BOARD OF PODIATRIC MEDICAL EXAMINERS

OPEN SESSION MEETING VIA GOOGLE MEET

AGENDA (AMENDED)

January 13, 2022

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

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

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 November 18, 2021 meeting** **Tab A**

B. BOARD PRESIDENT'S REPORT

C. EXECUTIVE DIRECTOR'S REPORT-Eva Schwartz

D. OLD BUSINESS:

1. **MPMA Bill -Podiatric Physician** **Tab F**

E. NEW BUSINESS:

1. **FPMB 2021 Q4 Newsletter** **Tab B**
2. **NPDB- Is It Reportable?** **Tab C**
3. **Electronic Prescribing Mandate** **Tab D**
4. **HB 55- Health Occupations- Nurse Anesthetists- Drug Authority and Collaboration** **Tab E**
5. **SB 77- Health Occupations Boards – Investigations – Right to Counsel** **Tab G**
6. **SB- 111- Occupational Licenses or Certificates – Pre–application Determinations – Criminal Convictions** **Tab H**
7. **Review eligibility for issuance of Full Active Podiatric License:**
   a. **Tobias Glister, DPM**
   b. **Mperera Simango-Yiadom, DPM**

F. ADJOURNMENT

BOARD OF PODIATRIC MEDICAL EXAMINERS

OPEN SESSION MEETING VIA GOOGLE MEET

MINUTES

November 18, 2021

Location Google Meet: https://meet.google.com/vjo-utuq-jnf?hs=224

Join by phone: (US) +1 657-226-0617 (PIN: 195725301)

The Public Meeting commenced at 1:09 PM, opened by the Board President, Dr. Adam Silverman.

Roll call was initiated by the Executive Director.

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

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

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

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

Representing MPMA: Richard Bloch, Esq., Executive Director, and Dr. Jay LeBow, MPMA member

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

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

A. MINUTES

1. **Approval of minutes from the October 14, 2021 meeting**

   The minutes from the October 14, 2021 meeting were approved unanimously, as submitted.

B. BOARD PRESIDENT'S REPORT

Dr. Silverman had nothing to report at this time.

C. EXECUTIVE DIRECTOR'S REPORT-Eva Schwartz

Ms. Schwartz extended appreciation to the Federation of Podiatric Medical Boards for their invitation for her and Dr. Silverman to attend their most recent Federation meeting held on November 5, 2021.

D. OLD BUSINESS:

1. **CSPE Licensing Examination Survey**

The Board discussed how the CSPE Licensing Exam Part 2, 2 will be suspended for the foreseeable future at this time.

E. NEW BUSINESS:

1. CME Accrual categories for the 2024-2025 license renewal effective Dec 1, 2021

The Board discussed continuing the current CME guidelines which allow for all 50 CME credits required for renewal of a providers Maryland license to be obtained online, with 25 directly related to podiatry for the 2024-2025 renewal cycle. The Board voted to continue the online CME accrual with one Board member opposed.

2. FPMB Topics- Fall Meeting 2021

Ms. Schwartz, Mr. Bloch and Dr. Lebow updated the Board on the topics discussed at the Federations Round Table meeting which included the ongoing White Paper discussion. The USMLE determined that podiatrists will not meet the education requirements therefore will be ineligible to take the exams. The White Paper also creates a division within a profession which can lead to multiple issues with credentialing and training. Lynn Curry with the Curry Group is working to gather information to create a unified report amongst all professions that will help guide Legislation in regard to the White Paper.

F. ADJOURNMENT

With no further business, the Public Session of the Board meeting concluded at 1:48 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: _____

J2 2lr1403
SB 169/21 – EHE CF 2lr0590

Bill No.: _____
Requested: _____
Committee: _____

Drafted by: Rowe
Typed by: Fran
Stored – 11/19/21
Proofread by _____
Checked by _____

By: **Senator Reilly**

A BILL ENTITLED

AN ACT concerning

Health Occupations – Podiatric Physicians

FOR the purpose of altering the term "podiatrist" to be "podiatric physician"; and generally relating to podiatric physicians.

BY repealing and reenacting, with amendments,
Article – Commercial Law
Section 13–104(1)
Annotated Code of Maryland
(2013 Replacement Volume and 2021 Supplement)

BY repealing and reenacting, without amendments,
Article – Corporations and Associations
Section 4A–101(a) and 5–101(a)
Annotated Code of Maryland
(2014 Replacement Volume and 2021 Supplement)

BY repealing and reenacting, with amendments,
Article – Corporations and Associations
Section 4A–101(t)(2)(viii) and 5–101(g)(2)(vii)
Annotated Code of Maryland
(2014 Replacement Volume and 2021 Supplement)

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

BY repealing and reenacting, without amendments,
Article – Courts and Judicial Proceedings
Section 3–2A–01(a)
Annotated Code of Maryland
(2020 Replacement Volume and 2021 Supplement)

BY repealing and reenacting, with amendments,
Article – Courts and Judicial Proceedings
Section 3–2A–01(f)(1)
Annotated Code of Maryland
(2020 Replacement Volume and 2021 Supplement)

BY repealing and reenacting, without amendments,
Article – Criminal Law
Section 3–101(a)
Annotated Code of Maryland
(2021 Replacement Volume and 2021 Supplement)

BY repealing and reenacting, with amendments,
Article – Criminal Law
Section 3–101(b)(3)
Annotated Code of Maryland
(2021 Replacement Volume and 2021 Supplement)

BY repealing and reenacting, with amendments,
Article – Education
Section 15–122(a)
Annotated Code of Maryland
(2018 Replacement Volume and 2021 Supplement)

BY repealing and reenacting, with amendments,
Article – Estates and Trusts
Section 7–401(bb)
Annotated Code of Maryland
(2017 Replacement Volume and 2021 Supplement)

BY repealing and reenacting, without amendments,

Article – Health – General
Section 3–401(a), 19–2001(a)(1), and 21–1112(a)(1)
Annotated Code of Maryland
(2019 Replacement Volume and 2021 Supplement)

BY repealing and reenacting, with amendments,
Article – Health – General
Section 3–401(b), 4–401(a)(7), 4–403(a)(1)(xvi), 15–103(c)(3), 19–351(b), 19–712.5(f), 19–2001(a)(4)(ii)8., and 21–1112(a)(2)
Annotated Code of Maryland
(2019 Replacement Volume and 2021 Supplement)

BY repealing and reenacting, without amendments,
Article – Health Occupations
Section 1–801(a), 8–512(a)(1), 12–101(a), 12–6A–01(a), and 16–101(a)
Annotated Code of Maryland
(2021 Replacement Volume)

BY repealing and reenacting, with amendments,
Article – Health Occupations
Section 1–801(d)(7), 8–512(a)(2), 12–101(b), 12–102(a), (c)(2)(ii), (d)(2), (e)(1), (f)(1), (g), and (m), 12–102.1(b), 12–102.2(b), 12–6A–01(b), and 14–5F–14(b)(3); and 16–101(d) and (e), 16–103, 16–202(a)(2) and (3), (c), and (d)(2) and (3), 16–205(a)(2) and (b)(3)(ii) and (iii) and (4), 16–307(f)(1), 16–308(a)(3) and (b), 16–310(a), 16–311(b), 16–318(a), 16–401, 16–402, 16–403, and 16–404 to be under the amended title "Title 16. Podiatric Physicians"
Annotated Code of Maryland
(2021 Replacement Volume)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 4–401(a)(1)(i) and (e)(3), 14–101(b), 14–110(a)(2)(ii)2., 15–702(b), 15–713(b) and (c), and 15–805(a)(2)
Annotated Code of Maryland
(2017 Replacement Volume and 2021 Supplement)

BY repealing and reenacting, without amendments,

Article – Insurance
Section 14–101(a) and 15–805(a)(1)
Annotated Code of Maryland
(2017 Replacement Volume and 2021 Supplement)

BY repealing and reenacting, with amendments,
Article – State Personnel and Pensions
Section 9–504(b)(2)(x)
Annotated Code of Maryland
(2015 Replacement Volume and 2021 Supplement)

BY repealing and reenacting, without amendments,
Article – Transportation
Section 13–616(a)(1)
Annotated Code of Maryland
(2020 Replacement Volume and 2021 Supplement)

BY repealing and reenacting, with amendments,
Article – Transportation
Section 13–616(a)(8) and (b)(1) and (2)(ii), 13–616.1(a)(2)(i) and (j), and 13–616.2(a)(1)(iii), (c)(1), and (h)
Annotated Code of Maryland
(2020 Replacement Volume and 2021 Supplement)

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

Article – Commercial Law

13–104.

This title does not apply to:

(1) The professional services of a certified public accountant, architect, clergyman, professional engineer, lawyer, veterinarian, insurance company authorized to do business in the State, insurance producer licensed by the State, Christian Science practitioner, land surveyor, property line surveyor, chiropractor, optometrist, physical therapist, **[**podiatrist**]** **PODIATRIC PHYSICIAN**, real estate broker, associate real estate

broker, or real estate salesperson, or medical or dental practitioner;

Article – Corporations and Associations

4A–101.

(a) In this title the following terms have the meanings indicated.

(t) (2) "Professional service" includes a service provided by:

(viii) A **[**podiatrist**]** **PODIATRIC PHYSICIAN**;

5–101.

(a) In this subtitle the following words have the meanings indicated.

(g) (2) "Professional service" includes, but is not limited to, a service provided by:

(vii) A **[**podiatrist**]** **PODIATRIC PHYSICIAN**;

Article – Courts and Judicial Proceedings

3–2A–01.

(a) In this subtitle the following terms have the meanings indicated unless the context of their use requires otherwise.

(f) (1) "Health care provider" means a hospital, a related institution as defined in § 19–301 of the Health – General Article, a medical day care center, a hospice care program, an assisted living program, a freestanding ambulatory care facility as defined in § 19–3B–01 of the Health – General Article, a physician, an osteopath, an optometrist, a chiropractor, a registered or licensed practical nurse, a dentist, a **[**podiatrist**]** **PODIATRIC PHYSICIAN**, a psychologist, a licensed certified social worker–clinical, and a physical therapist, licensed or authorized to provide one or more health care services in Maryland.

Article – Criminal Law

3–101.

(a) In this subtitle the following words have the meanings indicated.

(b) "Licensed health care professional" means a duly licensed or certified:

(3) **[**podiatrist**]** **PODIATRIC PHYSICIAN**;

Article – Education

15–122.

(a) This section applies only to an institution of higher education that awards a degree that an individual may use to meet the educational requirements for licensure under the Health Occupations Article as a physician, advanced practice nurse, dentist, physician assistant, or **[**podiatrist**]** **PODIATRIC PHYSICIAN**.

Article – Estates and Trusts

7–401.

(bb) If the estate is of a physician, **[**podiatrist**]** **PODIATRIC PHYSICIAN**, optometrist, or dentist who was a sole practitioner, the administrator shall follow the notice requirements under § 4–305 of the Health – General Article before the destruction or transfer of any medical records of a patient of the decedent.

Article – Health – General

3–401.

(a) In this subtitle the following words have the meanings indicated.

(b) "Authorized prescriber" means a licensed registered nurse, licensed dentist, licensed physician, licensed physician's assistant, licensed **[**podiatrist**]** **PODIATRIC PHYSICIAN**, or other individual authorized by law to prescribe prescription or nonprescription drugs or devices.

4–401.

(a) In this section, "provider" means:

(7) A **[**podiatrist**]** **PODIATRIC PHYSICIAN**; or

4–403.

(a) (1) In this section, a "health care provider" means:

(xvi) A **[**podiatrist**]** **PODIATRIC PHYSICIAN**;

15–103.

(c) (3) The Secretary may contract with insurance companies or nonprofit health service plans or with individuals, associations, partnerships, incorporated or unincorporated groups of physicians, chiropractors, dentists, **[**podiatrists**]** **PODIATRIC PHYSICIANS**, optometrists, pharmacists, hospitals, nursing homes, nurses, including nurse anesthetists, nurse midwives and certified nurse practitioners, opticians, and other health practitioners who are licensed or certified in this State and perform services on the prescription or referral of a physician.

19–351.

(b) (1) A hospital or related institution that provides services that licensed **[**podiatrists**]** **PODIATRIC PHYSICIANS** are authorized to perform under Title 16 of the Health Occupations Article, other than incidental care, shall include, in its bylaws, rules, or regulations, provisions for use of facilities by and staff privileges for qualified **[**podiatrists**]** **PODIATRIC PHYSICIANS**.

(2) The hospital or related institution may restrict use of facilities and staff privileges by **[**podiatrists**]** **PODIATRIC PHYSICIANS** to those **[**podiatrists**]** **PODIATRIC PHYSICIANS** who meet the qualifications that the hospital or related institution sets for granting those privileges.

(3) The qualifications that the hospital or related institution sets for granting privileges for services that licensed **[**podiatrists**]** **PODIATRIC PHYSICIANS** are authorized to perform under Title 16 of the Health Occupations Article shall include consideration of the training, education, and experience of the **[**podiatrist**]** **PODIATRIC**

PHYSICIAN.

19–712.5.

(f) If a health maintenance organization authorizes, directs, refers, or otherwise allows a member or subscriber to access a hospital emergency facility or other urgent care facility for a medical condition that requires emergency surgery, the health maintenance organization:

(1) Shall reimburse the physician, oral surgeon, periodontist, or **[**podiatrist**]** **PODIATRIC PHYSICIAN**, who performed the surgical procedure, for follow–up care that is:

(i) Medically necessary;

(ii) Directly related to the condition for which the surgical procedure was performed; and

(iii) Provided in consultation with the member's or subscriber's primary care physician; and

(2) May not impose on the member or subscriber any co–payment or other cost–sharing requirement for any follow–up care that exceeds what a member or subscriber is required to pay for services rendered by a physician, oral surgeon, periodontist, or **[**podiatrist**]** **PODIATRIC PHYSICIAN** who is a member of the provider panel of the health maintenance organization.

19–2001.

(a) (1) In this subtitle the following words have the meanings indicated.

(4) (ii) "Health care practitioner" does not include:

8. A **[**podiatrist**]** **PODIATRIC PHYSICIAN**.

21–1112.

(a) (1) In this section the following terms have the meanings indicated.

(2) "Authorized prescriber" means a licensed dentist, licensed physician, licensed **[**podiatrist**]** **PODIATRIC PHYSICIAN**, licensed veterinarian, certified nurse midwife to the extent permitted under § 8–601 of the Health Occupations Article, certified nurse practitioner to the extent permitted under § 8–508 of the Health Occupations Article, or other individual authorized by law to prescribe prescription or nonprescription drugs or devices.

Article – Health Occupations

1–801.

(a) In this subtitle the following words have the meanings indicated.

(d) "Health care professional" means:

(7) A **[**podiatrist**]** **PODIATRIC PHYSICIAN** licensed by the State Board of Podiatric Medical Examiners;

8–512.

(a) (1) In this section the following words have the meanings indicated.

(2) "Authorized prescriber" means a licensed registered nurse, licensed dentist, licensed physician, licensed physician's assistant, licensed **[**podiatrist**]** **PODIATRIC PHYSICIAN**, or other individual authorized by law to prescribe prescription or nonprescription drugs or devices.

12–101.

(a) In this title the following words have the meanings indicated.

(b) "Authorized prescriber" means any licensed dentist, licensed dental hygienist with prescriptive authority under § 4–206.4 of this article, licensed physician, licensed **[**podiatrist**]** **PODIATRIC PHYSICIAN**, licensed veterinarian, advanced practice nurse with prescriptive authority under § 8–508 of this article, or other individual authorized by law to prescribe prescription or nonprescription drugs or devices.

12–102.

(a) (1) In this section the following terms have the meanings indicated.

(2) "In the public interest" means the dispensing of drugs or devices by a licensed dentist, physician, or **[**podiatrist**]** **PODIATRIC PHYSICIAN** to a patient when a pharmacy is not conveniently available to the patient.

(3) "Personally preparing and dispensing" means that the licensed dentist, physician, or **[**podiatrist**]** **PODIATRIC PHYSICIAN**:

(i) Is physically present on the premises where the prescription is filled; and

(ii) Performs a final check of the prescription before it is provided to the patient.

(c) (2) This title does not prohibit:

(ii) A licensed dentist, physician, or **[**podiatrist**]** **PODIATRIC PHYSICIAN** from personally preparing and dispensing the dentist's, physician's, or **[**podiatrist's**]** **PODIATRIC PHYSICIAN'S** prescriptions when:

1. The dentist, physician, or **[**podiatrist**]** **PODIATRIC PHYSICIAN**:

A. Has applied to the board of licensure in this State which licensed the dentist, physician, or **[**podiatrist**]** **PODIATRIC PHYSICIAN**;

B. Has demonstrated to the satisfaction of that board that the dispensing of prescription drugs or devices by the dentist, physician, or **[**podiatrist**]** **PODIATRIC PHYSICIAN** is in the public interest;

C. Has received a written permit from that board to dispense prescription drugs or devices except that a written permit is not required in order to dispense starter dosages or samples without charge; and

D. Posts a sign conspicuously positioned and readable

regarding the process for resolving incorrectly filled prescriptions or includes written information regarding the process with each prescription dispensed;

2. The person for whom the drugs or devices are prescribed is a patient of the prescribing dentist, physician, or **[**podiatrist**]** **PODIATRIC PHYSICIAN**;

3. The dentist, physician, or **[**podiatrist**]** **PODIATRIC PHYSICIAN** does not have a substantial financial interest in a pharmacy; and

4. The dentist, physician, or **[**podiatrist**]** **PODIATRIC PHYSICIAN**:

A. Complies with the dispensing and labeling requirements of this title;

B. Records the dispensing of the prescription drug or device on the patient's chart;

C. Allows the Office of Controlled Substances Administration to enter and inspect the dentist's, physician's, or **[**podiatrist's**]** **PODIATRIC PHYSICIAN'S** office at all reasonable hours and in accordance with § 12–102.1 of this subtitle;

D. On inspection by the Office of Controlled Substances Administration, signs and dates an acknowledgment form provided by the Office of Controlled Substances Administration relating to the requirements of this section;

E. Except for starter dosages or samples without charge, provides the patient with a written prescription, maintains prescription files in accordance with § 12–403(c)(13) of this title, and maintains a separate file for Schedule II prescriptions;

F. Does not direct patients to a single pharmacist or pharmacy in accordance with § 12–403(c)(8) of this title;

G. Does not receive remuneration for referring patients to a pharmacist or pharmacy;

H. Complies with the child resistant packaging requirements regarding prescription drugs under Title 22, Subtitle 3 of the Health – General Article;

I. Complies with drug recalls;

J. Maintains biennial inventories and complies with any other federal and State record–keeping requirements relating to controlled dangerous substances;

K. Purchases prescription drugs from a pharmacy or wholesale distributor who holds a permit issued by the Board of Pharmacy, as verified by the Board of Pharmacy;

L. Annually reports to the respective board of licensure whether the dentist, physician, or **[**podiatrist**]** **PODIATRIC PHYSICIAN** has personally prepared and dispensed prescription drugs within the previous year; and

M. Completes ten continuing education credits over a 5–year period relating to the preparing and dispensing of prescription drugs, offered by the Accreditation Council for Pharmacy Education (ACPE) or as approved by the Secretary, in consultation with each respective board of licensure, as a condition of permit renewal;

(d) This title does not prohibit:

(2) A licensed dentist, licensed physician, or licensed **[**podiatrist**]** **PODIATRIC PHYSICIAN** from personally dispensing a drug or device sample to a patient of the licensed dentist, licensed physician, or licensed **[**podiatrist**]** **PODIATRIC PHYSICIAN** if:

(i) The sample complies with the labeling requirements of § 12–505 of this title;

(ii) No charge is made for the sample; and

(iii) The authorized prescriber enters an appropriate record in the patient's chart.

