BOARD OF PODIATRIC MEDICAL EXAMINERS

OPEN SESSION MEETING VIA GOOGLE MEET

AGENDA

October 14, 2021

Location Google Meet: http://meet.google.com/wii-jiyb-pvr

Join by phone: (US) +1 337-451-1853 PIN: 296 043 049#

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 September 9, 2021 meeting** **Tab A**

B. BOARD PRESIDENT'S REPORT

C. EXECUTIVE DIRECTOR'S REPORT-Eva Schwartz

D. OLD BUSINESS:

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

E. NEW BUSINESS:

1. **FPMB 2021 Q3 Newsletter** **Tab B**
2. **Topics Quarterly Newsletter Volume 36/No. 3 Fall 2021 from**

   Gordon, Feinblatt, Rothman & Hollander **Tab C**
3. **Announcements regarding postponement of APMLE Part II CSPE** **Tab D**
4. **2020-2021 Part II CSPE Bulletin:**

   https://www.apmle.com/wp-content/uploads/2020/09/CSPE-2020-09.24.20.pdf

F. ADJOURNMENT

BOARD OF PODIATRIC MEDICAL EXAMINERS

OPEN SESSION MEETING VIA GOOGLE MEET

MINUTES

September 9, 2021

Location Google Meet: http://meet.google.com/eer-nczi-fum

Join by phone: (US) +1 929-276-0791 PIN: 165 397 224#

The Public Meeting commenced at 1:12 PM, opened by the Board President, Dr. Yvonne Umezurike.

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

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

Consumer Members present: Ms. Frona Kroopnick. Consumer Member Lynne Brecker was absent.

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

Oladunni Akinpelu, Information Technology Specialist for Boards and the Kidney Commission

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

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

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

A. ELECTIONS

The election for all Board Officer Positions was held via the submission of ballots to Ms. Schwartz.

The results were tabulated and Ms. Schwartz announced the names of the newly elected officers:

President, Dr. Adam Silverman

Vice President, Dr. David Gottlieb

Treasurer/Secretary, Frona Kroopnick

CONGRATULATIONS TO ALL!

Dr. Silverman opened the meeting **and 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 July 8, 2021 meeting

The minutes from the July 8, 2021 meeting were approved unanimously, as submitted.

C. BOARD PRESIDENT'S REPORT

Dr. Silverman reminded podiatrists that renewals will be opening in October, so its time to begin finalizing the accrual of CMEs and preparing to submit their renewal application.

Additionally, Dr Silverman stated that as previously posted on the Board's website, the clarification about the type of required CME's is available on mbpme.org: CME's can be accrued online or in person, including the CPR, with the exception that 25 CME's can be accrued online or in person, but must be in the subject matter of the practice of podiatric medicine and surgery.

D. EXECUTIVE DIRECTOR'S REPORT-Eva Schwartz

Ms. Schwartz discussed the policies regarding CME approval request submissions. The approval request must be accompanied with a course syllabus and be submitted directly to her or Elizabeth Kohlhepp, who will then forward the completed request to the CME Chair, and if applicable to the Board members. **CME requests are NOT to be submitted directly to Board members.** Additionally, Ms. Schwartz reiterated that all 50 CMEs may be obtained online for **this renewal period only**, however, 25 CME approved credits of the required 50 CME approved credits, must be accrued on topics exclusive to the practice of podiatric medicine and surgery.

E. OLD BUSINESS:

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

There are no updates at this time.

F. NEW BUSINESS:

1. NPDB Insights

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

2. New Board Member Orientation

The Board was made aware that there will be a New Board Member Orientation next month and all are encouraged to attend. The Orientation will be held virtually and all sessions will also be recorded and available to view if someone is not available at the time of the live seminar.

3. Implicit bias training is a requirement for all licensees:

https://health.maryland.gov/mhhd/Documents/MHHD-Recommended-Health-Equity-Trainings.pdf

The Board was made aware that starting in April of 2022 all licensees will be required to take a course on Implicit Bias Training. The Board will list the approved courses to fulfill the mandated training on the website.

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

a. Kurtis Bertram, DPM

b. Alexandra Kaikis, DPM

c. Andrew Wilson, DPM

d. Huguette Disasi, DPM

The above individually identified licensure candidates were approved unanimously for the issuance of a Full Maryland License.

G. OTHER

1. Ms. Schwartz discussed with the Board an inquiry received from the State of California through the Federation requesting details on the type of regulatory authority that each Podiatric Board may have, if in effect, over podiatric x-ray technicians in their respective States. After a general discussion, the Board submitted, that in Maryland, podiatric X-ray technicians are not regulated by the Board of Podiatry.

2. Dr. Lebow updated the Board on the White Paper discussion. The Federation is working to become a current resource and has requested to have a seat at the table to participate in discussions. Mr. Bloch with the MPMA, along with seven other States, have currently joined in on discussions with the APMA regarding the White Paper.

ADJOURNMENT

With no further business, the Public Session of the Board meeting concluded at 1:43 PM.

Respectfully submitted by Eva Schwartz, Executive Director, Signature and date_ _____

and Elizabeth Kohlhepp, Deputy Executive Director, Signature and date_____

Signature by Frona Kroopnick, Board Secretary/Treasurer: _____

Federation of Podiatric Medical Boards

12116 Flag Harbor Drive ◆ Germantown, MD 20874 ◆ 202-810-3762 ◆ www.fpmb.org

B

Member Podiatric Medical Boards Newsletter — Q3 2021

PRESIDENT'S MESSAGE

Barbara A. Campbell, DPM
Cave Creek, Arizona

The FPMB has grown again in its membership roll! I am happy to welcome the U.S. Virgin Islands Board of Medicine *(USVIBOM)* as a Member Board. We look forward to their active participation as our newest Member Board.

One of the FPMB's strategic objectives is to be a strong resource of information for the benefit of our Member Boards and the greater podiatric community. Currently, the FPMB collects critical data via its Member Boards Update Form, formal requests for information, and organizations within the *FPMB Network*. This valuable data is reported via the FPMB's website, newsletter, and email blasts.

The FPMB Data Initiative Project is an extension of this strategic objective to continue moving the organization forward. The additional data the FPMB will be collecting will allow the FPMB to become an even greater source of information to our Member Boards and the podiatric community. This valuable and insightful information benefits our Member Boards in navigating issues of licensure, scope of practice, and legislative protocol, to name a few. Frequently, data provided by the FPMB has aided a Member Board in building a case and providing substantive background information to support key licensure and regulation objectives.

(Continued on page 3)

EXEC'S MESSAGE

Russell J. Stoner
Germantown, Maryland

FPMB Empowers Informed Decision Making in Times of Rapid Change

They say that the only constant is change; however, the rate of change continues to increase *(i.e., COVID-19, Part II CSPE suspension, Joint Task Force AMA resolution, federal and state legislation, etc.)*. The FPMB is a key resource for Member Boards to engage in informed decision-making.

This newsletter is one of many of the FPMB's information delivery platforms for our Member Boards and other key stakeholders. Re-

(Continued on page 4)

NEWSLETTER HIGHLIGHTS

- Does the ABPM comment on "Board Certification and State Licensure" affect your state? Let the FPMB know.
- The FPMB is planning a Fall Member Boards meeting focused on the Joint Task Force and the return of the popular Round Robin discussion.
- Has your state sent its updated Member Boards Update Form? The FPMB supports Member Boards and licensees with this info; don't be left out.

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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)**

apma
Advancing foot and ankle medicine and surgery

fsmb
FEDERATION OF STATE MEDICAL BOARDS

NATIONAL BOARD OF PODIATRIC MEDICAL EXAMINERS 1956

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)

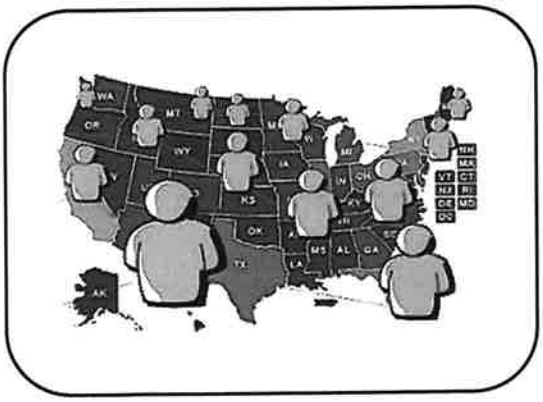
The FPMB provides primary source verification of:

- 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

APMLE
American Podiatric Medical Licensing Examination

NCQA
Measuring quality. Improving health care.



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

President's Message continued from page 1)

For example, the FPMB receives calls for information by Member Boards and other key stakeholders seeking responses from other Member Boards across the entire country. These requests for information are a means by which Member Boards can assist and support each other. Theses requests are often related to practice issues being experienced in a state.

The FPMB's membership benefits the most when <u>every</u> Member Board is engaged and responsive.

For instance, the Podiatric Medical Board of California *(PMBC)* recently requested information regarding radiology regulation for podiatric medical practices. I would like to thank the Member Boards who participated in this request, and I encourage those that have not yet responded to do so. The FPMB's membership benefits the most when <u>every</u> Member Board is engaged and responsive.

This recent PMBC request is a prime example of the benefit of being involved with the FPMB. I can personally attest to having received beneficial information from a request when developing recently passed legislation in Arizona.

The FPMB will continue to be a source of information for its members regarding the American Medical Association *(AMA)* resolution and associated white paper presented by the Joint Task Force of the American Academy of Orthopaedic Surgeons *(AAOS)*, American College of Foot and Ankle Surgeons *(ACFAS)*, American Orthopaedic Foot & Ankle Society *(AOFAS)*, and American Podiatric Medical Association *(APMA)*. The FPMB's goal is to keep the lines of communication open on these issues and educate our membership. Please visit the FPMB's dedicated Joint Task Force webpage to stay informed.

The FPMB is planning a Fall Member Boards meeting.

The FPMB is planning a Fall Member Board meeting. Discussions regarding the Joint Task Force *(AMA resolution and white paper)* are planned as well as a another Round Robin Discussion given the success of the one at the Annual Meeting on April 30, 2021. Since we have lots of previously submitted topics remaining to be discussed, most of the fall meeting will be geared towards the Round Robin Discussion. We are looking forward to another robust, beneficial, and engaging activity.

As always, I appreciate my fellow Board Members and their engagement in our FPMB activities. Strong participation from Member Boards is appreciated as it ultimately helps <u>all</u> members and gives us more to build on. Additionally, thank you to our executive director, Russ Stoner, for his professionalism and dedication to the FPMB and our membership. Just as you have answered the call to serve your respective states, the FPMB is dedicated in its service to you, our Member Boards.

NATIONAL BOARD OF PODIATRIC MEDICAL EXAMINERS

Roland Ramdass, DPM, President

NBPME to Survey State Licensing Boards

The National Board of Podiatric Medical Examiners *(NBPME)* is evaluating options regarding the recently suspended American Podiatric Medical Licensing Examination *(APMLE)* **Part II Clinical Skills Patient Encounter** *(CSPE)* examination.

The first step is to determine which, if any, of the skills tested in that program are deemed essential by stakeholders. The second step will then be to evaluate how best to conduct the examination.

FPMB Member Boards should be alert for an email requesting their participation and response in a survey that is scheduled to be distributed in mid-October 2021.

Please direct any questions to the NBPME executive office at NBPMEOfc@aol.com.

JOINT TASK FORCE OF ORTHOPAEDIC SURGEONS AND PODIATRIC SURGEONS

The Joint Task Force* has unanimously endorsed a white paper and American Medical Association *(AMA)* resolution seeking to "improv[e] the standardization process for assessment of podiatric medical students and residents by initiating a process enabling them to take the [United States Medical Licensing Examination] USMLE."

As a member of the Joint Task Force, the American Podiatric Medical Association *(APMA)* strongly believes that DPMs are physicians and surgeons whose education and training are comparable to the education and training of MDs and DOs. The APMA therefore supports a uniform model for licensing to demonstrate to health-care consumers that DPMs have met the same rigorous standards as other physicians.

The white paper, AMA resolution, and any uniform licensing model clearly intersect with the FPMB and its Member Boards in fulfilling their mandate of protecting the public's health, safety, and welfare through the proper licensing, disciplining, and regulation of podiatric physicians. The FPMB submitted a letter to the podiatric organizations of the Joint Task Force declaring the critical need for inclusivity regarding the future direction of licensure and regulation for the profession. The FPMB serves as the voice of its Member Boards and their key stakeholders of licensees and the public.

The FPMB has developed a Joint Task Force webpage to help inform and educate its Member Boards. A Fall Member Boards Meeting is being planned to further engagement on this topic.

**The Joint Task Force is comprised of the American Academy of Orthopaedic Surgeons (AAOS), American College of Foot and Ankle Surgeons (ACFAS), American Orthopaedic Foot & Ankle Society (AOFAS), and American Podiatric Medical Association (APMA).*

(Executive Director's Message continued from page 1)

view the following suggestions to maximize your value from each issue:

- Give extra attention to the guest articles from key podiatric organizations *(i.e., ABPM, NBPME, etc.)*. These provide an overview of these organizations, identify key issues, and/or provide important notifications.
- Scan through the federal and state legislative news updates. These are organized by category *(i.e., licensing, telehealth, board structure, etc.)* and offer critical insight into the focus and priorities nationwide of these legislative bodies.
- Scan through the news clips. These are also organized by category *(i.e., licensure & regulation, examinations, discipline, education, etc.)* and offer key insights into the broader field of medicine, licensure, and regulation across the country.

What features do <u>you</u> value most? What would <u>you</u> like to see added? Your feedback is always welcomed and appreciated.

***** ANNOUNCEMENT *****

FALL MEMBER BOARDS MEETING

The FPMB is preparing to hold an online meeting for its Member Boards this fall.

The agenda will focus on the **Joint Task Force** and a return of the popular **Round Robin discussion**.

The official date and agenda will be forthcoming.

KEY DATES

- **September 30, 2021**
  - ◊ Due date for completion of the Member Board Update Form
- **Mid-October 2021**
  - ◊ Distribution of the NBPME's APMLE Part II CSPE survey
- **October 31, 2021**
  - ◊ Due date for payment of Member Board dues
- **December 2021**
  - ◊ Publishing date for next FPMB Newsletter
- **Fall 2021**
  - ◊ Member Boards meeting

FPMB'S COVID-19 INFO & RESOURCES WEBPAGE

Are <u>your</u> state's updates current and accurate?

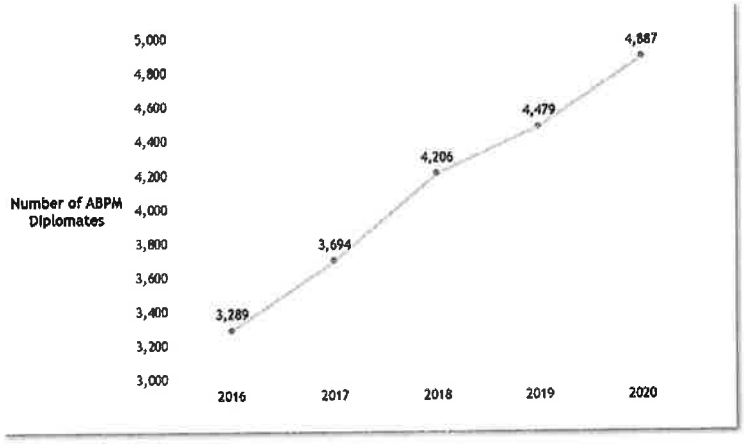
The FPMB has updated its COVID-19 information and resources webpage. Make sure <u>your</u> updates related to CMEs, licensure, telehealth, scope of practice, etc. are current and accurate in the State-by-State Updates section.

