Texas patients, with the same standard of care as if rendered in person.

Texas SB 992 - Allows physicians licensed in other jurisdictions to practice telemedicine with Texas patients so long as the standard of care is equal to what the patient would receive in-person, and allows a patient-physician relationship to be established via telehealth.

Vermont H 357 - Allows licensed healthcare providers, including physicians and PAs, to be "deemed" to be licensed in the state to provide services in-person or via telemedicine, so long as they are licensed and in good standing in another state, and not subject to any disciplinary proceedings. Out-of-state physicians are subject to Vermont's Office of Professional Regulation and any applicable professional regulatory board.

West Virginia HB 2024 **[E]** - Allows health care practitioners licensed and in good standing in another jurisdiction to pay a fee to become registered with the appropriate medical board (MD or DO) and become an "interstate telehealth practitioner" and practice medicine with West Virginia patients. West Virginia holds jurisdictional authority, but the registrant has the responsibility to report any restrictions placed on their license in other jurisdictions to the applicable West Virginia board.

Wisconsin AB 148 **[E]** - Authorizes licensing boards to grant temporary permits to healthcare providers, including physicians and PAs, who hold a license in good standing and free of disciplinary actions in another jurisdiction, that have applied for a permanent credential in the state.

Wisconsin AB 159 - Allows a physician 90 days per year of medical practice at a recreational or educational camp if they are licensed in good standing by another state or a foreign country with similar licensure standards, and the individual is not under active investigation by a licensing authority.

Wisconsin SB 202 - Authorizes health care providers licensed in another jurisdiction to provide services for which they are licensed in Wisconsin or via telehealth under a temporary permit during a national emergency or if the practitioner has applied for a permanent license in the state.

(Continued on page 20)

(Legislative News continued from page 19)

Maintenance of Certification

Florida HB 1411 - Allows reciprocity for individuals with medical marijuana cards/registrations in other jurisdictions to be qualified to use in-state dispensaries.

Minnesota SF 1055 - Adds opiate addiction to the list of qualified medical conditions eligible for medical marijuana recommendation.

New Mexico SB 340 - Allows practitioners to recommend medical marijuana to residents of other states that are enrolled in medical marijuana programs in their jurisdictions.

Oregon SB 758 - Adds PAs, NPs, naturopaths, dentists, and optometrists to the definition of "provider" that can recommend medical marijuana. Adds chronic stress and depression to the list of qualified conditions.

Tennessee HB 621 - Legalizes medical marijuana, requires a bona fide patient-practitioner relationship for consultation, creates a registry for patients, and defines qualifying medical conditions as cancer, glaucoma, HIV, AIDS, hepatitis, Crohn's disease, PTSD, debilitating pain, severe nausea, and seizures, among other ailments.

Texas SB 1502 - Clarifies that a physician is specialty board-certified once the physician becomes initially certified, and they need not maintain certification.

Medical Marijuana

Delaware SB 60 – Adds PAs and NPs to the list of healthcare practitioners that can recommend medical marijuana for adult patients.

Florida HB 1411 - Allows reciprocity for individuals with medical marijuana cards/registrations in other jurisdictions to be qualified to use in-state dispensaries.

Minnesota SF 1055 - Adds opiate addiction to the list of qualified medical conditions eligible for medical marijuana recommendation.

New Mexico SB 340 - Allows practitioners to recommend medical marijuana to residents of other states that are enrolled in medical marijuana programs in their jurisdictions.

North Carolina SB 669 – Legalizes medical marijuana, requires a bona fide patient-practitioner relationship prior to recommending medicinal marijuana for a patient, creates a registry for patients, and defines qualifying medical conditions as cancer, glaucoma, HIV, AIDS, hepatitis, Crohn's disease, PTSD, debilitating pain, severe nausea, and seizures among other ailments.

Ohio HB 60 - Adds autism to the list of qualifying conditions for which medical marijuana can be recommended.

Oregon HB 3369 – Defines physicians, NPs, and naturopaths as "primary care professionals" that can recommend medical marijuana to registered marijuana cardholders.

Oregon SB 758 - Adds PAs, NPs, naturopaths, dentists, and optometrists to the definition of "provider" that can recommend medical marijuana. Adds chronic stress and depression to the list of qualified conditions.

Tennessee HB 621 - Legalizes medical marijuana, requires a bona fide patient-practitioner relationship for consultation, creates a registry for patients, and defines qualifying medical conditions as cancer, glaucoma, HIV, AIDS, hepatitis, Crohn's disease, PTSD, debilitating pain, severe nausea, and seizures, among other ailments.

Texas HB 1535 - Adds acute pain and PTSD to the list of qualifying conditions for which physicians may recommend low-THC cannabis.

Military Licensure/Reciprocity

Arkansas SB 78 [E] - Automatically grants licensure to a military member, their spouse, or veteran relocating to the state as long as the applicant holds a license from another state or territory in good standing, with a similar scope of practice.

(Continued on page 21)

(Legislative News continued from page 20)

Idaho S 1083 - Expedites licensure by endorsement process of qualified military applicants to within 15 days.

Maryland HB 1006 - Allows military members and their spouses with valid licenses to receive an expedited, temporary (six-month) license so long as they have a license in good standing from another jurisdiction and have established residency in the state.

Rhode Island SB 275 - Requires the Board to issue an occupational license or certificate to a military member and/or their spouse so long as they've held that license or certificate for at least a year in another jurisdiction, are in good standing without disqualifying criminal record and have no complaint, allegation or investigation currently pending.

Naturopaths

North Dakota SB 2274 - Authorizes naturopaths to prescribe, dispense, administer, and procure drugs and medical devices; plan and initiate therapeutic regimens, but prohibits the prescription or dispensation of schedule I through V substances.

