michigan MEDICINE®
THE OFFICIAL MAGAZINE OF THE MICHIGAN STATE MEDICAL SOCIETY » VOL. 122 / NO. 2
March/April 2023

A NEW DAWN A NEW DAY

A New Lansing

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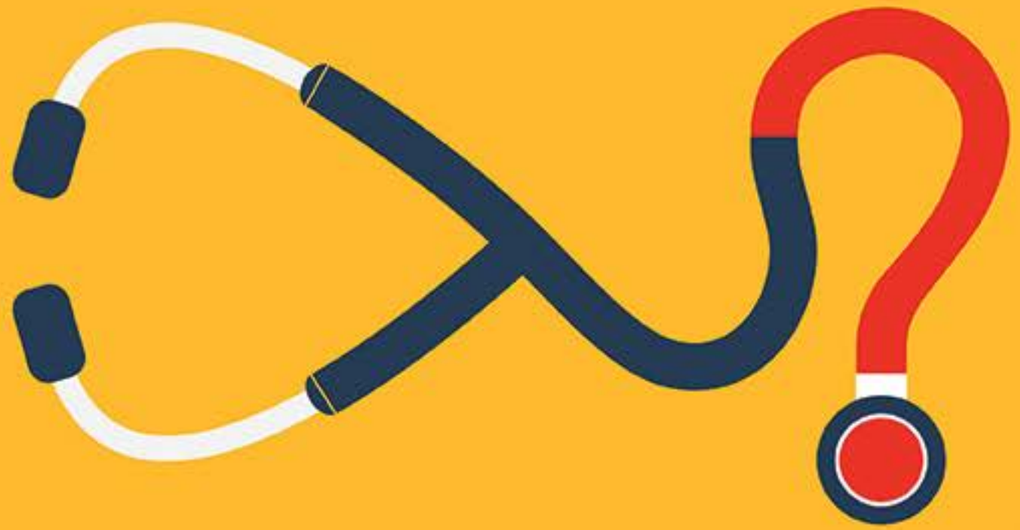
do you have in your malpractice insurance?



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Dear colleagues,

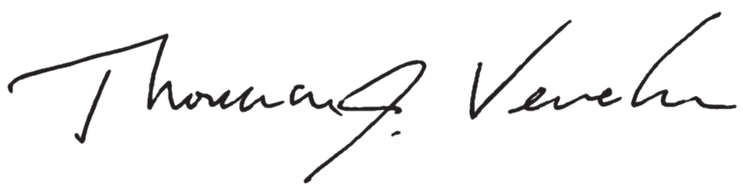
Sixty brand-new lawmakers. **Nine billion dollars** of surplus funding. **Forty years** since Democrats had complete control of the state Capitol. We don't know exactly what this legislative term has in store, but we do know one thing: it's going to be action-packed.

For the first time in three years, COVID-19 won't be the prevailing issue. Based on the Governor's plans laid out in her State of the State speech and budget proposal, tax cuts, education funding, and gun safety are her utmost priorities. And the Legislature has their own list. With power comes competing priorities—many of these lawmakers have been waiting years just to get a hearing on a bill, let alone to see it cross the finish line.

MSMS will pick up with many of the same policy challenges as last session, but with the additional burden of educating new lawmakers on the complex issues affecting the practice of medicine and practice management. Scope infringement, staff shortages, Medicaid uplift, and emerging public health threats will be the bulk of advocacy work this year, and yet that's far from an exhaustive list. Our feature article this month summarizes more than a dozen issues we are tracking, so we can keep our membership apprised as key proposals and policies move through the process.

Our government affairs team has their work cut out for them. Let's give them the support they need to lift up our voices, collectively and individually. Working together, we will convey the critical importance of physician-led care and help bring about the pragmatic, sensible policy changes that will benefit patients and public health alike.

Onward,



Thomas Veverka, MD, FACS

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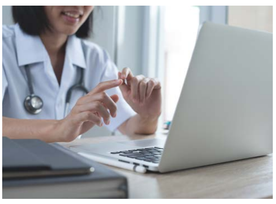