(e) (1) This title does not prohibit:

(i) A dentist, physician, or **[**podiatrist**]** **PODIATRIC PHYSICIAN** from administering a prescription drug or device in the course of treating a patient; or

(ii) A licensed dental hygienist from administering medication under § 4–206.4 of this article.

(f) (1) This title does not prohibit a dentist, physician, or **[**podiatrist**]** **PODIATRIC PHYSICIAN** from personally dispensing a starter dosage of a prescription drug or device to a patient of the dentist, physician, or **[**podiatrist**]** **PODIATRIC PHYSICIAN**, provided that:

(i) The starter dosage complies with the labeling requirements of § 12–505 of this title;

(ii) No charge is made for the starter dosage; and

(iii) The dentist, physician, or **[**podiatrist**]** **PODIATRIC PHYSICIAN** enters an appropriate record on the patient's chart.

(g) This title does not prohibit a dentist, physician, or **[**podiatrist**]** **PODIATRIC PHYSICIAN** from dispensing a prescription drug or device in the course of treating a patient:

(1) At a medical facility or clinic that is operated on a nonprofit basis;

(2) At a health center that operates on a campus of an institution of higher education; or

(3) At a public health facility, a medical facility under contract with a State or local health department, or a facility funded with public funds.

(m) A dentist, physician, or **[**podiatrist**]** **PODIATRIC PHYSICIAN** who fails to comply with the provisions of this section governing the dispensing of prescription drugs or devices shall:

(1) Have the dispensing permit revoked; and

(2) Be subject to disciplinary actions by the appropriate licensing board.

12–102.1.

(b) The Office of Controlled Substances Administration shall enter and inspect the office of a dentist, physician, or **[**podiatrist**]** **PODIATRIC PHYSICIAN** who holds:

(1) An initial dispensing permit:

(i) Within 6 months after receiving the report required under § 12–102(l)(1) of this subtitle; and

(ii) At least one more time during the duration of the permit; and

(2) A renewed dispensing permit at least two times during the duration of the permit.

12–102.2.

(b) The Board of Dental Examiners, the Board of Physicians, and the Board of Podiatric Medical Examiners shall charge a fee to a dentist, physician, or **[**podiatrist**]** **PODIATRIC PHYSICIAN** who holds a dispensing permit in an amount that will produce funds to approximate but not exceed the documented costs to the Office of Controlled Substances Administration for inspections of dispensing permit holders.

12–6A–01.

(a) In this subtitle the following words have the meanings indicated.

(b) "Authorized prescriber" means a licensed physician, licensed **[**podiatrist**]** **PODIATRIC PHYSICIAN**, or certified advanced practice nurse with prescriptive authority under § 8–508 of this article.

14–5F–14.

(b) A license does not authorize a licensee to:

(3) Practice or claim to practice as a medical doctor or physician, an osteopath, a dentist, a **[**podiatrist**]** **PODIATRIC PHYSICIAN**, an optometrist, a psychologist, a nurse practitioner, a physician assistant, a chiropractor, a physical therapist, an acupuncturist, or any other health care professional unless licensed under this article;

Title 16. **[**Podiatrists**]** **PODIATRIC PHYSICIANS**.

16–101.

(a) In this title the following words have the meanings indicated.

(d) "Licensed **[**podiatrist"**]** **PODIATRIC PHYSICIAN"** means, unless the context requires otherwise, a **[**podiatrist**]** **PODIATRIC PHYSICIAN** who is licensed by the Board to practice podiatry.

(e) **[**"Podiatrist"**]** **"PODIATRIC PHYSICIAN"** means an individual who practices podiatry.

16–103.

(a) All osseous surgical procedures of the ankle, arthrodeses of 2 or more tarsal bones, and complete tarsal osteotomies that are performed by a licensed **[**podiatrist**]** **PODIATRIC PHYSICIAN** shall be performed in a licensed hospital or ambulatory surgical center, subject to the provisions of § 19–351 of the Health – General Article.

(b) A licensed **[**podiatrist**]** **PODIATRIC PHYSICIAN** who performs an osseous surgical procedure of the ankle, arthrodesis of 2 or more tarsal bones, or a complete tarsal osteotomy in a licensed ambulatory surgical center must:

(1) Have current surgical privileges at a licensed hospital for the same procedure; and

(2) Meet the requirements of the ambulatory surgical center.

(c) Nothing in this title shall prohibit a licensed hospital or ambulatory surgical center from establishing qualifications or delineating privileges for the performance of surgical procedures of the human foot or ankle, the anatomical structures that attach to the human foot, or the soft tissue below the mid–calf by a licensed **[**podiatrist**]** **PODIATRIC PHYSICIAN** in the hospital or ambulatory surgical center.

16–202.

(a) (2) Of the 7 Board members:

(i) 5 shall be licensed **[**podiatrists**]** **PODIATRIC PHYSICIANS**; and

(ii) 2 shall be consumer members.

(3) The Governor shall appoint the **[**podiatrist**]** **PODIATRIC PHYSICIAN** members, with the advice of the Secretary, from a list of names submitted by the Maryland Podiatric Medical Association. The number of names on the list shall be twice the number of vacancies.

(c) Each **[**podiatrist**]** **PODIATRIC PHYSICIAN** member of the Board shall be:

(1) A licensed practicing **[**podiatrist**]** **PODIATRIC PHYSICIAN** of recognized ability and integrity;

(2) A resident of this State who has practiced actively in this State for at least 5 years immediately before appointment; and

(3) A licensed **[**podiatrist**]** **PODIATRIC PHYSICIAN** with peer review experience.

(d) Each consumer member of the Board:

(2) May not be or ever have been a **[**podiatrist**]** **PODIATRIC PHYSICIAN** or in training to become a **[**podiatrist**]** **PODIATRIC PHYSICIAN**;

(3) May not have a household member who is a **[**podiatrist**]** **PODIATRIC PHYSICIAN** or in training to become a **[**podiatrist**]** **PODIATRIC PHYSICIAN**;

16–205.

(a) In addition to the powers set forth elsewhere in this title, the Board may:

(2) After consulting with the State Board of Pharmacy, adopt rules and regulations regarding the dispensing of prescription drugs by a licensed **[**podiatrist**]** **PODIATRIC PHYSICIAN**; and

(b) In addition to the duties set forth elsewhere in this title, the Board shall:

(3) On receipt of a written and signed allegation, including a referral from the Commissioner of Labor and Industry:

(ii) Provide notice to the licensed **[**podiatrist**]** **PODIATRIC PHYSICIAN** that an allegation has been received and forward a copy of the allegation to the licensed **[**podiatrist**]** **PODIATRIC PHYSICIAN** within 60 days of receipt of the allegation, unless the Board:

1. Makes an affirmative determination that the disclosure would prejudice the investigation of the allegation and notifies the licensee of the determination;

2. Disposes of the allegation within 60 days of the date of receipt of the allegation; or

3. Makes an affirmative determination that any action that the Board may take as a result of the investigation into the allegation will most likely not result in formal disciplinary action; and

(iii) Periodically notify the licensed **[**podiatrist**]** **PODIATRIC PHYSICIAN** and all persons of interest of the status of the allegation until such time as the allegation is resolved; and

(4) Except for an office of a **[**podiatrist**]** **PODIATRIC PHYSICIAN** in a hospital, related institution, freestanding medical facility, or freestanding birthing center, conduct an unannounced inspection of the office of a **[**podiatrist**]** **PODIATRIC PHYSICIAN** against whom a complaint has been filed with the Board regarding a violation of the Centers for Disease Control and Prevention's guidelines on universal precautions to determine compliance at that office with the guidelines.

16–307.

(f) (1) A **[**podiatrist**]** **PODIATRIC PHYSICIAN** has a grace period of 30 days after the **[**podiatrist's**]** **PODIATRIC PHYSICIAN'S** license expires in which to renew the license retroactively, if the **[**podiatrist**]** **PODIATRIC PHYSICIAN**:

(i) Otherwise is entitled to have the license renewed; and

(ii) Pays to the Board the renewal fee and any late fee set by the Board.

16–308.

(a) (3) The Board shall reinstate the license of a **[**podiatrist**]** **PODIATRIC PHYSICIAN** who has been on inactive status and who does not meet the requirements of paragraph (2)(vii) of this subsection, if the **[**podiatrist**]** **PODIATRIC PHYSICIAN** meets the continuing medical education requirements prescribed by the Board.

(b) The Board shall reinstate the license of a **[**podiatrist**]** **PODIATRIC PHYSICIAN** who has been on inactive status and who has failed to renew the license for 1 licensing cycle or a 2–year period, whichever is longer, for any reason, if the **[**podiatrist**]** **PODIATRIC PHYSICIAN**:

(1) Meets the renewal requirements of § 16–307(c) through (f) of this subtitle and subsection (a) of this section;

(2) Pays to the Board all past–due renewal fees and the reinstatement fee set by the Board; and

(3) Meets the requirements for obtaining a new license under this subtitle.

16–310.

(a) Unless the Board agrees to accept the surrender of a license, a licensed **[**podiatrist**]** **PODIATRIC PHYSICIAN** or holder of a limited license may not surrender the license nor may the license lapse by operation of law while the licensee is under investigation or while charges are pending against the licensee.

16–311.

(b) Subject to the hearing provisions of § 16–313 of this subtitle, the Board, on the affirmative vote of a majority of its members then serving, may revoke the license of a **[**podiatrist**]** **PODIATRIC PHYSICIAN** who practices podiatry while the **[**podiatrist's**]** **PODIATRIC PHYSICIAN'S** license is suspended.

16–318.

(a) The Board may issue a temporary license to a **[**podiatrist**]** **PODIATRIC PHYSICIAN** licensed in another state to practice or teach podiatry in this State if:

(1) The license issued from the other state has licensing requirements equivalent to those in this State; and

(2) The licensed **[**podiatrist**]** **PODIATRIC PHYSICIAN** pays a temporary license fee as determined by the Board.

16–401.

A licensed **[**podiatrist**]** **PODIATRIC PHYSICIAN** may not append to the name of the licensee or use as a title any word or abbreviation that suggests that the licensee is licensed to practice medicine rather than podiatry.

16–402.

(a) Except as otherwise provided in this section, a **[**podiatrist**]** **PODIATRIC PHYSICIAN** may practice only under the name on the license of the **[**podiatrist**]** **PODIATRIC PHYSICIAN**.

(b) This section does not prohibit a **[**podiatrist**]** **PODIATRIC PHYSICIAN** from practicing in a professional association, limited liability company, or in any other group practice otherwise allowed by law.

(c) This section does not prohibit a **[**podiatrist**]** **PODIATRIC PHYSICIAN** from advertising under a trade name in connection with the practice of podiatry if:

(1) The use of the trade name is not deceptive or misleading;

(2) The advertisement in which the trade name appears includes:

(i) The name of the licensed **[**podiatrist**]** **PODIATRIC PHYSICIAN**; or

(ii) The name of the licensed **[**podiatrist**]** **PODIATRIC PHYSICIAN** and the name of the business entity under which podiatric services are provided;

(3) The name of the licensed **[**podiatrist**]** **PODIATRIC PHYSICIAN** who provides podiatric services appears on:

(i) The billing invoices; and

(ii) Any billing receipts given to a patient; and

(4) Treatment records are maintained and clearly identify the licensed **[**podiatrist**]** **PODIATRIC PHYSICIAN** who performed the podiatric treatment or service for any patient.

16–403.

(a) In this section, **[**"podiatrist**]** **"PODIATRIC PHYSICIAN** rehabilitation committee" means a committee that:

(1) Is defined in subsection (b) of this section; and

(2) Performs any of the functions listed in subsection (d) of this section.

(b) For purposes of this section, a **[**podiatrist**]** **PODIATRIC PHYSICIAN** rehabilitation committee is a committee of the Board or a committee of the Maryland Podiatry Association that:

(1) Is recognized by the Board; and

(2) Includes but is not limited to **[**podiatrists**]** **PODIATRIC PHYSICIANS**.

(c) A rehabilitation committee of the Board or recognized by the Board may function:

(1) Solely for the Board; or

(2) Jointly with a rehabilitation committee representing another board or boards.

(d) For purposes of this section, a **[**podiatrist**]** **PODIATRIC PHYSICIAN** rehabilitation committee evaluates and provides assistance to any **[**podiatrist**]** **PODIATRIC PHYSICIAN**, and any other individual regulated by the Board, in need of treatment and rehabilitation for alcoholism, drug abuse, chemical dependency, or other physical, emotional, or mental condition.

(e) (1) Except as otherwise provided in this subsection, the proceedings, records, and files of the **[**podiatrist**]** **PODIATRIC PHYSICIAN** rehabilitation committee are not discoverable and are not admissible in evidence in any civil action arising out of matters that are being or have been reviewed and evaluated by the **[**podiatrist**]** **PODIATRIC PHYSICIAN** rehabilitation committee.

(2) Paragraph (1) of this subsection does not apply to any record or document that is considered by the **[**podiatrist**]** **PODIATRIC PHYSICIAN** rehabilitation committee and that otherwise would be subject to discovery or introduction into evidence in any arbitration or civil proceeding.

(3) For purposes of this subsection, civil action does not include a proceeding before the Board or judicial review of a proceeding before the Board.

(f) A person who acts in good faith and within the scope of jurisdiction of the **[**podiatrist**]** **PODIATRIC PHYSICIAN** rehabilitation committee is not civilly liable for any action as a member of the **[**podiatrist**]** **PODIATRIC PHYSICIAN** rehabilitation committee or for giving information to, participating in, or contributing to the function of the **[**podiatrist**]** **PODIATRIC PHYSICIAN** rehabilitation committee.

16–404.

If a **[**podiatrist**]** **PODIATRIC PHYSICIAN** is engaged in the private practice of podiatry in this State, the **[**podiatrist**]** **PODIATRIC PHYSICIAN** shall display the notice developed under § 1–207 of this article conspicuously in each office where the **[**podiatrist**]** **PODIATRIC PHYSICIAN** is engaged in practice.

Article – Insurance

4–401.

(a) This section applies to:

(1) each insurer that provides professional liability insurance to:

(i) a physician, nurse, dentist, **[**podiatrist**]** **PODIATRIC PHYSICIAN**, optometrist, or chiropractor licensed under the Health Occupations Article; or

(e) (3) A report that relates to a nurse, dentist, **[**podiatrist**]** **PODIATRIC PHYSICIAN**, optometrist, or chiropractor shall be filed with the appropriate licensing board for these health care providers.

14–101.

(a) In this subtitle the following words have the meanings indicated.

(b) "Health care provider" means a chiropractor, dentist, hospital, optometrist, pharmacist, physician, **[**podiatrist**]** **PODIATRIC PHYSICIAN**, or psychologist.

14–110.

(a) The Commissioner shall issue a certificate of authority to an applicant if:

(2) the Commissioner is satisfied:

(ii) that:

2. each subscriber is entitled to reimbursement for podiatric, chiropractic, psychological, or optometric services, regardless of whether the service is performed by a licensed physician, licensed **[**podiatrist**]** **PODIATRIC PHYSICIAN**, licensed chiropractor, licensed psychologist, or licensed optometrist;

15–702.

(b) Notwithstanding any other provision of a self–funded group insurance plan subject to this section, if the plan provides for reimbursement for a service that is within the lawful scope of practice of a physician, dentist, or **[**podiatrist**]** **PODIATRIC PHYSICIAN**, the plan may not prohibit a person covered by the plan from being reimbursed for the service regardless of whether the service is performed by a physician, dentist, or

[podiatrist**]** **PODIATRIC PHYSICIAN**.

15–713.

(b) Notwithstanding any other provision of an individual, group, or blanket health insurance policy or contract subject to this section, if the policy or contract provides for reimbursement for a service that is within the lawful scope of practice of a licensed **[**podiatrist**]** **PODIATRIC PHYSICIAN**, the insured or any other person covered by or entitled to reimbursement under the policy or contract is entitled to the same amount of reimbursement for the service regardless of whether the service is performed by a physician or licensed **[**podiatrist**]** **PODIATRIC PHYSICIAN**.

(c) This section does not prohibit, and may not be construed as prohibiting, the determination of reimbursement based on the geographic location of the delivery of service, the preeminent qualifications of a physician or **[**podiatrist**]** **PODIATRIC PHYSICIAN**, or the need to provide services in an underserved area of the State.

15–805.

(a) (1) In this section the following words have the meanings indicated.

(2) "Authorized prescriber" means a licensed dentist, licensed physician, or licensed **[**podiatrist**]** **PODIATRIC PHYSICIAN** who is authorized under the Health Occupations Article to prescribe a pharmaceutical product.

Article – State Personnel and Pensions

9–504.

(b) The certificate required under subsection (a) of this section shall be signed by one of the following:

(2) if authorized to practice in a state and performing within the scope of that authority:

(x) a **[**podiatrist**]** **PODIATRIC PHYSICIAN**;

Article – Transportation

13–616.

(a) (1) In this subtitle the following words have the meanings indicated.

(8) "Licensed **[**podiatrist"**]** **PODIATRIC PHYSICIAN"** means a **[**podiatrist**]** **PODIATRIC PHYSICIAN** who is licensed by the State Board of Podiatric Medical Examiners to practice podiatry as described in § 16–101 of the Health Occupations Article.

(b) (1) The owner of any vehicle described in paragraph (3) of this subsection may apply to the Administration for the assignment to that vehicle of a special disability registration number and special disability registration plates, if a certified nurse practitioner, licensed physician, licensed physician assistant, licensed chiropractor, licensed optometrist, licensed **[**podiatrist**]** **PODIATRIC PHYSICIAN**, or licensed physical therapist certifies, in accordance with paragraph (2) of this subsection, that the applicant:

(i) Has lung disease to such an extent that forced (respiratory) expiratory volume for one second when measured by spirometry is less than one liter, or arterial oxygen tension (PO2) is less than 60 mm/hg on room air at rest;

(ii) Has cardiovascular disease limitations classified in severity as Class III or Class IV according to standards accepted by the American Heart Association;

(iii) Is unable to walk 200 feet without stopping to rest;

(iv) Is unable to walk without the use of, or assistance from, a brace, cane, crutch, another person, prosthetic device, or other assistive device;

(v) Requires a wheelchair for mobility;

(vi) Has lost a foot, leg, hand, or arm;

(vii) Has lost the use of a foot, leg, hand, or arm;

(viii) Has a permanent impairment of both eyes so that:

1. The central visual acuity is 20/200 or less in the better eye, with corrective glasses; or

2. There is a field defect in which the peripheral field has contracted to such an extent that the widest diameter of visual field subtends an angular distance no greater than 20 degrees in the better eye; or

(ix) Has a permanent disability that adversely impacts the ambulatory ability of the applicant and which is so severe that the person would endure a hardship or be subject to a risk of injury if the privileges accorded a person for whom a vehicle is specially registered under this section were denied.

(2) For the purposes of this section, the qualifying disabilities specified in paragraph (1) of this subsection shall be certified as follows:

(ii) A licensed chiropractor, licensed **[**podiatrist**]** **PODIATRIC PHYSICIAN**, or licensed physical therapist may certify conditions specified in paragraph (1)(iii) through (vii) and (ix) of this subsection;

13–616.1.

(a) A person may apply to the Administration for a parking placard on a form provided by the Administration if the applicant:

(2) (i) Has a permanent disability as described in § 13–616(b)(1) of this subtitle and as certified by a licensed physician, licensed physician assistant, licensed chiropractor, licensed optometrist, licensed **[**podiatrist**]** **PODIATRIC PHYSICIAN**, or licensed physical therapist, as defined in § 13–616(a) of this subtitle; or

(j) In accordance with the provisions of this section, each board for licensed physicians, licensed physician assistants, licensed chiropractors, licensed optometrists, licensed **[**podiatrists**]** **PODIATRIC PHYSICIANS**, or licensed physical therapists shall be responsible for the development and maintenance of a database system, with which the Administration can interface and verify licensure.

