**BOARD OF PODIATRIC MEDICAL EXAMINERS**

**OPEN SESSION MEETING VIA GOOGLE MEET**

**AGENDA**

**June 11, 2021**

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

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

**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 May 13, 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** **Tab C**

**E. NEW BUSINESS:**

1. **Topics Quarterly Newsletter Volume 36/No. 1 Spring 2021 from Gordon, Feinblatt, Rothman & Hollander** **Tab B**
2. **Review eligibility for issuance of Full Active Podiatric License:**
   a. **Gurvikram Boparai, DPM**

**H. ADJOURNMENT**

A

**BOARD OF PODIATRIC MEDICAL EXAMINERS**

**OPEN SESSION MEETING VIA GOOGLE MEET**

**MINUTES**

**May 13, 2021**

**Location: https://meet.google.com/qaj-tuba-bvv?hs=224**

**Join by Phone: (US) +1 240-560-3699 (PIN: 979436218)**

**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, Cohen, Silverman, Gottlieb and Fox**

**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: Richard Bloch, Esq., Executive Director, and 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 March 11, 2021 meeting**

The minutes from the March 11, 2021 meeting were approved unanimously, as submitted.

**B. BOARD PRESIDENT'S REPORT -Dr. Umezurike**

Dr. Umezurike discussed updates from the most recent Federation meeting that she and Ms. Schwartz attended.

**C. EXECUTIVE DIRECTOR'S REPORT-Eva Schwartz**

**1. Report on the NPDB Guidebook: https://www.npdb.hrsa.gov/resources/NPDBGuidebook.pdf**

Ms. Schwartz distributed the National Practitioner Data Bank Guidebook for informational purposes. There was discussion on how the process to perform a data bank search is now regulated.

**D. OLD BUSINESS:**

**1. HB 182/SB 169 – Podiatric Physician**

The Board discussed HB 182/SB 169 – Podiatric Physician and how it never left the Subcommittee Hearing in HGO. The MPMA may introduce the Bill next legislative session.

**2. SB 247-State Board of Podiatric Medical Examiners Sunset Extension**

The Board was made aware that SB 247- State Board of Podiatric Medical Examiners Sunset Extension has passed unanimously.

**4. SB 952 - Health Occupations – Internship and Residency Training Requirements – Waiver for Former Service Members Injured in Combat**

The Board was made aware that SB 952- Health Occupations – Internship and Residency Training Requirements – Waiver for Former Service Members Injured in Combat did not pass.

**5. SB 005- Public Health – Implicit Bias Training and the Office of Minority Health and Health Disparities**

The Board discussed SB 005 which requires all initial and first-time renewal licensees to complete a mandatory Implicit Bias training program approved by the Cultural and Linguistic Healthcare Professional Competency Program. The Bill did pass and is expected to be in effect by October 1, 2021.

**6. COMAR 10.40.12.01-.06 Telehealth (BOARD OF PODIATRIC MEDICAL EXAMINERS)**

The Board was made aware that the proposed regulations were signed and approved by the Secretary and have moved to the AELR committee in Annapolis for their 15 day review. Once approved, the regulations will be posted in the register for 30 days for public comment. The finalized regulations will be posted on the Board's website.

**7. Changes in CME Requirements for the 2022-2023 Licensure Cycle:**

The Board has recognized the hardships and safety issues ensued by the COVID-19 pandemic, and based on those concerns, has changed the CME requirements ONLY for the duration of the 12-1-2019 through 12-1- 2021 accrual window, which covers the 2022-2023 licensure renewal cycle.

ALL 50 CME's may be attained online or in person, including the CPR for the non-lapsing certification, HOWEVER, 25 of the CME's, must be specific to podiatric medicine. CPR re-certification may be included as part of this specific CME accrual category.

**E. NEW BUSINESS:**

**1. MEDCHI- Medical Records Copying Fee as of February 2021**

The Board was given a copy of MEDCHI's most recent medical records copy fee schedule for informational purposes.

**2. Topics Quarterly Newsletter Volume 35/No. 4 Winter 2020 from Gordon, Feinblatt, Rothman & Hollander**

The Board received a copy of the Topics Quarterly Newsletter Volume 35/No. 4 Winter 2020 from Gordan, Feinblatt, Rothman, & Hollander for informational purposes.

**3. NPDB Insights**

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

**4. AMA to Consider Resolution with Goal of Allowing DPMS to Take USMLE Exams**

The Board discussed many major concerns over the AMA's proposed resolution to allow podiatrists to take the USMLE Exams. If passed, educational standards of universities could be in jeopardy and new licensing issues may arise. Dr. LeBow informed the Board that the Federation was not happy with the proposed plan.

**5. Review eligibility for issuance of Full Active Podiatric License:**

**a. Daphne Davis, DPM**

**b. Anthony Camarda, DPM**

**c. Zahra Dehghani, DPM**

**d. Trevor Klinkner, DPM**

**e. Bakr Asif, DPM**

**f. Milton Rosario, DPM**

**g. Scott Burstyn, DPM**

**h. Su Kim, DPM**

The above individually identified licensure candidates were approved for the issuance of a Full Maryland License. One Board member abstained from the vote on licensure for Dr. Kim.

