It’s Deja Vu All Over Again

Yogi Berra

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

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

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

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

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

**Representation**
The FPMB provides representation to:
- American Podiatric Medical Association (APMA)*
- American Society of Podiatric Executives (ASPE)
- Federation of State Medical Boards (FSMB)
- National Board of Podiatric Medical Examiners (NBPME)
- Professional Licensing Coalition (PLC)

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

**Public Policy & Advocacy**
The FPMB supports its Member Boards by:
- Advocating for the restoration of antitrust immunity
- Monitoring and reporting on the increased focus on occupational licensing reform
- Increasing license portability *(model law, licensure compact, etc.)*

**Primary Source Verification (Licensure)**
The FPMB provides primary source verification of:
- APMLE Part I/II/III Score Reports
- Disciplinary Action Reports

**Under 1 Business Day**: Median turnaround time from order placed to downloaded by Member Board

**Collaboration & Communication**
The FPMB is a catalyst for its Member Boards by:
- Collecting and disseminating information that results in changes to requirements, regulatory structure, etc.
- Publishing key contact, general, licensure, and regulatory information to be viewed and compared
- Publishing a quarterly newsletter
The mission of the Connecticut Board of Podiatric Medical Examiners (the Board) is to maintain and regulate standards of practice in podiatric medicine.

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

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

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

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

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

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

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

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

Contact the FPMB now to be featured in the next Member Board Spotlight!
understand each stakeholder’s perspectives on achieving physician parity and gaining recognition as physicians without qualification in federal health plans. This had been prompted by the stakeholders’ responses to the White Paper presented by the Joint Task Force as well as the associated American Medical Association (AMA) Resolution.

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

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

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

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

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

**Who is the FPMB?**

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

**Who are the members of the FPMB?**

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

**What is the composition of the FPMB Executive Board?**

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

**What are the application requirements?**

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

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

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

**Are Executive Board positions paid or volunteer?**

The FPMB Executive Board is comprised of volunteer positions.

**How to apply to serve on the FPMB Executive Board?**

Applications will be sent during the month of January 2021. Contact the FPMB Executive Office at fpmb@fpmb.org with your name, Board, email address, phone number, and mailing address to receive an application.
“temporary” measures are still in place or are being reinstated.

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

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

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

Have a safe, healthy, and happy New Year!

(Executive Director’s Message continued from page 1)

FPMB 2021 FALL MEETING RECAP

The FPMB held a successful and very engaging 2021 Fall Meeting with its Member Boards on November 5:

New FPMB Member/Affiliate Boards

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

FPMB Executive Board Vacancy

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

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

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

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

Important Dates/Reminders

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

(Continued on page 9)
The American Association of Colleges of Podiatric Medicine (AACPM) is a nationally recognized education organization whose mission is to serve as the leader in facilitating and promoting excellence in podiatric medical education leading to the delivery of the highest quality lower extremity healthcare to the public. AACPM’s membership consists of the nine accredited U.S. podiatric medical schools and more than 200 hospitals and institutions that offer postdoctoral training in podiatric medicine.

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

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

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

- **American Association of Colleges of Podiatric Medicine Application Service (AACPMAS)**
  
  A centralized application service known as AACPMAS which processes all applications submitted for admission to the schools and colleges of podiatric medicine. Applicants complete one application irrespective of how many schools they apply to. National application and matriculant data is collected through AACPMAS and reported on AACPM’s website.

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

- **Central Application Service for Podiatric Residencies (CASPR)**
  
  An online application and matching service for fourth-year students interested in applying for residency positions in teaching hospitals. All CPME-approved residency programs participate in CASPR.

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

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

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

Facebook | Twitter | Instagram
EDUCATION AND RESIDENCY PLACEMENT STATISTICS
American Association of Colleges of Podiatric Medicine

2021 - 2022 TOTAL ENROLLMENT
Fall Semester

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Source: Colleges of Podiatric Medicine

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

RESIDENCY APPLICANTS: Class of 2021
Placed in Residencies 534 (99.8%)
To Be Placed 1 (0.2%)
TOTAL 535 (100.0%)

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

Prior Year Applicants:
Placed in Residencies
Prior Years
To Be Placed
TOTAL

When taking overall placements into consideration, 547 (99.8%) of the 548 residency applicants have found residency positions for the 2021-2022 training year.
Advancements in Scope of Practice Laws Continue Amid the Pandemic

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

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

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

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

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

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

—Chad Appel, JD, Director
APMA Center for Professional Advocacy
Diabetes Campaign Educates At-Risk Audience

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

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

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

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

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

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

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

Post-Meeting Survey Results

Member Boards Round Robin Topics

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

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

Why Member Boards Should Attend FPMB Meetings

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

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

Member Board Update Forms were distributed on August 31, 2021 with a response due date of September 30, 2021. **RED** states (see map below) have not responded yet and should respond as soon as possible.