Rhode Island HB 5900 - Removes a requirement that naturopaths operate under a collaboration and consultation agreement with a physician.

Pain Management

Missouri HB 1398 - Requires the Department of Corrections to defer to the substance use disorder treatment prescribed by a physician for individuals incarcerated that need it, and prohibits dose and durations limits to MAT treatments.

Physician Assistant Scope of Practice

Illinois HB 1826 - Clarifies that physicians are not liable for PA actions, unless the physician has "reason to believe the PA lacked the competency to perform the act." It also changes definitions from "delegating" to "collaborating" and allows PAs to practice to their level of education, training, and experience.

Louisiana HB 442 - Removes provisions regarding physician supervision of PAs, defines the scope of PAs work to be according to their education, training, and competence; lists healthcare services that can be rendered by PAs, and makes PAs liable for the services they render, instead of supervising physicians.

New York S 5956 - Adds PAs to definition of primary care practitioner for Medicaid managed care programs.

Texas HB 4352 - Changes nomenclature from physician supervision to physician collaboration, adds "evaluating, diagnosing, managing, and providing medical treatment; interpreting diagnostic tests and providing consultations" to a PA's scope, and removes the liability from the supervising physician to the PA providing care.

West Virginia SB 714 - Removes provision that PAs need a practice agreement to practice, and replaces that with a "practice notification" with the appropriate board, allows appropriately licensed PAs the ability to prescribe up to a three-day supply of Schedule II controlled substances, and considers PAs "providers," meaning they are reimbursed at the same rate as physicians.

Wisconsin AB 125 [E] – Changes a PA's practice from "under the supervision of a physician" to "in collaboration with a physician," and specifies that PAs are individually and independently responsible for the quality of the care they render. The bill allows PAs to delegate care to clinically trained health care workers, redefines PAs scope of practice "to order, prescribe, procure, dispense and administer prescription drugs, medical devices, services and supplies," and creates a new Physician Assistant Affiliated Credentialing Board, composed of eight PAs and one public member, that is attached to the Medical Examining Board.

Physician Malpractice / Misconduct

Florida HB 7005 - Provides heightened liability protections for negligence claims against a health care provider that made a good faith effort to substantially comply with applicable COVID-19 guidance.

(Continued on page 22)

(Legislative News continued from page 21)

Florida SB 1934 - Bars physicians charged with serious crimes such as sexual assault, possession of child pornography or homicide, among other charges, from seeing patients until those charges are resolved.

Georgia HB 458 - Requires all members of the Medical Board to participate in training and education to support greater understanding of sexual misconduct, sexual boundaries, and impacts of trauma and implicit bias within three months of their appointment. It authorizes the Board to refuse license, certificate, or permit or issue discipline to an individual that pleads guilty, is found guilty by a court or by the Board of sexual assault on a patient. It also requires continuing education requirements for physicians to include training regarding professional boundaries and physician sexual misconduct.

North Carolina HB 195 - States that it is unlawful for a health care provider to knowingly and willfully destroy, alter, or falsify a medical record to conceal the commission of an error by a health care provider that resulted in injury or death, to unlawfully obtain money or something of value, or conceal any material fact. The former are punished as felonies and the latter a misdemeanor.

Tennessee HB 1045 - Authorizes the Board, when learning of an indictment against a practitioner for a controlled substance violation or sexual offense, to immediately suspend a prescriber's ability to prescribe controlled substances until the case against the healthcare prescriber reaches final disposition.

Physician Mental Health and Wellness

Indiana SB 365 - Supports physicians who seek professional support to address career fatigue, burnout and behavioral health concerns with important confidentiality and immunity protections, among other aspects.

Texas SB 1143 - Prohibits any action from being taken when a healthcare professional discloses confidential mental health information to any medical, mental health or law enforcement personnel.

Prescribing Practices

Arkansas SB 505 – Requires practitioners to prescribe an opioid antagonist concurrently with any opioid prescriptions greater than 50 MME, a benzodiazepine is prescribed, or if the patient has a history of opioid use disorder. The bill also mandates the Medical Board publish guidance or address the circumstances in which a healthcare professional is required to prescribe an opioid antagonist.

Georgia HB 474 - Requires a practitioner who prescribes at least 50 MME of opioids to a patient to concurrently prescribe an opioid antagonist.

Illinois HB 3596 - Requires that a prescription for a controlled substance in Schedules II-V must be sent electronically.

Minnesota HF 1851 - Redefines "intractable pain" to include cancer, sickle cell disease, rare diseases, orphan diseases, severe injuries, and health conditions requiring palliative or hospice care, and requires a written and signed "patient-provider agreement" providing for the terms of treatment.

New York A 6116 - Allows practitioners to prescribe a greater than 30-day supply of controlled substances during an emergency.

PDMPs

Arizona SB 1091 - Grants PDMP access to health insurers that are either investigating a complaint or performing a drug utilization review.

Illinois HB 3487 - Requires the Department of Public Health to check with the state's PDMP and certify that an individual is permitted to use medical marijuana.

Illinois SB 1844 – Requires opioid treatment programs to share the data of consenting patients with the Illinois Prescription Monitoring Program, but prohibits conditioning the provision of treatment on consent.

Massachusetts HD 2564 - Urges the Board to establish rules by which information about patient's opioid maintenance treatment is included in the state PDMP.