**F. OTHER**

**1.** The Board expressed their gratitude and said a heartfelt farewell to Board member, Phillip Cohen DPM, who will be retiring from the Board prior to the June meeting.

**G. ADJOURNMENT**

**With no further business, the Public Session of the Board meeting concluded at 1:58 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:** _____

VOL. 36/NO. 1 SPRING 2021

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B

# Topics

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



## *New Test for Expert Testimony*

Physicians are often called upon to give expert testimony. They are asked to give their opinions as to whether a particular course of treatment did or did not meet community standards, or whether a particular course of treatment was an acceptable method, albeit cutting edge, or a little behind the times.

Now, the test for whether specific scientific evidence should or should not be admitted in a case has changed, or at least evolved, in Maryland.

### A. *Daubert*

In 1993, in *Daubert v. Merrill Dow Pharmaceuticals*, the U.S. Supreme Court established standards to evaluate the admissibility of expert testimony. The Supreme Court introduced a five-part test of non-exclusive factors for trial courts to consider when weighing whether scientific expert testimony should be admitted into evidence.

Among other factors, the *Daubert* test includes whether or not a theory or technique can be tested; and whether the expert testimony is an "unjustifiable extrapolation" from an "accepted premise to an unfounded conclusion." As a result, a *Daubert* test often requires a trial judge to have at least a basic understanding of the science at issue to assess the admissibility of opinion testimony.

### B. *Frye-Reed*

Until recently, Maryland courts have not formally used the *Daubert* standard to assess the admissibility of expert witness testimony. Instead, Maryland courts have relied on a test, known as the *Frye-Reed* test.

*continued on page 2*

The *Frye-Reed* test originated from a 1923 case in which the District of Columbia Court of Appeals held that the test for determining the admissibility of expert testimony was whether the basis of the scientific opinion offered into evidence was "generally accepted as reliable within the expert's relevant scientific community."

Now, in an August 2020 opinion in *Rochkind v. Stevenson*, Maryland's highest appellate court has formally retired the *Frye-Reed* test, and has adopted Daubert as controlling law in Maryland.

### C. *Rochkind*

Upon reaching the age of 20, Starlena Stevenson filed a negligence lawsuit against her landlord alleging that she suffered from psychological disorders and injuries as a result of her exposure to lead paint as a child. During the litigation, one of Stevenson's expert witnesses, Dr. Hall-Carrington, opined in a medical report that her lead poisoning was a significant contributing factor in causing her neuropsychological problems.

The landlord sought to exclude Hall-Carrington's opinion under the *Frye-Reed* test. However, the opinion was admitted into evidence by the trial judge, and the jury subsequently entered a significant verdict in favor of Ms. Stevenson.

In deciding the case, Maryland's highest appellate court said the *Daubert* test was generally more flexible than the "general acceptance" test of *Frye-Reed*, which the court noted was "uncompromising." Further, the court explained that while Maryland has historically refrained from explicitly adopting the *Daubert* standard, Maryland courts have been continuously expanding the *Frye-Reed* test over time, such that the test has "drifted" to very much resemble the *Daubert* standard.

However, to prevent further confusion, Maryland's highest appellate court held that it was now time formally to adopt *Daubert* as the standard to govern the admissibility of expert testimony in Maryland.

More specifically, the court in *Rochkind* set forth 10 non-exclusive factors that should be considered when assessing the admissibility of expert opinion testimony. These factors include, among other things: whether or not a theory can be tested; whether the theory is subject to peer review or publication; whether the theory or technique is generally accepted; and whether the expert has accounted for obvious alternative explanations.

Accordingly, the appellate court in *Rochkind* sent the case back to the trial court to implement Maryland's new tests for assessing the admissibility of expert testimony.

### D. Consequences

Unlike the *Frye-Reed* test, the *Daubert* test generally gives trial courts greater discretion to admit novel expert testimony, as long as it is based on sound scientific principles.

Indeed, Maryland's adoption of *Daubert* might open some doors for those seeking to use cutting-edge science as a factual basis for expert opinion. In such cases, a *Daubert* analysis will likely shift the focus away from whether a test is generally accepted within a scientific community, and focus more squarely on the reliability of the methodology used to arrive at the opinion.

On the other hand, while the *Rochkind* decision seems intended to bring clarity for those seeking to admit or exclude expert testimony in Maryland, trial judges now have 10 factors to weigh instead of one. Further, while *Frye-Reed* test did not require a court to wade into a deep understanding of the expert opinion to determine whether it was generally accepted, *Rochkind* seems to require such a deeper analysis.

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


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Notwithstanding the above, *Rochkind* may not dramatically change the way Maryland courts assess opinion admissibility. Indeed, as Maryland's highest appellate court noted in its opinion, implementation of *Frye-Reed* in Maryland had already "drifted" to very much resemble *Daubert*.