AMERICAN BOARD OF PODIATRIC MEDICINE

Melissa J. Lockwood, DPM, FACPM, Vice President

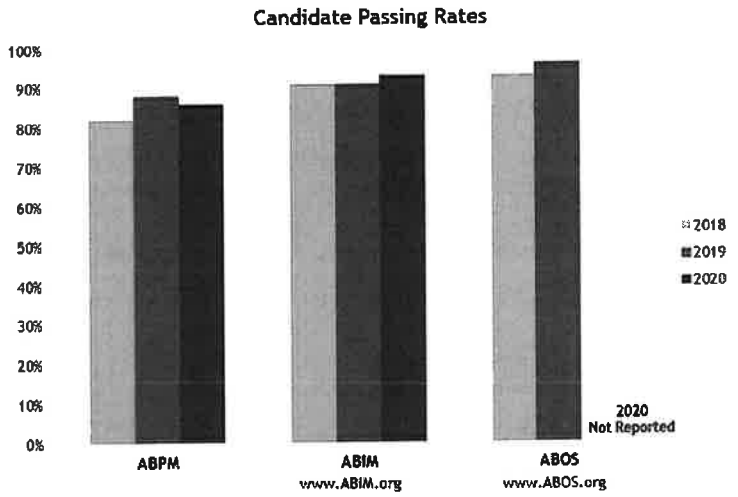
"Certifying Today's Podiatrist"

The ABPM is the fastest growing certification board in the field of podiatric medicine and surgery over the last 10 years! We are proud to report that the ABPM has almost 5,000 diplomates. ABPM is certifying in the comprehensive care that podiatrists provide to patients every day!



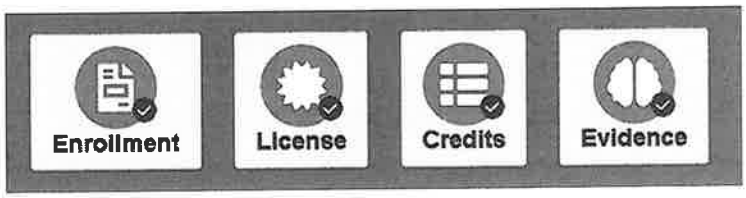
Comparable Standards to ABMS

ABPM has proven to be an industry leader, aligning our certification process to achieve parity with allopathic and osteopathic medicine. After much consideration, the Board has decided to combine the Qualification *(Part 1)* and Certification *(Part 2)* exams and discontinue the status of "Board Qualified" in lieu of the ABMS standard language and process, "Board Eligible." Similar to allopathic certification processes, once a candidate completes a three-year, CPME-approved residency program, they will be Board Eligible until they pass the Certification Exam and be granted the status Board Certified. Candidates have 8 years from completion of residency to attempt their first exam. Additionally, the ABPM board pass rates are commensurate with American Board of Medical Specialties *(ABMS)* rates. The bar graph shows ABPM compared with the American Board of Internal Medicine *(ABIM)* and the American Board of Orthopedic Surgery *(ABOS)* over three years.



Maintenance of Certification (MOC)

The Maintenance of Certification *(MOC)* Program has proven itself to be a hallmark of our recertification process for over 10 years. The MOC is an ongoing learning process that is a required and critical component of maintaining ABPM board certification. Rather than maintaining certification with a high stakes exam every 10 years, or uploading cases for review every 3 years, the MOC is an annual process that is now streamlined and easy to use. The MOC is intended to strengthen a Diplomate's practice and improve patient safety and clinical outcomes. This can be instilled by ensuring current licensing, maintaining continuing education credits on an annual basis, and demonstrating cognitive expertise in the specialty of podiatric medicine. These can be recorded on a Diplomate's personalized dashboard where they have a checklist to ensure completion of all requirements.



(Continued on page 6)

(American Board of Podiatric Medicine continued from page 5)

There is data to suggest that MOC is associated with improved patient outcomes, higher physician compensation, and fewer disciplinary actions. MOC pathways are on par with our osteopathic and allopathic medicine colleagues and their maintenance of certification processes. Further information regarding the MOC can be found on the Board's website at https://podiatryboard.org/pages/moc.

Certificates of Added Qualification (CAQ)

The Certificates of Added Qualification *(CAQ)* were developed by the ABPM in response to the changes in public needs and the desire of podiatrists to be recognized for their commitment to a subspecialty of podiatry. Currently there are CAQs in Amputation Prevention and Wound Care, as well as Podiatric Sports Medicine. The certificate process is available to any podiatrist certified by a CPME-recognized board with specific practice interest and demonstrable expertise in this area. The Diplomate must pass a validated, knowledge-based examination. More information about the CAQs can be found at https://podiatryboard.org/pages/caq-exams.

Note: The Certificate of Added Qualification (CAQ) is a special distinction created and issued solely by the ABPM to recognize a podiatric physician who has established additional competency beyond board certification in either Amputation Prevention and Wound Care or Podiatric Sports Medicine.

Hospital Privileging and Credentialing

It is important to stay current as education, residency, and credentialing standards change periodically. The ABPM strives to provide our Diplomates with the most up-to-date information on hospital privileging and credentialing. The ABPM has developed both a comprehensive website to direct medical staff to (https://podiatryprivileges.com/) and a webform for our Diplomates to complete should they run into difficulty with an insurance panel or hospital understanding and recognizing our credential (https://podiatryboard.org/pages/forms/hospital-privileging-mediation). Once submitted, the privileging committee will intervene and provide a personal approach to our Diplomates and the hospitals to ensure appropriate credentialing.

The ABPM is concerned that a handful of states are using board certification as a requirement for a podiatrist to have access to the full scope of podiatric practice.

Board Certification and State Licensure

The ABPM is concerned that a handful of states are using board certification as a requirement for a podiatrist to have access to the full scope of podiatric practice *(usually the ankle)*. In some cases, this requirement has been legislated, in others it is a medical board ruling. There is not a comparable scenario with MD/DO licensure. For example, an MD/DO does not have to be first board certified in dermatology before having the scope to practice on the skin. Additionally, state licensure is a requirement to be board certified and the reverse practice causes confusion. The ABPM is evaluating the best approach to reverse this practice and we encourage FPMB Member Boards to reach out to the ABPM President Dr. Lee Rogers or Executive Director Dr. James Stavosky if there is concern.

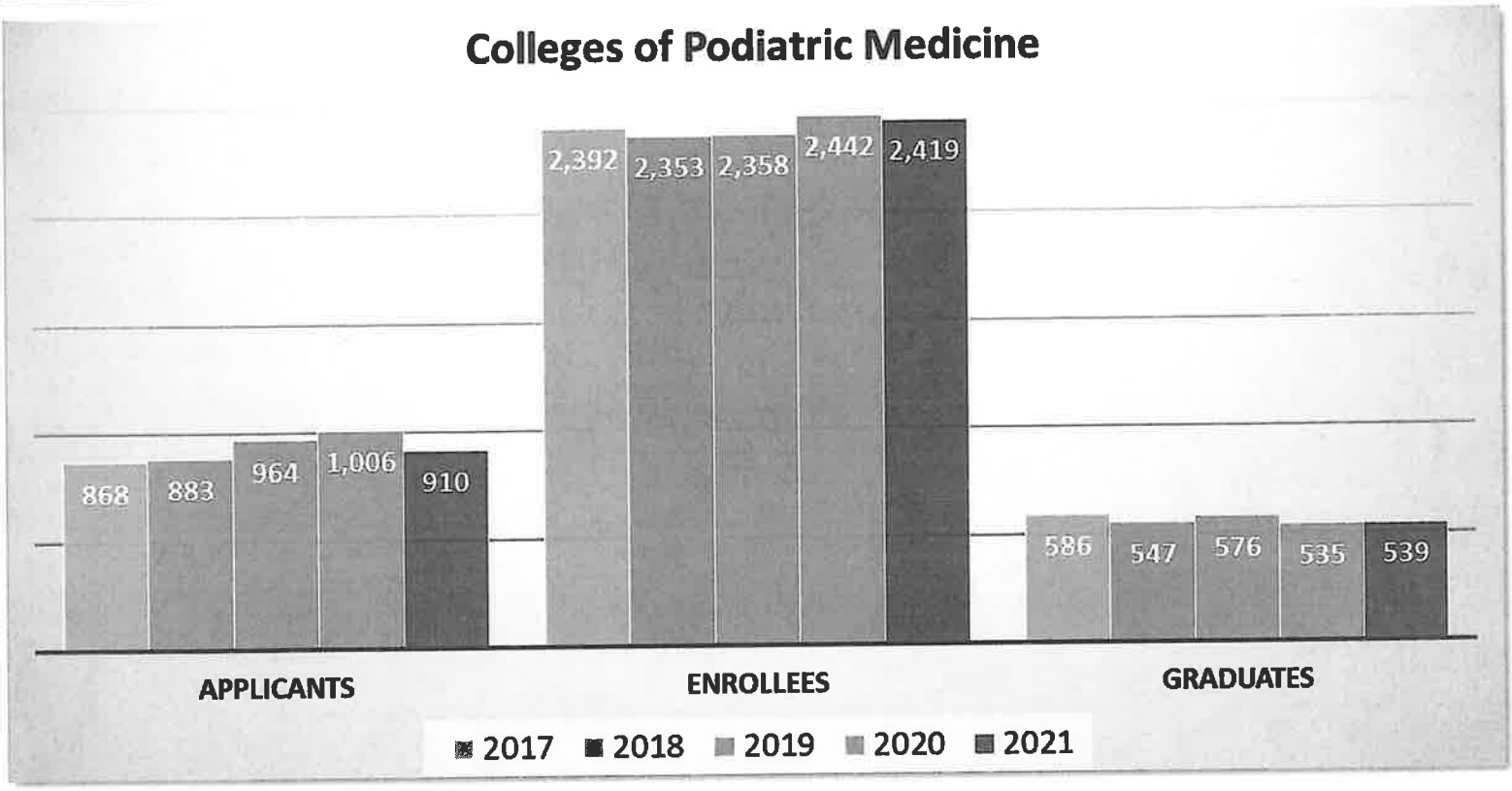
Our Mission

The American Board of Podiatric Medicine *(ABPM)* continues to strive to protect the health and welfare of the public through an ongoing process of evaluation and certification of the podiatrists in the specialty of Podiatric Orthopedics and Primary Podiatric Medicine. ABPM has worked on the forefront in educating the public and podiatric community on the importance of "milestone"-based residency education, comprehensive medicine, and biomechanical requirements that all podiatric physicians need in the 21st century.

For more information about the ABPM, please visit https://www.podiatryboard.org.

EDUCATION AND RESIDENCY PLACEMENT STATISTICS

American Association of 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.

OCCUPATIONAL LICENSING BOARD ANTITRUST DAMAGES RELIEF ACT

Professional Licensing Coalition

Background

In 2015, the U.S. Supreme Court ruled in *North Carolina State Board of Dental Examiners v. Federal Trade Commission (NC Dental)* that the NC Dental Board had engaged in anti-competitive behavior by asserting that teeth-whitening services provided by mall kiosks and salons were engaged in the unauthorized practice of dentistry. The Court ruled that the NC Dental Board was not entitled to so-called "state action" immunity from federal antitrust laws because its actions were not actively supervised by the state. The Court reasoned that active supervision is necessary for state agencies composed of active market participants because their private interests are so strong that they create an increased risk of anti-competitive conduct that may not be readily apparent to them.

The Court identified a few constant requirements of active supervision, including:

- State officials must have and exercise the power to review the substance of the agency's actions and overrule or modify them if not in accordance with state policy,
- The state supervisor may not itself be an active market participant, and
- The adequacy of supervision will depend on all the circumstances of a particular case.

States continue to struggle with applying the NC Dental ruling and establishing appropriate state oversight over boards.

States continue to struggle with applying the *NC Dental* ruling and establishing appropriate state oversight over boards that include market participants so that board decisions may be covered by state action immunity. Thus far, individual states are responding with proposed legislation, executive orders from governors' offices, and opinions from state attorneys general offices. These responses include:

- Requiring oversight by higher regulatory authority *(e.g., supervisory agency or AG office)*, and
- Restructuring the composition of board to include more non-market participants.

It remains unclear which of these actions, if any, would definitively be considered active supervision of a licensing board by the state.

Main Issue

The prospect of money damages in antitrust suits exposes state boards, their members and staffs to liability risk and creates a disincentive to serve on state boards. If found liable under current antitrust law, state treasuries and these individuals may now be subjected to treble damages and attorney's fees. While some states indemnify their licensing boards, other states do not.

Plaintiffs have sought from $1 million to over $11 million in treble damages from boards and individuals.

Several cases have been filed since the *NC Dental decision*, and while the vast majority of these cases have been dismissed or resulted in no judgment against the defendants, the threat of damage claims is significant and the cost to litigate these cases is significant. In those suits where known damage claims are asserted, plaintiffs have sought from $1 million to over $11 million in treble damages from the state boards and, in many cases, from individual board members.

(Continued on page 9)

(Occupational Licensing Board Antitrust Damages Relief Act continued from page 8)

A federal solution is necessary to ensure that current and prospective state board members are not deterred from serving.

FPMB Position

The FPMB believes that a federal solution is necessary to ensure that current and prospective state board members are not deterred from serving because they are uncertain about potential liability that could arise from their public service. This legislation provides a balanced approach to protecting the public and allowing for competition in the marketplace for consumers.

Federal Advocacy Efforts

The FPMB is an active member of the Professional Licensing Coalition *(PLC)*, a coalition of multiple professional licensing boards and associations, working to enact legislation to provide antitrust damages relief for licensing boards, board members, and their staffs *(trebled under the antitrust laws)*. The coalition includes medical, engineering, accounting, social work, psychology, physical therapy, architectural, landscape architect, and veterinary professions.

The PLC worked to introduce H.R. 8680, the Occupational Licensing Board Antitrust Damages Relief Act of 2020, late in the 116th Congress.

The PLC worked with Representatives Jamie Raskin *(D-MD)* and Mike Conaway *(R-TX)* to introduce H.R. 8680, the *Occupational Licensing Board Antitrust Damages Relief Act of 2020*, late in the 116th Congress. With Rep. Conaway's retirement, Rep. Raskin is looking for a new Republican cosponsor to lead in this bipartisan issue. Sen. John Cornyn *(R-TX)* also introduced similar legislation in the 115th Congress, and is looking for a lead Democrat to join before reintroducing in that chamber.

The bill does not prevent government enforcers, such as the Federal Trade Commission *(FTC)*, from suing under the Clayton Act. It also does not prevent private parties from suing for injunctive relief and attorney's fees, if successful.

To qualify for the damages limitation, the bill provides that licensing boards must be structured as follows:

- Operate under a state law that requires an occupational license for the occupation regulated by the board, specifies the qualifications for the license, and requires that professional and ethical standards be met;
- Have all members of the board appointed by the state's chief executive officer, the legislature, or other designated elected state officer;
- Include board members representing the public's interest;
- Provide mechanisms allowing people aggrieved by the board to contest its actions including:
    - The opportunity to provide evidence, argument, and analysis as to the contested action;
    - Review of all evidence gathered by the board relating to the action;
    - Receipt of a written decision from the board after any hearing; and,
    - The opportunity to appeal any decision to an independent adjudicator, including a court.

State Advocacy Forum Focuses on Partnerships

The APMA State Advocacy Forum, hosted by the Center for Professional Advocacy, is a unique biennial event that allows leaders from APMA component organizations to come together for collaboration and education. The 2021 event, held August 20–21 in Atlanta, highlighted the best of these elements through the theme "Partners in Progress." While every state legislature has its own idiosyncrasies, what is common across all of them is that strong partnerships—with legislative champions, other associations, and more—lead to effective change.

More than 65 member volunteers and state leaders representing 30 state component societies attended the event, with a handful also participating online. Georgia Podiatric Medical Association *(GPMA)* was chosen to host this year's forum in recognition of their recent legislative successes. "We used the information we learned at the 2019 State Advocacy Forum to create the roadmap that led to our wins," said Marit Sivertson, GPMA executive director, during a panel discussion in which the GPMA talked about their processes.

One major change GPMA made on their way to modernizing their scope-of-practice law was to hire a new lobbying firm that included former Georgia Speaker of the House Terry Coleman. At the forum Coleman provided advice about working with legislators, including understanding personal relationships *(e.g., turns out the committee chair's brother was an orthopedist, so how can you change your approach)* to how to create effective and memorable advocacy materials. He highlighted the many partnerships needed to move legislation forward and anticipate potential roadblocks, such as the governor's office, state agencies, and other decision makers. He also gave pointers on providing testimony before a committee or legislature: make sure you understand the ground rules, keep it short and to the point instead of overwhelming with too much information, and be prepared for questions.