13–616.2.

(a) A person may apply to the Administration for a temporary parking placard on a form provided by the Administration if:

(1) (iii) A licensed physician, licensed physician assistant, licensed chiropractor, licensed optometrist, licensed **[**podiatrist**]** **PODIATRIC PHYSICIAN**, or licensed physical therapist, as defined in § 13–616(a) of this subtitle, certifies that the disability is not permanent but would substantially impair the applicant's mobility or limit or impair the applicant's ability to walk for at least 3 weeks, and is so severe that the applicant would endure a hardship or be subject to risk of injury if the temporary parking placard were denied; or

(c) (1) A temporary parking placard for a person with a disability issued under this section shall be valid for a period of time the licensed physician, licensed physician assistant, licensed chiropractor, licensed optometrist, licensed **[**podiatrist**]** **PODIATRIC PHYSICIAN**, or licensed physical therapist has determined that the applicant, the dependent of the applicant, or the individual who depends on the applicant for transportation is likely to have the disability, not to exceed 6 months.

(h) In accordance with the provisions of this section, each board for licensed physicians, licensed physician assistants, licensed chiropractors, licensed optometrists, licensed **[**podiatrists**]** **PODIATRIC PHYSICIANS**, or licensed physical therapists shall be responsible for the development and maintenance of a database system with which the Administration can interface and verify licensure.

SECTION 2. AND BE IT FURTHER ENACTED, That in every law, executive order, rule, regulation, policy, or document created by any official, employee, or unit of this State, podiatrists are renamed podiatric physicians, as provided in this Act.

SECTION 3. AND BE IT FURTHER ENACTED, That the publisher of the Annotated Code of Maryland, in consultation with and subject to the approval of the Department of Legislative Services, shall correct, with no further action required by the General Assembly, cross–references and terminology rendered incorrect by this Act. The publisher shall adequately describe any correction that is made in an editor's note following the section affected.

SECTION 4. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2022.

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

Member Podiatric Medical Boards Newsletter — Q4 2021

PRESIDENT'S MESSAGE

Barbara A. Campbell, DPM
Cave Creek, Arizona

On behalf of myself and my fellow FPMB Executive Board members, I wish you a very happy, healthy, and prosperous 2022. I hope your holidays have been filled with the meaning and the joy of the season.

The FPMB held its 2021 Fall Meeting for Member Boards on November 5. By design, the greatest portion of the meeting was devoted to the round robin discussion of submitted topics from Member Boards. The FPMB surveyed participants after the meeting and received strong positive feedback. For example, regarding the round robin, participants stated: "Keep this an open forum discussion, please that was very helpful" and "Most enjoyable because of the free format and less structured intercommunications." Additional suggestions were made as well on how to enhance the forum, and the FPMB will certainly take these points into consideration when planning the next event. Many thanks to those who participated in the survey as it helps the FPMB to improve its service to its Member Boards.

On November 8, 2021, the FPMB Executive Director, Mr. Stoner, and I participated in a telephone interview with Lynn Curry, PhD (*Curry Corp)*. Dr. Curry was hired by American Podiatric Medical Association *(APMA)* to facilitate discussions with key stakeholders. The goal of the discussion was to better un-

(Continued on page 4)

EXEC'S MESSAGE

Russell J. Stoner
Germantown, Maryland

"It's Deja Vu All Over Again" - Yogi Berra

The surge in COVID-19 and emerging variant *(omicron)* we are experiencing now is an unfortunate repeat of this time a year ago. Thankfully, things are not exactly the same, and outcomes have improved.

The FPMB commends its Member Boards for another year of protecting the public and serving the podiatric profession in very challenging circumstances. This has required unprecedented flexibility and adaptability, and many

(Continued on page 5)

NEWSLETTER HIGHLIGHTS

IN THIS ISSUE

MISSION: 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

MEMBER BOARD SPOTLIGHT

Connecticut Board of Podiatric Medical Examiners

The mission of the Connecticut Board of Podiatric Medical Examiners *(the Board)* is to maintain and regulate standards of practice in podiatric medicine.

The Board is a five-member, independent board consisting of three DPMs and two public members. All members are appointed by the Governor. The Board mainly serves the public by safeguarding the safe and ethical practice of podiatry. It ensures that the rules and regulations governing the practice of podiatry allow the profession to practice at the highest level and maintain evolving standards of care. It also acts to discipline podiatrists who practice outside the standards of care as determined by the Board.

Disciplinary actions are investigated first by the Department of Health *(DPH)*. All complaints by the public, hospitals, or any individuals are sent to podiatric experts chosen by the DPH and approved by the Board. After expert review, the complaint is either deemed worthy for review or not. The worthy complaints are then handled by a DPH investigator and assigned an Assistant Attorney General. A consent agreement is drawn and, if the podiatrist agrees to the terms, which may be a fine, education, or both, the consent agreement is signed and the Board generally signs off on it. If the podiatrist refuses to sign a consent agreement, then a formal hearing is called with representation of the podiatrist by legal counsel, if desired. Most cases are resolved by consent agreement.

Over the years the Board has made declaratory rulings with regard to scope of practice. One infamous ruling done in the 1980s that allowed for podiatrists to perform ankle surgery was overturned by the Connecticut Supreme Court. Subsequently, the legislature updated the podiatry statute to include ankle surgery.

Questions about history and physical *(H&P)* examination by podiatrists and hyperbaric oxygen *(HBO)* chamber management were both clarified by declaratory rulings. These require granting intervenor status to any aggrieved party and a hearing. Both of the aforementioned issues were resolved in favor of podiatrists. The Board has issued a declaratory ruling with respect to shoe stores and orthotic devices. The question of whether or not noninvasive vascular testing is in the scope of practice for a podiatrist was answered in the affirmative by a Board declaratory ruling. These rulings can be found on the CT.gov website. The Board is proactive in reminding podiatrists not to prescribe medications outside of their scope of practice.

Connecticut has no state-mandated CME credit system, and residency training is not required to practice.

Connecticut is an outlier in two practices common throughout the country. First, there is no state mandated continuing medical education *(CME)* credit system. Despite repeated requests from the Connecticut Podiatric Medical Association *(CPMA)*, there has been no effort by the DPH to institute CME credits. The prevailing reason is that hospitals, malpractice companies, and certifying boards require and monitor CME activity.

Second, the Connecticut statute does not require residency training to practice. The statute was written before residency training was available for podiatrists, and there has been no effort to change it. The practice of podiatry has evolved such that hospital privileges are almost a necessity, and the hospitals require residency training. This is certainly an area for further discussion.

—Martin M. Pressman, DPM, FACFAS, Chairman
Connecticut Board of Podiatric Medical Examiners

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

President's Message continued from page 1)

derstand each stakeholder's perspectives on achieving physician parity and gaining recognition as physicians without qualification in federal health plans. This had been prompted by the stakeholders' responses to the White Paper presented by the Joint Task Force as well as the associated American Medical Association *(AMA)* Resolution.

All stakeholder organizations were presented with a series of questions in preparation for their own discussions with Dr. Curry. The themes of these questions were incorporated in the FPMB's presentation and discussion on this topic during the 2021 Fall Meeting to ensure that the FPMB Executive Board was properly positioned to speak on behalf of its Member Boards. The FPMB then compiled a report in response to the questions to serve as a basis for the interview discussion. Mr. Stoner and I felt that the discussion went well and that there was no doubt about the FPMB's stance, concerns, and opinions.

Dr. Curry's report will be presented to the APMA's Board of Trustees in December 2021, and is expected to be the topic of a town hall during the APMA's House of Delegates in March 2022. The FPMB will continue to keep its Member Boards informed.

Finally, serving on the FPMB Executive Board has been one of the most engaging and rewarding experiences in my years protecting the public and serving the profession. Please review the announcement below for a unique opportunity to lead and serve.

*** OPPORTUNITY TO SERVE ON FPMB EXECUTIVE BOARD ***

The FPMB has an Executive Board position, Director, to fill by the May 2021 Annual Meeting. The following is of interest to perspective applicants:

Who is the FPMB?

The FPMB is an empowering leader, helping Member Boards work independently and collectively to promote and protect the public's podiatric health, safety, and welfare.

Who are the members of the FPMB?

The FPMB is comprised of Member Boards that are any board, committee, or other group created or appointed for licensure to practice podiatric medicine in accordance with law and empowered by the laws of the District of Columbia, of any State of the U.S.A., or any territory or insular possessions of the U.S.A. which is empowered to discipline doctors of podiatric medicine and/or pass on the qualifications of applicants for licensure to practice podiatric medicine.

What is the composition of the FPMB Executive Board?

The FPMB Executive Board is comprised of five positions: President, Vice President *(President-Elect)*, Secretary-Treasurer, and two Directors.

What are the application requirements?

Applicants must be members or employees of a Member Board at the time of election and must not have previously served on the FPMB Executive Board during the previous three years. The applicant's Member Board must be current with its dues.

How long is the term for an FPMB Executive Board member?

FPMB Executive Board members serve a four-year term. They may be elected to a second four-year term, provided they are still a member or employee of a Member Board that is current with its dues.

Are Executive Board positions paid or volunteer?

The FPMB Executive Board is comprised of volunteer positions.

How to apply to serve on the FPMB Executive Board?

Applications will be sent during the month of January 2021. Contact the FPMB Executive Office at fpmb@fpmb.org with your name, Board, email address, phone number, and mailing address to receive an application.

(Executive Director's Message continued from page 1)

"temporary" measures are still in place or are being reinstated.

The FPMB is here to serve and support you in addressing these and many other challenges. As one Member Board recently stated after our 2021 Fall Meeting, "You all help navigate national issues and give perspective on shared problems and act as a facilitator of information on how to handle challenging issues, rules, and law implementation."

Speaking of the 2021 Fall Meeting, the FPMB Executive Board and I continue to be impressed and energized by the engagement of our meeting participants. In particular, the round robin provides a truly unique opportunity for real-time interaction between Member Boards across the country. We will continue to foster these critical communication opportunities.

Finally, I would like to offer my thanks and gratitude to the FPMB Executive Board for their exemplary service over the last year. There will be a vacancy to fill in 2022, so please consider joining this exceptional group in service and leadership.

Have a safe, healthy, and happy New Year!

FPMB 2021 FALL MEETING RECAP

The FPMB held a successful and very engaging 2921 Fall Meeting with its Member Boards on November 5:

New FPMB Member/Affiliate Boards

- **U.S. Virgin Islands Board of Medicine** [Member Board]
- **College of Physicians and Surgeons of British Columbia *(Canada)*** [Affiliate Member]

FPMB Executive Board Vacancy

Directors-at-Large shall each serve for a term of four (4) years and shall be eligible to be reelected to one (1) additional term.

Nominees must be members or employees of a dues-paid Member Podiatric Medical Board at the time of election, and must not have previously served on the FPMB Board of Directors during the previous three (3) years.

FPMB Executive Board Members have opportunities to serve on additional boards and committees:

- **National Board of Podiatric Medical Examiners *(NBPME)***
- **Continuing Education Committee *(CEC)* of the Council on Podiatric Medical Education *(CPME)***
- **Federation of State Medical Boards *(FSMB)***

Important Dates/Reminders

- **Member Board Update Forms**
  - ◊ September 30, 2021
- **FY 2021-2022 Member Dues**
  - ◊ October 31, 2021
- **Nominations/Applications for FPMB Executive Board Position**
  - ◊ January 2022
- **2022 Annual Meeting**
  - ◊ Mid-May 2022

(Continued on page 9)

FPMB'S COVID-19 INFO & RESOURCES WEBPAGE

Are your state's updates current and accurate?

COVID-19 continues to be a factor to consider for 2022.

Make sure your COVID-19 updates related to CMEs, licensure, telehealth, scope of practice, etc. are current and accurate in the State-by-State Updates section of our webpage.

KEY DATES

- **January 2022**
  - ◊ FPMB Executive Board Nominations / Applications
- **March 31, 2022**
  - ◊ Publishing date for next FPMB Newsletter
- **April 28-30, 2022**
  - ◊ FPMB Executive Board Meeting *(at FSMB Ann. Mtg.)*
- **May 2022**
  - ◊ FPMB Annual Meeting *(dues-paid Member Boards)*
- **June 22, 2022**
  - ◊ APMLE Part III Score Release

*** ANNOUNCEMENT ***

NATIONAL BOARD OF PODIATRIC MEDICAL EXAMINERS

The NBPME thanks all FPMB Member Boards who participated in the APMLE Part II Clinical Skills Patient Encounter *(CSPE)* organizational survey.

The survey report is being reviewed by the CSPE committee and their report will be discussed at the NBPME's March 2021 meeting.

AMERICAN ASSOCIATION OF COLLEGES OF PODIATRIC MEDICINE

"A national forum for the exchange of ideas, issues formation, and concerns relating to podiatric medical education."

The American Association of Colleges of Podiatric Medicine *(AACPM)* is a nationally recognized education organization whose mission is to serve as the leader in facilitating and promoting excellence in podiatric medical education leading to the delivery of the highest quality lower extremity healthcare to the public. AACPM's membership consists of the nine accredited U.S. podiatric medical schools and more than 200 hospitals and institutions that offer postdoctoral training in podiatric medicine.

The AACPM serves as a national forum for the exchange of ideas, issues formation, and concerns relating to podiatric medical education. The association's vision is to ensure, through collaboration and other appropriate means, that academic podiatric medicine is a vibrant community of schools and residency programs and other entities staffed with administrators, teachers, and researchers capable of educating and training a podiatric workforce relevant to the needs of the public, generating new biomedical knowledge, and providing academically based health services.

The AACPM also serves as a resource to students, residents, and practitioners by providing direct access to academic institutions; highlighting opportunities for clerkships and residencies; and linking students to mentors that guide their career development.

The AACPM administers several national service programs and projects, including:

- **American Association of Colleges of Podiatric Medicine Application Service *(AACPMAS)***

  A centralized application service known as AACPMAS which processes all applications submitted for admission to the schools and colleges of podiatric medicine. Applicants complete one application irrespective of how many schools they apply to. National application and matriculant data is collected through AACPMAS and reported on AACPM's website.

- **DPM Clerkship Program**

  An online application and rotation offer acceptance service for third-year students applying for their third- and fourth-year clerkship rotations.

- **Central Application Service for Podiatric Residencies *(CASPR)***

  An online application and matching service for fourth-year students interested in applying for residency positions in teaching hospitals. All CPME-approved residency programs participate in CASPR.

- **Centralized Residency Interview Program *(CRIP)***

  The CRIP interview process provides a means of saving time and money as hospital faculty and residency candidates interview together in one major city for one six-day period in January each year.

- **Curricular Guide for Podiatric Medical Education**

  The Curricular Guide for Podiatric Medical Education is designed to be a guidance document approved by the AACPM's Board of Directors and represents a collaborative effort by the association's member colleges. The contents of this document are a set of recommendations on what a comprehensive curriculum may look like to ensure all graduates have mastered the essential objectives for preparation for podiatric medical residency training.

For more information about AACPM, please visit https://aacpm.org/ or the association's social media:

Facebook | Twitter | Instagram

EDUCATION AND RESIDENCY PLACEMENT STATISTICS

American Association of Colleges of Podiatric Medicine

2021 - 2022 TOTAL ENROLLMENT
Fall Semester

CLASS YEAR	AZCPM	BUSPM	CSPM	DMU-CPMS	KSUCPM	NYCPM	SCPM	TUSPM	WUCPM	TOTAL
2025	40	67	40	60	104	101	97	95	44	648
2024	36	67	45	60	105	84	92	83	42	614
2023	35	63	45	50	110	87	87	87	47	611
2022	34	58	42	48	100	66	80	80	38	546
TOTAL	145	255	172	218	419	338	356	345	171	2419

Source: Colleges of Podiatric Medicine

The following is residency placement data as of June 30, 2021:

RESIDENCY APPLICANTS: Class of 2021

Placed in Residencies	534	(99.8%)
To Be Placed	1	(0.2%)
TOTAL	535	(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%)	3 (100.0%)
To Be Placed	0 (0.0%)	0 (0.0%)	0 (0.0%)
TOTAL	10 (100.0%)	0 (100.0%)	3 (100.0%)

When taking overall placements into consideration, 547 (99.8%) of the 548 residency applicants have found residency positions for the 2021-2022 training year.

AMERICAN PODIATRIC MEDICAL ASSOCIATION

Center for Professional Advocacy

apma Advancing foot and ankle medicine and surgery

Advancements in Scope of Practice Laws Continue Amid the Pandemic

In 2020, most state legislation that was not about the COVID-19 pandemic came to a halt, but in 2021, state legislatures took up other issues including scope of practice. In 2021, American Podiatric Medical Association *(APMA)* State Component Societies made several developments to modernize their scope-of-practice laws to include the ankle and governing and related structures of the lower leg.

In 2021, APMA State Component Societies made several developments to modernize their scope-of-practice law.

The Alabama Podiatric Medical Association *(ALPMA)* made significant progress in the spring of 2021 as the House Health Committee passed its scope-of-practice legislation and the Senate Health Committee held a hearing on the bill. While the legislative session ended before the bills could advance, it is the first time an Alabama legislative committee recognized the full capabilities of Alabama podiatrists. While the legislature has been out of session, ALPMA has continued to build momentum and reached out to legislators to gain a strong start in 2022. APMA leadership and Center for Professional Advocacy *(CPA)* staff have aided ALPMA and their lobbyists during these efforts.

In Massachusetts, the Joint Committee on Public Health again heard testimony on scope-of-practice legislation that would allow podiatrists to treat the foot and lower leg. The Massachusetts Foot and Ankle Society testified in support of the legislation and organized physicians from other specialties to testify to help demonstrate broad support for this legislation. The CPA reached out to national organizations to submit testimony, including the Foot and Ankle Section of the American Public Health Association, the Podiatric Medical and Surgical Section of the National Medical Association, and the Alliance of Wound Care Stakeholders. APMA President Jeffrey DeSantis, DPM, FACFAS, submitted written testimony on behalf of APMA and its members, as well.

The Mississippi Podiatric Medical Association *(MSPMA)* made significant inroads this year. MSPMA developed and strengthened legislative relationships and invited the state component's bill sponsor, State Senator Hillman Frazier, to the state meeting in May to share his support for the bill directly with members. Dr. DeSantis also participated in this meeting and spoke with Dr. Frazier. Throughout the year, CPA staff has worked with MSPMA leadership.

To help states societies, the Center for Professional Advocacy hosted its second Scope-of-Practice Advocacy Summit in June.

To help states societies, the CPA hosted its second Scope-of-Practice Advocacy Summit in June. The summit was for state components advocating to modernize their scope-of-practice laws to include the ankle and governing and related structures of the lower leg. The meeting allowed participants to share their experiences, identify common issues and struggles, and collaborate to develop solutions to advance their state scope-of-practice advocacy efforts. State component leaders, their lobbyists, the APMA Board of Trustees, the CPA Advisory Group, and staff participated in this 90-minute virtual meeting. These state societies will once again introduce legislation in 2022.

For more information about the CPA and APMA's scope-of-practice advocacy efforts, visit www.apma.org/CPA.

—Chad Appel, JD, Director
APMA Center for Professional Advocacy

AMERICAN PODIATRIC MEDICAL ASSOCIATION
Communications Committee

apma
Advancing foot and ankle medicine and surgery

Diabetes Campaign Educates At-Risk Audience

In November, the American Podiatric Medical Association's *(APMA)* 2021 Diabetes Awareness Month campaign targeted a niche audience of Hispanic men and significantly exceeded benchmarks from previous campaigns. The campaign reached its intended audience through a diverse mix of media and tactics with the message that "it's time (es hora)" to take care of your diabetes and prevent complications in your feet.