Many Maryland courts had already been considering various *Daubert* factors when assessing the admissibility of expert testimony. Therefore, only time will tell if *Rochkind* will significantly modify the way Maryland courts assess the admissibility of expert testimony.

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# *Selling to Private Equity*

*This is the third part of a three-part series of articles pertaining to the sale of physician practices to private equity firms. The first installment addressed the environment that is encouraging such sales, as well as the purchase price of such sales. The second installment pertained to tax considerations and allocations of the purchase price. This third installment discusses the deal structure, and the pros and cons of such sales.*

Prior to the COVID-19 crisis, physicians were selling their practices to private equity companies at an ever-increasing pace. While those acquisitions have slowed, the pace will likely quicken as health care begins to normalize. Accordingly, it is important for physicians to understand the reasons, elements and pros and cons of such transactions.

### A. Due Diligence

Once a purchase price is agreed upon between a private equity firm and a physician practice, the private equity firm will have its lawyers and its consultants perform due diligence on the physician practice target to confirm that the financial information being relied upon is correct, and to determine if there are irregularities that would give the buyer headaches in the future.

The buyer's due diligence will focus on, among other things, the physician practice's relationships with entities to which it refers, and entities that refer to it, to make sure the relationships are in compliance with applicable law. Similarly, the due diligence will try to determine if the practice entity has any billing irregularities, including any upcoding.

In fact, although all physician practices should have vibrant compliance programs and always be structured in compliance with applicable law, it is often a private equity firm's "due diligence police" that will uncover an irregularity before a regulator might find that irregularity.

Therefore, physician practices that are imagining an eventual sale to a private equity company have an additional reason to comply with the law, namely to avoid a private equity company backing out of a lucrative deal because of the irregularities that the due diligence police find during their examination of the practice.

### B. Deal Structure

The acquisition documents of a private equity firm's purchase of a physician practice are similar to the acquisition documents used in the purchase and sale of any business. The seller will make representations and warranties about itself, and indemnify the buyer from breaches of those promises and from liabilities that pre-date the purchase.

The parties will negotiate how long that indemnification will expose the seller, whether there is any tolerance before the indemnification is triggered, and whether some of the purchase price will be held back or placed in escrow to support such indemnification.

### C. Organizational Structure

The law in all 50 states varies with respect to whether people who are not licensed to practice medicine may own a company that practices medicine. As a result, the target physician practice may often be purchased by a captive physician practice that is actually owned by a nominee physician, with that captive practice being subject to a management agreement.

That management agreement will provide that money not needed to pay physicians and other clinicians is transferred to the management company, and it will actually be the

*continued on page 4*

management company that is owned by the private equity firm.

In this regard, it is significant to note that private equity funds are different than management companies. Private equity funds expect to receive current earnings from their portfolio companies, but their focus is to profit from the sale of their interests, while a management company's focus is on current earnings via management.

### D. Pros and Cons

The most significant pro involved in a physician's sale to private equity is the potentially lucrative purchase price, especially for baby boomer owners looking for an exit strategy.

The transaction may also provide access to new capital to support growth, offer management expertise, capitalize on brand recognition, give the practice an ability to build out ancillary services, create cost savings from consolidating back office functions, achieve other economies of scale, and perhaps allow for more favorable contracts with payors.

The cons of doing such a deal include losing control of the practice and living through a significant change in practice culture. Curiously, private equity firms often leave physicians alone to be physicians, but major decisions, such as hiring and firing or changing office locations, will no longer be made by the previous owners. In fact, it is often difficult for such owners to learn to become employees.

However, perhaps the most significant con to selling to private equity firms involves wrestling with the question of who is the next owner. Private equity firms will resell the practice and no one knows who the eventual purchaser will be.

The eventual purchaser may be a very efficient professional manager, which would be a good outcome. On the other hand, the physician practice may turn into a hot potato, and be sold from one private equity firm to another, until a private equity firm buys the practice for too much money. Also, the first private equity firm or a subsequent private equity firm may be using debt to finance its purchases, as opposed to investors' money, and that debt could eventually weigh down the practice in its entirety.

There is also the ultimate risk of physician loyalty. People usually seek out a physician's services due to the skill and reputation of the physician. If the private equity firm cannot attract and retain good physicians, then the enterprise will not succeed.

### E. Hospital System versus Private Equity

There are differences between being purchased by a private equity firm versus being purchased by a local hospital system.

The most significant difference is the sale price. Hospital systems are not paying physicians multiples of earnings before interest, taxes, depreciation, and amortization (EBITDA) for their practices. Hospitals are prohibited from doing so, because the extra payment may be viewed as a payment for future referrals to the hospital system.

There is an exception to the foregoing. If the physician is actually intending to retire after the sale, in which case there would not be future referrals, a hospital system can pay some additional amounts in that situation.