Attendees had an opportunity to learn more about the recent APMA activities, including the white paper created by the Joint Task Force of Orthopaedic and Podiatric Surgeons that includes a pathway to podiatry students taking the USMLE. The attendees were brought up to speed on the history of the task force and the long path toward parity that led to the creation of the paper.

The forum included several breakout sessions that allowed attendees to come together in small groups to discuss common challenges and swapped solutions to address those challenges. Topics of discussion included:

- scope-of-practice modernization;
- oversight of physician extenders;
- encouraging grassroots involvement; and
- interacting with state legislators.

Other breakouts led to robust discussions about grassroots advocacy, and how to involve podiatrist members no matter the size of the APMA state component. One easy way to make grassroots advocacy accessible for everyone is to use APMA eAdvocacy (www.apma.org/eadvocacy). The site includes social media contact information for all legislators from the federal down to the county level.

During the forum, several state components gave updates about how they have used their CPA Innovation Grants. The grants provide funds for states to use on a variety of focused advocacy issues, such as scope modernization, physician definition, and general education. In discussing their individual projects, attendees were able to learn new ideas they can enact in their own states.

The next State Advocacy Forum will be held in 2023. For more information about the event, visit www.apma.org/stateadvocacyforum.

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

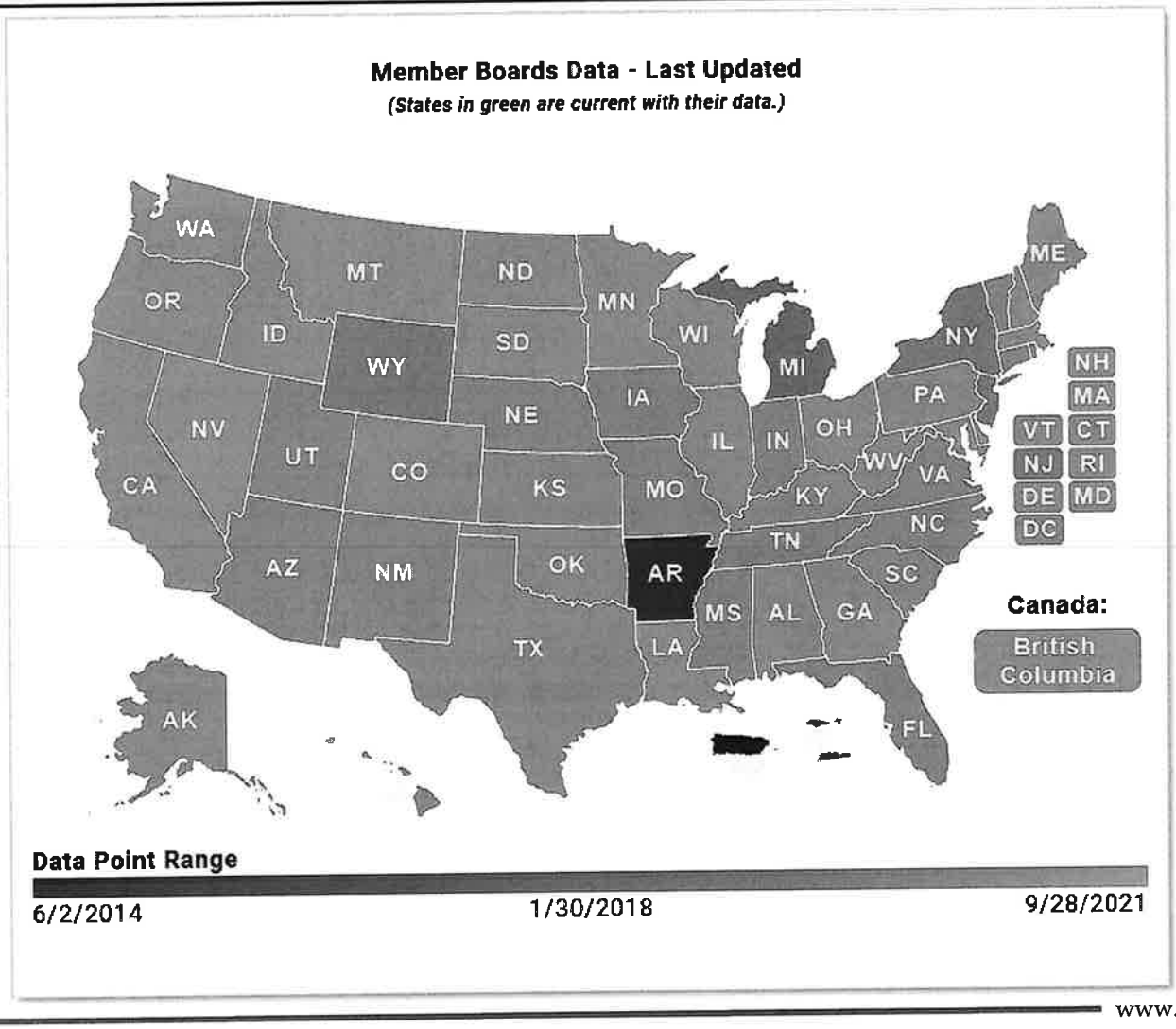
Enables visitors to compare all 15+ **general** and **licensure** data points across all, or a subset of, Member Boards.

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. Blue states *(see map below)* have not responded yet and should respond as soon as possible.

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

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) — ❖Q2 2021❖

Reports Ordered via Online System

100.00%

FPMB - Median Report Processing Time

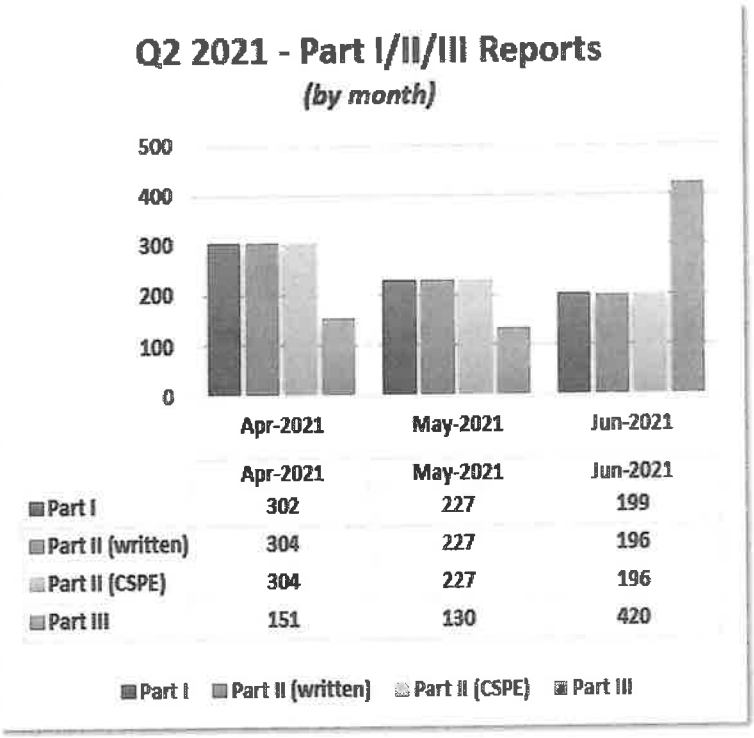
< 1 business hour

Member Boards - Electronic Delivery

53

Member Boards - Median Download Time

4.13 business hours

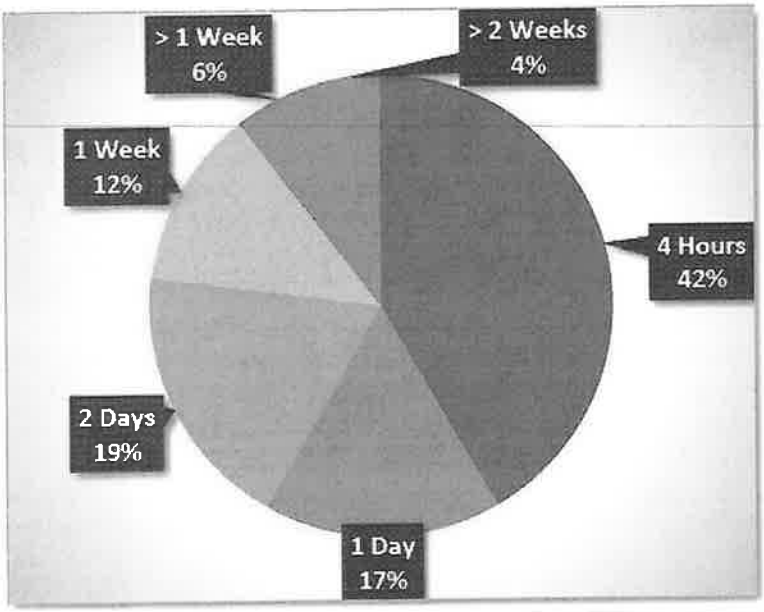


	Apr-2021	May-2021	Jun-2021
Part I	302	227	199
Part II (written)	304	227	196
Part II (CSPE)	304	227	196
Part III	151	130	420

EFFICIENCY IN LICENSURE — ❖Q2 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 **Q2 2021**:

Within 4 Hours

Arizona
California
Connecticut
District of Columbia
Florida
Illinois
Indiana
Kentucky
Louisiana
Missouri
Montana
Nevada
New York
North Carolina
Ohio
Oregon
South Dakota
Utah
Washington
Wyoming

Within 1 Day

British Columbia
Georgia
Hawaii
Idaho
Kansas
Massachusetts
New Hampshire
West Virginia

Within 2 Days

Alabama
Colorado
Michigan
Nebraska
New Jersey
New Mexico
Pennsylvania
South Carolina
Texas

NOTE: The 37 Member Boards listed above downloaded reports within 2 business days (median). Not listed are 11 Member Boards taking longer than 2 business days (median); 5 of these took more than 1 business week (median).

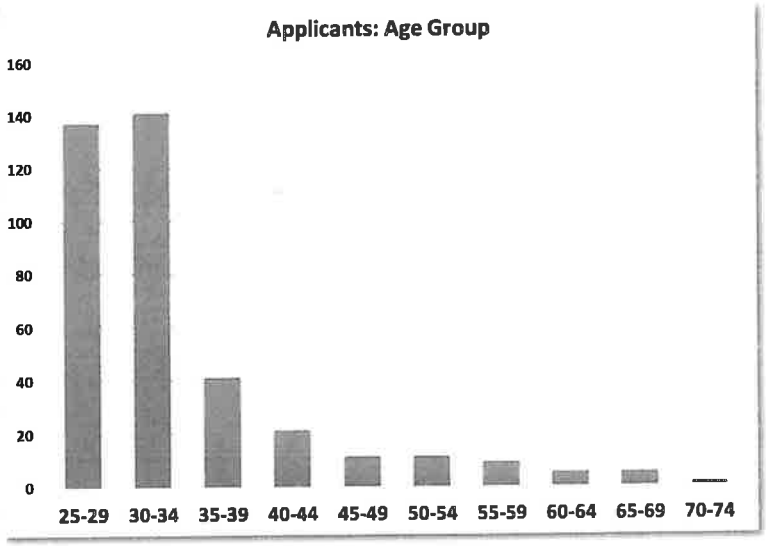
Occupational licensure reform seeks efficiency in licensure, especially for military spouses. Timely downloads of reports enables the FPMB to demonstrate efficiency of its Member Boards.

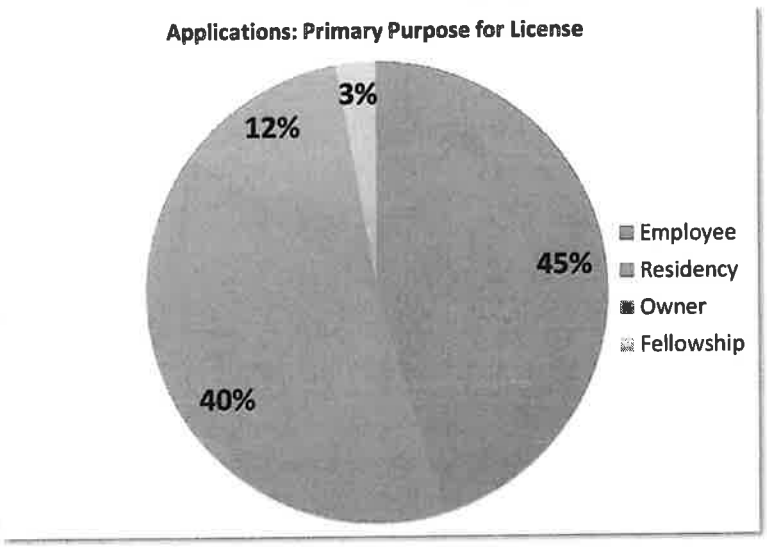
APPLICANT / APPLICATION STATISTICS — ❖June - August 2021❖

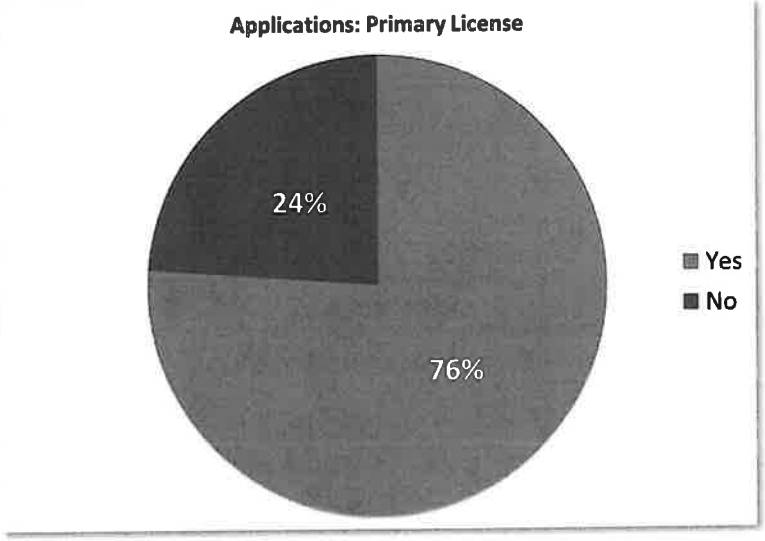
The following insights are based on data collected from podiatrists using the FPMB's primary verification source system as part of the licensure process:

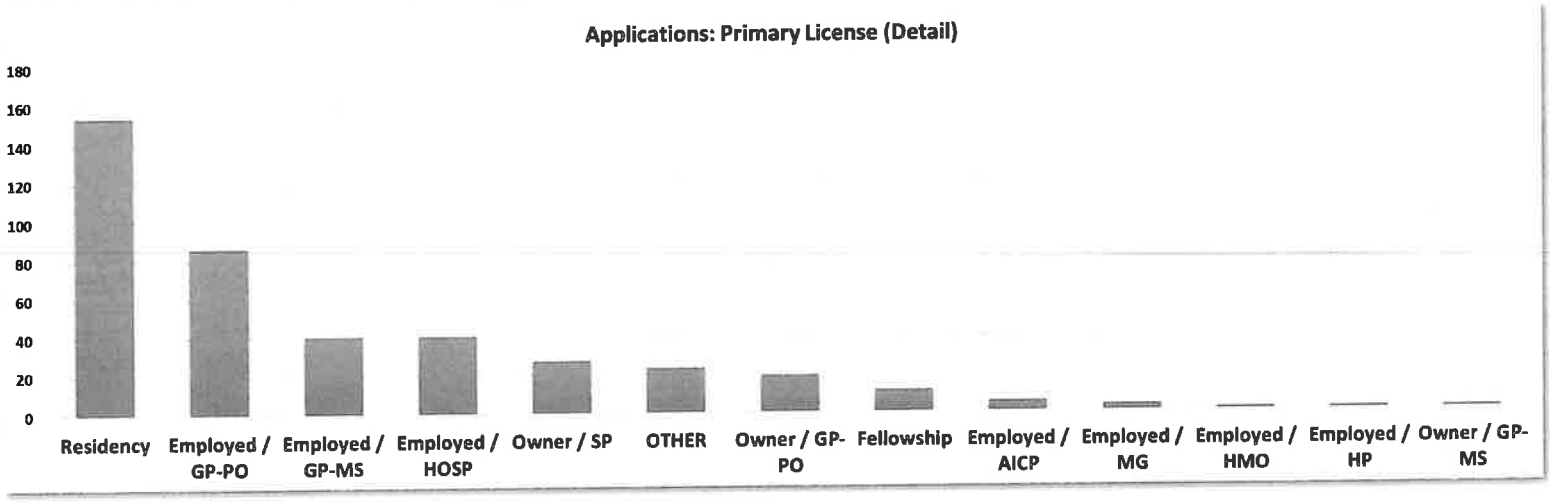
- **Applicants: Age Group**
- **Applications: Primary Purpose for License**
- **Applications: Is Primary License**

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 ❖

COVID-19 Pandemic

The COVID-19 Prevention and Awareness Act of 2021 (H.R. 173) was introduced by **Rep. Nydia Velazquez (D-NY)** and would authorize the CDC to award various grants to federally qualified health centers and other organizations to prevent, treat, and raise awareness of certain diseases or conditions, such as asthma or cancer, that increase the risk of mortality from COVID-19.