NEWS CLIPS

Licensure

An Announcement from the Joint Task Force of Orthopaedic and Podiatric Surgeons ☆
American Podiatric Medical Association
March 2021
- White Paper
- Resolution
- FAQ
- Explainer

NBPME cancels APMLE Part II CSPE for Class of 2021 ☆
NBPME
February 2021

NBPME: The future of APMLE Part II CSPE ☆
NBPME
March 2021

Work to relaunch USMLE Step 2 Clinical Skills exam discontinued ☆
USMLE
January 2021

USMLE policy updates following Step 2 CS discontinuation ☆
USMLE
March 2021

Support of suspension of COMLEX-USA Level 2-PE and continued osteopathic assessment ☆
AACOM, AOA, NBOME
February 2021

Nurse Practitioners in Massachusetts granted full practice authority
Credentialing Resource Center
January 2021

FSMB launches online resource for telehealth license portability
mHealthIntelligence
January 2021

Characteristics and outcomes of individuals engaging in USMLE irregular behavior, 2006–2015
Journal of Medical Regulation
February 2021

Does pass/fail on medical licensing exams predict future physician performance in practice? A longitudinal cohort study of Alberta physicians
Journal of Medical Regulation
February 2021

The Interstate Medical Licensure Compact: Attending to the underserved
JAMA
March 2021

COVID-19

FPMB: COVID-19 Information and Resources ☆
Federation of Podiatric Medical Boards
June 2021

FSMB: COVID-19 Information and Resources
Federation of State Medical Boards
June 2021

Medical Board of California outlines penalties for providers giving COVID-19 vaccines out of order
Becker's Hospital Review
December 2020

Nearly 40% of Americans still hesitant to visit physician's office due to COVID-19
Becker's Hospital Review
January 2021

COVID-19 pandemic drives huge growth in virtual specialty care
Fierce Healthcare
January 2021

COVID-19 is exacerbating physician retention and burnout
Fierce Healthcare
February 2021

Discipline & Misconduct

Ohio Supreme Court rules doctor's admission to medical board can be used in criminal case
Ohio Supreme Court PIO
December 2020

Q&A with FSMB CEO Dr. Humayun Chaudhry: Should physicians face disciplinary actions for misinformation?
WebMD
January 2021

Framework for Just Culture: RI Board of Medical Licensure and Discipline
Journal of Medical Regulation
February 2021

State medical board recommendations for stronger approaches to sexual misconduct by physicians
JAMA
March 2021

Diversity, Equity & Inclusion

FSMB Symposium on racism and disparities in health care now available online
FSMB
January 2021

Education

Thousands of physicians can't get into residency programs
Becker's Hospital Review
February 2021

Driven by the pandemic and 'the Fauci effect,' applicants flood public health schools
STAT
March 2021

Workforce

Five stats on physician burnout in 2020
Becker's Hospital Review
January 2021

Nation's physician workforce evolves: More women, older, and toward different specialties
AAMC News
February 2021

Texas Medical Board warns of new scam targeting health care professionals
Houston 2
February 2021

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More women are becoming physicians, four other workforce insights
Becker's Hospital Review
February 2021

Health workers face immense psychological toll from pandemic
ABC News
February 2021

Researchers underestimated toll of EHR-related clinician burnout, study finds
Becker's Hospital Review
February 2021

They served on the COVID-19 front lines. Now these emergency medicine doctors can't find jobs
AAMC News
February 2021

Hospitals work to help doctors struggling with mental health issues
KMBC
March 2021

The 10 elements contributing to burnout
Becker's ASC Review
March 2021

The 10 specialties that are the least burned out
Becker's Hospital Review
March 2021

The 10 specialties that are the most burned out
Becker's Hospital Review
March 2021

FBI: Impostors posing as regulators threaten medical licensees nationwide with license suspension
Professional Licensing Report
March 2021

Opioids / Substance Abuse

HHS expands access to treatment for opioid use disorder
HHS
January 2021

Pandemic fuels record overdose deaths
NPR
January 2021

Success Rates of Monitoring for Healthcare Professionals with a Substance Use Disorder: A Meta-Analysis
Journal of Clinical Medicine
January 2021

Opioid overdoses up nearly 30% during pandemic, study says
Becker's Hospital Review
February 2021

Adaptations to substance use disorder monitoring by Physician Health Programs in response to COVID-19
Journal of Substance Abuse Treatment
February 2021

CDC: Record number of people have died of drug overdoses during the pandemic
Becker's Hospital Review
February 2021

Nine stats that show opioid misuse is climbing during the pandemic
Becker's Hospital Review
February 2021

Rural Health

101 rural hospitals have shut down since 2013: Five things to know
Becker's Hospital Review
January 2021

Many rural Americans face long haul to access care
HealthLeaders
January 2021

12 states with the most rural hospitals at risk of closure
Becker's Hospital Review
January 2021

Nearly half of all rural hospitals in the red
Fierce Healthcare
February 2021

Why rural hospital closures hit a record high in 2020
Hospital CFO Review
March 2021

Telehealth

Telehealth use soared in early months of pandemic
HealthLeaders
January 2021

The specialties that used telehealth the most in 2020
Fierce Healthcare
February 2021

How the telehealth boom is changing physician training
AMA News
February 2021

From the Arctic to the Amazon, telehealth is having a moment
Christian Science Monitor
March 2021

NOTICE

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BOARD NEWSLETTERS, NEWS, & ANNOUNCEMENTS

[POD+] *Denotes agency includes podiatry*

➢ ALABAMA

Alabama State Board of Podiatry

🔗 **Alabama Board of Medical Examiners**

❖ 🔗 Spring 2021

➢ ALASKA

Alaska State Medical Board [POD+]

➢ ARIZONA

🔗 **Arizona State Board of Podiatry Examiners**

➢ ARKANSAS

Arkansas Board of Podiatric Medicine

🔗 **Arkansas State Medical Board**

➢ BRITISH COLUMBIA

🔗 **College of Physicians and Surgeons of BC** [POD+]