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

*The data the FPMB collects and reports will be expanding to support its Data Initiative. The need and value of this initiative has only increased during the COVID-19 pandemic and from recent information requests the FPMB has received from Member Boards and other key stakeholders.*
The FPMB recognizes the following Member Boards for their timely download of reports sent in Q3 2021:

**Within 4 Hours**
- Arizona
- California
- Colorado
- Connecticut
- Georgia
- Indiana
- Kentucky
- Mississippi
- Montana

**Within 1 Day**
- British Columbia
- Idaho
- Oregon

**Within 2 Days**
- Arkansas
- Florida
- Maine
- Massachusetts
- Michigan
- Pennsylvania
- Wisconsin

**South Dakota**

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

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

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

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

Legislation Moving Through Congress

The Dr. Lorna Breen Health Care Provider Protection Act (S. 610/H.R. 1667) was passed by the Senate by a unanimous voice vote on August 6. The measure was sponsored by Senators Kaine (D-VA), Cassidy (R-LA), Reed (D-RI) and Young (R-IN) in the Senate and Representatives Wild (D-PA), Krishnamoorthi (D-IL), Chu (D-CA), and McKinley (R-WV) in the House. The bill was previously introduced during the 116th Congress in response to stress and burnout in the healthcare workforce during the COVID-19 pandemic and would provide grants for training healthcare professionals in evidence-informed strategies to reduce and prevent suicide, burnout, mental health conditions, and substance use disorders, and encourage those at risk to seek support and treatment. The bill also requires a comprehensive study on health care professional mental and behavioral health and burnout. For bill text click here.

License Portability

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

Combatting Misinformation

The Biosecurity Information Optimization for Defense Act of 2021 was introduced by Rep. Eric Swalwell (D-CA) and would establish the “National Bio-defense Directorate,” an interagency forum for bio-defense preparedness. The Directorate would be charged with developing “a national strategy with respect to combatting public health misinformation and disinformation that threatens the national security, and associated implementation plan, including a review and assessment of Federal government communications policies, practices, programs and initiatives,” among other matters. The bill would also define misinformation and disinformation.
The Protecting Rural Telehealth Access Act (S. 1988) was introduced by Sens. Joe Manchin (D–WV), Joni Ernst (R–IA), Jeanne Shaheen (D–NH) and Jerry Moran (R–KA) and would make certain pandemic–limited telehealth flexibilities permanent, including allowing payment parity for audio–only health services for clinically appropriate appointments, permanently waiving geographic restrictions, allowing patients to be treated from their homes; permanently allowing rural health clinics and Federally Qualified Health Centers to serve as distance sites, removing restrictions on “store and forward” technologies, and allowing Critical Access Hospitals (CAHs) to directly bill for telehealth services.

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

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

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

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

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

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

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

The Rural and Frontier Telehealth Expansion Act (S. 2197) was introduced by Sens. Jacky Rosen (D–NV), Shelley Capito (R–WV), Dan Sullivan (R–AK), Jon Tester (D–MT), Ben Ray Lujan (D–NM), and Lisa Murkowski (R–AK) and would increase Federal Medical Assistance Percentage
(Legislative News continued from page 14)

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

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

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

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

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

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

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

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

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

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

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Veterans Affairs

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

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

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

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

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

Opioids

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

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

The **Medication Access and Training Expansion (MATE) Act (S. 2235)** was introduced by Sen. Michael Bennet (D-CO) and Sen. Susan Collins (R-ME)
and would create a one-time training requirement on treating and managing patients with opioid and other substance use disorders in order to register or renew registration with the DEA to dispense controlled substances in schedule II, III, IV, or V, unless the prescriber is otherwise qualified; allow medical, PA, and advanced nursing schools to fulfill the training requirement through their curriculum; and authorize federal grants for medical programs that develop the curricula to best identify and treat SUDs.

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

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

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

Substance Use Disorder Treatments

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

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

Pandemic Response

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

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Liability Protection

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

Health Care Workforce

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

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

Physician Assistants

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

Graduate Medical Students

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

Mental Health

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

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

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

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

Mobile Health Clinics

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

Broadband

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

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

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

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

National Practitioner Data Bank (NPDB)

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

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Federal Regulatory News

Highlights

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

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

On June 28, President Biden nominated Dr. Rahul Gupta to lead the Office of National Drug Control Policy. Dr. Gupta was previously health commissioner of West Virginia and, if confirmed, would be the first physician to serve as Director of ONDCP.

On July 13, CMS announced a $15 million funding opportunity for states to strengthen community-based mobile crisis intervention services to address mental health or substance use related crises through Medicaid.