The APMA Communications Committee settled on the audience and goals for the campaign with the knowledge that, according to the Centers for Disease Control and Prevention *(CDC)*, Hispanics are twice as likely as non-Hispanic whites to be diagnosed with diabetes. "Combine that with greater barriers to care, and this is a population at very high risk for serious complications from diabetes," said APMA President Jeffrey DeSantis, DPM, FACFAS.

Sociocultural factors often drive Hispanic men, in particular, to avoid necessary health care. "That's why it's so important to educate this population about how they can manage their diabetes and protect their feet, which will keep them on the job and at the heart of their families," said Communications Committee Chair Priya Parthasarathy, DPM.

The campaign relied on a dedicated web page, www.apma.org/diabetes, available in both English and Spanish, a press release, and a paid in-app advertising campaign with Spanish-language ads. APMA is delighted with the outcomes of the campaign in spreading this important message to an at-risk audience.

(FPMB 2021 Fall Meeting Recap continued from page 5)

Joint Task Force of Orthopaedic Surgeons and Podiatric Surgeons *(White Paper & AMA Resolution)*

- **The "Big Picture" – Parity & Challenges**
- **Joint Task Force, White Paper, and AMA Resolution**
- **APMA Statement to Licensing Boards**
- **Relevance to FPMB Member Boards**
- **Implications and Discussion**

Member Boards Round Robin Topics

- **Scope of Practice**
- **Licensing Examinations**
- **CMEs**
- **Complaints / Discipline / Physician Re-Entry**
- **Board Governance and Operations**

Meeting participants across all of the Member Boards contributed to a high level of participation, exchange, and engagement resulting in impactful board networking.

Why Member Boards Should Attend FPMB Meetings

"You all help navigate national issues and give perspective on shared problems and act as a facilitator of information on how to handle challenging issues, rules, and law implementation."

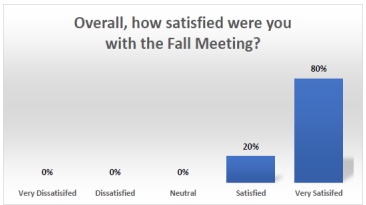
"This meeting is the only way boards can exchange information about all aspects of medical boards in real time."

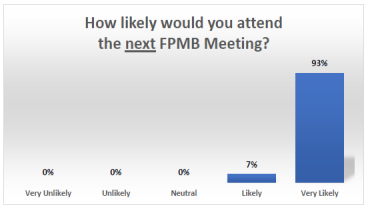
"To better understand the issues affecting the profession, the regulation of such profession, and to gain insight into issues that are coming or may be coming."

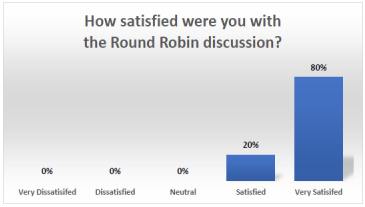
"There is tremendous value in learning what is occurring in other jurisdiction as much of what is shared is advantageous to other jurisdictions."

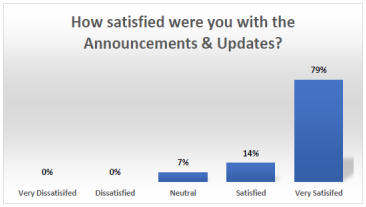
"Discussion of common problems shared by the Member Boards is helpful in addressing issues and solving problems for each board."

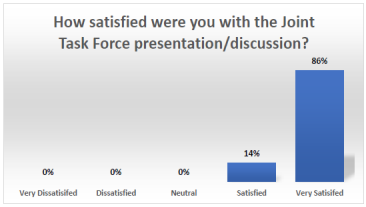
Post-Meeting Survey Results











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

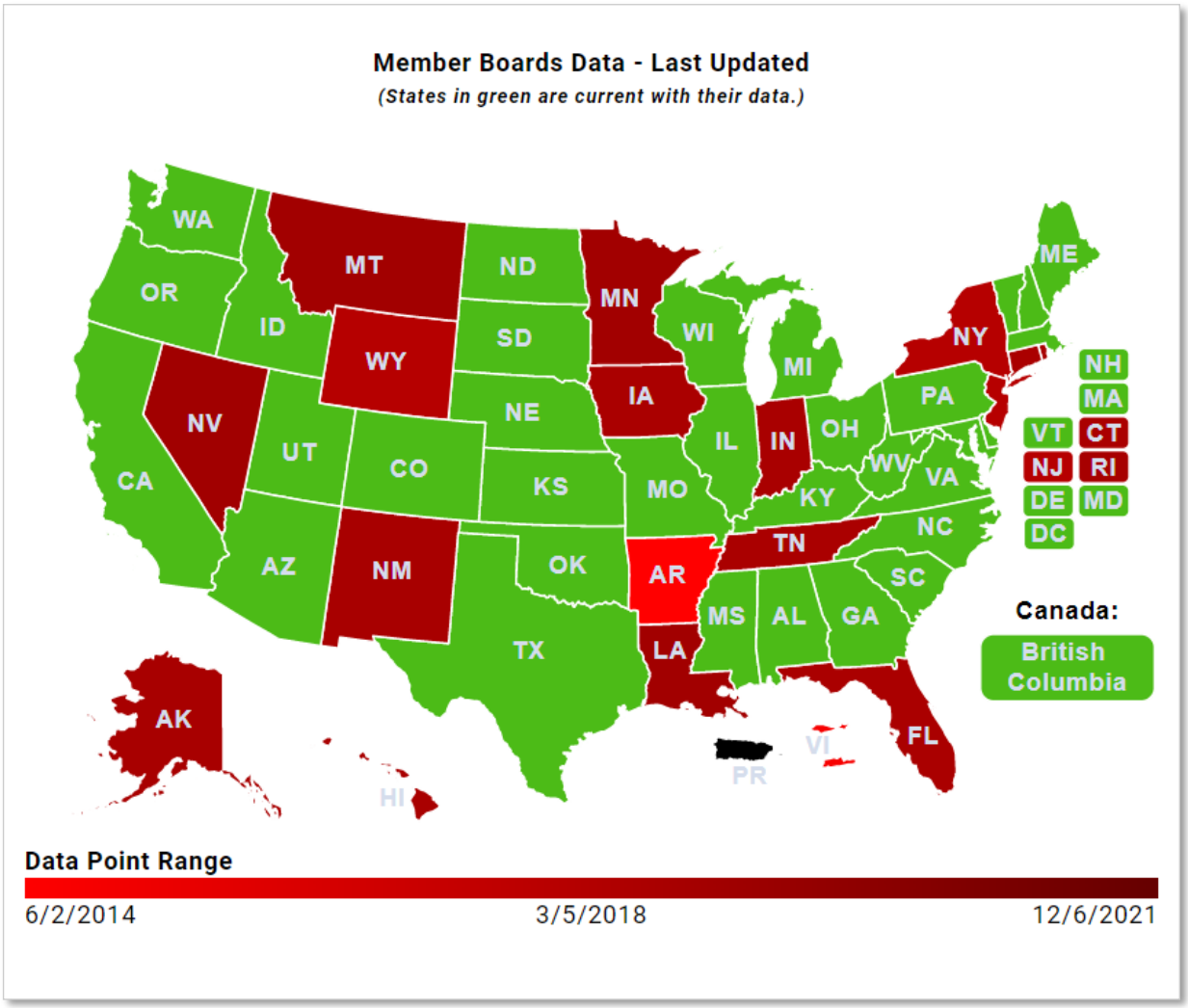
Enables visitors to compare all 15+ **general** and **licensure** data points across all, or a subset of, Member Boards.

YOUR Accurate, Complete, and Current Data is CRITICAL!

Member Board Update Forms were distributed on August 31, 2021 with a response due date of September 30, 2021. **RED** 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.

The data the FPMB collects and reports will be expanding to support its Data Initiative. The need and value of this initiative has only increased during the COVID-19 pandemic and from recent information requests the FPMB has received from Member Boards and other key stakeholders.



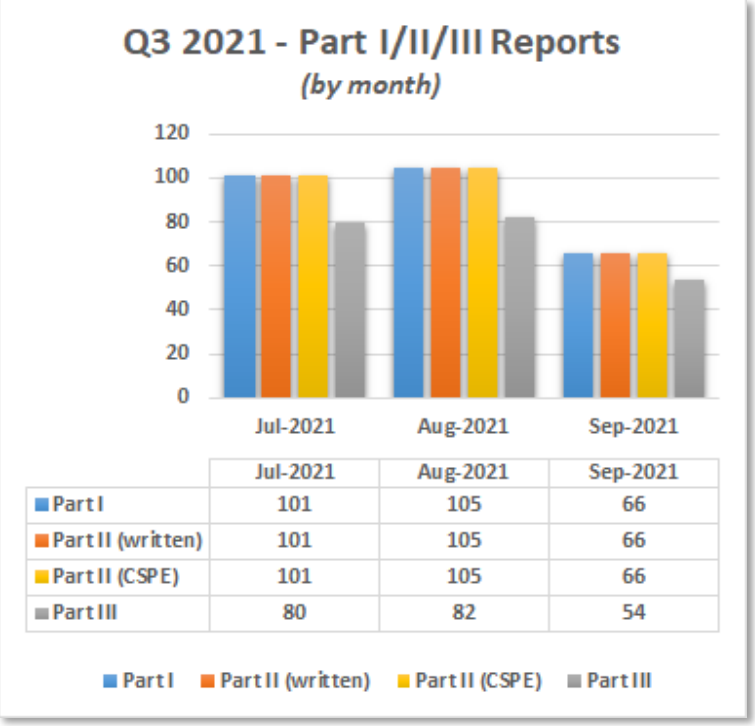
PRIMARY SOURCE VERIFICATION (LICENSURE) — ❖Q3 2021❖

Reports Ordered via Online System
100.00%

FPMB - Median Report Processing Time
< 1 business hour

Member Boards - Electronic Delivery
53

Member Boards - Median Download Time
5.12 business hours

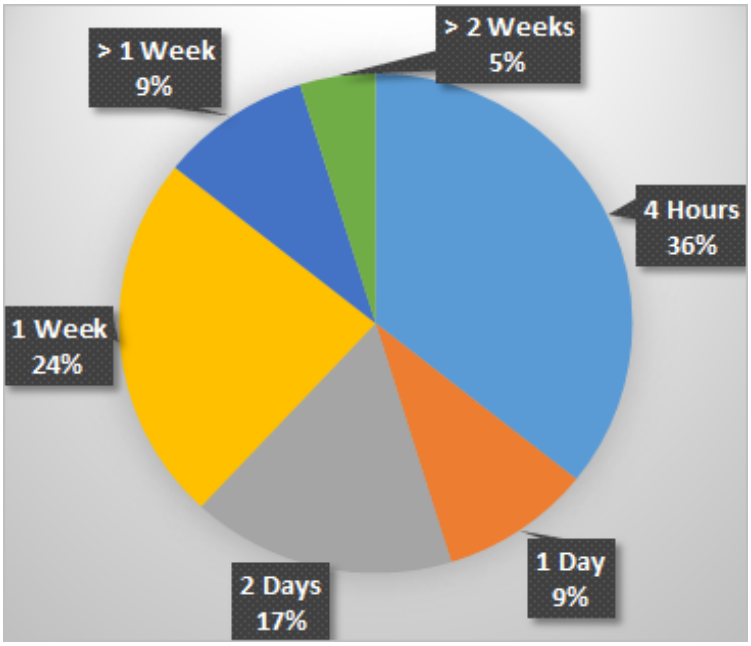


	Jul-2021	Aug-2021	Sep-2021
Part I	101	105	66
Part II (written)	101	105	66
Part II (CSPE)	101	105	66
Part III	80	82	54

EFFICIENCY IN LICENSURE — ❖Q3 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 **Q3 2021**:

Within 4 Hours

Arizona
California
Colorado
Connecticut
Georgia
Indiana
Kentucky
Mississippi
Montana
New Jersey
North Carolina
Ohio
Texas
Utah
Washington

Within 1 Day

British Columbia
Idaho
Oregon
South Dakota

Within 2 Days

Arkansas
Florida
Main
Massachusetts
Michigan
Pennsylvania
Wisconsin

NOTE: The 26 Member Boards listed above downloaded reports within 2 business days (median). Not listed are 16 Member Boards taking longer than 2 business days (median); 6 of these took more than 1 business week (median).

Overall, median download time increased by 25% compared to Q2 2021. Please download reports promptly.

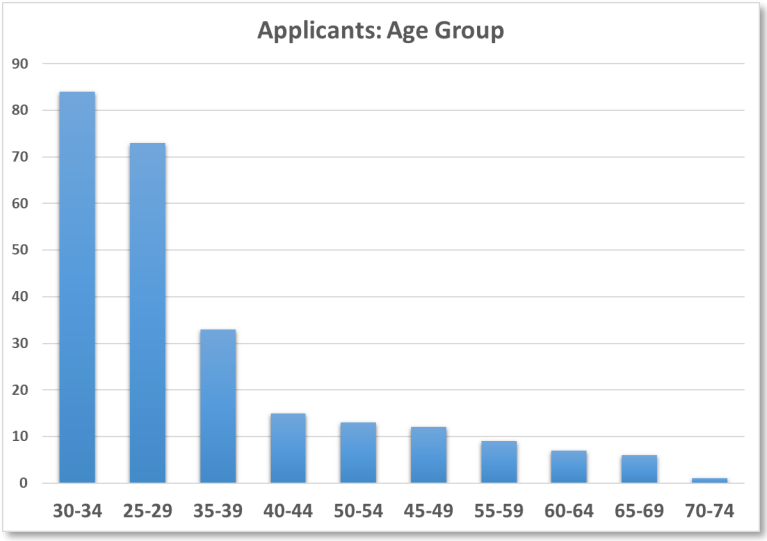
Occupational licensure reform seeks efficiency in licensure, especially for military spouses. Timely downloads of reports enables the FPMB to demonstrate efficiency of its Member Boards.

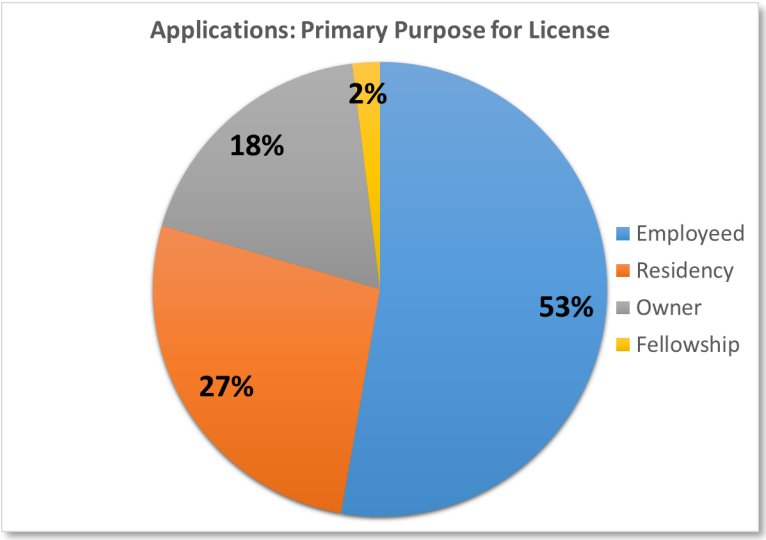
APPLICANT / APPLICATION STATISTICS — ❖Q3 2021❖

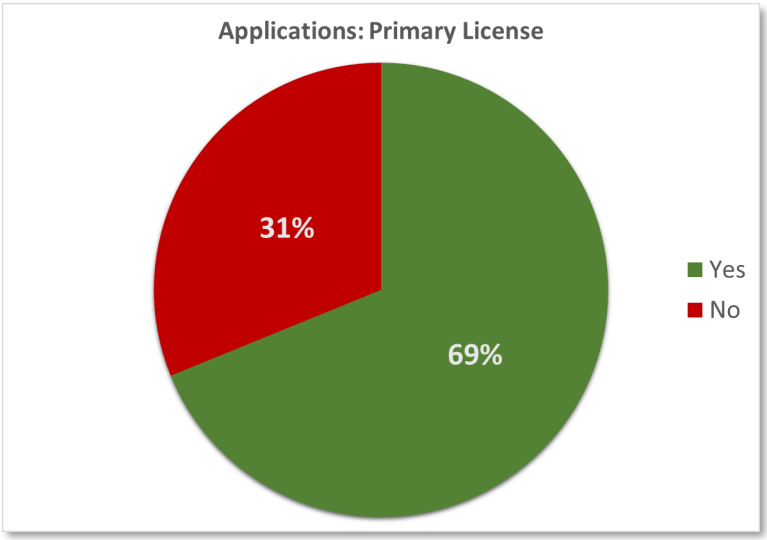
The following insights are based on data collected from podiatrists using the FPMB's primary verification source system as part of the licensure process:

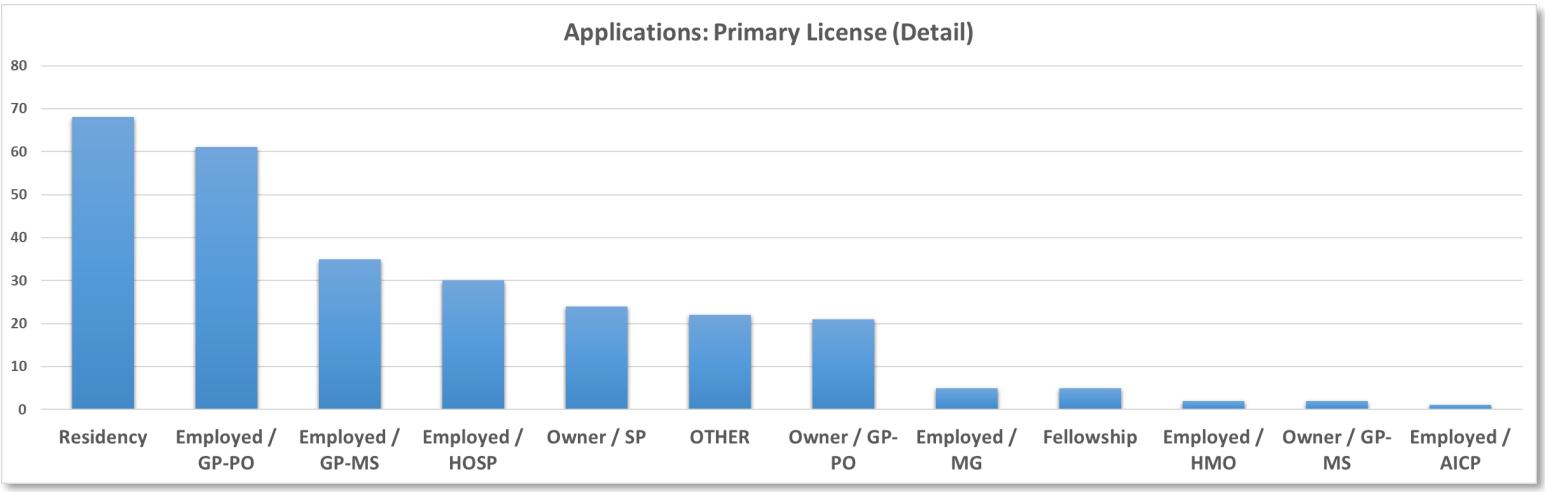
- **Applicants: Age Group**
- **Applications: Primary Purpose for License**
- **Applications: Is Primary License**

NOTE: The number of applications may be greater than the number of applicants, since an applicant may apply for licensure in multiple states.