➢ CALIFORNIA

🔗 **Podiatric Medical Board of California**

🔗 **Medical Board of California**

❖ 🔗 Winter 2021

➢ COLORADO

🔗 **Colorado Podiatry Board**

🔗 **Colorado Medical Board**

➢ CONNECTICUT

Connecticut Board of Examiners in Podiatry

Connecticut Medical Examining Board

➢ DELAWARE

Delaware Board of Podiatry

Delaware Board of Medical Licensure and Discipline

➢ DISTRICT OF COLUMBIA

District of Columbia Board of Podiatry

🔗 **District of Columbia Board of Medicine Newsletter**

FLORIDA

🔗 **Florida Board of Podiatric Medicine**

🔗 **Florida Board of Medicine**

➢ GEORGIA

Georgia State Board of Podiatry Examiners

🔗 **Georgia Composite Medical Board**

➢ HAWAII

🔗 **Hawaii Medical Board** [POD+]

➢ IDAHO

Idaho Board of Podiatry

🔗 **Idaho Board of Medicine**

❖ 🔗 Summer 2021

➢ ILLINOIS

🔗 **Department of Financial & Professional Regulation** [POD+]

➢ INDIANA

Indiana Board of Podiatric Medicine

🔗 **Indiana Professional Licensing Agency**

➢ IOWA

🔗 **Iowa Board of Podiatry Examiners**

🔗 **Iowa Board of Medicine**

➢ KANSAS

🔗 **Kansas State Board of Healing Arts** [POD+]

➢ KENTUCKY

🔗 **Kentucky Board of Podiatry**

🔗 **Kentucky Board of Medical Licensure**

❖ 🔗 Spring 2021

➢ LOUISIANA

🔗 **Louisiana State Board of Medical Examiners** [POD+]

❖ 🔗 April 2021

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➢ MAINE

🔗 **Maine Board of Licensure of Podiatric Medicine**

🔗 **Maine Board of Licensure in Medicine**

❖ 🔗 Spring 2021

➢ MARYLAND

🔗 **Maryland Board of Podiatric Medical Examiners**

🔗 **Maryland Board of Physicians**

❖ 🔗 Spring 2021

➢ MASSACHUSETTS

Massachusetts Board of Registration in Podiatry

🔗 **Massachusetts Board of Registration in Medicine**

➢ MICHIGAN

Michigan State Board of Podiatric Medicine and Surgery

Michigan Board of Medicine

➢ MINNESOTA

🔗 **Minnesota Board of Podiatric Medicine**

🔗 **Minnesota Board of Medical Practice**

➢ MISSISSIPPI

🔗 **Mississippi State Board of Medical Licensure** [POD+]

❖ 🔗 March 2021

➢ MISSOURI

🔗 **Missouri State Board of Podiatric Medicine**

🔗 **Missouri Board of Registration for the Healing Arts**

➢ MONTANA

🔗 **Montana Board of Medical Examiners** [POD+]

➢ NEBRASKA

Nebraska Board of Podiatry Licensing Unit

Nebraska State Board of Health

➢ NEVADA

Nevada State Board of Podiatry

🔗 **Nevada State Board of Medical Examiners**

❖ 🔗 April 2021

➢ NEW HAMPSHIRE

New Hampshire Board of Podiatry

New Hampshire Board of Medicine

➢ NEW JERSEY

🔗 **New Jersey State Board of Medical Examiners** [POD+]

➢ NEW MEXICO

🔗 **New Mexico Board of Podiatry**

🔗 **New Mexico Medical Board**

➢ NEW YORK

🔗 **New York State Education Department** [POD+]

➢ NORTH CAROLINA

🔗 **North Carolina Board of Podiatry Examiners**

🔗 **North Carolina Medical Board**

❖ 🔗 March-April 2021

➢ NORTH DAKOTA

North Dakota Board of Podiatric Medicine

🔗 **North Dakota Board of Medicine**

❖ 🔗 May 2021

➢ OHIO

🔗 **State Medical Board of Ohio** [POD+]

❖ 🔗 June 2021

➢ OKLAHOMA

Oklahoma Board of Podiatric Medical Examiners

🔗 **Oklahoma Board of Medical Licensure and Supervision**

❖ 🔗 May 2020

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➢ OREGON

🔗 **Oregon Medical Board** [POD+]

❖ 🔗 Spring 2021

➢ PENNSYLVANIA

🔗 **Pennsylvania State Board of Podiatry**

🔗 **Pennsylvania State Board of Medicine**

➢ PUERTO RICO

Puerto Rico Board of Examiners in Podiatry

Puerto Rico Board of Medical Licensure and Discipline

➢ RHODE ISLAND

Rhode Island Board of Examiners in Podiatry

🔗 **Rhode Island Board of Medical Licensure**

SOUTH CAROLINA

🔗 **South Carolina Board of Podiatry Examiners**

🔗 **South Carolina Board of Medical Examiners**

➢ SOUTH DAKOTA

South Dakota Board of Podiatry Examiners

South Dakota Board of Medical and Osteopathic Examiners

➢ TENNESSEE

Tennessee Board of Podiatric Medical Examiners

🔗 **Tennessee Board of Medical Examiners**

➢ TEXAS

🔗 **Texas Podiatric Medical Examiners Advisory Board**

🔗 **Texas Medical Board**

❖ 🔗 May 2021

➢ UTAH

Utah Podiatric Physician Licensing Board

Utah Physicians Licensing Board

➢ VERMONT

🔗 **Vermont State Board of Medical Practice** [POD+]

➢ VIRGINIA

🔗 **Virginia Board of Medicine** [POD+]