Interstate Licensure for Telehealth Can Fuel Practice Growth

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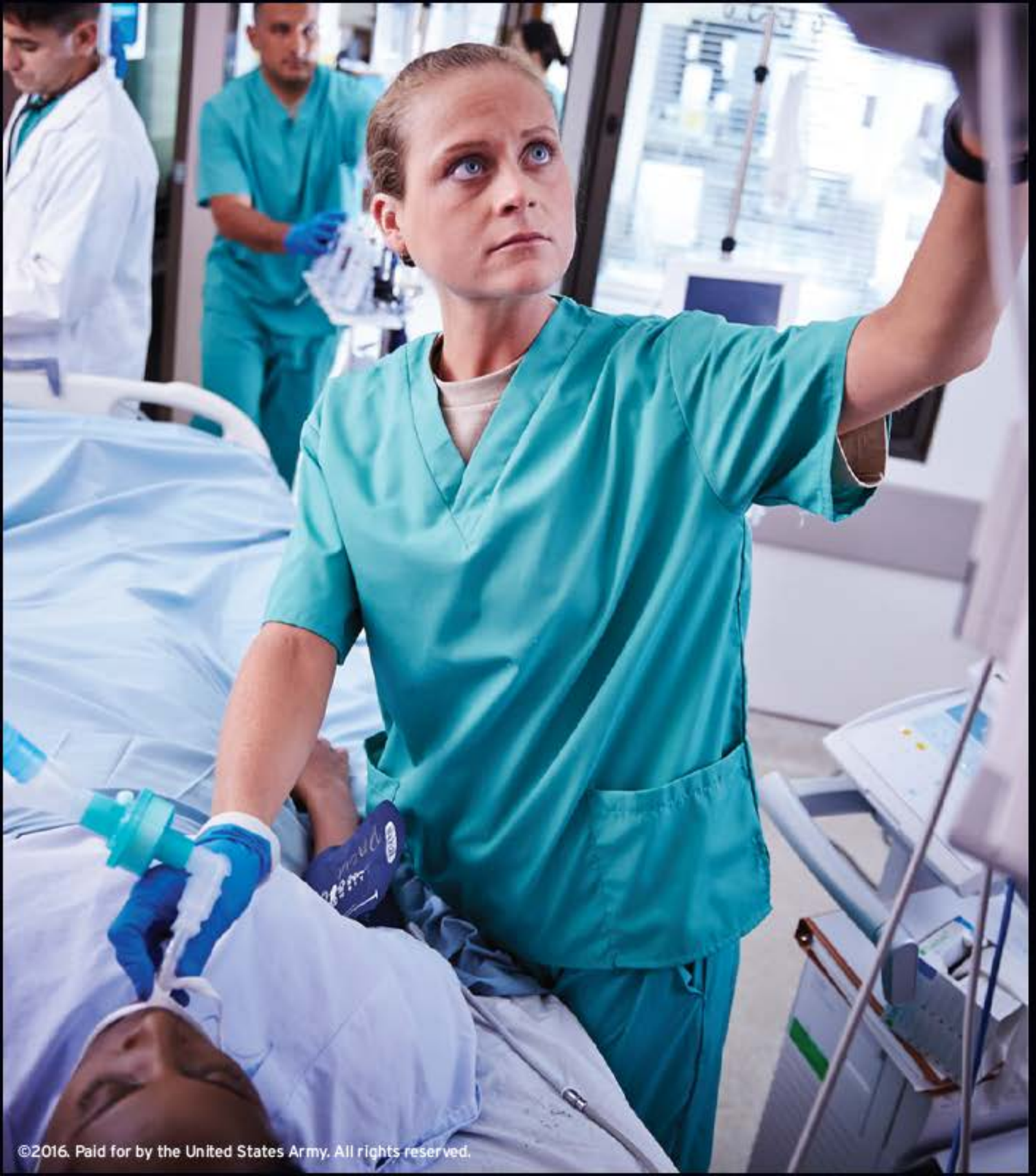

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ASK OUR LAWYER

FTC Considers Banning Covenants Not to Compete

By Daniel J. Schulte, JD, MSMS Legal Counsel

Q: I am reading media accounts that the FTC is about to ban all covenants not to compete. When will this happen? Will the covenant not to compete in my employment agreement that I signed two years ago be banned? Will Michigan law that allows covenants not to compete have to be changed also?

On January 5, 2023, the FTC issued a Notice of Proposed Rulemaking (the "Proposed Rule"). The Proposed Rule would ban covenants not to compete in employment agreements. Covenants not to compete obtained in connection with the sale of a business would remain enforceable in accordance with their terms and to the extent allowed by state law. Examples of such covenants not to compete are those contained in a purchase agreement or a standalone document entered into in connection with a purchase agreement.

An FTC summary of the Proposed Rule can be found by clicking on the following link: Non-Compete Clause Rulemaking | Federal Trade Commission (ftc.gov). Specifically, the Proposed Rule declares that it is "an unfair method of competition for an employer to enter into or attempt to enter into a non-compete clause with a worker; maintain with a worker a non-compete clause; or represent to a worker that the worker is subject to a non-compete clause where the employer has no good faith basis to believe that the worker is subject to an enforceable non-compete clause."