Otherwise, hospital systems sometimes pay signing or retention bonuses. However, generally, hospitals only pay for the assets that they purchase, and sometimes pay for something called workforce in place. Workforce in place is basically a headhunting fee equal to a percentage of the acquired practice's payroll, paid in consideration of the acquired practice having developed its workforce.

Both hospitals and private equity firms will allow an acquired practice to retain its accounts receivable, and both may advance or reimburse a selling physician for the cost of the doctor obtaining a malpractice tail to cover his or her prior acts.

On the other hand, ongoing compensation may be much more generous from a local hospital system than a private equity firm. In fact, future compensation from a hospital system may even include a raise, recognizing that the hospital system may have better contracts with payors than the acquired practice.

Ongoing compensation from a hospital system might also be based on wRVUs, which would relieve the physician from worrying whether a patient is a Medicaid patient, Medicare patient or has commercial insurance.

Hospital systems, however, have difficulties in paying acquired physicians for the ancillaries that they generate, due to certain legal restraints, notwithstanding that the acquired physicians may have historically profited from the ancillaries that they provided in their own practices. Nevertheless, hospital systems can be creative in this regard, and can share some of such profits with physicians, provided that certain legal requirements are met.

Often there is more room to negotiate some flexibility in regard to non-compete provisions with an acquisition by a hospital system, rather than private equity firms.

While the headaches of management are relieved by a sale to either a local hospital system or a private equity firm, curiously, hospital systems sometimes get more involved in a doctor's doctoring than private equity firms.

While all local hospitals will not survive, many will, and, therefore, there is greater stability involved in selling to a hospital system versus not knowing to whom the private equity firm will sell the physician's practice in three to five years.

Once physician revenue stabilizes after the COVID-19 crisis, all of the environmental factors, such as money attracting money and market fragmentation, will still exist, and, therefore, the volume of private equity physician acquisition deals in the future will remain significant.

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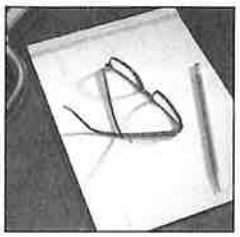

# *Maryland Regulatory News*

**1.** Following the retirement of State Secretary of Health Robert R. Neall in December 2020, Governor Hogan nominated Acting Secretary of Health Dennis R. Schrader as his replacement. Secretary Schrader has prior experience as the Deputy Administrator of the Federal Emergency Management Agency and at the University of Maryland Medical System where he focused on major project development and hospital operations.

**2.** Governor Hogan accelerated planned rate increases for Medicaid behavioral health and long-term care services. Legislation passed in 2019 called for a rate hike by July 1, 2021, but Governor Hogan announced that the new rates go into effect on January 1, 2021. Nursing facilities, Rare and Expensive Care Management (REM) and private duty nursing, among other services, all received a 4% increase. Applied behavioral analysis, therapeutic behavioral services, mental health care and behavioral health home programs are among the services that received a 3.5% payment increase.

**3.** In January 2021, the Maryland Department of Health launched "Operation Courage," a support program designed to address the mental health needs of frontline workers and first responders who have led the ongoing fight against the COVID-19 pandemic. This program, established in response to data that indicates that more than half of essential health care workers are experiencing adverse mental health symptoms stemming from their role in addressing the pandemic, offers a free online assessment and a consultation. Providers needing further care will be eligible for up to six weeks of therapy, with waived co-pays where possible and a sliding scale fee schedule to make the program accessible to those without insurance. A similar program, the Maryland COVID-19 Crisis Support Program, offers free mental health services to employees of long-term care facilities.

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# *New Information Blocking Rule*

When relying on a variety of different health care providers for care, patients frequently encounter challenges accessing their medical records or transferring information from one provider to another. Health care professionals encounter the same roadblocks when their practices transition to a new electronic health record (EHR) platform or they try to send information from their EHR platform to other providers, clinical databases, or local health information exchanges that do not use compatible software.

A new rule from the U.S. Department of Health and Human Services (HHS) Office of the National Coordination for Health IT (ONC) is scheduled to go into effect April 5, 2021, to facilitate increased patient and systemic access to electronic health information (EHI) by encouraging EHR interoperability and by limiting information blocking practices.

### A. What are Interoperability and Information Blocking?

Interoperability is the seamless sharing of information between different systems. In this case, because HHS acknowledges that providers choose from a variety of EHR systems to meet their needs, the new rule is designed to encourage technical practices and innovation to facilitate the transfer of information between different EHR platforms.

Information blocking is any action that a provider knows will hinder or even just discourage a patient, other providers, or payors from accessing EHI, and the new rule prohibits it, unless the provider with the EHI is required to withhold the information by law or meets one of several exceptions outlined in the rule.

### B. Safe Harbors, Remedies and Penalties

Information blocking exceptions or safe harbors include blocking the release of EHI to prevent harm to the patient or another person, to protect the patient's privacy, to protect the security of the EHI, or when access is technically infeasible or temporarily unavailable because of events such as system maintenance.