❖ 🔗 March 2021

➢ WASHINGTON

🔗 **Washington Podiatric Medical Board**

🔗 **Washington Medical Commission**

❖ 🔗 Spring 2021

➢ WEST VIRGINIA

🔗 **West Virginia Board of Medicine** [POD+]

❖ 🔗 June 2021

➢ WISCONSIN

Wisconsin Podiatry Affiliated Credentialing Board

🔗 **Wisconsin Medical Examining Board**

❖ 🔗 May 2021

➢ WYOMING

Wyoming Board of Registration in Podiatry

Wyoming Board of Medicine

➢ CPME

🔗 **Council on Podiatric Medical Education**

❖ 🔗 April 2021

➢ IMLCC

🔗 **Interstate Medical Licensure Compact Commission**

❖ 🔗 December 2020

➢ NBPME

🔗 **National Board of Podiatric Medical Examiners**

❖ 🔗 Spring 2021

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ATTORNEYS AT LAW

Topics

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New Stark and Anti-Kickback Rules

The U.S. Department of Health and Human Services (HHS) and Centers for Medicare and Medicaid Services (CMS) have issued new rules modernizing the Stark and Anti-Kickback laws.

The rules, now in effect, update both laws to reflect the industry trend of encouraging value-based care arrangements, rather than traditional fee-for-service models. While the new rules contain many regulatory updates, this article focuses on new exceptions to the laws designed to promote value-based care.

A. Stark Law

The Stark Law generally prohibits physicians from referring Medicare and Medicaid patients to other providers with whom the referring physician (or a close relative) has a financial relationship, unless a specific exception applies. Providers looking to develop new arrangements focused on value and quality have often been inhibited by Stark and forced to try to shoehorn new arrangements into narrow exceptions not designed with value-based care in mind.

Under the new rule, providers will be able to accept remuneration paid under a value-based arrangement. Arrangements will be divided into tiers with greater regulatory flexibility available to providers who assume greater financial risk.

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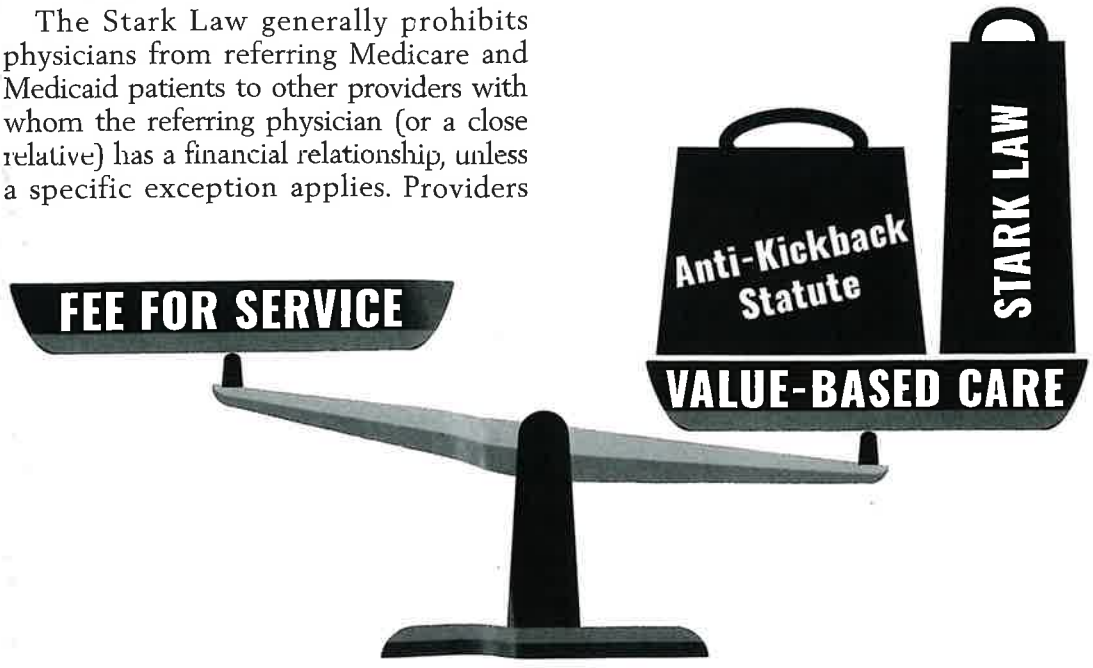

Providers will be able to receive remuneration in 1) value-based arrangements with no financial down side risk; 2) arrangements when a "meaningful downside financial risk" (MDFR) requires the provider forego at least 10% of the remuneration if the value-based arrangement fails to deliver value; or 3) arrangements where a "value-based enterprise" (VBE) assumes "full financial risk" (FFR) and assumes total financial responsibility for patient care for a target population for a specific time frame.

For example, now it is clear that an entity can both refer patients to a physician and withhold a portion of the physician's pay until the physician completes care coordination, or adopts a certain type of patient tracking software.

Providers who participate in value-based arrangements indirectly will also be able to benefit from the new rule.

B. Anti-Kickback Statute

The Anti-Kickback Statute is broader than Stark and prohibits anyone from offering or receiving monetary or in-kind remuneration for services payable by a federal health care program, unless the action generally fits into, or almost fits into, a regulatory safe harbor.

The new rule creates additional safe harbors designed to accommodate value-based arrangements.

A new safe harbor will protect participants in a value-based enterprise from receiving in-kind remuneration from a value-based arrangement, regardless of whether the participants assume any financial risk to facilitate care coordination activities. However, this exception does not extend to monetary remuneration.

For example, a hospital could now provide a staff member who performs care coordination services to a physician group that refers patients to the hospital to help the physician group decrease unnecessary readmissions, subject to the specific parameters of the new safe harbor.