PRIMARY PURPOSE KEY:
Residency: Residency
Fellowship: Fellowship
Owner / SP: Owner / Solo Practice
Owner / GP-PO: Owner / Group Practice-Podiatry Only
Owner / GP-MS: Owner / Group Practice-Multi Specialty
Employed / GP-PO: Employed / Group Practice-Podiatry Only
Employed / GP-MS: Employed / Group Practice-Multi Specialty
Employed / HOSP: Employed / Hospital
Employed / HMO: Employed / HMO
Employed / HP: Employed / Health Plan
Employed / MG: Employed / Military or Government
Employed / AICP: Employed / Academic Institution, participating in Clinical Practice
Employed / AIRT: Employed / Academic Institution, Research/Teaching, Only (no Clinical Practice)
Retired: Retired
OTHER: Other (specify)

LEGISLATIVE NEWS

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

❖ FEDERAL LEGISLATIVE NEWS ❖

Executive Actions

On July 9, **President Biden** signed an Executive Order on Promoting Competition in the American Economy, calling on several federal agencies to take action on competition-related matters through oversight, rule promulgation, and other means. The EO states that "some overly restrictive occupational licensing requirements can impede workers' ability to find jobs and to move between States," and encourages the Federal Trade Commission to address "unfair occupational licensing restrictions," as one of the 72 actions outlined in the text.

Legislation Moving Through Congress

The Dr. Lorna Breen Health Care Provider Protection Act (S. 610/H.R. 1667) was passed by the Senate by a unanimous voice vote on August 6. The measure was sponsored by **Senators Kaine (D-VA)**, **Cassidy (R-LA)**, **Reed (D-RI)** and **Young (R-IN)** in the Senate and **Representatives Wild (D-PA)**, **Krishnamoorthi (D-IL)**, **Chu (D-CA)**, and **McKinley (R-WV)** in the House. The bill was previously introduced during the 116th Congress in response to stress and burnout in the healthcare workforce during the COVID-19 pandemic 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.

Licensing

The Temporary Responders for Immediate Aid in Grave Emergencies (TRIAGE) Act (H.R. 5248) was introduced by **Rep. Jason Crow (D-CO)** and **Rep. Mike Waltz (R-FL)** and would codify the Provider Bridge Program under HRSA, which streamlines the process for mobilizing health care professionals by navigating licensure requirements and verifying credentials, among other functions; and provide grants to enable states, territories, and tribes to expedite emergency license renewals for former health care workers, so long as their license was in good standing prior to reactivation during the COVID-19 pandemic. The FSMB endorsed this legislation.

License Portability

The Inspire to Serve Act of 2021 (H.R. 3000) was introduced by **Reps. Jimmy Panetta (D–CA)**, **Don Bacon (R–NE)**, **Chrissy Houlahan (D–PA)**, **Mike Waltz (R–FL)**, **Seth Moulton (D–MA)**, **Salud Carbajal (D–CA)**, **Jason Crow (D–CO)**, **Dean Phillips (D–MN)**, and **Kai Kahele (D–HI)** and would, among other things, allow federal employees licensed "to practice medicine, osteopathic medicine, dentistry, psychology, nursing, therapy, or another health profession," to practice and perform authorized duties for the Federal Government in any United States jurisdiction "regardless of where such health care professional or the patient involved is located, if the practice is within the scope of the authorized Federal duties of such health care professional."

Combatting Misinformation

The Biosecurity Information Optimization for Defense Act of 2021 was introduced by **Rep. Eric Swalwell (D-CA)** and would establish the "National Biodefense Directorate," an interagency forum for biodefense preparedness. The Directorate would be charged with developing "a national strategy with respect to combatting public health misinformation and disinformation that threatens the national security, and associated implementation plan, including a review and assessment of Federal government communications policies, practices, programs and initiatives," among other matters. The bill would also define misinformation and disinformation.

(Continued on page 14)

(Legislative News continued from page 13)

Telehealth

The Protecting Rural Telehealth Access Act (S. 1988) was introduced by **Sens. Joe Manchin (D–WV)**, **Joni Ernst (R–IA)**, **Jeanne Shaheen (D–NH)** and **Jerry Moran (R–KA)** and would make certain pandemic–limited telehealth flexibilities permanent, including allowing payment parity for audio–only health services for clinically appropriate appointments, permanently waiving geographic restrictions, allowing patients to be treated from their homes; permanently allowing rural health clinics and Federally Qualified Health Centers to serve as distance sites, removing restrictions on "store and forward" technologies, and allowing Critical Access Hospitals (CAHs) to directly bill for telehealth services.

The Telemental Health Care Access Act of 2021 (S. 2061 / H.R. 4058) was introduced by **Sens. Bill Cassidy (R–LA)**, **Tina Smith (D–MN)**, **John Thune (R–SD)**, and **Ben Cardin (D–MD)** in the Senate and **Rep. Doris Matsui (D–CA)** and **Rep. Bill Johnson (R–OH)** in the House and would remove the requirement that Medicare beneficiaries be seen in person within six months of being treated for mental health services through telehealth; the bill also mandates a report on the utilization of mental health services furnished through telehealth, focusing on fraud and abuse prevention.

The Audio–Only Telehealth for Emergencies Act (S. 2111) was introduced by **Sen. John Kennedy (R–LA)** and would allow physicians delivering care during a public health emergency or a major disaster declaration to receive the same compensation for audio–only telehealth visits as they would receive for in–person appointments.

The Telehealth HSA Act (S. 2097) was introduced by **Sen. John Kennedy (R–LA)** and would permanently waive an IRS regulation that forces employees to pay out–of–pocket for telehealth services if they have a high–deductible health plan, a waiver that currently but temporarily exists due last year's CARES.

The Enhance Access to Support Essential Behavioral Health Services (EASE) Act (S. 2112 / H.R. 4036) was introduced by **Sen. John Kennedy (R–LA)** in the Senate and **Rep. Gus Bilirakis (R–FL)** in the House and would allow mental health professionals providing telehealth services through Medicare and Medicaid to be reimbursed at the same levels as if they were conducting in–person visits, allowing patients to receive care in their homes.

The Increasing Rural Telehealth Access Act (S. 2110)/Rural Remote Monitoring Patient Act (H.R. 4008) were introduced by **Sen. John Kennedy (R–LA)** in the Senate and **Rep. Dan Newhouse (R–WA)** and **Rep. Tom O'Halleran (D–AZ)** in the House and would fund a $50 million pilot program through HRSA to expand access to health care by improving remote patient monitoring technology, like blood pressure cuffs, biosensors and blood glucose monitors, for individuals in rural areas with low connectivity, 2G cellular frequency.

The Expanding Access to Mental Health Services Act (H.R. 4012) was introduced by **Rep. Matt Rosendale (R–MT)** and would permanently broaden mental health options, including intake examinations and therapy, via telehealth (video and telephone) for Medicare participants.

The Advancing Telehealth Beyond COVID–19 Act of 2021 (H.R. 4040) was re–introduced by **Rep. Liz Cheney (R–WY)** and **Rep. Debbie Dingell (D–MI)** and would permanently remove prerequisites for telehealth appointments that were temporarily waived under the pandemic relief package known as the CARES Act, such as designated originating sites, waive restrictions on access to smart devices for remote patient monitoring, and allow physicians to bill Medicare for audio–only telemedicine services, when appropriate.

The Rural and Frontier Telehealth Expansion Act (S. 2197) was introduced by **Sens. Jacky Rosen (D–NV)**, **Shelley Capito (R–WV)**, **Dan Sullivan (R–AK)**, **Jon Tester (D–MT)**, **Ben Ray Lujan (D–NM)**, and **Lisa Murkowski (R–AK)** and would increase Federal Medical Assistance Percentage

(Continued on page 15)

(Legislative News continued from page 14)

(FMAP), one of the factors that determines the size of Federal payments to a State for medical services, funding for telehealth services, including audio–only telehealth, by five percentage points in frontier states or states with limited access to broadband if those states cover telehealth services under Medicaid.

A discussion draft of the Cures Act 2.0 was released by **Rep. Fred Upton (R–MI)** and **Rep. Dianna DeGette (D–CO)** and includes several measures to enhance Medicare coverage for telehealth, through both new programs and permanent extensions of changes enacted during the pandemic. A section-by-section summary of the draft, which includes the TIKES Act and the Telehealth Modernization Act, is available here.

- The Telehealth Improvement for Kids' Essential Services (TIKES) Act, would help states integrate telehealth into Medicaid and Children's Health Insurance Program (CHIP)

- The Telehealth Modernization Act, would eliminate geographic and originating site restrictions in Medicare coverage of telehealth services and allow the Health and Human Services Secretary to expand the list of healthcare providers who could use telehealth as well as the types of services covered by Medicare

The Improving Medicare Beneficiary Access to Innovative Diabetes Technologies Act (S. 2146) was re-introduced by **Sen. Susan Collins (R-ME)** and **Sen. Jeanne Shaheen (D-NH)** and would improve Medicare coverage for diabetes maintenance via telemedicine, including implantable continuous glucose monitors, insulin dosing systems, mHealth apps and platforms. The bill would create an HHS task force to develop policies regarding coverage and payment.

The Helping Ensure Access to Local Telehealth (HEALTH) Act (H.R. 4437) was introduced by **Rep. Glenn Thompson (R-PA)** and **Rep. G.K. Butterfield (D-NC)** and would codify Medicare reimbursement for telehealth services rendered by Federally-qualified health centers (FQHCs) and rural health clinics (RHCs), permanently remove originating and distant site requirements, as well as allowing FQHCs and RHCs to continue to utilize audio-only telehealth visits for patients who do not have access to broadband.

The Telehealth Coverage and Payment Parity Act (H.R. 4480) was re-introduced by **Rep. Dean Phillips (D-MN)** and **Rep. Steve Chabot (R-OH)** and would require group health plans and insurers to provide coverage for telehealth services, including mental health and substance use disorder services, if such services are medically necessary and would be covered in-person, and with application of the same cost-sharing requirements (including a deductible, copayment, or coinsurance) as would apply if rendered in-person.

The Evaluating Disparities and Outcomes of Telehealth (EDOT) During the COVID-19 Emergency Act of 2021 (H.R. 4770) was re-introduced by **Rep. Robin Kelly (D-IL)** and would require an HHS study on the use of Medicare and Medicaid telehealth services during COVID-19, including utilization, service type, expenditures, savings, fraud, privacy, geographic and demographic information. The FSMB actively engaged on this bill last Congress and offered our support again this year.

The Helping Every American Link To Healthcare ("HEALTH") Act of 2021 (H.R. 4748) was introduced by **Rep. Madison Cawthorn (R-NC)** and **Rep. Jeff Duncan (R-SC)** and would revise HIPAA regulations to allow providers to provide telehealth services using any non-public facing audio or video communication product (such as FaceTime, Zoom, or Skype; among others) during the 7-year period beginning after the current COVID-19 public health emergency.

The Rural Telehealth Expansion Act (H.R. 4918) was introduced by **Rep. Matt Rosendale (R-MT)** and would expand Medicare to cover store-and-forward telehealth services, which includes asynchronous electronic communications of photos, messages, and video clips between patient and primary care provider, to all 50 states. Currently, Medicare covers this service only for patients in Hawaii and Alaska.

(Continued on page 16)

(Legislative News continued from page 15)

Veterans Affairs

The Sgt. Ketchum Rural Veterans Mental Health Act of 2021 (H.R. 2441) was signed into law by President Biden on June 30 and will establish new VA Rural Access Network for Growth Enhancement (RANGE) Centers for the program, which will focus on meeting the mental health care needs of rural veterans. The Act also directs the Government Accountability Office (GAO) to study whether mental health care furnished through certain VA programs is sufficient to meet the needs of rural veterans; how best to expand certain resources; the demand and wait time for such services; and the number of rural veterans that have died by suicide or overdose while on a wait list or during the study; among other items. This bill was previously featured in our May 2021 Advocacy Newsletter.

The Veterans Improved Access to Care Act of 2021 (H.R. 3027) introduced by **Rep. Jason Crow (D-CO)** would amend the 2018 VA MISSION Act to expand reporting on staffing at the VA to include information on the duration of the hiring process. The bill would also create a pilot program to assess reducing the time it takes to onboard new VHA medical providers, prioritizing facilities that are "facing hiring shortages of licensed independent medical providers." Additionally, it would require the VA to develop a strategy for reducing the duration of the hiring process for licensed professional medical providers by half.

The VA Hiring Enhancement Act (H.R. 3401) introduced by **Rep. Vicky Hartzler (R-MO)** would limit the applicability of non-Department of Veterans Affairs non-compete covenants to the appointment of certain VHA personnel and to require certain VHA physicians to complete residency training.

The Department of Veterans Affairs Continuing Professional Education Modernization Act (VA CPE Modernization Act) (H.R. 3693) introduced by **Reps. Julia Brownley (D-CA)** and **Marianette Miller-Meeks (R-IA)**, would improve reimbursement for continuing professional education for health care professionals in the Department of Veterans Affairs.

The Better Examiner Standards and Transparency (BEST) for Veterans Act of 2021 (S. 2329) was introduced by **Sen. Marco Rubio (R-FL)** and **Sen. Kyrsten Sinema (D-AZ)** and would compel the VA Secretary to take action to ensure that only currently licensed health care professionals conduct medical disability examinations (MDEs) on veterans, and authorizes a yearly report on the pilot program allowing MDEs to be performed by contract health care providers and on the Secretary's actions to ensure that providers meet requirements.

Opioids

The Non–Opioid Directive (NOD) Act (H.R. 4098) was introduced by **Reps. David B. McKinley (R–WV)**, **Lisa Blunt Rochester (D–DE)**, **John Curtis (R–UT)**, and **Tom O'Halleran (D–AZ)** and would allow patients to notify health professionals that they do not wish to be treated with opioids, instruct HHS to develop a revokable non–opioid Pain Management Directive that will be included in a patient's medical record, available to every enrollee in a group health plan during enrollment to opt –in or opt–out, and lastly, extends full liability protections to providers who mistakenly administer an opioid when a patient has signed a directive.

The Rural Area Opioid Prevention Pilot Program Act (H.R. 2985) was introduced by **Reps. Conor Lamb (D–PA)**, **Abigail Spanberger (D–VA)** and **Mariannette Miller–Meeks (R–IA)** and would fully authorize the DOJ's Rural Responses to the Opioid Epidemic Initiative pilot program, which identifies current gaps in prevention, treatment, and recovery services for individuals who encounter the criminal justice system within rural areas.

The Medication Access and Training Expansion (MATE) Act (S. 2235) was introduced by **Sen. Michael Bennet (D–CO)** and **Sen. Susan Collins (R–**

(Continued on page 17)

(Legislative News continued from page 16)

ME) and would create a one–time training requirement on treating and managing patients with opioid and other substance use disorders in order to register or renew registration with the DEA to dispense controlled substances in schedule II, III, IV, or V, unless the prescriber is otherwise qualified; allow medical, PA, and advanced nursing schools to fulfill the training requirement through their curriculum; and authorize federal grants for medical programs that develop the curricula to best identify and treat SUDs.

The Safer Prescribing of Controlled Substances Act (S. 2354) was re-introduced by **Sen. Edward Markey (D-MA)** and would require all federally licensed controlled substance prescribers to complete mandatory education pertaining to best practices for pain management, non-opioid therapies, methods for diagnosing and treating a substance use disorder, linking patients to evidence-based treatment for substance use disorders, and tools to manage adherence and diversion of controlled substances.

The Preventing Overdoses and Saving Lives Act of 2021 (H.R. 5224) was introduced by **Rep. French Hill (R-AR)** and **Rep. Debbie Dingell (D-MI)** and would create a grant program that allows states and localities to conduct research on the opioid crisis, create a strategic plan on their response to the opioid crisis, and implement co-prescribing, prescribing an opioid antidote such as naloxone in tandem with an opioid; in their jurisdiction.

The Improving Medicaid Programs' Response to Overdose Victims and Enhancing (IMPROVE) Addiction Care Act (S. 1575 / H.R. 4203) was introduced by **Sen. Pat Toomey (R-PA)** and **Sen. Joe Manchin (D-WV)** in the Senate and **Rep. Markwayne Mullin (R-OK)** in the House and would require states that use drug utilization review programs to alert doctors if their Medicaid-enrolled patient has suffered a previous nonfatal overdose and when a patient suffers a fatal overdose, connect recent opioid overdose survivors who receive Medicaid benefits with treatment opportunities, and perform ongoing reviews and provider education.

Substance Use Disorder Treatments

The Comprehensive Addiction and Recovery Act (CARA) 3.0 Act of 2021 (H.R. 4341) was introduced by **Reps. David Trone (D-MD)**, **Tim Ryan (D-OH)**, **David McKinley (R-WV)**, and **Brian Fitzpatrick (R-PA)**, among others, and would increase the funding levels for the Comprehensive Addiction & Recovery Act (CARA) programs enacted in 2016, including research into non-opioid pain management alternatives and long-term treatment outcomes to sustain recovery from addiction; establishing a National Commission for Excellence in Post-Overdose Response, requiring physicians and pharmacists use their state PDMP upon prescribing or dispensing opioids, and mandating physician education on addiction, treatment, and pain management; among other aspects. The companion bill, S. 987, was introduced earlier this year and featured in May's Advocacy News.

The Health Enterprise Zones Act (H.R. 4510) was re-introduced by **Reps. Anthony Brown (D-MD)**, **Steny Hoyer (D-MD)**, **Terri Sewell (D-AL)**, **Ann Kuster (D-NH)**, **Lisa Blunt Rochester (D-DE)**, **Robin Kelly (D-IL)** and **Tony Cárdenas (D-CA)** and would provide incentives including tax credits, student loan repayment, federal grants and a 10% Medicare reimbursement bonuses for healthcare providers to practice in "Health Enterprise Zones," designated areas with measurable and documented racial, ethnic, or geographic health disparities and an average income below 150% of the Federal poverty line, among other conditions.

Pandemic Response

The National Security Council Modernization Act (H.R. 4491) was introduced by **Rep. Eric Swalwell (D-CA)** and would give the secretary of Health and Human Services a permanent seat on the president's National Security Council (NSC), as well as encourage the attendance of the CDC Director and Surgeon General at meetings of the NSC to encourage viewing emerging public health threats as potential national security threats.

(Continued on page 18)

(Legislative News continued from page 17)

Liability Protection

The Coronavirus Provider Protection Act (H.R. 3021) was introduced by **Rep. Luis Correa (D–CA)** and **Rep. Michael Burgess (R–TX)** and would offer liability protection to health care providers who act in good faith and abide by government guidelines while caring for patients during the COVID–19 pandemic, with certain exceptions.

Health Care Workforce

The Pathways To Health Careers Act (H.R. 4449) was re-introduced by **Rep. Danny Davis (D-IL)** and seeks to modernize and fund the Health Profession Opportunity Grant (HPOG) program with $425 million for grants to better support low-income workers as they seek training and education for health care careers as nurses, health information technicians and surgical technicians. Among other things, the bill would revise HPOG to make all U.S. territories eligible, ensure that every state have an HPOG program, refunding Tribal HPOG programs, create a pilot program for training individuals with conviction records, and a pilot program for career pathway training into doula, midwife, and other pregnancy and birth professions.

The Healthcare Workforce Resilience Act (S. 1024 / H.R. 2255) was reintroduced by **Sen. Richard Durbin (D-IL)** in the Senate and **Rep. Brad Schneider (D-IL)** in the House and would make up to 40,000 previously unused immigrant visas, exempt from per-country limitations, available to international nurses (25,000) and physicians (15,000) who apply during the Covid emergency declaration, and up to 90 days after the declaration is rescinded.

Physician Assistants

The Physician Assistant Education Public Health Initiatives Act of 2021 (H.R. 3890) was introduced by **Rep. Karen Bass (D–CA)** and would allow PA education programs access to federally qualified health centers and other underserved settings for their clinical training, and authorize new funding to research and improve telehealth training for PA students.

Graduate Medical Students

The Student Assisted Vaccination Effort (SAVE) Act (S. 2114) was introduced by **Sen. Mark Kelly (D–AZ)** and **Sen. Susan Collins (R–ME)** and would permanently extend emergency provisions from the Public Readiness and Emergency Preparedness (PREP) Act to allow medical, nursing, pharmacy, and physician assistant students, among others; to administer vaccines during future federally declared public health emergencies with appropriate training and supervision.