If a provider's actions fail to meet a specific exception that does not automatically mean a provider is information blocking, though it may prompt a fact driven inquiry into the provider's intent, ability to control the interoperability of the data, and the effect of the action.

In addition to prohibiting providers from stopping or delaying the flow of data, the rule contains affirmative rights for patients. For example, patients can request that their doctor send their EHI to a third-party app of the patient's choosing free of charge.

The U.S. Office of Inspector General has proposed that information blocking could result in fines of up to one million dollars, though the total would depend on the specific facts of the case.

### C. Additional Changes

In addition to the new information blocking rule, HHS is considering additional steps to increase ease of patient access to medical records. Under proposed rules relating to the Health Insurance Portability and Accountability Act (HIPAA), HHS would require providers to respond to patient requests for medical records in 15 days, instead of 30 days.

HHS will consider comments on this proposal in the spring of 2021, with possible implementation later this year.

### D. Recommendations

As a result of the new information blocking rule, providers should review their existing EHI policies, coordinate with IT platforms and other providers to increase system interoperability, and review agreements to make sure that data sharing is not overly burdensome or restricted.

The rule also contains more detail about the parameters of each exception outlined above, so before denying or delaying a request for EHI, providers may want to consult their health care attorney to determine if the provider's actions meet a safe harbor's requirements.

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# *Did You Know?*

**Medicare Payment Increase:** Did you know that, although the 2021 Medicare Fee Schedule originally proposed cuts to the payment rate of certain specialists, including radiologists, physical therapists, anesthesiologists, cardiac and general surgeons, and infectious disease doctors, more than 400 medical groups lobbied Congress to intervene, resulting in a bipartisan effort to eliminate the cuts? The proposed cuts sparked outrage from specialists, many of whom lost revenue as elective procedures declined or were temporarily prohibited due to COVID-19. Instead, the Consolidated Appropriations Act passed in December 2020 contained a 3.75% increase in Medicare payments for all providers.

**Telehealth:** Did you know that as the use of telehealth continues to surge during the COVID-19 pandemic, HHS has made it easier for patients to access care by allowing providers to deliver certain types of telehealth across state lines regardless of local rules? This declaration, made under the Public Readiness and Emergency Preparedness Act (PREP Act), allows licensed providers to order and to administer HHS-approved COVID-19 countermeasures via telehealth, for the duration of the public health emergency.

**Nursing Home Arbitration:** Did you know that a federal court in Arkansas, in *Northport v. HHS*, recently held that long-term facilities must comply with 2019 Centers for Medicare & Medicaid Services rules about pre-dispute arbitration agreements? The rules set procedural parameters on the use of arbitration agreements, such as requiring nursing homes to explain fully the rule in the patient's language and making clear that admission does not hinge on the patient's agreement to arbitrate.

**Doctors Strict Liability:** Did you know that a Connecticut court held that a doctor who had recommended and used an ultimately defective mesh product to treat a patient was not strictly liable for the resulting damages? In *Farrell v. Johnson & Johnson*, the patient, in addition to suing the product's manufacturer, sued the surgeon who implanted the mesh product. While some jurisdictions have extended strict liability for express misrepresentations in commercial transactions, the patient here sought to extend strict liability to a misrepresentation in the treatment setting. The court held that the doctor could not be strictly liable for his alleged misrepresentation of the mesh, because the doctor was not a seller of the product, and the patient primarily sought the doctor's service for treatment, not specifically to purchase the product. Further, the court observed that while sellers often rely on statements of fact, doctors generally provide opinions.

**Future Blues Competition:** Did you know that the Blue Cross Blue and Blue Shield Associations (BCBS) agreed to pay $2.67 billion to settle an antitrust claim which alleged that the "Blues," consisting of a dozen independent insurers affiliated with BCBS, illegally divided the U.S. health insurance market based on geographic "service areas" to avoid competing with each other? BCBS also agreed to a "monitoring committee" that will oversee changes to BCBS' rules and regulations to prevent potential antitrust violations in the future. However, the payout does not end the litigation because a group of health care providers who raised the same claim, and are now seeking class action status, were not parties to the settlement.

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## Gordon Feinblatt's on the Move!

Gordon Feinblatt is moving to its new space at 1001 Fleet Street in Baltimore after more than 50 years in the historic Garrett Building on Redwood Street. Our attorneys and staff are expected to occupy this new location in the spring. Follow us on Twitter or LinkedIn @GordonFeinblatt so we can keep you posted on our move to the Harbor East community and other informative updates.

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# *Maryland's Hospital Rates Deliver Savings*

In the past 10 years, the Center for Medicare and Medicaid Innovation (Innovation Center) has piloted more than 50 payment models in various jurisdictions aimed at decreasing spending and increasing quality. Of all the pilots, only five have actually delivered savings, including Maryland's hospital rate setting system.

For decades, Maryland has operated under a unique Medicare waiver that allows Maryland's Health Services Cost Review Commission to set the rates paid by all payors at each hospital in the State. The program has evolved over time, most recently shifting to a global budget model in 2014, pursuant to an Innovation Center pilot program.