Similar to the new Stark rule, there is also more flexibility for value-based enterprises that assume more financial risk. Under the Anti-Kickback safe harbor, entities that "meaningfully share" in "substantial downside risk" or FFR will be able to receive both monetary and in-kind remuneration.

C. Definitions Matter

Both new rules have specific definitions and regulatory requirements, and while the rules are aligned and similar in nature, they are not identical. Providers wishing to pursue a new value-based arrangement under the new rules will need to make sure their proposed arrangement fits the parameters of both laws.

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New Surprise Billing Law Coming in 2022

In the latest effort to improve transparency in health care costs, Congress passed the "No Surprises Act" (the Act) in December 2020, to protect patients from receiving large, unanticipated bills for out-of-network care.

Surprise billing generally occurs when a patient with insurance receives out-of-network care either 1) when on an emergency basis, for example, the patient is taken by ambulance to an out-of-network hospital during a medical

emergency, or 2) when a patient receives care from an out-of-network provider at an in-network facility, or vice versa.

Typically, in either scenario, patients are unable to choose different providers or are unaware of which providers on the care team are in-network versus out-of-network, and are surprised to receive larger than anticipated bills as a result. The Act has multiple components to prevent or limit these unexpected costs.

A. Notice and Charge Limits

First, the Act states that out-of-network practitioners providing scheduled services at in-network facilities must give advanced written notice to patients about expected out-of-network care, including a good faith estimate of cost and a description of in-network alternatives.

If a patient agrees to move forward after receiving proper notice, providers can continue to charge out-of-network rates. However, this exception does not apply to radiology, pathology, emergency, anesthesiology, diagnostic and neonatal services, or when no in-network option is available.

In scenarios when patients cannot or do not receive notice, or no in-network alternative exists, patients will only be responsible for the "recognized" cost-share amount they would have paid if the care they received had been provided in-network.

The recognized amount may be determined either by (1) state law, and Maryland has such a provision applicable in certain instances, (2) the qualifying payment amount, or (3) in states with all-payer models, as Maryland has for hospital care, an amount approved by the state. Qualifying payment amounts are to be determined by a formula set by the U.S. Department of Health and Human Services (HHS).

B. Independent Dispute Resolution

Uninsured patients will also receive new protections. HHS will establish a new Independent Dispute Resolution (IDR) process for patients to dispute bills that are "substantially in excess" of a good faith estimate.

Providers will also be able to use the IDR process when payment disputes arise with health insurance plans, including "batch disputes" with multiple bills when the service is furnished in the same circumstances (that is, the same provider, facility or plan) or for similar medical conditions.

If the parties are unable to resolve their dispute, they will each submit a final offer to an IDR entity with relevant supporting documentation. After considering various factors, the IDR entity will determine which payment offer, the plan's or the provider's, to accept. The IDR entity will not be allowed to consider public payer rates from Medicare or Medicaid or billed charges when determining the most appropriate offer.

Health care plans will also be required to maintain updated in-network provider lists, and provide patients with "Advanced Explanation of Benefits" prior to scheduled procedures or upon request.

HHS is expected to publish additional regulations relating to the implementation of the Act in the coming months.

The law goes into effect January 1, 2022, so providers should take steps now to revise policies and practices in anticipation of that date.

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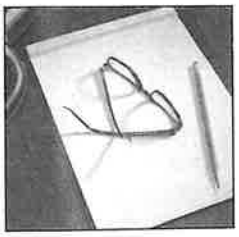

Maryland Regulatory News

1. The Maryland Health Care Commission (HCC) now offers a virtual Telehealth Readiness Assessment tool, that takes about 20 minutes to complete, for small practices to determine their readiness to implement or to grow their telehealth capabilities. The HCC also offers a Telehealth Implementation Program for Ambulatory Practices, in which interested practices partner with a coach to discuss technical requirements and clinical best practices, and to educate staff on telehealth issues.

2. As of March 11, 2021, the Maryland Board of Physicians (MBP) now offers an online application option for physicians who have completed the Federation of State Medical Board's Uniform Application for initial medical

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licensure in Maryland. This online process does not replace the current MBP application, but does streamline the process so providers seeking to practice in Maryland do not have to duplicate basic application information.

3. During the height of the COVID-19 Pandemic, Maryland's Governor Hogan issued an Executive Order that temporarily suspended all licensing renewal deadlines across professions, including health care providers. Governor Hogan recently issued a revised Executive Order that ends the extension, effective June 30, 2021. License holders must renew their license prior to that date to continue practicing.

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New Maryland Health Care Laws

The 2021 Maryland Legislative Session established a host of new requirements that will impact health care providers and insurers in the State. Here are summaries of some of the new legislation.

1. Telehealth

Starting July 1, 2021, non-Medicare insurance coverage and reimbursement requirements will be expanded to include health care services provided by telehealth. Non-medicare health insurance carriers will be required to provide coverage for telehealth regardless of the patient's location at the time the services are provided.

Non-Medicare telehealth coverage must also include counseling and treatment for mental health conditions and substance use disorders, and at least until July 1, 2023, such telehealth will also include audio-only conversations between a health care provider and patient.

Also until July 1, 2023, a non-Medicare carrier must reimburse for telehealth services at the same rate as if the services were provided in person. Medicaid reimbursement requirements will be similarly expanded to include telehealth.

2. Equity Issues

All health care providers, including physicians, nurses, psychologists, pharmacists, dentists and other allied health professionals, will be required to show that they completed an approved implicit bias training program the first time they renew their license or certification after April 1, 2022. Implicit bias is defined in the law to include "prejudicial negative feelings or beliefs about a group that an individual holds without being aware of the feelings or beliefs."