On July 13, U.S. Surgeon General Dr. Vivek Murthy issued an Advisory on Building a Healthy Information Environment. The Advisory warns the public about misinformation, noting that “Health misinformation is an urgent threat to public health. It can cause confusion, sow mistrust, and undermine public health efforts, including our ongoing work to end the COVID-19 pandemic.” The full text of the Advisory is available here.

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

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

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

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

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

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

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

- **Telehealth Technology-Enabled Learning Program (TTELP)**
- **Telehealth Resource Centers (TRCs)**
- **Evidence-Based Direct to Consumer Telehealth Network Program (EB TNP)**
- **Telehealth Centers of Excellence (COE) program**

On August 26, the Federal Communications Commission announced it had awarded $42 million for Round 2 of the COVID-19 Telehealth Program. The COVID-19 Telehealth Program, put into place by 2020’s CARES Act, supports the efforts of healthcare providers to continue serving their patients by providing telecommunications services, information services, and connected devices necessary to enable telehealth during the COVID-19 pandemic. According to FCC acting chair Jessica Rosenworcel, “the applicants that received funding include the hardest-hit and lowest-income areas in the country, tribal communities, and previously unfunded states and territories.”

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

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

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

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

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

- **PRF payment methodology.**

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

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

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

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**STATE LEGISLATION OF INTEREST**

**Interstate Medical Licensure Compact**

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

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

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

**State Waivers Update**

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

**Telemedicine**

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

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**Recently Enacted Regulation**

**Active Supervision**

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

**Board Structure and Function**

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

**Civil Immunity**

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

**Continuing Medical Education**

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

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

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

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

**Graduate Medical Education**

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

**License Portability**

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

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

**Medical Marijuana**

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

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

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

Military Licensure

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

Opioids

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

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

Pain Management

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

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

Physician Assistant/APRN Scope of Practice

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

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

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

Physician Misconduct

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

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

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

**Prescription Drug Monitoring Programs (PDMPs)**

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

**Public Health**

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

**Telemedicine**

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

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

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

**Pending Legislation of Interest**

**Board Structure and Function**

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

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

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

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

**Continuing Medical Education (CME)**

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

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

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Federation of Podiatric Medical Boards

License Portability

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

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

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

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

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

Medical Marijuana

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

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

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

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

Physician Assistant / APRN Scope of Practice

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

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

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

**Wisconsin SB 394 & AB 396** – Creates a new system of licensure for APRNs, requiring applicants to hold, or concurrently apply for, an RN license; have completed an accredited graduate-level or post-
graduate-level education program and hold a current national certification approved by the board; possess malpractice liability insurance; and pay a fee, among other conditions.

**Physician Misconduct**

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

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

**Physician Wellbeing**

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

**Prescribing Practices**

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

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

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

**Prescription Drug Monitoring Programs (PDMPs)**

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

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

**Substance Use Disorder Treatment**

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

**Telemedicine**

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

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

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

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

Licensure & Regulation

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

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

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

* Joint Task Force of Orthopaedic and Podiatric Surgeons
  FPMB
  October 2021

* FSMB ‘Strongly Opposes’ State Laws Barring Disinfo Docs From Discipline
  MedPage Today
  December 2021

Licensure Examinations

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

* USMLE policy updates following Step 2 CS discontinuation
  USMLE
  July 2021

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

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

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

COVID-19 Resources

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

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

Discipline & Misconduct

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

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

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

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

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

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

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

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

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

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

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

Diversity, Equity & Inclusion

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

Education

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

Opioids / Substance Abuse

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

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

(Continued on page 29)
Study: Severe opioid overdoses up by nearly one-third during pandemic
HealthDay News
July 2021

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

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

Rural Health

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

Technology

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

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

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

Telehealth

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

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

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

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

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

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

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

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

Workforce

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

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

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

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

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

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

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

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

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

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

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

How practice culture affects physician burnout
Medical Economics Journal
September 2021

NOTICE

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

[P] Denotes agency that licenses/regulates podiatry

➢ ALABAMA
  Alabama State Board of Podiatry [P]
  ↩ Alabama Board of Medical Examiners
    ❖ Fall 2021

➢ ALASKA
  Alaska State Medical Board [P]

➢ ARIZONA
  ↩ Arizona State Board of Podiatry Examiners [P]
  ↩ Arizona Medical Board
    ❖ Winter/Spring 2021
  ↩ Arizona Board of Osteopathic Examiners in Medicine and Surgery

➢ ARKANSAS
  Arkansas Board of Podiatric Medicine [P]
  ↩ Arkansas State Medical Board

➢ BRITISH COLUMBIA
  ↩ College of Physicians and Surgeons of BC [P]