Under this model, a total revenue ceiling is established for each hospital based on the hospital's annual revenue in 2013. Those budgets are then periodically adjusted to reflect inflation, the results of quality indicators, and service changes.

Under this pilot, Maryland's total Medicare spending declined by more than $25 per Medicare beneficiary per month since 2014. Those savings were driven by significant reductions in hospital outpatient expenditures and inpatient admissions. As a result, Maryland is credited with saving Medicare approximately $679 million over three years, which far exceeds the pilot's minimum savings target.

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**Coming in Future Issues**

- **New Referral Exceptions**
- **Surprise Medical Bills**
- **Competitive Health Insurance**
- **COVID-19 Immunity**

Good evening everyone.

Despite the Secretary signing off on the regs, the Governor's office is taking issue with the regs not being consistent with the verbiage that passed in HB 123/SB 3 - Preserve Telehealth Access Act of 2021. There was some discussion provided by the Boards' AAGs that the "audio-only" portion of the bill would not apply to us because the bill involved the Health-General Article, not Health Occupations. As you know, we were all required to make our regs consistent with one another and we used the Physicians' draft as our template. The language used in the regulations proposals state (not all are exactly the same):

*(7) Telehealth.*

*(a) "Telehealth" means a mode of delivering health care services through the use of telecommunications technologies by a health care practitioner to a patient at a different physical location than the health care practitioner.*

*(b) "Telehealth" includes synchronous and asynchronous interactions.*

*(c) "Telehealth" does not include the provision of health care services solely through:*

*(i) Audio-only calls;*

*(ii) Email messages; or*

*(iii) Facsimile transmissions.*

The pertinent language in the bill is (highlighted in green):

(4) "HEALTH CARE PROVIDER" MEANS:

(I) A PERSON WHO IS LICENSED, CERTIFIED, OR OTHERWISE AUTHORIZED UNDER THE HEALTH OCCUPATIONS ARTICLE TO PROVIDE HEALTH CARE IN THE ORDINARY COURSE OF BUSINESS OR PRACTICE OF A PROFESSION OR IN AN APPROVED EDUCATION OR TRAINING PROGRAM;

(II) A MENTAL HEALTH AND SUBSTANCE USE DISORDER PROGRAM LICENSED IN ACCORDANCE WITH § 7.5–401 OF THIS ARTICLE;

(7) (I) "TELEHEALTH" MEANS THE DELIVERY OF MEDICALLY NECESSARY SOMATIC, DENTAL, OR BEHAVIORAL HEALTH SERVICES TO A PATIENT AT AN ORIGINATING SITE BY A DISTANT SITE PROVIDER THROUGH THE USE OF TECHNOLOGY–ASSISTED COMMUNICATION.

(II) "Telehealth" includes:

1. SYNCHRONOUS and asynchronous interactions;

2. FROM JULY 1, 2021, TO JUNE 30, 2023, BOTH INCLUSIVE, AN AUDIO–ONLY TELEPHONE CONVERSATION BETWEEN A HEALTH CARE PROVIDER AND A PATIENT THAT RESULTS IN THE DELIVERY OF A BILLABLE, COVERED HEALTH CARE SERVICE; AND

3. REMOTE PATIENT MONITORING SERVICES.

So here's the problem...We are being told that the regs must conform to the bill by removing (c)(i) from the definition of telehealth (see highlighted section). The State wants this because many people don't have computer access. I believe this is a substantive change to what has already been voted on so this may require another Board vote in an open meeting. For some boards, this may require an emergency meeting. In order for these regs to move to the next step (the AELR Committee), everyone has to agree to make this change. Those that choose not to, will not get a sign off from the Governor's Office.

So, here's the plan:

.01 Scope.
A. This chapter governs the practice of [health occupation] using telehealth as an adjunct to, or replacement for, in-person patient visits.
*B. Nothing in these regulations restricts or limits reimbursement requirements pursuant to the Health General and Insurance Articles of the Annotated Code of Maryland.*

MARYLAND REGISTER

# Proposed Action on Regulations

| Transmittal Sheet<br><br>**PROPOSED OR REPROPOSED**<br><br>**Actions on Regulations** | **Date Filed with AELR Committee** | **TO BE COMPLETED BY DSD**<br>Date Filed with Division of State Documents<br><br>Document Number<br><br>Date of Publication in MD Register |
|---|---|---|

**1. Desired date of publication in Maryland Register:**

**2. COMAR Codification**

| Title | Subtitle | Chapter | Regulation |
|---|---|---|---|
| 10 | 40 | 12 | 01-.06 |

**3. Name of Promulgating Authority**

Maryland Department of Health

**4. Name of Regulations Coordinator**
Jason Caplan

**Telephone Number**
410-767-6499

**Mailing Address**

201 West Preston Street

| City | State | Zip Code |
|---|---|---|
| Baltimore | MD | 21201 |

**Email**
Jason.caplan2@maryland.gov

**5. Name of Person to Call About this Document**
Lillian Reese

**Telephone No.**
410-764-5978

**Email Address**
lillian.reese@maryland.gov

**6. Check applicable items:**

**X-** New Regulations

_ Amendments to Existing Regulations
Date when existing text was downloaded from COMAR online: .