Mental Health

The Behavioral Health Crisis Services Expansion Act (S. 1902) was re–introduced by **Sen. Catherine Cortez Masto (D–NV)** and **Sen. John Cornyn (R–TX)** and would create a continuum of behavioral health crisis services including 24/7 crisis hotlines and call centers, mobile crisis services, behavioral health urgent care facilities, 23–hour crisis stabilization and observation beds, and short–term crisis residential options. The bill would also provide insurance coverage for behavioral health crisis services, funding a grant program for communities to share successful ideas and services, and establish a panel of experts to improve coordination among 911 dispatchers and 988 crisis hotline call centers.

The Improving Mental Health Access from the Emergency Department Act (S. 2157 / H.R. 1205) was introduced by **Sen. Shelley Capito (R–WV)** and **Sen. Maggie Hassan (D–NH)** in the Senate and **Rep. Raul Ruiz (D–CA)** and **Rep. Brian Fitzpatrick (R–PA)** and would authorize a competitive grant program for emergency departments to implement innovative approaches for treating acute mental health episodes, expedite the transition to

(Continued on page 19)

(Legislative News continued from page 18)

post–emergency care through expanded coordination with a series of follow–up care aspects, increase the supply of inpatient psychiatric beds and alternative care settings, and expand alternative treatment methods such as tele–psychiatric support and peak period crisis clinics, among others.

The Physician Assistant Higher Education Modernization Act of 2021 (H.R. 2274) was also introduced by **Rep. Karen Bass (D-CA)** and would: reinstate authorities to make certain Stafford Loans available to PAs and others; make PAs eligible for certain incentives when serving as primary care providers or faculty members through loan forgiveness programs; provide grant eligibility for PA programs at Historically Black Colleges and Universities and Predominantly Black Institutions; prioritize PA postbaccalaureate opportunities for Hispanic Americans; and support matriculation and PA education programs at rural serving institutions of higher education.

Mobile Health Clinics

The Maximizing Outcomes through Better Investments in Lifesaving Equipment for (MOBILE) Health Care Act (S. 958) was introduced by **Sen. Jacky Rosen (D–NV)** and **Sen. Susan Collins (R–ME)** and would expand the allowable use criteria in the New Access Points Grant program to include part–time mobile clinics and renovation, acquisition, and new construction of health centers within the program to increase access to affordable, accessible, quality health care services in rural and underserved communities.

Broadband

The Broadband Parity Act of 2021 (S. 1884) introduced by **Sen. Jacky Rosen (D–NV)** and **Sen. Shelley Capito (R–WV)** and would direct the FCC to coordinate with federal agencies to establish a baseline level of service internet providers must provide customers when offering service via a federal broadband support program in order to increase access to uniform and reliable internet service.

The Broadband Reform and Investment to Drive Growth in the Economy (BRIDGE) Act of 2021 (S. 2071) was introduced by **Sen. Michael Bennet (D–CO)**, **Sen. Angus King (I–ME)**, and **Sen. Rob Portman (R–OH)** and would provide $40 billion to States, Tribal Governments, and U.S. Territories, prioritizing unserved, underserved, and high–cost areas to ease access to affordable, high–speed broadband with "future proof" networks that strive to meet the long–term needs of communities.

The Nationwide Dig Once Act (H.R. 3703) was reintroduced by **Reps. Anna G. Eshoo (D-CA)**, **David McKinley (R-WV)**, and **Antonio Delgado (D-NY)** and would mandate the inclusion of the "broadband conduit" – plastic pipes which house fiber-optic communications cables – during the construction of any road receiving federal funding in areas that lack broadband, such as rural and unserved communities. The legislation was included in the INVEST in America Act (H.R. 3684), the surface transportation reauthorization legislation that passed the House July 1.

The Accelerating Rural Broadband Deployment Act (H.R. 3970) was introduced by **Rep. John Curtis (R-UT)** and **Rep. Tom O'Halleran (D-AZ)** and would grant federal agencies the ability to approve a license of occupancy – no longer than 30 years but renewable - authorizing the deployment of the equipment required to deploy broadband service on a federal right-of-way, and mandate a 60-day limit to respond to a broadband permit request.

National Practitioner Data Bank (NPDB)

The Promote Responsible Oversight and Targeted Employee background Check Transparency for Seniors (PROTECTS) Act (S. 2214) was introduced by **Sen. Marco Rubio (R-FL)** and **Sen. Jacky Rosen (D-NV)** and would ease the process of accessing the NPDB, which maintains record of malpractice settlements and adverse actions in a health professional's history, for care providers like nursing homes and home health agencies.

(Continued on page 20)

(Legislative News continued from page 19)

Federal Regulatory News

Highlights

On June 17, the **Federal Communications Commission** issued updated guidance on the Connected Care Pilot Program, which makes up to $100 million available to help defray the costs of providing certain telehealth services for eligible health care providers, with a particular emphasis on providing connected care services to low–income and veteran patients. The FCC this week voted to approve 36 additional pilot projects for a total of over $31 million in funding, bringing the total to over $57 million in funding for 59 pilot projects serving patients in 30 states plus Washington, DC. The list of new grantees is available here.

On June 28, the **Drug Enforcement Administration (DEA)** published a Final Rule entitled Registration Requirements for Narcotic Treatment Programs with Mobile Components. The rule allows registrants authorized to dispense methadone to add a "mobile component" to their existing DEA registration. The rule aims to provider greater access to "needed services in remote or underserved areas," and is effective on July 28, 2021. The DEA's announcement on the final rule is available here.

On July 9, **Dawn O'Connell** was sworn in as the **Assistant Secretary for Preparedness and Response (ASPR) at the Department of Health and Human Services**. ASPR collaborates with hospitals, healthcare coalitions, biotech firms, community members, state, and local governments to improve readiness and response capabilities to, and recovery from disasters and public health emergencies.

On July 13, **CMS** issued the Calendar Year (CY) 2022 Medicare Physician Fee Schedule Proposed Rule for comment. The rule would extend some of the temporary changes to telemedicine made during the COVID-19 pandemic to 2023. It also includes changes "to address the widening gap in health equity highlighted by the COVID-19 Public Health Emergency (PHE) and to expand patient access to comprehensive care, especially in underserved population." A fact sheet on the Proposed Rule is available here and an overview of the Quality Payment Program (QPP) Proposals.

On July 13, **President Biden** nominated **Dr. Rahul Gupta to lead the Office of National Drug Control Policy**. Dr. Gupta was previously health commissioner of West Virginia and, if confirmed, would be the first physician to serve as Director of ONDCP.

On July 15, **CMS** announced a $15 million funding opportunity for states to strengthen community-based mobile crisis intervention services to address mental health or substance use related crises through Medicaid.

On July 15, **U.S. Surgeon General Dr. Vivek Murthy** issued an **Advisory on Building a Healthy Information Environment**. The Advisory warns the public about misinformation, noting that "Health misinformation is an urgent threat to public health. It can cause confusion, sow mistrust, and undermine public health efforts, including our ongoing work to end the COVID-19 pandemic." The full text of the Advisory is available here.

On July 16, **HHS** announced that $103 Million in funding will be made available through **HRSA** to "reduce burnout and promote mental health among the health workforce." The three funding opportunities are: Promoting Resilience and Mental Health Among Health Professional Workforce; Health and Public Safety Workforce Resiliency Training Programs; and Health and Public Safety Workforce Resiliency Technical Assistance Center. The full announcement is available here.

On July 19, **HHS Secretary Xavier Becerra** formally extended the COVID-19 Public Health Emergency for 90 days, the fifth successive PHE extension. This declaration allows a series of waivers concerning the provision of telemedicine, including allowing more providers to bill Medicare for tele-

(Continued on page 21)

(Legislative News continued from page 20)

health services, and reimbursing for audio-only telehealth as well as waiving select oversight and reporting requirements.

On August 12, the Biden Administration announced, through the Department of Agriculture, that it would make up to $500 million in grants, available for telehealth, mobile integrated health and other programs that help rural communities access healthcare, nutrition assistance and COVID-19 vaccines through Recovery and Impact Grants.

- Recovery Grants are earmarked for public groups, non-profits and tribes supporting rural healthcare systems and may be used to increase COVID-19 vaccine distributions and telehealth services, purchase medical supplies, build or improve upon temporary or permanent healthcare structures, replace revenue lost during the pandemic, support staffing needs for vaccine distribution and testing and for operations associated with banks and food distribution facilities.

- Impact Grants focus on long-term projects and go to regional partnerships, public groups, non-profits and tribes that are tackling regional healthcare issues in response to the pandemic and planning a more sustainable post-pandemic strategy.

On August 18, the Biden Administration announced the distribution of $19 million to 36 award recipients through HRSA within the following telehealth programs:

- Telehealth Technology-Enabled Learning Program (TTELP)

- Telehealth Resource Centers (TRCs)

- Evidence-Based Direct to Consumer Telehealth Network Program (EB TNP)

- Telehealth Centers of Excellence (COE) program

On August 26, the Federal Communications Commission announced it had awarded $42 million for Round 2 of the COVID-19 Telehealth Program. The COVID-19 Telehealth Program, put into place by 2020's CARES Act, 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. According to FCC acting chair Jessica Rosenworcel, "the applicants that received funding include the hardest-hit and lowest-income areas in the country, tribal communities, and previously unfunded states and territories."

On August 27, HHS announced $10.7 million will go into the Pediatric Mental Health Care Access Program, which enables pediatric mental healthcare providers to use connected health to consult with, train, provide assistance to and participate in care management plans with primary care providers. The expansion broadens the program's reach from 21 awards in 21 states (awarded in May and featured in our June Advocacy News) to 45 awards in 40 states, as well as the District of Columbia, the U.S. Virgin Islands, as well as Chickasaw Nation and the Red Lake Band of the Chippewa Indians.

On September 9, President Biden announced COVID-19 vaccinations will be required for workers in most health care settings that receive Medicare or Medicaid reimbursement, including but not limited to hospitals, dialysis facilities, ambulatory surgical settings, and home health agencies. The mandate will apply to approximately 50,000 providers and covers a majority of health care workers across the country.

Also on September 9, HHS expanded liability protections under the Public Readiness and Emergency Preparedness (PREP) Act to licensed pharmacists, qualified pharmacy technicians and pharmacy interns that administer FDA-authorized COVID-19 therapies. Under the PREP Act, providers are im-

(Continued on page 22)

(Legislative News continued from page 21)

mune from liability for claims of injury or loss resulting from the administration of authorized disease countermeasures.

On September 10, HHS, through HRSA , announced $25.5 billion in new funding available for health care providers affected by the pandemic, including $8.5 billion in American Rescue Plan (ARP) resources for providers who serve rural Medicaid, Children's Health Insurance Program (CHIP), or Medicare patients, and an additional $17 billion for Provider Relief Fund (PRF) Phase 4 for a broad range of providers who can document revenue loss and expenses associated with the pandemic.

- PRF payment methodology.

On September 13, HHS announced it had awarded $123 million in grants through the Substance Abuse and Mental Health Services Administration (SAMHSA) to combat the nation's opioid overdose epidemic through the following programs:

- Medication Assisted Treatment for Prescription Drug and Opioid Addiction (MAT-PDOA)
- Tribal Opioid Response Grants (TOR)
- Screening, Brief, Intervention, and Referral to Treatment (SBIRT)
- Strategic Prevention Framework for Prescription Drugs (SPF Rx)
- First Responder-Comprehensive Addiction and Recovery Act Grants (FR-CARA)
- Providers Clinical Support System – Universities (PCSS-Universities)

On September 20, CMS announced it had awarded $15 million in planning grants to 20 states to support expanding community-based mobile crisis intervention services for Medicaid beneficiaries, focusing on substance use-related or mental health crises. To see the list of award recipients, click here.

❖ STATE LEGISLATION OF INTEREST ❖

Interstate Medical Licensure Compact

On July 1, Ohio Governor Mike DeWine signed Senate Bill 6 into law, making Ohio the 35th Member State of the IMLC (33 states, DC, and Guam).

As of July 30, 2021, the IMLCC has processed 14,965 applications resulting in 22,165 licenses to practice medicine issued to qualified physicians (MD and DO) by participating state and territorial medical and osteopathic boards.

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

State Waivers Update

Since the COVID-19 pandemic began last March, the FSMB has maintained charts documenting state waivers on out–of–state physicians practicing in–person and via telemedicine, as well as expediting licensure for inactive or retired physicians. Currently, 22 states are allowing out–of–state physicians to practice in person, 18 via telemedicine, and 21 are expediting licensure for inactive or retired physicians.

Telemedicine

New Jersey Administrative Code 8:53 – Regulations implementing the 2017 New Jersey Telemedicine and Telehealth Act require telemedicine or telehealth organizations to register with, and pay a fee to the New Jersey Department of Health before providing telemedicine services to patients located in the state. Registration and payment are unnecessary for healthcare facilities that utilize telehealth services in addition to in-person evaluation and care services, according to Department guidance. For more information about the registration process, click here.

(Continued on page 23)

(Legislative News continued from page 22)

Recently Enacted Regulation

Active Supervision

Louisiana HB 398 – Creates the Occupational Licensing Review Program in the office of the Attorney General, which gives the AG the authority to enter into an agreement to provide active supervision of proposed occupational regulations and proposed anti–competitive disciplinary actions of a state occupational licensing board, and also provides boards and board members immunity from federal antitrust laws.

Board Structure and Function

Alaska SB 21 - Transfers the authority to regulate paramedic licensure from the Medical Board to the Department of Health and Social Services.

Civil Immunity

Alaska SB 65 - Provides immunity for consulting physicians and PAs, so long as the consulting provider does not examine or treat the patient, is not compensated, is not serving in a locum tenens role, and has never had the patient under their care previously.

Continuing Medical Education

Connecticut SB 1 – Requires hospitals to include implicit bias training as part of their regular training to staff members who provide direct care to women who are pregnant or in the postpartum period.

Illinois SB 677 - Mandates that health care professionals that work with elderly populations must complete 3 hours of CME on the diagnosis, treatment, and care of individuals with cognitive impairments.

Maryland HB 28 – Requires applicants for the renewal of a license or certificate issued by a health occupations board to attest to completion of an approved implicit bias training program the first time they renew their license or certificate after April 1, 2022.

Minnesota HF 33 – Requires employees of hospitals with obstetric care and/or birth centers, who routinely care for patients who are pregnant or postpartum, to take a continuing education course on anti–racism training and implicit bias.

Graduate Medical Education

Maine LD 1629 – Clarifies that an applicant meets post–graduate training requirements if they have graduated from a medical school accredited by the LCME and completes 24 months of ACGME–accredited PGT.

License Portability

Illinois HB 2776 - Requires the Board to issue an occupational license/certificate to a military member and/or their spouse within 30 days (formerly 60) so long as they've held that license/certificate in another jurisdiction, are in good standing and meet the requirements and standards for licensure in the state.

Kansas HB 2208 - Allows physicians holding an unrestricted license in another state to practice telemedicine on Kansas patients if they receive a telemedicine waiver from the State Board of Healing Arts. Out-of-state physicians must complete an application, pay a fee, meet existing state qualifications, and not be subject of any investigation or disciplinary action. The physician must follow state laws and regulations, and the Board of Healing Arts holds disciplinary jurisdiction.

Medical Marijuana

New Jersey A 1635 & S 619 – Allows for prescribers to recommend medical marijuana via telehealth for people who face barriers to in–person care, including children in long–term care facilities and patients who are developmentally disabled, housebound, terminally ill or in hospice care. Bill also eliminates the initial in–person examination and annual meeting requirements.

(Continued on page 24)

(Legislative News continued from page 23)

Pennsylvania HB 1024 – Empowers the state's Medical Marijuana Advisory Board to continue to consider new medical conditions for eligibility, and adds cancer remission therapy and neuropathies associated with the central nervous system to qualifying conditions; increases product dispensing from a 30–day supply to a 90–day supply; permits a dispensary to have a pharmacist or physician available either in person or by synchronous interaction; and permits a PA or RN, in lieu of a physician or pharmacist, to verify patient certifications.

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

Military Licensure

Louisiana HB 197 – Grants an occupational or professional license or certificate to an individual and their spouse/dependents who establishes residency in the state and has held a license for at least a year in another state, is in good standing, has not faced disciplinary action and has met the exam, education, experience, and training requirements of license–holders in the state.

Opioids

Colorado HB 21–1276 – Requires insurers to make both opioid and non–opioid medication for the same indication available at the lowest cost–sharing tier. Bill also indefinitely continues the prohibition on prescribing more than a seven–day supply of an opioid to a patient that has not had an opioid prescription in the past.

New Jersey A 5703 – Requires insurers to provide coverage for opioid antidotes without prior authorization requirements, and allows practitioners and pharmacists to administer or dispense the antidotes to any person without an individual prescription.

Pain Management

Illinois SB 1842 – Requires the PDMP to issue an unsolicited report to prescribers, dispensers, and their designees informing them of potential medication shopping when a person utilizes five (rather than three) or more prescribers or five (rather than three) or more pharmacies, or both, within a six-month (rather than continuous 30 day) period.

Illinois HB 2589 - Provides that a health care professional or other person acting under the direction of a health care professional may store and dispense an opioid antagonist - without generating or affixing a patient-specific label - to a patient that has been prescribed an opioid.

Physician Assistant/APRN Scope of Practice

Texas HB 2093 – Adds PAs to the list of "non–physician mental health professionals."

Delaware HB 141 and HB 21 - HB 21 enters Delaware into the APRN Compact, while HB 141, the companion bill, clarifies that APRNs are independent licensed practitioners, with a scope of practice that includes advanced assessment, diagnosing, prescribing, and ordering, among other responsibilities. The bill removes the requirement for APRNs to have a collaborative agreement, although employers and health care organizations may still require one. Lastly, the bill reforms the APRN Committee, which is under the Board of Nursing, by removing the requirement that four of the members are physicians that work with APRNs.

New York S 1239 - Allows physicians, PAs, and NPs to train unlicensed school personnel to administer glucagon or epinephrine in emergency situations when healthcare professionals are unavailable

Physician Misconduct

Florida SB 1934 – Bars physicians charged with serious crimes such as sexual assault, possession of child pornography or homicide (as well as sexual misconduct against a patient, kidnapping, false imprisonment, human trafficking, enticing a child, among others) from seeing patients until those charges are resolved.

(Continued on page 25)

(Legislative News continued from page 24)

Prescribing Practices

Massachusetts S 2475 – Extends certain Covid–era waivers until May 1, 2022, including allowing licensed pharmacists and pharmacist interns to administer methadone and buprenorphine as part of treating opioid use disorder.

Rhode Island HB 6328 – Removes the possession buprenorphine from the list of controlled substances that can result in criminal penalties.

Prescription Drug Monitoring Programs (PDMPs)

Colorado SB 21–098 – Recommends continuing the state PDMP until 9/1/28, authorizes the Pharmacy Board to identify prescription drugs that aren't currently listed on the PDMP but should be added, and authorizes deputy coroners to access the PDMP.

Public Health

Rhode Island HB 5245 – Authorizes a pilot program that would be designed, monitored, and evaluated to generate data to inform policymakers on the feasibility, effectiveness, and legal aspects of an overdose prevention site (OPS) in reducing harms and health care costs related to, among other things, injection drug use.

Telemedicine

Louisiana HB 270 – Redefines telemedicine to include asynchronous store–and–forward transfer technology and remote patient monitoring technologies, and to prohibit non–HIPAA compliant email and fax.

Maine LD 791 – Makes permanent the emergency measure that mandated payment parity between services rendered in–person and via telehealth.

Rhode Island SB 4 – Allows patient's home to be an originating site when clinically appropriate, adds telephone audio–only to the definition of telemedicine.