Telehealth

The Home Health Emergency Access to Telehealth (HEAT) Act (S. 1309) was re-introduced by **Sen. Susan Collins (R-ME)** and **Sen. Roger Marshall (R-KS)** and would authorize Medicare reimbursement for home health services provided through telehealth, with beneficiary consent, during a public health emergency. The bill also mandates that telehealth services constitute no more than half of the billable visits made during the 30-day payment period.

The Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2021 (S. 1512 / H.R. 2903) was re-introduced by **Sens. Brian Schatz (D-HI), Roger Wicker (R-MS), Ben Cardin (D-MD), John Thune (R-SD), Mark Warner (D-VA)** and **Cindy Hyde-Smith (R-MS)**, among others in the Senate, and **Rep. Mike Thompson (D-CA)** and **Rep. David Schweikert (R-AZ)** in the House, and would permanently remove all geographic restrictions on Medicare telehealth services and expand originating sites to include the home and other sites; allow health centers and rural health clinics to provide beneficiaries with telehealth services (a provision temporarily in place due to the pandemic); grant the HHS Secretary the permanent authority to waive telehealth restrictions (a provision temporarily in place due to the pandemic); allow waivers of telehealth restrictions during future public health emergencies; and authorize a study on telehealth usage during the COVID-19 pandemic.

The Telehealth Expansion Act of 2021 (S. 1704) was introduced by **Sen. Steven Daines (R-MT)** and **Sen. Catherine Cortez Masto (D-NV)** and would allow Americans with high-deductible health plans, defined as at least $1,350, with health savings accounts to use telehealth services without needing to first meet their deductible, permanently extending a CARES Act policy that was set to expire at the end of the year.

The Permanency for Audio-Only Telehealth Act (H.R. 3447) was re-introduced by **Rep. Jason Smith (R-MO)** and **Rep. Josh Gottheimer (D-NJ)** and would require the Centers for Medicare and Medicaid Service (CMS) to permanently continue reimbursing Medicare providers for certain audio-only telehealth evaluation and management services, mental and behavioral health services, which are scheduled to expire at the end of the public health emergency. Additionally, the bill would remove geographic restrictions to allow Medicare beneficiaries' homes to be included as telehealth originating sites.

The Telehealth Improvement for Kids' Essential Services (TIKES) Act of 2021 (S. 1798) was introduced by **Sen. Tom Carper (D-DE)** and **Sen. John Cornyn (R-TX)** and would lay out strategies for states to implement more telehealth options and research how to increase access for enrollees in Medicaid and CHIP. Its House companion, H.R. 1397, was introduced in February.

(Continued on page 15)

(Legislative News continued from page 14)

Substance Use Disorder

The Comprehensive Addiction and Recovery Act (CARA) 3.0 Act of 2021 (S. 987) was introduced by **Sen. Rob Portman (R-OH)**, **Sen. Jeanne Shaheen (D-NH)**, and **Sen. Sheldon Whitehouse (D-RI)** and would augment the funding authorization levels for the 2016 Comprehensive Addiction & Recovery Act (CARA) programs, 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 Residential Substance Use Disorder Treatment Act (S. 1046) was introduced by **Sen. John Cornyn (R-TX)** and **Sen. Sheldon Whitehouse (D-RI)** and would improve the Residential Substance Abuse Treatment (RSAT) for inmates by adopting and encouraging approved medication-assisted treatment, requiring program staff to be trained on the science of addiction, ensuring continuity of care after incarceration to reduce the risk of relapse and overdose and allowing grantees to use RSAT funds to offer treatment to individuals during short periods of incarceration.

Antitrust

The Restoring Board Immunity Act (H.R. 3147) was introduced by **Rep. Darrell Issa (R-CA)** and **Rep. Tim Walberg (R-MI)** and would establish a limited antitrust exemption for occupational licensing boards in states that meet specific requirements, including establishing an Office of Supervision of Occupational Boards to review actions of boards or providing for a judicial review of licensing laws that meet several requirements outlined in the legislation. Bill text is available here.

Licensing

The Freedom to Work Act (H.R. 3145) was introduced by **Rep. Diana Harshbarger (R-TN)** and "would require federal executive agencies to review their authorities, regulations, or policies that directly impose occupational licensing requirements or cause state, local, or tribal governments to adopt occupational licensing requirements. Those agencies would then have to identify any changes that would either rescind or offer the least restrictive alternative to any occupational licensing requirements." The press release is available here.

The Military Spouse Licensing Relief Act of 2021 (S. 1084 / H.R. 2650) was introduced by **Sen. Mike Lee (R-UT)** in the Senate and **Rep. Mike Garcia (R-CA)** in the House and would give military spouses with valid professional licenses in one state reciprocity in the state where their spouse is currently serving on military orders, so long as their license is in good standing. The licensee must comply with the new state's standards of practice, discipline, and continuing education requirements, and the bill does not preempt the states' authority to set their own licensing standards.

The Conrad State 30 and Physician Access Reauthorization Act (S. 1810 / H.R. 3541) was reintroduced by **Sens. Amy Klobuchar (D-MN)**, **Susan Collins (R-ME)**, **Jacky Rosen (D-NV)**, and **Joni Ernst (R-IA)** in the Senate and **Rep. Brad Schneider (D-IL)** and would allow international doctors to remain in the U.S. upon completing their residency under the condition that they practice in areas experiencing doctor shortages. In addition, the legislation extends the Conrad 30 program for three years, improves the process for obtaining a visa, and allows for the program to be expanded beyond 30 slots if certain thresholds are met.

The Accelerating Kids' Access to Care Act (S. 1544 / H.R. 3089) was introduced by **Sen. Chuck Grassley (R-IA)** in the Senate and **Rep. Katherine Clark (D-MA)** in the House and would establish a process for qualifying out-of-state pediatric care providers to enroll in another state's Medicaid program to treat children with complex medical conditions.

(Continued on page 16)

(Legislative News continued from page 15)

Opioids

The Federal Initiative to Guarantee Health by Targeting (FIGHT) Fentanyl Act (H.R. 1910) was introduced by **Rep. Steve Chabot (R-OH)** and **Rep. Bob Latta (R-OH)** and would permanently list all fentanyl analog drugs as schedule I controlled substances under the Controlled Substances Act, where they have been temporarily listed by the DEA since 2018. The Senate companion, S. 339, was introduced by **Sen. Rob Portman (R-OH)** and **Sen. Joe Manchin (D-WV)** in March.

The Non-Opioid Directive (NOD) Act (S. 1292) was introduced by **Sen. Joe Manchin (D-WV)** and would instruct the Department of Health and Human Services (HHS) to develop a non-opioid Pain Management Directive that will be included in a patient's medical record. Participation is voluntary and an individual may revoke a NOD form by themselves, a guardian or patient advocate at any time and in any manner. The bill allows an exception for providers to override the directive in the event a patient is receiving emergency treatment and also extends full liability protections (criminal and civil) for providers who mistakenly administer an opioid when a patient has signed a directive or for failing to administer or prescribe an opioid.

The Non-Opioids Prevent Addiction in the Nation (NOPAIN) Act (S. 586 / H.R. 5172) was re-introduced by **Sens. Shelley Moore Capito (R-WV), Rob Portman (R-OH), Joe Manchin (D-WV)**, and **Jeanne Shaheen (D-NH)** in the Senate and **Rep. Terri Sewell (D-AL)** and **Rep. David McKinley (R-WV)** in the House and would direct CMS to provide separate Medicare reimbursement for non-opioid treatments used to manage pain in both hospital outpatient departments and the ambulatory surgery center settings. Currently, hospitals receive the same payment regardless of whether a physician prescribes an opioid or a non-opioid, so hospitals may rely on opioids, which are typically dispensed by a pharmacy after discharge at little or no cost to the hospital.

The Extending Temporary Emergency Scheduling of Fentanyl Analogues Act (H.R. 2630) was introduced by **Rep. Chris Pappas (D-NH)** and was signed into law on May 4, extending the emergency, temporary scheduling of fentanyl and fentanyl analogs to October 22, 2021.

The Lessening Addiction By Enhancing Labeling (LABEL) Opioids Act (H.R. 1026) was re-introduced by **Rep. Greg Stanton (D-AZ)** and would require the Food and Drug Administration (FDA) to issue regulations requiring labels on opioid prescription bottles with a consistent, clear, and concise warning that opioids may cause dependence, addiction, or overdose.

The Dispose Unused Medications and Prescription Opioids (DUMP Opioids) Act (S. 957) was introduced by **Sen. John Kennedy (R-LA)** and would allow everyone in a community to use drop boxes for medicine disposal which are available at certain VA medical centers for veterans to use. The bill instructs the VA Secretary to designate times that the public can use the boxes and carry out public information campaigns to highlight their use. The legislation passed the Senate by unanimous consent on April 22 and awaits action in the House.

The Budgeting for Opioid Addiction Treatment (LifeBOAT) Act (S. 1723) was re-introduced by **Sen. Joe Manchin (D-WV)** and **Sen. Tammy Baldwin (D-WI)** and cosponsored by **Sens. Richard Blumenthal (D-CT), Maggie Hassan (D-NH), Angus King (I-ME), Amy Klobuchar (D-MN), Jeanne Shaheen (D-NH), Tina Smith (D-MN), Elizabeth Warren (D-MA)** and **Sheldon Whitehouse (D-RI)**; and would establish a 1 cent stewardship fee on each milligram of active opioid ingredient in a prescription pain pill to fund efforts to provide and expand access to substance abuse treatment, including establishing new residential and outpatient addiction treatment facilities, recruiting and increasing reimbursement for certified mental health providers, and expanding access to long-term, residential treatment programs; among other interventions.

(Continued on page 17)

(Legislative News continued from page 16)

The Support, Treatment, and Overdose Prevention (STOP) Fentanyl Act of 2021 (S. 1457 / H.R. 2366), introduced by **Sen. Edward Markey (D-MA)** and **Sen. Elizabeth Warren (D-MA)** in the Senate and **Rep. Ann Kuster (D-NH)** in the House, would enhance the public health surveillance of fentanyl-related substances, report on evidence-based interventions to reduce overdose deaths, improve access to Naloxone, establish Federal Good Samaritan immunity protections for individuals providing care to someone who is overdosing, expand access to Medication Assisted Treatment (MAT), and maintain enhanced telehealth access to opioid use disorder treatment, among other aspects.

The Dispose Unused Medications and Prescription Opioids (DUMP Opioids) Act (S. 2591) was introduced by **Rep. Mariannette Miller-Meeks (R-IA)** and would allow everyone in a community to use drop boxes for medicine disposal which are available at certain VA medical centers for veterans to use. The bill instructs the VA Secretary to designate times that the public can use the boxes and carry out public information campaigns to highlight their use. The Senate companion bill, S. 957, passed the Senate by unanimous consent on April 22.

The State Opioid Response Grant Authorization Act of 2021 (H.R. 2379) was re-introduced by **Rep. David Trone (D-MD)** and would authorize $9 billion over six years in flexible funding for State Opioid Response (SOR) Grants and Tribal Opioid Response (TOR) Grants to fight the opioid epidemic on the front lines.

The Opioid Prescription Verification Act (H.R. 2355) was re-introduced by **Rep. Rodney Davis (R-IL)** and would incentivize states to adopt systems that require pharmacists to verify an individual's identification when dispensing prescribed medications and to maintain the state's PDMP, amongst other provisions. It would also require the CDC to work with other agencies to develop materials and guidance to pharmacists on verifying the identity of individuals picking up prescriptions.

Health Equity

The Social Determinants Accelerator Act (H.R. 2503) was re-introduced by **Reps. Cheri Bustos (D-IL), Tom Cole (R-OK), Jim McGovern (D-MA)** and **Markwayne Mullin (R-OK)** and would make up to $25 million available to state, local and tribal governments to develop plans to target social determinants, such as stable housing, reliable transportation and access to healthy foods, that negatively impact high-need patients.

The Social Determinants for Moms Act (H.R. 943 / S. 851) was introduced by **Rep. Lucy McBath (D-GA)** in the House and **Sen. Richard Blumenthal (D-CT)** in the Senate and would establish a task force across agencies and departments to coordinate federal efforts to address social determinants of health for pregnant and postpartum people, including stable housing, extending WIC eligibility, transportation barriers, and child care access.

The Pursuing Equity in Mental Health Act (H.R. 1475) was re-introduced by **Rep. Bonnie Watson Coleman (D-NJ)** and would authorize $805 million in grants and other funding to support research, improve the pipeline of culturally competent providers, build outreach programs that reduce stigma, and develop a training program for providers to effectively manage disparities in the suicide rates among Black youth. The bill was passed by the House on May 12.

The COVID-19 Health Disparities Action Act of 2021 (H.R. 1400 / S. 465) was re-introduced by **Rep. Tony Cardenas (D-CA)** in the House and **Sen. Robert Menendez (D-NJ)** in the Senate and would address the impact of the COVID-19 pandemic on communities of color by requiring targeted testing, contract tracing, public awareness campaigns, and outreach efforts specifically directed at racial and ethnic minority communities and other populations that have been made vulnerable to the COVID-19 pandemic.

(Continued on page 18)

(Legislative News continued from page 17)

Public Health

The Health Force, Resilience Force, and Jobs To Fight COVID-19 Act of 2021 (H.R. 460 / S. 32) was introduced by **Rep. Jason Crow (D-CO)** in the House and **Sen. Kirstin Gillibrand (D-NY)** in the Senate and would create a "Health Force" within the CDC and expand FEMA's On-Call Response/ Recovery Employees; to recruit, train, and employ Americans to expand our public health workforce to respond to the COVID-19 pandemic, aid the country's vaccine distribution campaign, and strengthen America's longer-term public health response.

Maternal Health

The Maternal Immunization Enhancement Act (S. 1114) and the Maternal Immunization Coverage Act (S. 1117) were re-introduced by **Sen. Maggie Hassan (D-NH)** and **Sen. Bill Cassidy (R-LA)**, the former aims to increase rates of Advisory Committee on Immunization Practices (ACIP)-recommended vaccination among pregnant Medicaid enrollees by directing CMS to issue guidance to states on how they can improve immunization and by improving data collection efforts on this population, while the latter would require that state Medicaid programs cover ACIP-recommended vaccines for pregnant Medicaid enrollees without cost-sharing.

The Birth Access Benefiting Improved Essential Facility Services (BABIES) Act (H.R. 3337) was re-introduced by **Rep. Katherine Clark (D-MA)** and **Rep. Jaime Herrera Beutler (R-WA)** and would create a payment program under Medicaid to reimburse birth centers for prenatal care, perinatal and postpartum mother and infant care.