_ Repeal of Existing Regulations

_ Recodification

_ Incorporation by Reference of Documents Requiring DSD Approval

_ Reproposal of Substantively Different Text:

: Md. R

(vol.) (issue) (page nos) (date)

Under Maryland Register docket no.: --P.

**7. Is there emergency text which is identical to this proposal:**

_ Yes **X-** No

**8. Incorporation by Reference**

_ Check if applicable: Incorporation by Reference (IBR) approval form(s) attached and 18 copies of documents proposed for incorporation submitted to DSD. (Submit 18 paper copies of IBR document to DSD and one copy to AELR.)

**9. Public Body - Open Meeting**

**X-** OPTIONAL - If promulgating authority is a public body, check to include a sentence in the Notice of Proposed Action that proposed action was considered at an open meeting held pursuant to General Provisions Article, §3-302(c), Annotated Code of Maryland.

_ OPTIONAL - If promulgating authority is a public body, check to include a paragraph that final action will be considered at an open meeting.

**10. Children's Environmental Health and Protection**

_ Check if the system should send a copy of the proposal to the Children's Environmental Health and Protection Advisory Council.

**11. Certificate of Authorized Officer**

I certify that the attached document is in compliance with the Administrative Procedure Act. I also certify that the attached text has been approved for legality by Rhonda Edwards, Assistant Attorney General, (telephone #410-767-6023) on October 8, 2020. A written copy of the approval is on file at this agency.

**Name of Authorized Officer**
Dennis R. Schrader

**Title** **Telephone No.**
Secretary of Health 410-767-6500

**Date**

# Title 10
# MARYLAND DEPARTMENT OF HEALTH
## Subtitle 40 BOARD OF PODIATRIC MEDICAL EXAMINERS
### 10.40.12 Telehealth

Authority: Health Occupations Article, §§1-1001—1-1006, Annotated Code of Maryland

**Notice of Proposed Action**

[]

The Secretary of Health proposes to adopt new Regulations .01—.06 under a new chapter, COMAR 10.40.12 Telehealth.
This action was considered by the Board of Podiatric Medical Examiners at a public meeting on October 8, 2020, notice of which was given by publication on the Board's website at https://health.maryland.gov/mbpme/Pages/index.aspx pursuant to General Provisions Article, §3–302(c), Annotated Code of Maryland.

**Statement of Purpose**

The purpose of this action is to provide new guidelines for podiatrists from which to practice telehealth pursuant to Chapters 15 and 16 (HB 448 and SB 402), Acts of 2020.

**Comparison to Federal Standards**

There is no corresponding federal standard to this proposed action.

**Estimate of Economic Impact**

The proposed action has no economic impact.

**Economic Impact on Small Businesses**

The proposed action has minimal or no economic impact on small businesses.

**Impact on Individuals with Disabilities**

The proposed action has no impact on individuals with disabilities.

**Opportunity for Public Comment**

Comments may be sent to Jason Caplan, Director, Office of Regulation and Policy Coordination, Maryland Department of Health, 201 West Preston Street, Room 512, Baltimore, MD 21201, or call 410-767-6499 TTY: 800-735-2258, or email to mdh.regs@maryland.gov, or fax to 410-767-6483. Comments will be accepted through . A public hearing has not been scheduled.

**Economic Impact Statement Part C**

A. Fiscal Year in which regulations will become effective: FY 2022
B. Does the budget for the fiscal year in which regulations become effective contain funds to implement the regulations?

C. If 'yes', state whether general, special (exact name), or federal funds will be used:

D. If 'no', identify the source(s) of funds necessary for implementation of these regulations:

E. If these regulations have no economic impact under Part A, indicate reason briefly:
These regulations define telehealth and establish procedures for podiatrists using telehealth in their practice.
F. If these regulations have minimal or no economic impact on small businesses under Part B, indicate the reason and attach small business worksheet.
See E. above.
G. Small Business Worksheet:

Attached Document:

# Title 10

# MARYLAND DEPARTMENT OF HEALTH

## Subtitle 40 BOARD OF PODIATRIC MEDICAL EXAMINERS

### *10.40.12 Telehealth*

*Authority: Health Occupations Article, §§1-1001—1-1006, Annotated Code of Maryland*

***.01 Scope.***

*This chapter governs the practice of podiatry using telehealth as an adjunct to, or replacement for, in-person patient visits.*

***.02 Definitions.***

*A. In this chapter, the following terms have the meanings indicated.*

*B. Terms Defined.*

*(1) "Asynchronous" means not occurring in real time.*

*(2) "In-person" means within the physical presence of the patient.*

*(3) "Interpretive services" means reading and analyzing images, tracings, or specimens through telehealth or giving interpretations based on visual, auditory, thermal, or ultrasonic patterns or other patterns as may evolve with technology.*