➢ CALIFORNIA
  ↩ Podiatric Medical Board of California [P]
  ↩ Medical Board of California
    ❖ Q3 2021
  ↩ Osteopathic Medical Board of California

➢ COLORADO
  ↩ Colorado Podiatry Board [P]
  ↩ Colorado Medical Board

➢ CONNECTICUT
  Connecticut Board of Examiners in Podiatry [P]
  Connecticut Medical Examining Board

➢ DELAWARE
  Delaware Board of Podiatry [P]
  Delaware Board of Medical Licensure and Discipline
    ❖ Fall 2021

➢ DISTRICT OF COLUMBIA
  District of Columbia Board of Podiatry [P]
  ↩ District of Columbia Board of Medicine Newsletter

➢ FLORIDA
  ↩ Florida Board of Podiatric Medicine [P]
  ↩ Florida Board of Medicine
  ↩ Florida Board of Osteopathic Medicine

➢ GEORGIA
  Georgia State Board of Podiatry Examiners [P]
  ↩ Georgia Composite Medical Board

➢ HAWAII
  ↩ Hawaii Medical Board [P]

➢ IDAHO
  Idaho Board of Podiatry [P]
  ↩ Idaho Board of Medicine
    ❖ Fall 2021

➢ ILLINOIS
  ↩ Dept. of Financial & Professional Regulation [P]

➢ INDIANA
  Indiana Board of Podiatric Medicine [P]
  ↩ Medical Licensing Board of Indiana

➢ IOWA
  ↩ Iowa Board of Podiatry Examiners [P]
  ↩ Iowa Board of Medicine

➢ KANSAS
  ↩ Kansas State Board of Healing Arts [P]

➢ KENTUCKY
  ↩ Kentucky Board of Podiatry [P]
  ↩ Kentucky Board of Medical Licensure
    ❖ Fall 2021

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LUSIANA
Louisiana State Board of Medical Examiners [P]
❖ October 2021

MAINE
Maine Board of Licensure of Podiatric Medicine [P]
Maine Board of Licensure in Medicine
❖ Fall 2021
Maine Board of Osteopathic Licensure

MARYLAND
Maryland Board of Podiatric Medical Examiners [P]
Maryland Board of Physicians
❖ Spring 2021

MASSACHUSETTS
Massachusetts Board of Registration in Podiatry [P]
Massachusetts Board of Registration in Medicine

MICHIGAN
Michigan State Board of Podiatric Medicine and Surgery [P]
Michigan Board of Medicine
Michigan Board of Osteopathic Medicine and Surgery

MINNESOTA
Minnesota Board of Podiatric Medicine [P]
Minnesota Board of Medical Practice

MISSISSIPPI
Mississippi State Board of Medical Licensure [P]
❖ October 2021

MISSOURI
Missouri State Board of Podiatric Medicine [P]
Missouri Board of Registration for the Healing Arts

MONTANA
Montana Board of Medical Examiners [P]

NEBRASKA
Nebraska Board of Podiatry Licensing Unit [P]
Nebraska Board of Medicine and Surgery

NEVADA
Nevada State Board of Podiatry [P]
Nevada State Board of Medical Examiners
❖ August 2021
Nevada State Board of Osteopathic Medicine
❖ July 2021

NEW HAMPSHIRE
New Hampshire Board of Podiatry [P]
New Hampshire Board of Medicine

NEW JERSEY
New Jersey State Board of Medical Examiners [P]

NEW MEXICO
New Mexico Board of Podiatry [P]
New Mexico Medical Board

NEW YORK
New York State Education Department [P]

NORTH CAROLINA
North Carolina Board of Podiatry Examiners [P]
North Carolina Medical Board
❖ November-December 2021

NORTH DAKOTA
North Dakota Board of Podiatric Medicine [P]
North Dakota Board of Medicine
❖ November 2021

OHIO
State Medical Board of Ohio [P]
❖ December 2021

OKLAHOMA
Oklahoma Board of Podiatric Medical Examiners [P]
Oklahoma Board of Medical Licensure and Supervision
Oklahoma State Board of Osteopathic Examiners

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VERMONT
- Vermont State Board of Medical Practice [P]
  - Fall 2021

VIRGINIA
- Virginia Board of Medicine [P]
  - September 2021

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

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

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

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

CPME
- Council on Podiatric Medical Education
  - October 2021

IMLCC
- Interstate Medical Licensure Compact Commission
  - September 2021

NBPME
- National Board of Podiatric Medical Examiners
  - Fall 2021
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FEDERATION OF PODIATRIC MEDICAL BOARDS
12116 Flag Harbor Drive
Germantown, Maryland 20874

Office: 202-810-3762
Fax: 202-318-0091
Email: fpmb@fpmb.org
Website: www.fpmb.org