The Midwives for Maximizing Optimal Maternity Services (MOMS) Act (H.R. 3352) was re-introduced by **Rep. Lucille Roybal-Allard (D-CA)** and **Rep. Jaime Herrera Beutler (R-WA)** and would establish two new funding streams for midwifery education to expand educational opportunities for midwives, giving special consideration to institutions that prioritize students planning to practice in health professional shortage areas and those that demonstrate a focus on increasing racial and ethnic minority representation in midwifery education.

The Helping Medicaid Offer Maternity Services (Helping MOMS) Act (H.R. 3345) was introduced by **Rep. Robin Kelly (D-IL)** and **Rep. Jaime Herrera Beutler (R-WA)** and would amend the American Rescue Plan to eliminate the time limit on the state option to elect extended postpartum Medicaid coverage, allowing states a permanent option to extend coverage. The bill would also increase the Federal Medical Assistance Percentage (FMAP) rate to 5% for pregnancy-related services in the first-year states adopt extended postpartum coverage.

The Mothers and Offspring Mortality and Morbidity Awareness (MOMMA's) Act (S. 411) was introduced by **Sen. Richard Durbin (D-IL)** and **Sen. Tammy Duckworth (D-IL)** and would extend the current 60-day coverage for postpartum care to one year under Medicaid and the Children's Health Insurance Program (CHIP), address disparities in health by supporting implicit bias training for clinicians on health equity issues, as well as provide guidance and options for states to adopt and pay for support services provided by doulas.

The Rural MOMS Act (H.R. 769 / S. 1491) was introduced by **Rep. Dan Newhouse (R-WA)** in the House and **Sen. Tina Smith (D-MN)** and **Sen. Lisa Murkowski (R-AK)** in the Senate and would direct the CDC to coordinate efforts with respect to maternal mortality and morbidity, to report on women's health conditions according to sociocultural and geographic contexts, and to emphasize research on pregnancy-related deaths; award new rural obstetric network grants to establish regional innovation networks to improve maternal mortality and morbidity, expand existing federal telehealth grant programs to include birth and postpartum services including pregnancy-related technology, and support training for health professionals to provide maternal care services in rural settings.

(Continued on page 19)

(Legislative News continued from page 18)

The Maternal Health Quality Improvement Act (S. 1675) was introduced by **Sen. Raphael Warnock (D-GA)** and **Sen. Bill Cassidy (R-LA)** and would authorize new grant programs for innovations in reducing maternal mortality, developing evidence-based best practices, improving maternal mortality review committee data, integrating health care services for pregnant and postpartum women and infants, and for racial and ethnic bias training for health care providers; create a study on best practices for training programs to reduce and prevent discrimination; expand the ability of the CDC to award grants for perinatal quality collaboratives.

The Data Mapping to Save Moms' Lives Act (H.R. 1218 / S. 198) was introduced by **Rep. G.K. Butterfield (D-NC)** in the House and **Sen. Jacky Rosen (D-NV)** in the Senate and would instruct the FCC to consult with the CDC to determine ways to incorporate data on maternal health outcomes, at least one year postpartum, into its existing broadband health mapping tools, which allow users to visualize, overlay, and analyze broadband and health data at national, state, and county levels; in an effort to reduce maternal mortality and morbidity in the U.S.

Mental Health

The Sgt. Ketchum Rural Veterans Mental Health Act of 2021 (H.R. 2441) was introduced by **Rep. Cynthia Axne (D-IA)** and would establish new VA Rural Access Network for Growth Enhancement (RANGE) programs, which provide a small team of specialists to meet the needs of rural veterans with serious mental health and daily living issues, and directs the Government Accountability Office (GAO) to study how the VA can improve mental health care for rural veterans. The bill passed the House on May 18, 2021.

The Mental Health Access Improvement Act of 2021 (H.R. 432) was introduced by **Rep. Mike Thompson (D-CA)** and would expand the network of providers that can deliver mental and behavioral health services to Medicare beneficiaries to include mental health counselors and marriage and family therapists.

The Improving Mental Health Access from the Emergency Department Act of 2021 (H.R. 1205) was introduced by **Rep. Raul Ruiz (D-CA)** and passed the House on May 12. The bill would award grants to emergency departments for expanding mental health programs, including increasing the supply of in-patient beds and coordination with regional service providers and bed availability, increased telepsychiatric support, and transportation services.

The Helping Emergency Responders Overcome (HERO) Act (H.R. 1480) was introduced by **Rep. Ami Bera (D-CA)** and **Rep. Brian Fitzpatrick (R-PA)** and passed the House on May 12. The bill would allow the Secretary, in coordination with the CDC, to develop a confidential database tracking suicide among public safety officers to analyze more effective intervention strategies. It would also authorize grants for peer support behavioral health and wellness programs within fire departments and emergency medical service agencies, and require the development of best practices for addressing post-traumatic stress disorder in public safety officers and educational materials. Additionally, the bill would allow the Secretary to award grants for establishing or enhancing health care provider behavioral health and wellness programs.

Medicaid

The Accelerating Kids' Access to Care Act (H.R. 3089 / S. 1544) was introduced by **Rep. Katherine Clark (D-MA)** in the House and **Sen. Chuck Grassley (R-IA)** in the Senate and would provide states with the ability to streamline screening and enrollment processes for out-of-state pediatric care providers that need to enroll in another state's Medicaid program to treat children with rare, complex medical conditions; while safeguarding program integrity processes.

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Broadband

The National Broadband Plan for the Future Act of 2021 (H.R. 870 / S. 279) was introduced by **Rep. Anna Eshoo (D-CA)** in the House and **Sen. Ed Markey (D-MA)** in the Senate and would instruct the FCC to update the National Broadband Plan and develop an updated roadmap for achieving universal connectivity, including an assessment of the progress in achieving the goals of the original national plan; how COVID-19 affected how people learn, work, receive medical information and treatment; and an analysis of the change in reliance people will have on services enabled by broadband internet access service as a result of COVID-19. Lastly, the FCC would be required to report annually on its progress toward achieving the goals of the updated plan.

The State Fix Act of 2021 (S. 944) was introduced by **Sen. Lindsey Graham (R-SC)** and **Sen. Tim Scott (R-SC)** and would provide the FCC with $20 billion in funding to states to hold reverse auctions for private contractors to bid to equip communities with broadband service, while banning the purchase and services of technologies from state-owned enterprises.

Veterans Affairs

The VA Provider Accountability Act (S. 2041) was introduced by **Senators Joe Manchin (D-WV), Jerry Moran (R-KS), Bill Cassidy (R-LA), Susan Collins (R-ME)** and **John Boozman (R-AR)** to ensure veterans are receiving quality care from qualified and vetted health care professionals. The legislation will require each VA medical center to compile, verify, and continuously monitor health care professionals' licensure status certification and registration; Drug Enforcement Administration (DEA) registration, and education, training, malpractice history and clinical competence. Of particular interest to state medical boards, is the provision that would require the Secretary to ensure that the appropriate medical center notify any clinical competency or quality of care concerns to the 1) appropriate licensing agency, registration, or certifying body in each state in which the health care professional is licensed, registered or certified; 2) the DEA; 3) the National Practitioner Data Bank; and 4) any other relevant entity.

The FSMB has long advocated for improving information sharing between Department of Veterans Affairs medical centers and state medical boards. More information can be found in **Sen. Joe Manchin's (D-WV)** press release here.

The Ensuring Quality Care for Our Veterans Act (H.R. 3059) was re-introduced by **Rep. Ralph Norman (R-SC)** and would require the Veterans Health Administration (VHA) to have a patient's records reviewed by an independent, non-government medical provider if it is determined that the patient received care from a provider within the VHA system whose license had been previously revoked for cause.

The Guaranteeing Healthcare Access to Personnel Who Served (GHAPS) Act (S. 1863) was introduced by **Sen. Kevin Cramer (R-ND)** and **Sen. Jerry Moran (R-KS)** and aims to close VA health care gaps by protecting veteran eligibility for MISSION's Veterans Community Care Program, directing the VA to create a telehealth strategic plan to deliver care to rural veterans, ensuring veterans with treatment-resistant depression can access necessary evidence-based care, and directing the GAO to report on the Foreign Medical Program to evaluate whether the program is adequately meeting the needs of overseas veterans.

Graduate Medical Education

The Doctors of Community (DOC) Act (H.R. 3671 / S. 1958) was introduced by **Rep. Frank Pallone (D-NJ)** in the House and **Sen. Patty Murray (D-WA)** in the Senate and would permanently authorize the Teaching Health Center Graduate Medical Education (THCGME) program to support the training of 1,600 new slots for primary care medical and dental residents with a focus on supporting residents in high-need communities.

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The Opioid Workforce Act of 2021 (S. 1438) was re-introduced by **Sen. Susan Collins (R-ME)** and **Sen. Maggie Hassan (D-NH)** and would help hospitals hire and train more doctors in addiction medicine, addiction psychiatry, and pain management by creating 1,000 new medical residency positions specific to addiction at teaching hospitals across the country.

The Student Loan Forgiveness for Frontline Health Workers Act (H.R. 2418) was re-introduced by **Rep. Carolyn Maloney (D-NY)** and would establish a program within the Departments of Education and Treasury that would forgive all public and private graduate student loans, including loans administered by the Health Resources and Services Administration, for health care workers who have made significant contributions to patient care, medical research, and testing during the COVID-19 national emergency.

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.

FEDERAL REGULATORY NEWS

Highlights

On April 27, the Department of Health and Human Services (HHS) released new Practice Guidelines for the Administration of Buprenorphine for Treating Opioid Use Disorder. The Guidelines:

- Exempts certain practitioners from the certification requirements related to training, counseling and other ancillary services
- Limits those utilizing the waiver to treating no more than 30 patients at any one time. Time spent practicing under the exemption will not qualify the practitioner for a higher patient limit.
- Establishes that physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives are required to be supervised by, or work in collaboration with, a DEA registered physician if required by state law to work in collaboration with, or under the supervision of, a physician when prescribing medications for the treatment of opioid use disorder.0
- Clarifies that practitioners who do not wish to practice under the exemption and its attendant 30 patient limit may seek a waiver per established protocols.
- Clarifies that the exemption applies only to the prescription of Schedule III, IV, and V drugs or combinations of such drugs, covered under the CSA, such as buprenorphine. It does not apply to the prescribing, dispensing, or the use of Schedule II medications such as methadone for the treatment of opioid use disorders.
- Requires practitioners to obtain a waiver under the CSA by submitting a Notice of Intent to SAMHSA under established protocols before treating patients with buprenorphine for opioid use disorder

On April 30, the **Food and Drug Administration** approved a nasal spray that delivers 8 milligrams of naloxone. Previously, FDA had 2 mg and 4 mg naloxone nasal spray products. Per the FSA News Release, "A higher dose of naloxone provides an additional option in the treatment of opioid overdoses."

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On May 10, **HHS** announced its Office for Civil Rights would interpret and enforce Title IX's prohibitions on discrimination to include sexual orientation and gender identity. Title IX prohibits discrimination on the basis of race, color, national origin, sex, age, or disability.

On May 13, the **CDC** announced new Guidance for Fully Vaccinated People, noting that they may:

- Resume activities without wearing masks or physically distancing, except where required by federal, state, local, tribal, or territorial laws, rules and regulations, including local business and workplace guidance
- Resume domestic travel and refrain from testing before or after travel or self-quarantine after travel
- Refrain from testing before leaving the United States for international travel (unless required by the destination) and refrain from self-quarantine after arriving back in the United States
- Refrain from testing following a known exposure, if asymptomatic, with some exceptions for specific settings
- Refrain from quarantine following a known exposure if asymptomatic
- Refrain from routine screening testing if feasible

On May 18, the Biden Administration announced it would disperse $3 billion to states to help people struggling with mental health and substance abuse problems during the Covid-19 pandemic. The funding comes from the **American Rescue Plan** and will be distributed by the **Substance Abuse and Mental Health Services Administration (SAMHSA)** through their Community Mental Health Services Block Grant and Substance Abuse Prevention and Treatment Block Grant Programs.

On May 19, the **Government Accountability Office (GAO)** published a report titled *Medicare and Medicaid: COVID-19 Program Flexibilities and Considerations for Their Continuation*. The highlights can be found here and the full report is available here.

On May 20, **HHS** announced the availability of $14.2 million from the **American Rescue Plan** to expand pediatric mental health care access – provided by child and adolescent psychiatrists, licensed mental health professionals, and care coordinators - by integrating telehealth services into pediatric primary care.

On June 10, the **Occupational Safety and Health Administration (OSHA)** announced an emergency temporary standard to help protect healthcare workers from contracting coronavirus. The rule requires healthcare employers to provide protective equipment like masks to screen and triage patients for the risk of Covid-19, ensure adequate ventilation and distancing, provide paid time off for workers to receive vaccinations and manage their side effects, among other measures. However, fully vaccinated workers are not required to wear masks or practice social distancing.

Telehealth Updates

On May 3, **Sen. Mark Warner (D-VA)** sent a letter to Attorney General Merrick Garland and DEA Acting Administrator Chris Evans, pressing the DEA to create a registration process for providers who want to use connected health channels to prescribe medications used in substance abuse treatment. Providers are prevented from prescribing controlled substances via telehealth by the Ryan Haight Act of 2008, which – among many things – mandates an in-person exam before any telehealth service is rendered. But that bill also allows the DEA to create a special registration process so that providers can use telehealth, but, more than ten years later, the agency has not finalized regulations allowing for prescriptions to be issued following a telehealth appointment.

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❖ STATE LEGISLATION OF INTEREST ❖

Interstate Medical Licensure Compact

On June 7, Texas Governor Greg Abbott signed House Bill 1616 into law and on June 23, Delaware Governor John Carney signed House Bill 160 into law, bringing the total number of IMLC members to **34** (32 states, DC, and Guam). On June 24, Ohio passed SB 6 and the legislation now moves to be signed into law by Governor Mike DeWine. Once signed, Ohio will become the 35th member of the IMLC.

Legislation to enact the Compact is active in Massachusetts (H 3773), Missouri (HB 516 and SB 300), New Jersey (A 1112), New York (A 5540 and S 5495), North Carolina (SB 380) and Oregon (HB 2335).

As of May 31, 2021, the IMLCC has processed 13,824 applications resulting in 20,061 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.

RECENTLY ENACTED REGULATION

Board Structure and Function

Alabama HB 45 - Recommends the continuance of the State Board of Medical Examiners and Medical Licensure Commission until October 1, 2025.

Idaho S 1024 – Removes and reassigns the previously existing hiring authority and associated financial obligations from the Medical Board, as well as other licensing boards, to the Division of Occupational and Professional Licenses.

Tennessee HB 1080 - Changes the composition of the Physician Assistant Board to nine members (from five), including seven PAs, one physician and one public member.

Collaborative Practice Agreements

Nevada SB 229 - Removes 100-mile distance limit between practitioner and pharmacist, prohibits a practitioner from authorizing a pharmacist to engage in an activity that is outside the practitioner's scope of practice, and expressly authorizes a pharmacist to possess and administer a controlled substance.

Wisconsin SB 168 - Allows a physician licensed in another state or Canada to practice for up to 90 days a year at a recreational and educational camp in the state so long as they are not under active investigation by a licensing authority or law enforcement authority and requires a form be submitted to the Medical Examining Board beforehand.

License Reciprocity

Arizona HB 2454 – Adds audio-only telephone to the definition of telemedicine if audio-visual technology is not reasonably available; creates a Telehealth Advisory Committee to promote best telehealth practices; and allows for health care providers licensed in good standing and not subject to current or past disciplinary actions in another jurisdiction, to provide telemedicine services to Arizona residents after registering with the applicable Arizona provider regulatory board or agency. Licensees must act in compliance with Arizona laws including scope of practice and liability insurance, which retains regulatory authority.

New Jersey A 4246 - Allows a professional licensing board to expedite licensing for a recent mental health graduate in another state to practice under the supervision of a licensed mental health professional in New Jersey during future emergencies.

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Oklahoma HB 2873 - Recognizes licenses for applicants with verifiable documentation demonstrating residency in state that have a valid license or certificate in good standing in another jurisdiction with substantially similar or equivalent requirements for in-state licensure, with at least a year of experience, and free of any pending complaint, investigation, or suspension.