*(4) "Remote patient monitoring" means the use of telehealth devices to collect medical and other forms of health data from patients that are securely provided to a telehealth practitioner in a different location for assessment, recommendation, and diagnosis.*

*(5) "Store and forward technology" means the asynchronous transmission of digital images, documents, and videos electronically through secure means.*

*(6) "Synchronous" means occurring in real time.*

*(7) Telehealth.*

*(a) "Telehealth" means a mode of delivering health care services through the use of telecommunications technologies by a health care practitioner to a patient at a different physical location than the health care practitioner.*

*(b) "Telehealth" includes synchronous and asynchronous interactions.*

*(c) "Telehealth" does not include the provision of health care services solely through:*

*(i) Audio-only calls;*

*(ii) Email messages; or*

*(iii) Facsimile transmissions.*

*(8) "Telehealth devices" means devices that gather visual or other data and remotely sends the images or data to a telehealth practitioner in a different location from the patient.*

*(9) "Telehealth practitioner" means a Maryland licensed podiatrist performing telehealth services within the scope of practice.*

***.03 Licensure.***

*A. Subject to the provisions of Health Occupations Article, Title 16, Subtitle 3, Annotated Code of Maryland, a telehealth practitioner shall be licensed in Maryland when providing telehealth services to a patient located in the State.*

*B. Telehealth practitioners licensed in this State are subject to the jurisdiction of the State and shall abide by the telehealth requirements of this chapter if either the telehealth practitioner or patient is physically located in this State.*

***.04 Standards of Practice for Telehealth.***

*A. Before providing telehealth services, a telehealth practitioner shall develop and follow a procedure to:*

*(1) Verify the identification of the patient receiving telehealth services within a reasonable degree of certainty through use of:*

*(a) Government issued photograph identification;*

*(b) Insurance, Medicaid, or Medicare card; or*

*(c) Documentation of the patient's:*

*(i) Date of birth; and*

*(ii) Home address;*

*(2) For an initial patient-telehealth practitioner encounter, disclose the telehealth practitioner's:*

*(a) Name;*

*(b) Contact information; and*

*(c) Maryland license number;*

*(3) Except for interpretive services, obtain oral or written acknowledgement from a patient or patient's parent or guardian if State law requires the consent of a parent or guardian including informing patients of the risks, benefits, and side effects of prescribed treatments;*

*(4) Securely collect and transmit a patient's medical health information, clinical data, clinical images, laboratory results, and self–reported medical health and clinical history, as necessary, and prevent access to data by unauthorized persons through encryption or other means;*

*(5) Notify patients in the event of a data breach;*

*(6) Ensure that the telehealth practitioner provides a secure and private telehealth connection that complies with federal and state privacy laws; and*

*(7) Establish safety protocols to be used in the case of an emergency, including contact information for emergency services at the patient's location.*

*B. Except when providing store and forward telehealth services or remote patient monitoring, a telehealth practitioner shall:*

*(1) Obtain or confirm an alternative method of contacting the patient in case of a technological failure;*

*(2) Confirm whether the patient is in Maryland and identify the specific practice setting in which the patient is located; and*

*(3) Identify all individuals present at each location and confirm they are allowed to hear the patient's health information.*

*C. A telehealth practitioner shall be held to the same standards of practice and documentation as those applicable for in-person health care settings.*

*D. A telehealth practitioner may not prescribe opioids for the treatment of pain through telehealth except if the patient is in a health care facility as defined in Health-General Article, §19-114, Annotated Code of Maryland.*

***.05 Patient Evaluation.***

*A. Except when providing asynchronous telehealth services or remote patient monitoring, a telehealth practitioner shall:*

*(1) Perform a clinical patient evaluation adequate to establish a diagnosis and identify underlying conditions or contraindications to recommended treatment options before providing treatment or prescribing medication through telehealth; and*

*(2) If clinically appropriate for the patient, provide or refer a patient to:*

*(a) In-person health care services; or*

*(b) Another type of telehealth service.*

*B. If the evaluation is adequate to comply with §A of this regulation, a telehealth practitioner may use:*

*(1) Telehealth devices;*

*(2) Live synchronous audio-visual communication;*

*(3) Other methods of performing a medical examination remotely; or*

*(4) A patient evaluation performed by another licensed health care practitioner providing coverage.*

*C. A telehealth practitioner may not treat a patient or issue a prescription based solely on an online questionnaire.*

***.06 Telehealth Practitioner Discipline.***

*A. The Board shall use the same standards of evaluating and investigating a complaint about and in disciplining a licensee who practices telehealth as it would use for a licensee who does not use telehealth technology in the licensee's practice.*

*B. The failure of a telehealth practitioner to comply with Regulations .04 and .05 of this chapter shall constitute unprofessional conduct and may be subject to disciplinary action by the Board.*

**DENNIS R. SCHRADER**

**Secretary of Health**