The General Assembly established the new Maryland Commission on Health Equity to identify measures for advancing health equity in the State, as well as provide advice on issues of racial, ethnic, cultural, or socioeconomic health disparities. Legislators also created a process for the designation of Health Equity Resource Communities (HERCs) in Maryland where resources are needed to reduce health disparities. HERCs, designated by the Maryland Community Health Resources Commission, must have a minimum population of 5,000 residents but still be small enough to allow for offered incentives to have a significant impact.

3. Medical Debt Collection

Hospitals will have to comply with new debt collection and reporting requirements starting in January 2022. Notably, hospitals will be required to submit to the Health Services Cost Review Commission (HSCRC) an annual report that includes the number of patients against whom the hospital has filed an action to collect a bad debt and the total dollar amount of the charges for hospital services provided to patients but not collected. Each report will be posted on the HSCRC website.

New debt collection requirements for hospitals also include prohibitions from wage garnishment against patients who are eligible for free or reduced-cost care, prohibitions from filing civil actions to collect debts within 180 days of the initial bill, and prohibitions from reporting to consumer reporting agencies within the same time period.

4. Informed Consent

The age for a minor to give informed consent for health care decisions will be lowered in some situations, from 16 to 12 years of age on October 1, 2021. If a health care provider determines that a minor who is at least 12 years old is mature and capable enough, then

that minor can give informed consent with the same capacity as an adult for consultation, diagnosis and treatment of a mental or emotional disorder by the health care provider or clinic. Minors younger than 16 years of age, however, may not consent to the use of prescription medications to treat mental or emotional disorders unless that consent is authorized under other laws.

5. Physicians

Genetic counselors will need to be licensed by the Maryland Board of Physicians (MBP) on or after January 1, 2024, to practice genetic counseling in the State. The new law defines the practice of genetic counseling, and requires MBP to adopt relevant regulations on licensure and practice.

6. Pharmacists

Pharmacists may substitute a therapeutically equivalent brand-name drug or device product for a prescribed generic equivalent, starting October 1, 2021. Pharmacists are currently required to inform retail consumers of the availability of a lower cost generic alternative. As of October 1, 2021, pharmacists will similarly be required to inform retail consumers of lower cost, brand-name alternatives, as well. The substitution can only be made if the prescription does not indicate that it must be dispensed as directed.

Pharmacy owners must follow customer notification procedures prior to closing a pharmacy for more than seven consecutive days, beginning October 1, 2021. These procedures include posting a notice in the pharmacy and on the website, as well as providing written and verbal notice to each client who picks up prescriptions, at least 14 days before the anticipated closing.

7. Facilities

Assisted living programs that have been appointed as representative payees for residents will be required to submit an annual report on or before June 1, 2021, to the Maryland Consumer Protection Division (CPD) of the Office of the Attorney General. This report will include information about the use of Social Security or other government benefits by residents. The new law, effective October 1, 2021, also requires the State Office of Health Care Quality (OHCQ) to refer allegations of unfair, abusive, or deceptive trade practices by an assisted living program to CPD and to the Office of Inspector General within the Maryland Department of Health (MDH).

Before December 1, 2022, MDH must revise and adopt regulations for assisted living programs and establish the number of staff needed at Alzheimer's special care units, as well as the number of dementia-specific training hours for that staff.

Licensed residential treatment centers, hospitals with a separately identified inpatient psychiatric service, and State mental health facilities are required to report sexual abuse or harassment complaints by a patient within 24 hours of receiving them, as of October 1, 2021. Reports must be made to several agencies, including OHCQ and the Behavioral Health Administration.

If the ownership of a nursing home is transferred to a person who does not own or operate another nursing home in Maryland at the time of transfer, then MDH will conduct an initial full survey within three months of the transfer and an unannounced on-site visit within 120 days of the completed survey, starting October 1, 2021. Currently, MDH makes a survey and site visit of each licensed nursing home once per year.

8. Interstate Licensure Compact

Several new laws allowed Maryland to enter new interstate licensure compacts this year. Interstate licensure compacts are intended to simplify the process of obtaining professional licensure in multiple states. The Psychology Interjurisdictional Compact for psychologists is now effective and authorizes practice via telepsychology to other compact states with some restrictions. The other approved compacts are contingent on the enactment of the law in other states. The Interstate Licensed Professional Counselors Compact, the Audiology and Speech-Language Pathology Interstate Licensure Compact, and the Interstate Occupational Therapy Licensure Compact will become effective if or when a number of additional states pass similar laws.

9. Health Information

The Maryland Health Care Commission (MHCC) is required to adopt regulations for the development and maintenance of a consent management application by the Chesapeake Regional Information System for our Patients (CRISP). The consent management application would allow a person to opt out of having

electronic health information shared or disclosed by a health information exchange (HIE) and requires HIEs to check opt-out status before sharing or disclosing electronic health information. Individuals can currently opt out through an online or mailed form or by telephone.

Starting October 1, 2021, health care providers or their representatives will no longer be allowed to charge a fee for providing copies of medical records requested by a patient to support a claim or appeal for Social Security benefits or Social Security Disability Income.

Starting July 1, 2021, nursing homes will be required to submit clinical information electronically to CRISP when requested by MDH.

10. Pharmacy Benefit Managers

In response to a recent Supreme Court decision, legislators repealed the exclusion of self-funded ERISA plans from a Maryland law that regulates pharmacy benefit managers (PBMs). The law will now be applicable, on the first day of the first plan year beginning on or after January 1, 2022, to contracts between PBMs and purchasers that are health and welfare benefits plans. The Maryland Insurance Administration will report to legislative committees before the end of the year about the scope of the Supreme Court decision and how to apply it to the Maryland's insurance code.