Vermont H 104 – Allows a healthcare professional who holds a valid license in good standing and without disciplinary proceedings in a different jurisdiction to provide clinical mental health counseling services to a patient located in Vermont using telemedicine.

Medical Marijuana

Oregon HB 3369 - Adds naturopaths to the list of "primary care professionals" that can recommend medical marijuana to registered marijuana cardholders.

Military Licensure

Kansas HB 2066 - Allows for military members and military spouses who do not qualify under the applicable Kansas law by endorsement, reinstatement, or reciprocity statutes that are licensed in another state to receive reciprocal licensure, provided they have worked for at least one year in the occupation, have no disqualifying criminal background or discipline on their license, and pay the required fees. The KSBH **may deny** an application if the board determines the applicant's qualifications are not substantially equivalent to those established by Kansas statute. Lastly, the bill also allows for Boards to grant temporary licenses to appropriately qualified professionals during emergencies.

Opioids

Washington SB 5195 - Requires practitioners to provide or confirm that a patient in an Emergency Department with an opioid overdose or in involuntary treatment with recent overdose has an opioid overdose reversal medication.

Physician Assistant Scope of Practice

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

Prescription Drug Monitoring Programs (PDMPs)

Missouri SB 63 – Enacts a statewide PDMP in Missouri, superseding St. Louis County's PDMP that was used by 80% of Missourians. The bill creates a "Joint Oversight Task Force of Prescription Drug Monitoring," comprised of six licensed healthcare professionals on state boards, which will oversee the creation of the centralized database. Dispensers that fail to utilize the PDMP can be subject to fines up to $1,000 per violation. The bill goes into effect August 28, 2021.

Physician Immunity

Nebraska LB 139 - Gives healthcare providers, including physicians, legal immunity for their treatment, including via telemedicine, or failure to provide treatment, that may have resulted in injury or death during the pandemic, except in a case of reckless, intentional misconduct.

Physician Misconduct

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

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

Prescribing Practices

Montana SB 374 - Allows medical practitioners (defined by Montana as someone licensed to practice medicine, dentistry, osteopathy, podiatry, optometry, or a nursing specialty) to dispense drugs so long as they are registered with the Board of Pharmacy, practicing within their license's scope of practice, dispense at their place of practice, and only to their patients.

Rhode Island SB 384 - Redefines "intractable pain," prohibits practitioners from refusing intensive treatment, and urges practitioners to prescribe, administer and dispense controlled substances without regard to the 2016 CDC Guidelines for Prescribing Opioids for Chronic Pain.

Public Health

Arizona SB 1250 - Allows cities and organizations to establish overdose and disease prevention programs to increase access to naloxone, sterile needle and syringe exchange programs, and other evidence-based harm reduction measures; and grants immunity from controlled substance violations for employees and volunteers participating in the harm reduction programs.

Telemedicine

Arkansas HB 1063 - Allows physicians licensed in-state to establish a patient-physician relationship via telehealth, including audio-only telephone, and mandates the Medical Board to promulgate rules for that purpose.

Connecticut HB 5596 - Bill allows for physicians licensed out-of-state to provide services via telemedicine to Connecticut residents for two years. Requires any Connecticut entity, institution, or provider contracting with an out-of-state provider to verify the provider's credentials and confirm they have professional liability insurance. The bill allows audio-only modalities when appropriate, which is also limited to the two-year time frame. The bill allows physicians and APRNs to recommend medical marijuana via telemedicine. Lastly, the bill also mandates a report, due January 1, 2022, regarding the expansion of the provision of telehealth services in the state.

Colorado HB 21-1190 - Redefines telemedicine to incorporate audio-only modalities.

Maryland SB 278 - Bars health occupations boards from establishing a separate standard of care for telehealth and specifies that such regulations must allow for the establishment of a practitioner-patient relationship through synchronous or asynchronous telehealth.

Montana HB 43 – Changes the definition of telemedicine to include audio-only and store-and-forward modalities and removes site restrictions and the mandate that a patient-provider relationship be first established in person.

Nebraska LB 400 and LB 487 - Prohibits insurance providers from rejecting claims because the patient did not meet with the doctor in-person and includes audio-only telemedicine for established patients in certain situations. The bills also mandate payment parity for telemental health services.

North Dakota HB 1465 - Adds audio-only telephone to the definition of telemedicine, limited e-visits or a virtual check-in, which is defined as a brief communication to decide whether an office visit or other service is needed.

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Oklahoma SB 674 – Changes the definition of telemedicine to remove geographic restrictions, include remote patient monitoring and store and forward modalities. The bill also mandates insurers cover services provided via telehealth that were previously covered if rendered in-person.

Oregon HB 2508 - Adds "health services transmitted via landlines, wireless communications, the Internet and telephone networks; synchronous or asynchronous transmissions using audio only, video only, audio and video or text-based media and transmission of data from remote monitoring devices," to the definition of telemedicine.

Texas SB 40 - Clarifies that "direct" observation or "direct" care or services to a patient can be done via telehealth. Also mandates the Texas Commission of Licensing and Regulation to promulgate rules to ensure that patients using telehealth services receive appropriate, quality care.

Tennessee SB 429 - Adds healthcare professional's offices as qualified destination sites and patient's home or remote sites as origination sites. The bill also removes prohibition on audio-only behavioral telehealth if no other modality is possible.

Washington HB 1196 - Requires that services provided by audio-only telemedicine be reimbursed at the same rate as they would be in-person, with certain exceptions, making permanent a temporary pandemic-related change.

Pending Legislation of Interest

Active Supervision

Louisiana HB 398 - Bill 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. The bill also provides immunity to boards and board members from federal antitrust laws.

Background Checks

New York A 7058 - Prohibits employment agencies and licensing boards from finding applicants in poor moral character solely for committing a felony more than ten years ago, or a misdemeanor more than five years ago; and allows applicants with certificates of good conduct to circumvent prohibitions against individuals with certain convictions from being licensed for select occupations.

Maine LD 1465 - Prohibits licensing boards from preemptively disqualifying applicants based on criminal history, requires boards to consider the nature and seriousness of the crime and if it is germane to the profession, the age when the crime was committed, the amount of time since the crime, the circumstances of the offense, and evidence of rehabilitation before rendering a licensing decision. It also makes certain criminal history record information in the possession of a licensing agency confidential.

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.

Louisiana SCR 73 - Directs health care professional licensing boards to evaluate other states' models for independent scope of practice reviews.

New Jersey S 3610 - Requires professional licensing boards to include in their rules and regulations implementing telemedicine and telehealth law requirements for emergency care plans that include standards and protocols for activating and coordinating with emergency care service providers serving the area in which the patient is located at the time of the telemedicine encounter.

Pennsylvania HB 1440 - Adds medical imaging professional, radiation therapist or radiologist assistant professions to nurse midwife, PA, NP, respiratory

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therapist, athletic trainer and perfusionist for eligibility for one position on the Medical Board. The bill also defines the functions, license requirements, scope of practice, CE requirements of medical imaging professionals, radiation therapists and radiologist assistants.

South Carolina H 4394 - Transfers the licensing and regulation of midwives to the State Board of Medical Examiners from the State Board of Nursing.

Texas SB 2115 - Requires healthcare licensing boards to refer complaints involving practitioners licensed by other licensing boards to the appropriate licensing board for investigation and possible discipline.

Wisconsin AB 296 - Requires occupational licensing boards to adopt the definitions of asynchronous telehealth service, interactive telehealth, remote patient monitoring, and telehealth as promulgated in this bill.

Continuing Medical Education (CME)

Illinois SB 677 – Mandates that healthcare professionals that work with elderly populations complete three hours of CME on the diagnosis, treatment, and care of individuals with cognitive impairments, including Alzheimer's and other dementias.

Missouri HB 937 - Requires physicians, health care practitioners, or mental health practitioners to annually complete up to two hours of cultural competency training as part of their license renewal and CME requirements.

New Jersey A 5808 - Allows certain healthcare professionals, including physicians and APRNs providing psychiatric services, to exchange two hours of volunteer service for one hour or credit of CME, up to 10 hours/credits of CME, per biennial renewal period.

License Portability and Reciprocity

Connecticut SB 1 - Enacts the Uniform Emergency Volunteer Health Practitioners Act (UEVHPA), model legislation that allows state governments during a declared emergency to give reciprocity to other states' licensees so that covered individuals may provide emergency health services without meeting the disaster state's licensing requirements. The UEVHPA is currently active in 17 states, plus DC and USVI. Additionally, the bill requires hospitals to include implicit bias training as part of their regular training to staff members.

Kansas SB 238 - Allows physicians licensed in other jurisdictions to practice telemedicine with Kansas patients so long as they've received a waiver from the Board of Healing Arts, have not faced any disciplinary actions, and meet state license qualifications. Waivers must be renewed annually, and recipients are subject to all state rules and regulations; disciplinary authority is retained by the KSBHA.

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.

Maine LD 649 - Allows physicians licensed in good standing and without disciplinary actions in another jurisdiction to provide services via telemedicine to Maine patients if they are registered with the Board. Registration must be renewed biennially. Bill also requires insurers to cover medically necessary health care services delivered through telehealth that is available to the provider and the patient.

North Carolina HB 868 - Allows the Medical Board to grant interstate telehealth licenses to practitioners licensed in another jurisdiction that have regis-

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tered with the Board, granted they do not have any current, pending, or disciplinary actions within the last five years; and do not provide services in-person in the state. The bill also creates an exemption to registration for out-of-state practitioners in response to emergency medical conditions or if they are in consultation with a practitioner licensed in state who has supervisory and ultimate authority over the diagnosis and health care of the patient.

Rhode Island SB 482 – Allows, during a future declared emergency, volunteer health practitioners licensed in other states to provide medical services pursuant to rules and regulations promulgated by the Department of Health. Also provides volunteer health practitioners with limited immunity for acts or omissions while providing services.

Medical Marijuana

Alabama SB 46 - Allows registered patients to use and safely access medical cannabis, after recommended by a physician, for qualifying conditions including autism, cancer-related pain, nausea, weight loss, Crohn's disease, epilepsy, and PTSD, among other conditions. Certifying physicians must complete a four-hour medical cannabis continuing medical education course and complete an exam.

Kansas SB 158 - Creates a medical marijuana program in Kansas, enumerates qualifying medical conditions, creates a registration process for caregivers and patients, empowers the State Board of Healing Arts (BOHA) to provide for the certification authorizing physicians to recommend medical marijuana, lists provider disqualifications, and creates an advisory committee to oversee implementation and regulation.

Louisiana HR 113 - Creates a legislative commission to study the laws and regulations pertaining to the cultivation, extraction, pharmaceutical and therapeutic use, distribution, and researching of marijuana.

North Carolina HB 929 - Legalizes medical marijuana, requires a bona fide patient-practitioner relationship prior to recommending medicinal marijuana for a patient for "debilitating medical conditions," and also creates rules for a commission to regulate and license dispensaries.

Military Licensure

California AB 107 - Requires the Board to issue a temporary, 12-month occupational license/certificate to a military member and/or their spouse within 30 days of application so long as a criminal background check does not show grounds for denial.

Hawaii HB 961 – Allows the spouse of an active-duty military member with a permanent change of station to Hawaii and holds a current, unencumbered license in another jurisdiction to apply for licensure on an expedited basis.

Illinois SB 2902 - Requires the Board to issue a provisional occupational license/certificate to a military member and/or their spouse so long as they hold a license/certificate in good standing in another jurisdiction, during the expedited 60-day full license application review period.

Occupational Licensing Reform

Massachusetts H 412 - Prohibits state boards from suspending, revoking, or denying a professional license based on an individual's default or delinquency on a federal student loan or health education loan.

Pain Management

Colorado HB 21-1276 - Requires insurers to make both opioid and non-opioid medications for the same indication available at the lowest cost-sharing tier. The 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

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prescription in the last year. Further, the bill indefinitely continues the requirement to query the state PDMP before prescribing a second fill for an opioid, and mandates that the PDMP is queried before prescribing or refilling a benzodiazepine. Lastly, the bill authorizes the Colorado Health Sciences Center to include in its educational materials the best practices for prescribing benzodiazepines and the potential harm of inappropriately limiting prescriptions to chronic pain patients.

New Jersey S 3698 - Requires state colleges and universities to supply accessible opioid antidotes and designate licensed medical professionals for their maintenance and administration.

Rhode Island HB 5245 & SB 16 – 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 in reducing harms and health care costs related to, among other things, injection drug use.

Physician Assistant / APRN Scope of Practice

Massachusetts S 740 & H 2229 - Removes requirement that physicians continuously supervise PAs and instead allows PAs to render services that are within their education, training, experience, and competency level. The bill also removes the burden of liability from the supervising physician to the PA.

Michigan SB 191 - Expands the definition of "mental health professional" to include PAs and allows PAs to conduct patient physical examinations for substance use disorder assessments and diagnosis.

New York A 6056 - Adds PAs to the list of practitioners, including physicians and NPs, that can serve as the "primary care practitioner" for Medicaid managed care programs.

Missouri HB 1224 – Removes the requirement that APRNs practicing under a CPA need continuous supervision from a supervising physician for at least a month but requires the supervision for "a period of time." Bill also removes 75-mile geographic distance limit from their collaborating physician.

South Carolina S 503 – Adds PAs and APRNs to physicians as healthcare professionals that are authorized to give orders electronically for home health services.

Physician Immunity

Alaska SB 65 - Provides immunity for physicians and PAs who are consulting with a provider who has responsibility for the care of the patient, so long as the consulting professional 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.

New Jersey S 3662 - Grants licensed physicians, who are providing care in a volunteer capacity, immunity from civil liability for any personal injury or wrongful death that is a result of any act or omission in the course of providing care or treatment, if the care or treatment was reasonably provided in good faith, except in cases of gross negligence or willful or wanton misconduct.

New Jersey S 3731 - Ends the civil immunity that was granted to certain health care professionals and health care facilities in relation to the public health emergency.

Physician Wellbeing

New Jersey A 5770 - Prohibits employers from discharging, harassing, or otherwise discriminating against a medical professional, or threatening to do so, on the basis that they took or requested any leave related to a qualifying diagnosis of post-traumatic stress disorder.

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Prescribing Practices

Massachusetts H 2361 - Requires practitioners to offer a prescription for naloxone or other opioid antidotes when prescribing at least 50 MME of opioids, the patient is concurrently prescribed benzodiazepines, or the patient is at an increased risk of, or has a history of overdose.

North Carolina HB 793 - Limits the initial prescription of controlled substances to three days' supply (from five) for any acute pain, unless the prescription is for post-operative acute pain.

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

Prescription Drug Monitoring Programs (PDMPs)

Colorado HB 21-1012 - Expands the state PDMP to track all prescription drugs prescribed in the state, except for non-controlled substances prescribed by veterinarians. Currently, the PDMP tracks all controlled substances prescribed in Colorado.

Illinois SB 1842 – Amends the Illinois Controlled Substances Act so that 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, the PDMP issues an unsolicited report to the prescribers, dispensers, and their designees informing them of potential medication shopping.

Illinois HB 601 – Mandates that information from opioid treatment programs cannot be entered into the state's PDMP without the participant's written consent, and any such information cannot be utilized for law enforcement purposes.

Substance Use Disorder Treatment

New York A 705 and S 6746 - Requires every substance use disorder (SUD) facility that is authorized to provide buprenorphine have at least one healthcare provider that is authorized to administer the drug.

New York S 649 - Removes the requirement for providers to receive prior authorization for the prescription of buprenorphine products, methadone, or naltrexone for the purposes of a medication-assisted treatment regimen.

Telemedicine

California AB 32 - Makes permanent pandemic-era changes to telemedicine including allowing audio-only modalities and requiring payment parity for services rendered via telemedicine.

California AB 457 - Creates the Telehealth Patient Bill of Rights, which would, among other things, protect the rights of a patient using telehealth to be seen by a health care provider with a physical presence within a reasonable geographic distance from the patient's home.