Pending Legislation of Interest

Board Structure and Function

California SB 806 – Amended bill increases license fee by 10%, maintains the physician majority on Medical Board (an earlier version would've established a public member majority), renames postgraduate training license to postgraduate license, and changes the date of the next Medical Board sunset review to 2024, instead of 2022.

Pennsylvania HB 1862 - Allows individuals with an institutional license the ability to practice at more than two affiliated facilities when practicing or teaching.

Pennsylvania SB 398 – Changes the composition of the state medical board from seven to nine, with seven members being physicians, one PA, and one nurse midwife, NP, athletic trainer, respiratory therapist or perfusionist. Bill also details the extent of the PAs collaborative practice agreements with their collaborating physician(s), including their scope of practice, the nature and degree of supervision, and the physician with primary responsibility, among other aspects.

Wisconsin SB 98 – Bill prohibits complementary and alternative health care (CAHC) practitioners from engaging in the practices of medicine and surgery, recommending the discontinuation of treatment that is prescribed by a healthcare professional, making a diagnosis, or purporting themselves as a credentialed professional. Bill also prohibits a person from acting as a CAHC if they were a credentialed health care professional and their credential revoked or suspended; unless it was subsequently reinstated.

Continuing Medical Education (CME)

New Jersey A 4253 – Requires healthcare professionals that have direct contact with patients, working at clinical laboratories or hospitals, to complete a cultural competency training program at least once biennially.

Wisconsin SB 259 - Creates the Genetic Counselors Affiliated Credentialing Board within the Wisconsin Medical Examining Board.

(Continued on page 26)

(Legislative News continued from page 25)

License Portability

Alaska HB 3009 - Allows healthcare providers licensed in another jurisdiction to provide telemedicine services to Alaska patients, including prescribing, excluding controlled substances, without an in-person examination, and without PA supervision (when normally required) until July 1, 2022. Also waives the requirement for hospitals and nursing facilities to seek background checks from the Department of Health and Social Services until the same date.

Massachusetts S 2472 – Extends emergency licenses to out–of–state physicians that served Massachusetts patients, including by telemedicine, through April 1, 2022.

Oregon SB 423 – Allows Oregon patients to receive health care services through telemedicine from out–of–state physicians, PAs, psychologists, or nurse practitioners licensed and in good standing in California, Idaho, or Washington.

Pennsylvania HB 1573 – Defines out–of–state telemedicine providers as a licensed healthcare provider that is working for the military, through a federally operated facility, in response to an emergency medical condition, or providing a provider–to–provider consultation. Bill also mandates that licensure boards promulgate final telemedicine regulations such that there is not a separate standard of care for telemedicine versus in–person care.

Pennsylvania HB 1868 - Requires licensing boards to issue a license to a qualified applicant that has passed all examination requirements, achieved a military occupational specialty, and has practiced that specialty for at least two of the last five years. Also requires boards to issue an expedited license to a military member or their spouse who is licensed in another state and is assigned to duty in the state. Lastly, the bill forgives late license renewal, so long as the late renewal is a direct result of deployment.

Medical Marijuana

Florida SB 162 - Increases the number of physician medical marijuana certification from three to five 70 -day supply limits, or from six to ten 35-day supply limits. Also, if the patient is a disabled veteran or permanently disabled, the limit is increased to ten 70-day supplies or twenty 35-day supplies. A physician must also evaluate the patient once every 52 weeks (increased from 30 weeks), or once every 104 weeks if the patient is a disabled veteran or permanently disabled.

Massachusetts HD 4394 - Bill would establish a pilot program within the Department of Health for veterans to use medical marijuana to treat certain conditions that are currently being treated with opioids.

North Carolina SB 711 – Legalizes medical marijuana, requires a bona fide patient–practitioner relationship prior to recommending medicinal marijuana for a patient, creates a registry for patients and caregivers, a Medical Cannabis Advisory Board, and defines qualifying medical conditions as cancer, severe PTSD, multiple sclerosis, and epilepsy among other ailments.

West Virginia SB 231 – Adds autism, anorexia, glaucoma, migraines, and seizures, among other conditions, to the list of medical marijuana qualifying conditions.

Physician Assistant / APRN Scope of Practice

Florida HB 1299 – Creates "autonomous physician assistant" position, which requires an unencumbered PA license, not being subject to a disciplinary action within the last 5 years, completed 4,000 years of clinical experience, completed a graduate–level course in pharmacology, and holds liability insurance, among other conditions.

Ohio HB 356 – Implores the Medical Board to develop rules regarding MAT and Schedule III–V controlled substances, encouraging PAs to use non–addicting MAT, the tapering of addicting MAT, and discourage life–long MAT.

Oregon HB 3036 – Removes requirement that a PA practice under supervising physician and instead requires a collaboration agreement with physician.

Wisconsin SB 394 & AB 396 – Creates a new system of licensure for APRNs, requiring applicants to hold, or concurrently apply for, an RN license; have completed an accredited graduate–level or post-

(Continued on page 27)

(Legislative News continued from page 26)

graduate–level education program and hold a current national certification approved by the board; possess malpractice liability insurance; and pay a fee, among other conditions.

Physician Misconduct

Pennsylvania HB 1816 - Requires healthcare providers to receive informed consent, in both verbal and written form, from an unconscious or anesthetized patient prior to pelvic, rectal or prostate examinations; unless exam was court-ordered to obtain evidence or in cases of a medical emergency.

Wisconsin AB 128 - Requires hospitals to have and enforce a policy requiring written and verbal informed consent before conducting a pelvic examination on a patient under general anesthesia or otherwise unconscious.

Physician Wellbeing

California AB 562 – Requires the Department of Consumer Affairs to establish, notify licensees, and solicit applications for a mental health resiliency program for licensed health care providers who provide or have provided in–person healthcare services to COVID–19 patients.

Prescribing Practices

Kentucky BR 376 - Authorizes the state's Department for Medicaid Services to cover up to 20 visits per event of chronic pain treatment including the specializations of acupuncture, massage, physical, or occupational therapy, psychotherapy, or chiropractic services.

New York S 7348 - Allows a practitioner, during a declared emergency, to issue a prescription for more than a 30-day supply of a controlled substance, so long as it is consistent with a written treatment plan that follows generally accepted national, professional, or governmental guidelines.

Puerto Rico PS 189 – Requires physicians to discuss the risks associated with the use opioid–based drugs with their patients before prescribing opioids.

Prescription Drug Monitoring Programs (PDMPs)

New York S 5199 – Adds the inappropriate prescription of controlled substances to the list of offenses the Health Department can analyze the state's PDMP.

Wisconsin AB 430 – Rescinds the exception that allows physicians to prescribe controlled substances without first consulting the state PDMP if the dosage is for three days or less.

Substance Use Disorder Treatment

Michigan SB 579 & HB 5163 – Requires hospitals that treat more than 50 opioid–related overdoses per year to implement an emergency–based medication–assisted treatment program, including maintaining protocols on and the capacity to provide evidence–based interventions, personnel who can possess and administer opioid agonist treatment, and personnel who specialize in the transition of care for discharged patients.

Telemedicine

Connecticut HB 6470 – Requires CT Medical Assistance (Connecticut Medicaid) to provide coverage for audio–only telehealth when clinically appropriate and provided to individuals who are unable to use or access comparable, covered audiovisual telehealth services.

Massachusetts S 678 – Prohibits insurers from requiring a co–pay for services rendered via telehealth, prior authorization for services that wouldn't require it if rendered in–person; and requires insurers to reimburse for interpreter services for patients with limited English proficiency, deaf, or hard of hearing.

New Jersey A 4179 – Prohibits geographical limitations on the origin of telehealth services (enabling home telehealth), prohibits restricting the technological platforms as long as they meet the applicable standards of care and meets federal privacy rules.

New York A 8079 – Redefines store and forward technology definition that narrowly defined it as patient digital images and pre–recorded videos, and removes condition that a provider needed to be at the originating site.

NEWS CLIPS

Licensure & Regulation

FSMB releases 2021 Annual Report: 'Challenge and Change'
FSMB
August 2021

Interstate Medical Licensure Compact Commission releases four-year data study
IMLCC
August 2021

Oklahoma again expediting some medical licenses due to COVID-19 surge
Oklahoman
August 2021

Joint Task Force of Orthopaedic and Podiatric Surgeons
FPMB
October 2021

FSMB 'Strongly Opposes' State Laws Barring Disinfo Docs From Discipline
MedPage Today
December 2021

Licensure Examinations

What every physician should know about getting a medical license
The DO
July 2021

USMLE policy updates following Step 2 CS discontinuation
USMLE
July 2021

USMLE Step 1 transition to pass/fail only score reporting
USMLE
September 2021

Evolution of Clinical Skills Assessment in the USMLE: Looking to the future after Step 2 CS discontinuation
Academic Medicine
September 2021

Change to USMLE step passing standard begins January 26, 2022
USMLE
December 2021

COVID-19 Resources

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

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

Discipline & Misconduct

FSMB: Spreading COVID-19 vaccine misinformation may put medical license at risk
FSMB
July 2021

Utah pharmacist disciplined for fraudulently filling out COVID-19 vaccine cards
KUTV
July 2021

Physicians' worst online behavior: Six details
Becker's ASC Review
August 2021

Most common bad behaviors from physicians in the workplace
Becker's Hospital Review
August 2021

Minnesota pediatrician disciplined for telling parents vaccines are unsafe
Minneapolis Star-Tribune
August 2021

Which specialties have the most incidents of bad physician behavior?
Becker's ASC Review
August 2021

Calls grow to discipline doctors spreading virus misinformation
New York Times
August 2021

Florida hospital removes doctor for offering parents $50 mask opt-out letters
The Hill
August 2021

Anti-parasite drug's use at Arkansas jail sparks probe by medical board
Associated Press
August 2021

What factors contribute to physician bad behavior?
Becker's ASC Review
September 2021

Mississippi medical board may revoke licenses of physicians who spread COVID-19 misinformation
Mississippi Free Press
September 2021

The False Claim Act and podiatrists
Podiatry Management
November/December 2021

Diversity, Equity & Inclusion

FSMB launches task force on health equity and medical regulation
FSMB
March 2021

Education

Report urges major reforms in the transition to residency
AAMC News
August 2021

Opioids / Substance Abuse

2020 drug overdoses jump 30%, hit record 93,000 deaths
Becker's Hospital Review
July 2021

2020 overdoses death, by state
Becker's Hospital Review
July 2021

(Continued on page 29)

(News Clips continued from page 28)

Study: Severe opioid overdoses up by nearly one-third during pandemic
HealthDay News
July 2021

CDC: One in five U.S. adults with chronic pain take opioids
Becker's Hospital Review
August 2021

Study: Laws that limit opioid prescription duration help cut length of use
UPI
August 2021

Rural Health

Dollar General: Rural America's new health hub?
Becker's Hospital Review
July 2021

Technology

How much time clinicians spend in the EHR, based on specialty
Becker's Hospital Review
July 2021

The growing threat of ransomware attacks on hospitals
AAMC News
July 2021

The social network for doctors is full of vaccine disinformation
CNBC
August 2021

Telehealth

As state emergencies end, providers look for new telehealth limits
mHealthIntelligence
June 2021

Texas telemedicine rules are changing. Here's what you can expect
Texas Standard
July 2021

Telehealth use stabilizing at levels 38 times higher than before pandemic
Becker's Hospital Review
July 2021

The pandemic has devastated the mental health of public health workers
Stateline
August 2021

Telehealth took off during the pandemic. Now, battles over state lines and licensing threaten patients' options
Time
August 2021

Three surprising trends in seniors' telemedicine use during the pandemic
STAT
August 2021

Telehealth leveling off at 20% or less of all appointments: Five things to know
Becker's Hospital Review
September 2021

How the annual physical visit is shifting to virtual
Becker's Hospital Review
September 2021

Workforce

The Complexities of Physician Supply and Demand: Projections From 2019 to 2034
AAMC
June 2021

Hospitals, private equity gobble up medical practices
Fierce Healthcare
June 2021

For providers with PTSD, the trauma of COVID-19 isn't over
AAMC News
June 2021

14% of physicians sought new employment due to COVID-19
Becker's Hospital Review
June 2021

Nearly four in 10 U.S. physicians have side gigs: Six Medscape survey findings
Becker's Hospital Review
July 2021

U.S. physician shortage could hit 124,000 and other recent stats about physicians
Becker's ASC Review
July 2021

Five states with the most physicians potentially close to retirement
Becker's ASC Review
July 2021

Half of health workers report burnout amid COVID-19
AMA News
July 2021

Survey: 70% of Americans trust their physicians, 22% trust hospital execs
Becker's Hospital Review
August 2021

10 numbers that show U.S. hospital staffing strains
Becker's Hospital Review
August 2021

New survey finds COVID-19 is taking a significant toll on physicians
Fierce Healthcare
August 2021

How practice culture affects physician burnout
Medical Economics Journal
September 2021

NOTICE

The news stories we choose to highlight do not necessarily represent the views or opinions of the FPMB or the state podiatric medical boards. They are presented for informational purposes and, though thoughtfully selected, do not imply endorsement, validation, or support of the facts, statements, or views contained within them.

BOARD NEWSLETTERS, NEWS, & ANNOUNCEMENTS

[P] Denotes agency that licenses/ regulates podiatry

ALABAMA

Alabama State Board of Podiatry [P]

Alabama Board of Medical Examiners

- Fall 2021

ALASKA

Alaska State Medical Board [P]

ARIZONA

Arizona State Board of Podiatry Examiners [P]

Arizona Medical Board

- Winter/Spring 2021

Arizona Board of Osteopathic Examiners in Medicine and Surgery

ARKANSAS

Arkansas Board of Podiatric Medicine [P]

Arkansas State Medical Board

BRITISH COLUMBIA

College of Physicians and Surgeons of BC [P]

CALIFORNIA

Podiatric Medical Board of California [P]

Medical Board of California

- Q3 2021

Osteopathic Medical Board of California

COLORADO

Colorado Podiatry Board [P]

Colorado Medical Board

CONNECTICUT

Connecticut Board of Examiners in Podiatry [P]

Connecticut Medical Examining Board

DELAWARE

Delaware Board of Podiatry [P]

Delaware Board of Medical Licensure and Discipline

DISTRICT OF COLUMBIA

District of Columbia Board of Podiatry [P]

District of Columbia Board of Medicine Newsletter

FLORIDA

Florida Board of Podiatric Medicine [P]

Florida Board of Medicine

Florida Board of Osteopathic Medicine

GEORGIA

Georgia State Board of Podiatry Examiners [P]

Georgia Composite Medical Board

HAWAII

Hawaii Medical Board [P]

IDAHO

Idaho Board of Podiatry [P]

Idaho Board of Medicine

- Fall 2021

ILLINOIS

Dept. of Financial & Professional Regulation [P]

INDIANA

Indiana Board of Podiatric Medicine [P]

Medical Licensing Board of Indiana

IOWA

Iowa Board of Podiatry Examiners [P]

Iowa Board of Medicine

KANSAS

Kansas State Board of Healing Arts [P]

KENTUCKY

Kentucky Board of Podiatry [P]

Kentucky Board of Medical Licensure

- Fall 2021

(Continued on page 31)

(Board Newsletters, News, & Announcements continued from page 30)

LOUISIANA

Louisiana State Board of Medical Examiners [P]

- October 2021

MAINE

Maine Board of Licensure of Podiatric Medicine [P]

Maine Board of Licensure in Medicine

- Fall 2021

Maine Board of Osteopathic Licensure

MARYLAND

Maryland Board of Podiatric Medical Examiners [P]

Maryland Board of Physicians

- Spring 2021

MASSACHUSETTS

Massachusetts Board of Registration in Podiatry [P]

Massachusetts Board of Registration in Medicine

MICHIGAN

Michigan State Board of Podiatric Medicine and Surgery [P]

Michigan Board of Medicine

Michigan Board of Osteopathic Medicine and Surgery

MINNESOTA

Minnesota Board of Podiatric Medicine [P]

Minnesota Board of Medical Practice

MISSISSIPPI

Mississippi State Board of Medical Licensure [P]

- October 2021

MISSOURI

Missouri State Board of Podiatric Medicine [P]

Missouri Board of Registration for the Healing Arts

MONTANA

Montana Board of Medical Examiners [P]

NEBRASKA

Nebraska Board of Podiatry Licensing Unit [P]

Nebraska Board of Medicine and Surgery

NEVADA

Nevada State Board of Podiatry [P]

Nevada State Board of Medical Examiners

- August 2021

Nevada State Board of Osteopathic Medicine

- July 2021

NEW HAMPSHIRE

New Hampshire Board of Podiatry [P]

New Hampshire Board of Medicine

NEW JERSEY

New Jersey State Board of Medical Examiners [P]

NEW MEXICO

New Mexico Board of Podiatry [P]

New Mexico Medical Board

NEW YORK

New York State Education Department [P]

NORTH CAROLINA

North Carolina Board of Podiatry Examiners [P]

North Carolina Medical Board

- November-December 2021

NORTH DAKOTA

North Dakota Board of Podiatric Medicine [P]

North Dakota Board of Medicine

- November 2021

OHIO

State Medical Board of Ohio [P]

- December 2021

OKLAHOMA

Oklahoma Board of Podiatric Medical Examiners [P]

Oklahoma Board of Medical Licensure and Supervision

Oklahoma State Board of Osteopathic Examiners

(Continued on page 32)

(Board Newsletters, News, & Announcements continued from page 31)

OREGON

- Oregon Medical Board [P]
  - Fall 2021

PENNSYLVANIA

- Pennsylvania State Board of Podiatry [P]
- Pennsylvania State Board of Medicine
- Pennsylvania State Board of Osteopathic Medicine

PUERTO RICO

- Puerto Rico Board of Examiners in Podiatry [P]
- Puerto Rico Board of Medical Licensure and Discipline

RHODE ISLAND

- Rhode Island Board of Examiners in Podiatry [P]
- Rhode Island Board of Medical Licensure

SOUTH CAROLINA

- South Carolina Board of Podiatry Examiners [P]
- South Carolina Board of Medical Examiners

SOUTH DAKOTA

- South Dakota Board of Podiatry Examiners [P]
- South Dakota Board of Medical and Osteopathic Examiners

TENNESSEE

- Tennessee Board of Podiatric Medical Examiners [P]
- Tennessee Board of Medical Examiners
- Tennessee Board of Osteopathic Examination

TEXAS

- Texas Podiatric Medical Examiners Advisory Board [P]
  - August 2021
- Texas Medical Board
  - September 2021

U.S. VIRGIN ISLANDS

- Virgin Islands Board of Medical Examiners [P]

UTAH

- Utah Podiatric Physician Licensing Board [P]
- Utah Physicians and Surgeons Licensing Board
- Utah Osteopathic Physicians and Surgeons Licensing Board

VERMONT

- Vermont State Board of Medical Practice [P]
- Vermont Board of Osteopathic Physicians and Surgeons

VIRGINIA

- Virginia Board of Medicine [P]
  - September 2021

WASHINGTON

- Washington Podiatric Medical Board [P]
- Washington Medical Commission
  - Fall 2021
- WA Board of Osteopathic Medicine and Surgery
  - Summer 2021

WEST VIRGINIA

- West Virginia Board of Medicine [P]
  - June 2021
- West Virginia Board of Osteopathic Medicine

WISCONSIN

- Wisconsin Podiatry Affiliated Credentialing Board
- Wisconsin Medical Examining Board
  - November 2021

WYOMING

- Wyoming Board of Registration in Podiatry
- Wyoming Board of Medicine

CPME

- Council on Podiatric Medical Education
  - October 2021

IMLCC

- Interstate Medical Licensure Compact Commission
  - September 2021

NBPME

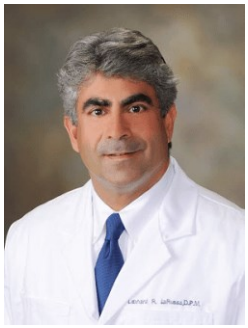
- National Board of Podiatric Medical Examiners
  - Fall 2021

2021-2022 FPMB EXECUTIVE BOARD

President

Barbara A. Campbell, DPM
Cave Creek, Arizona

Vice-President



Leonard R. La Russa, DPM
Americus, Georgia

Secretary-Treasurer

Marlene Reid, DPM
Chicago, Illinois

Director

Judith A. Manzi, DPM
Santa Clara, California

Past President/Director

Bruce R. Saferin, DPM
Toledo, Ohio

Director Emeritus

Jay S. LeBow, DPM
Baltimore, Maryland

VISION STATEMENT

The FPMB is an empowering leader, helping Member Boards work independently and collectively to promote and protect the public's podiatric health, safety, and welfare.