11. Medicaid Coverage

New Medicaid requirements, as of January 1, 2022, include extending coverage for eligible women with family incomes of up to 250% of the federal poverty level from 60 days to one year following the end of pregnancy. Also, Medicaid will only be able to limit the frequency of covered dental cleanings or oral health care to no more than every 120 days within a plan year.

12. Nurses

An advanced practice registered nurse (APRN) will soon be able to delegate nursing or other technical tasks to an assistant as long as the assistant only performs the tasks he or she is trained to perform and the APRN provides on-site supervision of the assistant. The Board of Nursing must first adopt regulations that may establish limitations on or otherwise clarify this delegation authority.

13. Residential Service Agencies

Beginning July 1, 2022, direct care and supervisory staff of residential service agencies, including any agency that employs or contracts with individuals directly for hire as home health care providers, must receive three hours of training on dementia within 45 days of starting employment. Staff already employed at a residential service agency on October 1, 2021, must complete the three-hour training by August 15, 2022.

14. Vending Machines

The sale of over-the-counter drugs in vending machines will no longer be prohibited as of October 1, 2021.

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Ending Antitrust Exemption for Health Insurers

On January 13, 2021, former President Trump signed into law the Competitive Health Insurance Reform Act of 2020 (CHIRA), which repeals the McCarran Ferguson Act's federal antitrust exemption for health insurers.

A. Origins

The McCarran Ferguson Act, enacted in 1945, gave states the power to regulate insurance and granted insurers a federal antitrust exemption. Specifically, the McCarran Ferguson Act exempted from federal antitrust law conduct that (1) constitutes the "business of insurance;" (2) is regulated by existing state law; and (3) does not constitute an act of boycott, coercion or intimidation.

Historically, courts have applied a narrow three-pronged test to determine whether the challenged conduct constitutes the "business of insurance." The test, which the United States Supreme Court announced in *Group Life & Health Insurance Co. v. Royal Drug Co.*, considers:

(1) Whether the conduct had the effect of transferring a policyholder's risk;

(2) Whether the conduct was an integral part of the policy relationship between insurer and policyholder; and

(3) Whether the conduct was limited to entities within the insurance industry.

B. Eliminating the Exemption

CHIRA effectively eliminates the McCarran Ferguson immunity for insurers engaged in the "business of health insurance." The operative language in the new law states: "Nothing contained in this Act shall modify, impair, or supersede the operation of any of the antitrust laws with respect to the business of health insurance (including the business of dental insurance and limited-scope dental benefits)."

CHIRA also clarifies that the Federal Trade Commission Act (FTCA) applies to all health insurers regardless of whether they are for profit or not. This is because the FTCA has been interpreted to exclude most non-profit entities due to its definition of the term "corporation," which only references entities operating for profit.

CHIRA, however, maintains immunity for agreements among health insurers:

(1) to collect, to compile or to disseminate historical loss data;

(2) to determine a loss development factor applicable to historical loss data;

(3) to perform actuarial services if such agreements do not involve a restraint of trade; and

(4) to develop or to disseminate a standard insurance policy form (including a standard addendum to an insurance policy form and standard terminology in an insurance policy) if such agreements do not require adherence to such standard form.

CHIRA also excludes insurers engaged in the business of life insurance (including annuities) and property or casualty insurance from the term "business of health insurance."

C. Practical Effects of CHIRA

Although it is too soon to predict the long-term consequences of CHIRA, opponents of the new law argue that CHIRA will:

- Result in increased and costly private antitrust litigation in both state and federal courts;
- Create conflicts between state and federal oversight requirements;
- Undermine existing state insurance regulations; and
- Increase antitrust scrutiny and risk for conduct that had been exempted previously under McCarran-Ferguson.

Notwithstanding the foregoing predictions, the impact of CHIRA is likely limited. Health insurers have always been subject to antitrust regulation under state laws. Further, the McCarran-Ferguson Act exemption was narrow, and already excluded many health insurer activities, such as mergers between health insurers and market allocation agreements. Nevertheless, health insurers should revisit previously exempt business practices, and exercise antitrust caution in light of CHIRA.

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Did You Know?

HHS Guidance: Did you know that after a 2019 Supreme Court decision found that the U.S. Department of Health and Human Services (HHS) improperly made significant changes to Medicare payment rates via guidance, HHS recently issued a rule reiterating that it cannot impose binding requirements on the health care industry via guidance? Although HHS can still issue guidance, HHS can no longer do so if the guidance would have an annual impact of $100 million or more, or if the guidance relates to a novel legal issue. Further, it can only issue guidance on even non-significant matters after a notice and comment period. HHS must also post all past and future guidance to an online database, and any guidance not added to the database will be considered rescinded. Interested parties may also petition HHS to correct guidance perceived to be unlawful.

Discovery of Credential Committee Records: Did you know that a hospital's credentialing committee records may be discoverable? In *Palmer v. Christina Care Health Services, Inc*, a Delaware court recently allowed an injured party in a medical malpractice case to conduct some discovery into records provided to or shared by the hospital's credentialing committee. While records generated as a part of a peer review process are generally privileged, the court concluded that a credentialing committee's work is typically more focused on personnel decisions that would not be protected by the same privilege.

End of Life Care: Did you know that the Maryland Hospital Association, MedChi, Maryland AARP and other groups have formed the Maryland Honoring Choices Coalition to educate Marylanders about end-of-life care and to ensure that choices about such care are respected through the use of advance health care directives? Interested organizations can learn more or join the coalition at http://www.medchi.org/Maryland-Honoring-Choices-Coalition.

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Coming in Future Issues

- **New Referral Exceptions**
- **COVID-19 Immunity**
- **American Recovery Act**