Illinois HB 3308 - Requires that health care services that are covered under an individual or group policy of accident or health insurance must be covered when delivered via telehealth when clinically appropriate in the same manner as any other benefit. Bill also creates a telehealth payment parity task force and allows services delivered by telehealth by early intervention providers under certain circumstances.

Montana SB 357 - Permits providers enrolled in the Medicaid program to provide medically necessary services by means of telehealth if the services meet the listed requirements.

New York S 6846 - Broadens the definition of telehealth provider to include "any licensed provider of a healthcare service that can appropriately render services via telemedicine."

North Carolina HB 149 - Requires insurers to cover telemedicine services even when the patient and physician have not established a relationship in-person, and clarifies that the relationship can be established via audio-visual communication or asynchronous technology, so long as the practitioner has access to the patient's medical history.

NEWS CLIPS

Licensure & Regulation

Joint Task Force of Orthopaedic and Podiatric Surgeons ☆
FPMB
September 2021

Cross-state licensing process now live in 30 states
AMA
April 2021

Nurse practitioners practice authority by state
Becker's Hospital Review
April 2021

New Hampshire Court: 'Anesthesiologist' title is restricted to MDs, DOs
AMA
April 2021

New North Carolina Medical Board Podcast: 'Don't be fooled by licensing board scams
MemberBoard Matters
April 2021

Licensure Examinations

NBPME cancels APMLE Part II CSPE for Class of 2021; The future of CSPE ☆
NBPME
March 2021

USMLE Step 1 pass/fail score reporting implementation date ☆
USMLE
April 2021

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

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

COVID-19 Pandemic

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

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

Pandemic leads doctors to rethink unnecessary treatment
Kaiser Health News
May 2021

Physicians, patients lost trust in U.S. healthcare system amid pandemic, survey finds
Healthcare Dive
May 2021

Discipline & Misconduct

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

Oregon doctor barred from practicing medicine after refusing to wear mask
Huffington Post
May 2021

British Columbia doctors warned they could face discipline for spreading COVID-19 misinformation
CBC
May 2021

DOJ charges telehealth executives, doctors with exploiting COVID-19 for $143 million in fraud
Fierce Healthcare
May 2021

Court: Board investigator did not violate licensee's 5th Amendment rights by conveying sexual misconduct admissions to police
Professional Licensing Report
May 2021

Apologies restore trust when physicians make errors
HealthLeaders Media
June 2021

Diversity, Equity & Inclusion

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

FSMB releases statement on diversity, equity and inclusion in medical regulation and health care
FSMB
April 2021

Michigan Department of Licensing and Regulatory Affairs promulgates implicit bias training rules for health professionals
Michigan.gov
June 2021

Education

How the 2021 Residency Match was influenced by the pandemic
AMA
April 2021

Top medical schools report surges in applications after pandemic
Becker's Hospital Review
April 2021

Medical schools overestimate number of graduates specializing in primary care, experts say
Becker's Hospital Review
April 2021

Challenges of transitioning to residency during pandemic
AMA
April 2021

Once banned, for-profit medical schools are on the rise again in the U.S.
NPR
June 2021

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The 15 skills medical schools expect from students on day one
AMA
June 2021

Opioids / Substance Abuse

Guide for future directions for the addiction and OUD treatment ecosystem
National Academy of Medicine
April 2021

CDC: Overdose deaths jumped 29% in 2020
Becker's Hospital Review
April 2021

Coordination needed to address clinician well-being and the opioid epidemic
JAMA
June 2021

Governor signs bill ending Missouri's designation as last state without a PDMP
Missouri Independent
June 2021

Rural Health

10 medical schools with the most graduates practicing in rural areas
Becker's Hospital Review
April 2021

Finding a doctor in rural America getting tougher, experts say
HealthDays News
May 2021

Technology

The AI physician will see you now — but do patients want to see them?
Becker's Hospital Review
May 2021

Telehealth

16 key takeaways from six recent telehealth reports
Becker's Hospital Review
May 2021

Patients, doctors like telehealth. Here's what should come next
AMA News
May 2021

Workforce

Virginia doctors worry pandemic burnout could push providers out of the field
Virginia Mercury
April 2021

The U.S. physician assistant workforce: Six stats to know
Becker's Hospital Review
April 2021

Pandemic having major impact on physician practice economics, new report says
HealthLeaders
April 2021

Number of Certified PAs expanded in every state prior to COVID-19 pandemic
PR Newswire
April 2021

Preventing clinician suicide: A call to action during the COVID-19 pandemic and beyond
Academic Medicine
May 2021

Top 10 factors contributing to burnout in women physicians
Medical Economics
May 2021

Record number of NPs are practicing in U.S.
Becker's Hospital Review
May 2021

Most physicians didn't work in private practices last year, AMA analysis finds
Becker's Hospital Review
May 2021

Most new physicians more worried about job security, pay than COVID-19, survey finds
Becker's ASC Review
May 2021

For the first time, less than half of physicians are in private practice
The DO
May 2021

Physicians in independent practice now minority in U.S.
The DO
May 2021

Empowered doctors, staff foster low medical practice burnout, poll finds
Healthcare Dive
May 2021

AAMC: 124,000 more physicians will be needed by 2034, with the largest gap among specialists
Fierce Healthcare
June 2021

Report Reinforces Mounting Physician Shortage
AAMC
June 2021

Report: Nearly half of physician practices owned by hospitals, corporate entities
Healthcare Dire
June 2021

Five states with the most 60+-year-old physicians
Becker's ASC Review
June 2021

Researchers predict a lower future U.S. physician shortage than in 2020
The DO
June 2021

NOTICE

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BOARD NEWSLETTERS, NEWS, & ANNOUNCEMENTS

[P] Denotes agency that licenses/ regulates podiatry

➢ ALABAMA

Alabama State Board of Podiatry [P]

Alabama Board of Medical Examiners

- Summer 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

- July 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

- Summer 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

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➢ KENTUCKY

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Kentucky Board of Medical Licensure

- Summer 2021

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➢ LOUISIANA

🔗 **Louisiana State Board of Medical Examiners [P]**

❖ 🔗 July 2021

➢ MAINE

🔗 **Maine Board of Licensure of Podiatric Medicine [P]**

🔗 **Maine Board of Licensure in Medicine**

❖ 🔗 Summer 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]**

❖ 🔗 March 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**

❖ 🔗 July-August 2021

➢ NORTH DAKOTA

North Dakota Board of Podiatric Medicine [P]

🔗 **North Dakota Board of Medicine**

❖ 🔗 August 2021

➢ OHIO

🔗 **State Medical Board of Ohio** [P]

❖ 🔗 August 2021

➢ OKLAHOMA

Oklahoma Board of Podiatric Medical Examiners [P]

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

❖ 🔗 May 2020

🔗 **Oklahoma State Board of Osteopathic Examiners**

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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

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Rhode Island Board of Medical Licensure

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South Carolina Board of Medical Examiners

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Vermont Board of Osteopathic Physicians and Surgeons

➢ VIRGINIA

Virginia Board of Medicine [P]

- March 2021

➢ WASHINGTON

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Washington Medical Commission

- Summer 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

- August 2021

➢ WYOMING

Wyoming Board of Registration in Podiatry

Wyoming Board of Medicine

➢ CPME

Council on Podiatric Medical Education

- April 2021

➢ IMLCC

Interstate Medical Licensure Compact Commission

- September 2021

➢ NBPME

National Board of Podiatric Medical Examiners

- Spring 2021

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Topics

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

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No Shield Laws for Maryland

With the emergence of COVID-19, many businesses have carefully taken various precautions to prevent, where possible, viral exposures to their employees and customers. Consequently, the world has witnessed the birth of many new phenomena, such as social distancing and the deployment of remote-work teams.

However, despite their good faith efforts to prevent further infections, many employers and businesses now are concerned about their potential liability to individuals who have nevertheless been exposed, injured or killed to or by the virus because of their actions or the actions of others.

A. More Than 30 States

In response, more than 30 states have now implemented some form of COVID-19 "shield law." Where adopted, these shield laws offer limited immunity that generally prevents people from suing for COVID-19 related injuries, insofar as the injuries arise out of ordinary negligence.

For example, South Dakota's shield law provides that there can be no relief against an individual or a business relating to an

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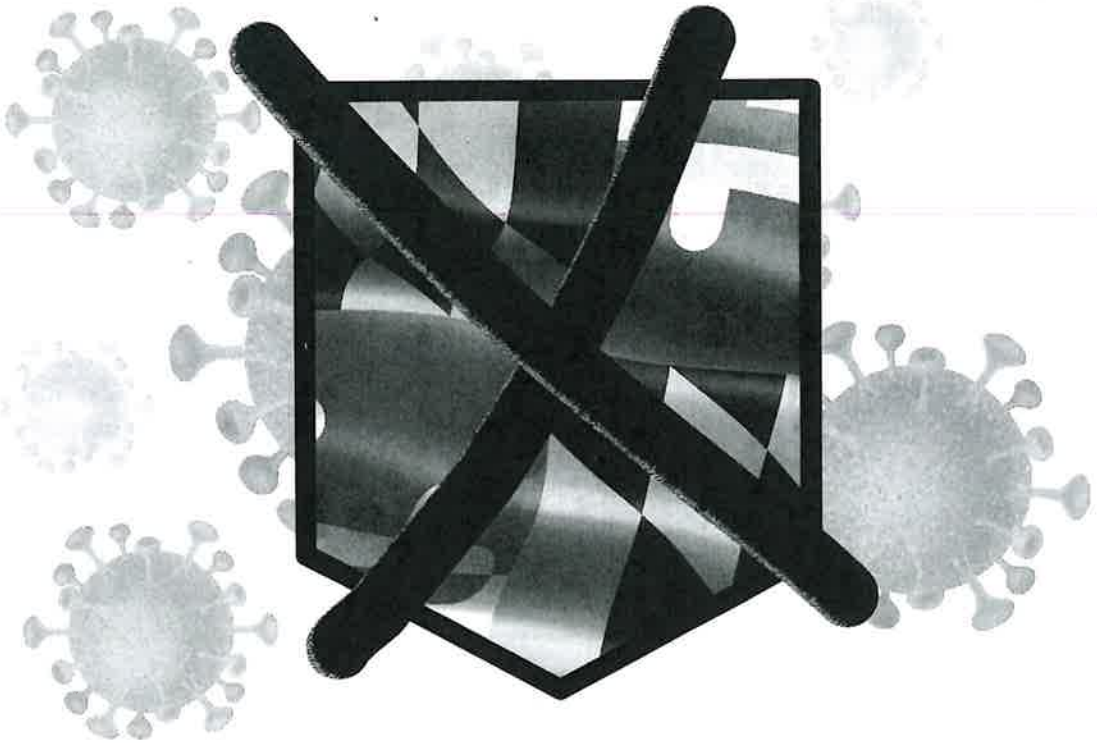

exposure to COVID-19 unless the injured party can prove the exposure was the result of intentional exposure with the intent to transmit COVID-19. As another example, the Tennessee COVID-19 Recovery Act provides that individuals and businesses cannot be held liable for losses arising from a COVID-19 exposure unless the injured person can show, by clear and convincing evidence, that the injury was caused by gross negligence or willful misconduct.

As one can imagine, the scope and breadth of the immunities granted in shield laws vary significantly from state to state. Nevertheless, in most of the states that have adopted COVID-19 shield laws, most businesses and others are shielded from liability unless the suing party can prove that either intentional or willful misconduct, or gross negligence resulted in the person contracting COVID-19. (To demonstrate gross negligence, a person must generally present evidence that the action or omission that caused the person to contract COVID-19 amounts to a reckless indifference to human life and was not merely a breach of a reasonable duty of care.)

B. Maryland

Several Maryland bills were proposed in 2021 that contemplated granting individuals and businesses immunity from liability relating to a COVID-19 exposure, unless the injured party could prove either gross negligence or an intentional action caused the harm. However, none of these bills made it past initial hearings. Thus, Maryland is now in the minority, along with approximately 16 other states, in having *not* enacted a shield law.

The proponents of the failed Maryland bills have argued that settlements from these cases are harmful to small businesses that have already lost significant revenue due to shutdowns. Conversely, opponents of these bills have argued such laws are unfair as they create escape hatches for businesses and others to evade legal consequences and to disclaim negligence.

Despite Maryland's failure to enact a shield law, the executive branch of the Maryland government did grant some temporary protections to health care providers by way of executive action. For example, pursuant to public safety legislation, a health care provider is immune from civil or criminal liability if the health care provider acts in good faith and under a catastrophic health emergency proclamation.

Since Governor Hogan issued a Declaration of State of Emergency in March of 2020, it appears that most "health care providers" would be afforded some limited protections from COVID-19 lawsuits when their actions were taken in good faith.

However, those protections were temporary. Governor Hogan lifted the State of Emergency effective July 1, 2021, followed by a 45-day grace period. Accordingly, the temporary protections for health care providers expired on or about August 15, 2021, for actions taken after that date.

C. Open Questions

Given that Maryland has not enacted a shield law, and with the state of emergency expired, there is an open question of whether Maryland will see an increase in COVID-19 negligence claims.

While it is possible that Maryland might see more negligence claims as opposed to states that have prohibited these cases, it is far from guaranteed. Even without a shield law in place, injured parties must meet a difficult burden of proof. For example, to prevail in a negligence lawsuit, people will need to present expert witness testimony from medical professionals or infectious disease experts to pinpoint the precise point in time when and where their COVID-19 exposure occurred.

Even for experts, this is challenging. Presently, it is thought that there is a latency

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period when COVID-19 can asymptomatically live in a human host for somewhere between four and 14 days. However, there are also now thought to be multiple strains of the virus in circulation with different rates of communicability, varying incubation periods and different rates of mortality. Thus, pinpointing the exact moment of exposure, and the harms that would or would not have occurred, but for negligence, will be very difficult.

Conversely, even if Maryland were to implement a shield law that blanketed businesses and others with immunity from simple negligence, it is not clear if such immunity would withstand future challenges in litigation or whether the courts would choose to uphold it.

These are, after all, unprecedented times.

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Key Health Care Provisions of the American Rescue Plan Act

On March 11, 2021, President Joseph R. Biden, Jr. signed the American Rescue Plan Act of 2021 (ARPA) into law. While ARPA is a broad piece of legislation, its key health care provisions evince the desire to tackle two public health challenges.

First, to address the immediate challenges presented by COVID-19, ARPA allocates funding to state, local and territorial governments, as well as to certain health care providers, for needs such as COVID-19 testing and treatment, and financial assistance for entities impacted most severely by the pandemic.

Second, in an effort to strengthen the public health infrastructure and to improve preparedness for handling future public health emergencies, ARPA contains funding for health care providers and public health organizations to grow their workforces, increase vaccine distribution capability, and otherwise improve their ability to deliver health care in times of crisis.

In addition to ARPA's primary goals, the law directs funding toward specific health concerns, such as mental health issues and substance abuse, and makes technical changes to Medicare and Medicaid, while offering new, temporary incentives for Medicaid expansion under the Affordable Care Act (ACA).

A. COVID-19 Funding

ARPA contains $8.5 billion in funding specifically for rural health care providers intended to reimburse expenses and lost profits attributable to COVID-19. The payments may not be used to reimburse expenses that are reimbursed by another source. Rural health care providers that receive funding to make up for lost profits attributable to COVID-19 may calculate their lost profits by comparing actual patient care revenue to budgeted patient care revenue.

Entities eligible to apply for reimbursement include providers and suppliers located in rural areas, providers and suppliers located in non-rural areas that serve rural patients, rural health clinics, and providers and suppliers that furnish home health, hospice or long-term care services in the residences of individuals who are located in rural areas.

As additional aid for rural health care providers, ARPA creates a $500 million grant program for rural health care providers that can be used for various purposes, including increasing capacity for vaccine distribution, increasing telehealth capabilities, increasing staffing for vaccine administration or testing, and providing medical supplies to increase surge capacity.

While the grant program allows for multiple permissible uses of the funding, many of the uses serve to modernize health care in rural communities and to improve preparedness for future public health emergencies.