This is *your* Federation.
This is *your* newsletter.
Your feedback is always welcomed!

Executive Director

Russell J. Stoner
Germantown, Maryland

FEDERATION OF PODIATRIC MEDICAL BOARDS

12116 Flag Harbor Drive
Germantown, Maryland 20874

Office: 202-810-3762
Fax: 202-318-0091

Email: fpmb@fpmb.org

Website: www.fpmb.org

Is It Reportable?

A physician applying for renewal of his hospital clinical privileges falsified his application by omitting information about an ongoing licensure investigation. The hospital took a professional review action to deny his renewal application, which the Medical Executive Committee (MEC) considered to be related to the practitioner's professional conduct, even though there was no actual patient harm. Should this be reported to the NPDB?

It depends. A clinical privileges action must be reported to the NPDB if it is the result of a professional review action that relates to professional competence or conduct that adversely affects, or could adversely affect, the health or welfare of a patient and lasts for a period longer than 30 days. Whether an action affects or could affect patient health or welfare is generally a determination that must be made by the entity taking the action. If, in the opinion of the MEC, the practitioner's falsification of his application could adversely affect the health or welfare of a patient, and the action is the result of a professional review, the action must be reported to the NPDB.

NPDB Virtual Education Request

Is your organization planning a meeting, conference, or webinar? You can request an NPDB representative attend your event (virtually, or in person when appropriate) and give a personalized talk on any NPDB topic! The NPDB's professional staff are knowledgeable about NPDB systems, operations, and regulations, and are able to provide you with the highest quality information geared specifically to your organization.

Fill out our Education Request Form to request an NPDB representative participate in one of your events. If you have questions, please call 301-443-2300.

Once you complete the form, it will prepopulate an email. Verify that your email system is sending the message to NPDBPolicy@hrsa.gov and attach the following:

- An invitation letter (on the **sponsoring organization's letterhead**)
- A draft event agenda

We look forward to helping you meet your organization's training needs.

NPDB Webcasts Archive

In 2021, we held three webcasts to help our users gain a deeper understanding about NPDB policies and operations. Video recordings and Q&A responses for these and other webcasts are archived so you can view them at any time.

Compliance Update: State Licensing Boards Webcast

This webcast includes a presentation on reporting requirements for state licensing and certification agencies and a Q&A session with NPDB staff. Topics covered include:

- the certified Self-Query response
- reporting regulated professions
- the compliance review process

This webcast also includes a Q&A session with NPDB staff.

Medical Malpractice Payments Reporting Requirements Webcast

Learn about reporting medical malpractice payments to the NPDB. Topics covered include:

- when a Medical Malpractice Payment Report should be submitted
- documentation required to demonstrate that the report meets all reporting requirements
- data on medical malpractice payment reporting
- additional resources to help you answer future questions

This webcast also includes a Q&A session with NPDB staff.

Is It Reportable? Reporting Scenarios Webcast

Improve your knowledge of the NPDB through an interactive reporting scenario presentation on the following topics:

- adverse clinical privileges scenarios
- medical malpractice payments
- state licensure actions

This webcast also includes a supplemental document which contains questions and answers.

For a complete list of all resources from past webcasts, including our presentations on attestation, querying, and reporting clinical privileges, visit our Events page.

Dear NPDB

Dear NPDB

What does my hospital administrator need to know about the NPDB?

Each hospital administrator (not to be confused with a Data Bank Administrator) is ultimately responsible for ensuring the organization complies with all regulatory requirements, including the federal requirement of NPDB reporting and querying. Proper oversight by the hospital administrator not only helps the hospital avoid sanctions for not reporting and additional malpractice liability for not querying appropriately, it also helps protect its community from health care fraud and abuse.

Reporting

Hospitals and other health care entities must report adverse clinical privileges actions to the NPDB that meet NPDB reporting criteria - that is, any professional review action that adversely affects the clinical privileges of a physician or dentist for a period of more than 30 days or the acceptance of the surrender of clinical privileges, or any restriction of such privileges by a physician or dentist, (1) while the physician or dentist is under investigation by a health care entity relating to possible incompetence or improper professional conduct, or (2) in return for not conducting such an investigation or proceeding. Clinical privileges include privileges, medical staff membership, and other circumstances (e.g., network participation and panel membership) in which a physician, dentist, or other health care practitioner is permitted to furnish medical care by a health care entity.

Note: A hospital may be subject to additional reporting requirements if it also meets the definition of another entity type, such as a medical malpractice payer, health plan, or government agency.

For a more detailed list of reportable actions, visit our Reportable Actions Table in Chapter E: Reports of the NPDB Guidebook.

Querying

Hospitals must query when physicians, dentists, and other health care practitioners apply for medical staff appointment (courtesy or otherwise) or for clinical privileges, and then every 2 years thereafter; and whenever practitioners request a change in their clinical privileges. Hospitals may query when performing professional review activities.

The NPDB recommends using Continuous Query to keep you informed about your practitioners 24 hours a day, 365 days a year. For instructions on how to use Continuous Query, visit our How to Enroll and Receive Continuous Query Notifications page.

The latest updates and resources are available at https://www.npdb.hrsa.gov.

Previous editions of NPDB Insights are available in our archive.

D

Maryland
DEPARTMENT OF HEALTH

Update: Electronic Prescriptions – Controlled Dangerous Substances
December 21, 2021

Health care practitioners must apply for a waiver by January 1, 2022. Compliance actions will be delayed until January 1, 2023.

To apply for a waiver, visit the Office of Controlled Substances website, Quick Links, Electronic Prescribing Waiver Request.
https://health.maryland.gov/ocsa/Pages/Electronic-Prescribing-Waiver-Request-form.aspx

Effective January 1, 2022, Senate Bill 0166 (CH0299)/House Bill 0512 (CH0230) (2020) Drugs and Devices – Electronic Prescriptions – Controlled Dangerous Substances requires licensed health care providers to electronically prescribe prescriptions for controlled dangerous substances and allows for waivers to be granted under certain circumstances. The effective date of the state law aligned with the comparable federal law (Section 2003 of the SUPPORT Act). In December 2020, Centers for Medicare and Medicaid Services (CMS) implemented the first phase of this mandate by naming the standard that prescribers must use for e-prescribing transmissions and delaying compliance actions until January 1, 2022.

On November 2, 2021, CMS announced they are delaying the start date for compliance actions to January 1, 2023, in response to stakeholder feedback. In order to maintain alignment with the federal government, MDH is also delaying compliance actions to January 1, 2023

However, to maintain compliance with Health General Article, §21-220(C) which requires implementation of e-prescribing on January 1, 2022 , a health care practitioner who is unable to electronically transmit prescriptions for controlled dangerous substance drugs must request a waiver from the electronic prescribing requirement. All requested waivers will be granted for calendar year 2022 only.

E

HOUSE BILL 55

J2 2lr1059

(PRE–FILED) CF 2lr0332

By: **Delegate Cullison**
Requested: October 29, 2021
Introduced and read first time: January 12, 2022
Assigned to: Health and Government Operations

A BILL ENTITLED

AN ACT concerning

Health Occupations – Nurse Anesthetists – Drug Authority and Collaboration

FOR the purpose of authorizing a nurse anesthetist to prescribe, order, and administer drugs, including controlled dangerous substances, without obtaining approval from a practitioner with whom the nurse anesthetist collaborates, subject to certain limitations; authorizing a nurse anesthetist to collaborate with a podiatrist; and generally relating to nurse anesthetists.

BY repealing and reenacting, with amendments,
Article – Health Occupations
Section 8–513, 12–101(b), and 12–102(e)
Annotated Code of Maryland
(2021 Replacement Volume)

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

Article – Health Occupations

8–513.

(a) In this section, "perioperative assessment and management" means the assessment and management of a patient preoperatively, intraoperatively, and postoperatively.

(b) (1) A nurse anesthetist may perform the following functions:

(i) Perioperative assessment and management of patients requiring anesthesia services;

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

(ii) Administration of anesthetic agents;

(iii) Management of fluids in intravenous therapy; [and]

(iv) Respiratory care; AND

(V) SUBJECT TO PARAGRAPH (4) OF THIS SUBSECTION, PRESCRIPTION, ORDERING, AND ADMINISTRATION OF DRUGS, INCLUDING A DRUG THAT IS CLASSIFIED AS A CONTROLLED DANGEROUS SUBSTANCE UNDER TITLE 5, SUBTITLE 4 OF THE CRIMINAL LAW ARTICLE.

(2) A nurse anesthetist has the right and obligation to refuse to perform a delegated act if in the nurse anesthetist's judgment, the act is:

(i) Unsafe;

(ii) An invalidly prescribed medical act; or

(iii) Beyond the clinical skills of the nurse anesthetist.

(3) Paragraph (1) of this subsection may not be construed to authorize a nurse anesthetist to:

(i) Diagnose a medical condition;

(ii) Provide care that is not consistent with the scope of practice of nurse anesthetists; or

(iii) Provide care for which the nurse anesthetist does not have proper education and experience.

(4) A NURSE ANESTHETIST MAY PRESCRIBE DRUGS UNDER PARAGRAPH (1) OF THIS SUBSECTION:

(I) ONLY IN AN AMOUNT THAT DOES NOT EXCEED A 10–DAY SUPPLY;

(II) ONLY FOR AN INDIVIDUAL WITH WHOM THE NURSE ANESTHETIST HAS, AT THE TIME OF PRESCRIPTION, ESTABLISHED A CLIENT OR PATIENT RECORD;

(III) ONLY IN CONNECTION WITH THE DELIVERY OF ANESTHESIA SERVICES; AND

(IV) WITHOUT OBTAINING APPROVAL FROM A PRACTITIONER

WITH WHOM THE NURSE ANESTHETIST COLLABORATES UNDER SUBSECTION (C) OF THIS SECTION.

(c) A nurse anesthetist shall collaborate with an anesthesiologist, a licensed physician, **[**or**]** a dentist**, OR A PODIATRIST** in the following manner:

(1) An anesthesiologist, a licensed physician, **[**or**]** a dentist**, OR A PODIATRIST** shall be physically available to the nurse anesthetist for consultation at all times during the administration of, and recovery from, anesthesia;

(2) An anesthesiologist shall be available for consultation to the nurse anesthetist for other aspects of the practice of nurse anesthesia; and

(3) If an anesthesiologist is not available, a licensed physician **[**or**]**, dentist**, OR PODIATRIST** shall be available to provide this type of consultation.

(d) The nurse anesthetist shall ensure that a qualified anesthesia provider:

(1) Performs a thorough and complete preanesthetic assessment;

(2) Obtains informed consent for the planned anesthetic intervention from the patient or an individual responsible for the patient; and

(3) Formulates a patient–specific plan for anesthesia care.

(e) The nurse anesthetist as part of the standards of practice shall:

(1) Implement and adjust an anesthesia care plan as needed to adapt to the patient's response to the anesthesia;

(2) Monitor a patient's physiologic condition for untoward identifiable reactions and initiate appropriate corrective actions as required;

(3) Enter prompt, complete, and accurate documentation of pertinent information on a patient's record;

(4) Transfer responsibility for care of a patient to other qualified providers in a manner that ensures continuity of care and patient safety;

(5) Ensure that appropriate safety precautions are taken to minimize the risks of fire, explosion, electrical shock, and equipment malfunction;

(6) Maintain appropriate infection control standards;

(7) Evaluate anesthesia care to ensure its quality;

(8) Maintain continual competence in anesthesia practice; and

(9) Respect and maintain the basic rights of patients.

(f) This section may not be construed to require a written collaboration agreement between a nurse anesthetist and an anesthesiologist, a physician, **[**or**]** a dentist, **OR A PODIATRIST.**

12–101.

(b) "Authorized prescriber" means any licensed dentist, licensed dental hygienist with prescriptive authority under § 4–206.4 of this article, licensed physician, licensed podiatrist, licensed veterinarian, advanced practice nurse with prescriptive authority under § 8–508 of this article, **LICENSED NURSE ANESTHETIST,** or other individual authorized by law to prescribe prescription or nonprescription drugs or devices.

12–102.

(e) (1) This title does not prohibit:

(i) A dentist, physician, or podiatrist from administering a prescription drug or device in the course of treating a patient; **[**or**]**

(ii) A licensed dental hygienist from administering medication under § 4–206.4 of this article**; OR**

(III) A NURSE ANESTHETIST FROM ADMINISTERING MEDICATION UNDER § 8–513 OF THIS ARTICLE.

(2) For the purposes of paragraph (1)(i) of this subsection, "administering" means the direct introduction of a single dosage of a drug or device at a given time, whether by injection or other means, and whether in liquid, tablet, capsule, or other form.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2022.

SENATE BILL 77

J2 2lr0611

(PRE–FILED)

By: **Senator West**
Requested: September 30, 2021
Introduced and read first time: January 12, 2022
Assigned to: Education, Health, and Environmental Affairs

A BILL ENTITLED

AN ACT concerning

Health Occupations Boards – Investigations – Right to Counsel

FOR the purpose of authorizing a licensee or certificate holder to be represented by counsel during an investigation by a health occupations board that may result in charges or sanctions; and generally relating to investigations by health occupations boards and the right to counsel.

BY adding to
Article – Health Occupations
Section 1–610
Annotated Code of Maryland
(2021 Replacement Volume)

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

Article – Health Occupations

1–610.

IF A HEALTH OCCUPATIONS BOARD INVESTIGATES A LICENSEE OR CERTIFICATE HOLDER AND THE INVESTIGATION MAY RESULT IN CHARGES OR SANCTIONS AGAINST THE LICENSEE OR CERTIFICATE HOLDER, THE LICENSEE OR CERTIFICATE HOLDER MAY:

(1) BE REPRESENTED BY COUNSEL DURING THE INVESTIGATION; AND

(2) HAVE COUNSEL PRESENT AT ANY INTERVIEW OF THE LICENSEE

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

OR CERTIFICATE HOLDER CONDUCTED BY OR ON BEHALF OF THE HEALTH OCCUPATIONS BOARD DURING THE INVESTIGATION.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2022.

SENATE BILL 111

C3, J2, E2 2lr0919

(PRE–FILED)

By: **Senator McCray**
Requested: October 24, 2021
Introduced and read first time: January 12, 2022
Assigned to: Judicial Proceedings

A BILL ENTITLED

AN ACT concerning

Occupational Licenses or Certificates – Pre–application Determinations – Criminal Convictions

FOR the purpose of establishing a process for potential applicants for an occupational license or certificate to obtain a determination from a department as to whether certain criminal convictions would be the basis for the denial of an application for a certain occupational license or certificate; and generally relating to pre–application determinations for criminal convictions and occupational licenses or certificates.

BY repealing and reenacting, with amendments,
Article – Criminal Procedure
Section 1–209
Annotated Code of Maryland
(2018 Replacement Volume and 2021 Supplement)

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

Article – Criminal Procedure

1–209.

(a) (1) In this section, "department" means:

(i) the Department of Agriculture;

(ii) the Department of the Environment;

(iii) the Maryland Department of Health;

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

(iv) the Department of Human Services;

(v) the Maryland Department of Labor; or

(vi) the Department of Public Safety and Correctional Services.

(2) "Department" includes any unit of a department specified in paragraph (1) of this subsection.

(b) This section does not apply to a person who was previously convicted of a crime of violence, as defined in § 14–101 of the Criminal Law Article.

(c) It is the policy of the State to encourage the employment of nonviolent ex–offenders and remove barriers to their ability to demonstrate fitness for occupational licenses or certifications required by the State.

(d) Except as provided in subsection (f) of this section, a department may not deny an occupational license or certificate to an applicant solely on the basis that the applicant has previously been convicted of a crime, unless the department determines that:

(1) there is a direct relationship between the applicant's previous conviction and the specific occupational license or certificate sought; or

(2) the issuance of the license or certificate would involve an unreasonable risk to property or to the safety or welfare of specific individuals or the general public.

(e) In making the determination under subsection (d) of this section, the department shall consider:

(1) the policy of the State expressed in subsection (c) of this section;

(2) the specific duties and responsibilities required of a licensee or certificate holder;

(3) whether the applicant's previous conviction has any impact on the applicant's fitness or ability to perform the duties and responsibilities authorized by the license or certificate;

(4) the age of the applicant at the time of the conviction and the amount of time that has elapsed since the conviction;

(5) the seriousness of the offense for which the applicant was convicted;

(6) other information provided by the applicant or on the applicant's behalf with regard to the applicant's rehabilitation and good conduct; and

(7) the legitimate interest of the department in protecting property and the safety and welfare of specific individuals or the general public.

(f) (1) This subsection does not apply to a conviction of a crime for which registration on the sex offender registry is required under Title 11, Subtitle 7 of this article.

(2) If a period of 7 years or more has passed since an applicant completed serving the sentence for a crime, including all imprisonment, mandatory supervision, probation, and parole, and the applicant has not been charged with another crime other than a minor traffic violation, as defined in § 10–101 of this article, during that time, a department may not deny an occupational license or certificate to the applicant solely on the basis that the applicant was previously convicted of the crime.

(G) (1) (I) BEFORE SUBMITTING AN APPLICATION FOR AN OCCUPATIONAL LICENSE OR CERTIFICATE, A POTENTIAL APPLICANT MAY REQUEST FROM A DEPARTMENT A DETERMINATION AS TO WHETHER A SPECIFIED CRIMINAL CONVICTION WOULD BE THE BASIS FOR DENIAL OF THE OCCUPATIONAL LICENSE OR CERTIFICATE TO THE APPLICANT.

(II) A DEPARTMENT SHALL PROVIDE THE DETERMINATION IN WRITING TO THE POTENTIAL APPLICANT.

(2) (I) EXCEPT AS PROVIDED IN SUBPARAGRAPH (II) OF THIS PARAGRAPH, A DETERMINATION UNDER PARAGRAPH (1) OF THIS SUBSECTION IS BINDING ON THE DEPARTMENT AND THE APPLICANT ON SUBMISSION OF AN APPLICATION FOR AN OCCUPATIONAL LICENSE OR CERTIFICATE TO THE DEPARTMENT.

(II) A DETERMINATION UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH IS NOT BINDING ON THE DEPARTMENT IF, ON THE APPLICANT'S SUBMISSION OF AN APPLICATION FOR AN OCCUPATIONAL LICENSE OR CERTIFICATE TO THE DEPARTMENT, THE APPLICANT:

1. HAS SUBSEQUENTLY BEEN CONVICTED OF A CRIME;

2. HAS PENDING CRIMINAL CHARGES; OR

3. HAD PREVIOUSLY UNDISCLOSED CRIMINAL CONVICTIONS.

(3) (I) A DEPARTMENT MAY SET A REASONABLE FEE TO COVER THE COSTS OF PROVIDING SERVICES UNDER PARAGRAPH (1) OF THIS SUBSECTION.

(II) THE FEE CHARGED SHALL BE SET SO AS TO PRODUCE FUNDS TO APPROXIMATE THE COSTS OF PERFORMING THE SERVICE.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2022.