The law also includes $450 million in funding to assist states and territories in deploying strike teams to Skilled Nursing Facilities to respond to COVID-19 outbreaks. To assist the vulnerable populations that reside in Skilled Nursing Facilities with preparedness for responding to COVID-19 and future public health emergencies, $200 million of the total funding is specifically allocated for the development of COVID-19 prevention protocols.

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In an attempt to reach populations underserved by traditional health care resources, ARPA provides $7.6 billion in funding to award grants to, and enter into agreements with, Federally Qualified Health Centers (FQHCs) and other community health organizations. These funds may be used to promote, to administer, and to track COVID-19 vaccines as well as for COVID-19 testing.

B. Infrastructure Funding

Consistent with the dual goals of ARPA, the funding may also be used to build out the health care infrastructure of FQHCs and other community health organizations, including by expanding and sustaining the health care workforce and by diversifying and enhancing the services provided.

Perhaps the largest investment toward the infrastructure and preparedness goal is the $7.6 billion allocated to the U.S. Department of Health and Human Services (HHS) for establishing, expanding and maintaining a public health workforce. Since state and local public health officials are often the first to respond to public health emergencies within their respective jurisdictions, this provision empowers HHS to make awards to these agencies to increase wages and to hire additional staff, such as investigators, epidemiologists, community health workers and disease intervention specialists.

In addition to state, local and territorial public health departments, nonprofit private and public entities with expertise in public health are also eligible for this funding.

To combat the medical staffing shortages that presented challenges in diagnosing and treating COVID-19, ARPA adds $800 million for National Health Service Corps loan repayment and scholarships, $100 million for Medical Reserve Corps, and $330 million for Teaching Health Centers that operate graduate medical residency programs for establishing new training programs and increasing the per-resident amount by $10,000.

C. Mental Health and Substance Abuse

In response to the increase in self-reported mental health issues and substance abuse during the COVID-19 pandemic, ARPA seeks to build up resources aimed at addressing those issues. The funding increases include $3 billion to be split between the Substance Abuse Prevention and Treatment and Community Mental Health block grant programs, $30 million to support community-based overdose prevention and syringe services, $100 million for behavioral health workforce education, and $80 million for pediatric mental health access.

D. Medicaid

For the 12 states that have not expanded Medicaid under the ACA, ARPA provides a 5% increase in the Federal Medical Assistance Percentage (FMAP) for two years should the states decide to expand Medicaid.

ARPA also requires state Medicaid programs and the Children's Health Insurance Program (CHIP) to provide coverage, with no cost sharing, for treatment of COVID-19 until one year following the end of the public health emergency. This requirement also includes COVID-19 vaccines at no cost to individuals enrolled in Medicaid or CHIP.

States also have the option to provide coverage to uninsured individuals for COVID-19 vaccines and treatment without cost sharing at 100% FMAP.

Other Medicaid changes include a new option to extend health coverage to women enrolled in Medicaid for up to 12 months following the birth of a child and a one-year temporary FMAP increase to improve home and community-based services. These changes are designed to facilitate vaccine distribution and administration, as well as provide health care to a broader base of individuals.

Other changes to Medicaid include the elimination of the cap on the maximum rebate amount for certain drugs and a technical fix to the Disproportionate Share Hospital (DSH) allotment.

As for the first change, drug manufacturers are required to pay Medicaid a rebate on all covered outpatient drugs. Statutory formulas determine the rebate amounts, but, in any case, the rebate is capped at 100% of the average manufacturer price. ARPA removes the cap on the rebate amount beginning January 1, 2024.

The second change is a technical fix for an unintended consequence of the Families First Coronavirus Response Act. That law provided states with a temporary 6.2% increase to the states' Medicaid programs' FMAP through the last calendar quarter of the public health emergency. ARPA allows HHS to recalculate DSH allotments when the states received the FMAP increase to ensure that the total DSH

payments a state makes are equal to the payment the state might have made without the FMAP increase.

E. Expanded Commercial Coverage

To address gaps in health care coverage caused by COVID-19-related job losses, ARPA makes COBRA coverage more affordable by subsidizing 100% of COBRA premiums through September 30, 2021.

To boost the percentage of Americans with health insurance generally, APRA expands the availability of advanced premium tax credits (APTCs) through 2022.

Prior to ARPA, APTCs were only available to individuals who obtained insurance through insurance exchange marketplaces and whose income fell between 100% and 400% of the federal poverty line. ARPA makes APTCs available to individuals with income greater than 400% of the federal poverty line based on a sliding scale. For instance, individuals with income greater than 400% of the federal poverty line will have premiums capped at 8.5% of income.

F. Medicare

Finally, ARPA makes two notable changes to Medicare. First, it restores the imputed "rural floor" protection for states designated by the Centers for Medicare and Medicaid Services (CMS) as "all urban." This change benefits rural hospitals in the all urban-designated states of New Jersey, Delaware, and Rhode Island. Because ARPA spends new money instead of reallocating money, the benefit to certain hospitals in those states does not come at the expense of funding to other hospitals.

Second, ARPA allows CMS to waive the requirement that Medicare will only cover ambulance services to the nearest appropriate medical facility. This requirement presented a problem during COVID-19 when many hospitals and other medical facilities were at capacity. Thus, transport to the nearest facility was impossible, imposing a significant cost burden upon Medicare beneficiaries. CMS has the authority to waive this requirement during any declaration of a public health emergency.

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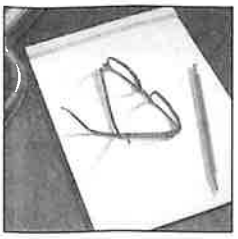

Maryland Regulatory News

1. In June, the Health Services Cost Review Commission (HSCRC) approved new hospital rates for fiscal year 2022. Maryland hospitals' revenues will be permitted to rise 2.34% (inclusive of an extraordinary adjustment of 0.20% to account for rising labor and malpractice costs due to COVID-19). Hospitals that administer high-cost oncology and infusion drugs will receive an additional 0.23%. The HSCRC will temporarily suspend the productivity adjustment for nonglobal budget hospitals, such as psychiatric hospitals and Mount Washington Pediatric Hospital, as a result of low volumes caused by the COVID-19 pandemic.

2. The HSCRC staff also made final recommendations on the Integrated Efficiency Policy. Maryland hospitals that score in the bottom of the HSCRC's efficiency matrix will have their global budget revenue reduced. As implemented currently, approximately $17.8M in inflation will be withheld across 10 hospitals in the State. On the other end of the spectrum, the currently five hospitals performing well on the efficiency matrix, and meeting other technical requirements will be eligible to apply for a global budget revenue enhancement.

3. The Maryland Department of Health (MDH) is proposing amendments to the regulations governing physician discipline actions. The proposed amendments are designed to bring the regulations in line with recent legislation that prohibits physicians from engaging in certain conduct. For example, the proposed amendments will explicitly state that a physician who fails to complete a required criminal history records check in accordance with the Health Occupations statute or fails to comply with the requirements of the Prescription Drug Monitoring Program may be subject to disciplinary action.

4. The MDH Behavioral Health Administration has launched a request for proposals for

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Residential Eating Disorder Programs, to determine if MDH should create a new licensure category for these types of treatment facilities. Applications for the pilot program will be accepted and approved on a rolling basis until March 1, 2022, with the project set to expire in 2025. At the project's conclusion, MDH will review each participant's efficacy and financial stability. Participants will not receive funding as part of the pilot but some current regulatory requirements will be waived.

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New Stark and Anti-Kickback Rules: Compensation and Technology

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

As discussed in the summer edition of *TOPICS*, the most transformative part of the rules, now in effect, update both laws to reflect the industry trend of encouraging value-based care arrangements, rather than traditional fee-for-service models. However, this article focuses on additional components of the new rules, including changes to physician compensation that allow for greater flexibility in compensation arrangements and cybersecurity updates.

A. Stark Law

The Stark Law generally prohibits physicians from referring Medicare and Medicaid patients to other providers with whom the referring physician (or a close relative) has a financial relationship, unless a specific exception applies.

1. Bonus and Profit-Sharing

Effective January 1, 2022, the new rule clarifies physician profit-sharing and bonus arrangements under Stark and prohibits the practice of "split pooling."

Currently, a group practice may pay a physician a share of "overall profits" derived from Designated Health Services (DHS) as long as the physician's share is not calculated in a way that relates to the volume or value of the physician's referral of DHS. DHS includes clinical laboratory services, physical therapy services, occupational therapy services, outpatient speech-language pathology services, radiology and certain other imaging services, and radiation therapy services and supplies.

Previously, some practices were pooling profits from DHS on a service-by-service basis and distributing those profits to a certain group of physicians (a practice referred to as "split pooling"). Under the new rule, practices may not split pool.

Instead profits must be shared in group practices in one of two ways: 1) the practice can aggregate *all* of the DHS profits of the entire group practice and then distribute those aggregated profits to any physician in the group practice; or 2) the practice can aggregate *all* of the DHS profits (not just profits from a particular service line) of any pods of at least five physicians and then distribute the profits within the pod.

In both cases, other components of the rule, such as not accounting for the value or volume of any single physician's referrals, must be followed.

If an entity has multiple pods, each pod may use its own distribution formula. However, the same distribution method must be used for each member of the pod and must be used for all of the profits generated by the pod.

CMS also confirmed that any physician can take advantage of these profit-sharing arrangements, not just owners. Assignments to pods may be based on any criteria, such as practice location, practice pattern, or longevity, so long as pods are not assigned in a way that accounts for the volume or value of referrals.

2. Limited Monetary Physician Compensation

The new law adds a new limited monetary compensation exception that allows physicians to be paid a total of up to $5,000 per calendar

year (adjusted for inflation) for items or services provided by the physician (directly or indirectly) without signing a written compensation agreement set in advance.

This compensation cannot account for the value or volume of referrals, exceed fair market value or be commercially unreasonable. If a provider has multiple such arrangements with the same entity, the total compensation for all of the arrangements must be less than the $5,000 limit.

3. Cybersecurity Technology

A new exception protects arrangements involving the donation of cybersecurity technology and related services, such as training or access to a health desk. Donors can be any individual or entity (unlike the narrower list of allowable donors for electronic health records).

B. Anti-Kickback Statute

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

1. Cybersecurity Technology and Services

Mirroring the new Stark Law exception, there is now protection for donations of cybersecurity technology and services, including certain cybersecurity hardware donations, under the AKS. The predominant purpose of the technology must be to promote cybersecurity efforts and, unlike the electronic health records safe harbor discussed below, there is no requirement that the recipient contribute any funds to the technology to qualify for the safe harbor.

2. Electronic Health Records

The new rule modifies an existing safe harbor, including modifying the timing of certain required recipient contributions, permitting certain donations of replacement technology and removing the sunset provision.

Providers wishing to take advantage of any of these new rules should ensure that each proposed arrangement meets all of the detailed requirements of the exception or safe harbor.

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Medigap Steering Incentive Allowed

In a July 2021 advisory opinion, the Office of Inspector General (OIG) for the Department of Health and Human Services (HHS) approved a proposal from a Medicare Supplemental Health (Medigap) insurer to offer a $100 premium credit to policyholders who choose an in-network hospital when receiving inpatient health care. Additionally, the in-network hospitals would provide a uniform discount on the Medicare Part A inpatient deductible to all of the Medigap insurer's policyholders.

Generally, the federal Anti-Kickback Statute (AKS) prohibits anyone from offering or receiving remuneration for any services payable by a federal health care program, unless the action generally fits into, or almost fits into, a regulatory safe harbor. Here, both the Medigap insurer and the hospitals would be offering remuneration to encourage people to use the services of the hospitals, which services would be covered by both Medicare and the Medigap plan.

However, in this case, the OIG concluded that the credit applied to future premiums, and the deductible discount, posed a low risk of abuse. Since the Medigap insurer pays for covered services for its policy holders, including the deductible, the OIG determined that it was not in the insurer's financial interest to encourage overutilization of Medicare covered services. Further, the OIG concluded that the credit and deductible were also unlikely to prompt patients to seek additional, unnecessary care.

While this opinion is limited to the transaction described by the unnamed parties requesting the opinion, it does give insight into how the OIG might consider other similar arrangements. Moreover, the opinion reflects the OIG's belief that an arrangement's influence, or lack thereof, on patients seeking care is an important ingredient in determining whether an arrangement potentially violates federal law.

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Did You Know?

Disclosure of Experience: Did you know that providers might need to tell their patients how much experience they have with a particular procedure before performing the procedure? In *Alghussein v. Kaan*, an appellate court in Hawaii held that it would be reasonable for a jury to decide that a patient needs to know about a doctor's experience with a proposed procedure as part of the informed consent process. A patient, who allegedly suffered a permanent injury following spinal surgery, filed suit against her doctor. The patient's claim was, in part, based on the premise that she had not been told the doctor, who usually used a posterior operation approach when performing spinal surgeries, had only performed a particular side technique approach four times prior to her case. While this case is not binding outside of Hawaii, doctors should consider if their experience with a procedure would be relevant in a patient's decision to move forward with care.

No Surprises Act: Did you know that Department of Health and Human Services has released its first regulation implementing the new "No Surprises Act." The No Surprises Act, which goes into effect January 1, 2022, prohibits providers from billing patients more than in-network rates when the patient is forced to use out-of-network care either because of an emergency or during a hospital stay. The regulation explains that a Qualifying Payment Amount (QPA) will be used to help determine the patient's share of the bill. The QPA will be calculated by considering a health plan's historic median contract rate for similar services, adjusted for geographic difference and the consumer price index.

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Coming in Future Issues

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- **No Poaching**
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CONCERNS REGARDING THE USMLE PROPOSAL

The National Board of Podiatric Medical Examiners has considered the proposal put forth in the White Paper issued by APMA and ACFAS. The board offers the following comments.

1. Trying to achieve parity by having DPM candidates attempt to pass USMLE is misguided.
2. The APMLE series is psychometrically sound, demonstrably valid and accepted by all states as the basis for safe and competent practice of podiatric medicine.
3. The NBPME disagrees that any part of the USMLE is appropriate for deciding whether a podiatrist is eligible for licensure.
4. The designation of 'Physician" is the prerogative of state licensing boards, not the AMA. The issue should be taken up in the proper venue.

THE FUTURE OF CSPE

March 2021

The NBPME has unanimously voted that the CSPE represents a unique, valid, reliable examination that tests skills not being tested in the Parts I, II, and III written examinations. The decision was also made to start an investigation into alternatives to the suspended version of the clinical skills patient encounter examination. It was acknowledged that the first version of CSPE examination was unpopular among the student population mainly because of the expense to candidates.

During the development, pilot process and then with the actual administration of the first version of the examination, the board became convinced of the appropriateness of testing these unique skills that are crucial to safe, effective, independent practice. That perspective is also shared by other licensing boards, including NBME and NBOME. To date, no groups have abandoned this examination. Boards have either continued to test or said they are suspending the current version of their examinations while pursuing alternate designs.

The CSPE examination is currently suspended. Investigation and evaluation of alternatives has only begun. Although it may be possible, it is unlikely that a new design would be developed, piloted and ready for administration for the Class of 2022.

NBPME is committed to the clinical skills program, and to providing routine updates to the stakeholders of our profession, including the AACPM, APMA, APMSA, CPME and FPMB, as we work alongside NBOME to further our mission and to create an examination that is valid, reliable and cost-effective.

NBPME CANCELS PART II CSPE FOR THE CLASS OF 2021

At a meeting Tuesday, February 9, 2021, the board decided that the many complications created by the global pandemic have made it impossible to continue the Clinical Skills Patient Encounter examination currently underway.

All candidates who have tested or scheduled will be reimbursed for the test fee and appropriate travel expenses. All affected students will be contacted after details have been completed.

Dr. Alyssa Stephenson, board president, stated that the NBPME intends to work with stakeholders including state licensing boards to determine the best path forward to continue to meet the goal of protecting the public health by examining all skills that are essential for safe independent practice.

Part II CSPE Exam information is now available. **Learn more by clicking here. (/about-the-exam/part-ii-cspe/)**