If the Proposed Rule takes effect, a prospective employer will not be able to include a covenant not to compete in a proposed employment agreement and your current employer would not be able to enforce a covenant not to compete already in place.

Therefore, the Proposed Rule would ban both the entering into of future covenants not to compete and covenants not to compete contained in existing employment agreements. If the Proposed Rule takes effect, a prospective employer will not be able to include a covenant not to compete in a proposed employment agreement and your current employer would not be able to enforce a covenant not to compete already in place. Language in the FTC's enabling legislation giving it jurisdiction over entities that carry on business "for profit" makes the applicability of the ban to nonprofits (e.g., hospitals, health systems, clinics, etc.) uncertain. If the ban is determined to not be applicable to nonprofits, physicians employed by a nonprofit will remain subject to their covenants not to compete and those employed by private practices and other for profit entities will be free of their covenants not to compete.

No changes to Michigan law would be needed to put the ban into effect. The Proposed Rule provides that it "shall supersede any State statute, regulation, order, or interpretation to the extent that such statute, regulation, order, or interpretation is inconsistent with" the Proposed Rule's ban of covenants not to compete in employment agreements. If a state has a law in place that already bans covenants not to compete, that state law would remain in force to the extent it provides greater protection to the employee than the Proposed Rule.

The Proposed Rule was issued subject to a 60-day public comment period beginning when it is published in the Federal Register. Following the expiration of this public comment period, the FTC has indicated its intention to quickly finalize the rule. The ban would take effect 180 days after the FTC publishes the final rule. However, the ban will face significant challenges in the courts[1] that will very likely delay when the ban becomes effective. The expected legal battle will likely take years.

It is important to note that the stated reasons for the Proposed Rule are not unique to physicians or other providers of healthcare services. Instead, the FTC is attempting to ban covenants not to compete in employment generally, stating in part that "the freedom to change jobs is core to economic liberty and to a competitive, thriving economy. Non-competes block workers from freely switching jobs, depriving them of higher wages and better working conditions, and depriving businesses of a talent pool that they need to build and expand."

The fact that a covenant not to compete is included in nearly every physician employment agreement, its enforcement likely prevents patient choice of a healthcare provider, and the disruption to the continuity of patient care are some of the noneconomic factors making the need for the ban unique to the healthcare industry.

RESOURCE

1. Among the challenges will be whether the Proposed Rule would apply to nonprofit entities. Some commentators are suggesting that the wording of the Proposed Rule means it does not apply to nonprofits (however the Proposed Rule does not expressly include this as an exception). Others are saying that the FTC does not have authority to regulate nonprofit entities. If it turns out that the ban on covenants not to compete does not apply to nonprofits, nonprofit hospitals would be able to maintain and continue to enforce their covenant not to compete agreements with physicians and for profit medical practices and other for profit entities will not.

DANIEL J. SCHULTE, JD, MSMS LEGAL COUNSEL IS A MEMBER AND MANAGING PARTNER OF KERR RUSSELL.

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ASK HUMAN RESOURCES

When Should We Use a Performance Improvement Plan with an Employee?

By Jodi Schafer, SPHR, SHRM-SCP | HRM Services | www.workwithhrm.com

Q: We've had several employee issues come up recently such as not completing work consistently or with quality, and also behaviors that go against policies in our Employee Handbook (e.g. attendance, being on personal calls too much at work, etc.). We are trying to address these issues while also giving the employee an opportunity to improve. We have a form called a Performance Improvement Plan (PIP), but I've never used one before and not sure if it applies to all these situations. Can you please help me understand when to use, or not use, a PIP?

Let's first start by better defining what a Performance Improvement Plan, or PIP, is. A performance improvement plan is a document that communicates with an employee their job-specific challenges as related to the expected result/performance outcomes, and what training and resources will be available to support the employee as they work towards improvement. The PIP also identifies potential consequences if improvement does not occur to the level indicated and/or within the timeframe provided. While this documentation will be helpful should termination result in the future, that is not the primary goal of a PIP. Instead, the intended outcome is employee development and performance improvement, as the name indicates.

When is using a PIP appropriate? Typically, PIPs are used for performance/ability related deficiencies that simple coaching hasn't corrected. Ideally, the supervisor has already brought the problem to the employee's attention verbally to understand more about what might be causing the issue. If the supervisor believes there may be a skill or capacity weakness, a PIP could be a great way to formally document the issue, outline the next steps that the employee will take, and identify key metrics and timelines to assess if improvements are occurring.

You want to choose the right communication tool to fit the circumstances. Start by first diagnosing the type of issue the employee is experiencing. Then, determine if there is a pattern to what you are seeing, taking into consideration how severe the issue is and if there is any indication that the employee has the capacity to change.

When would a PIP not be appropriate? A performance improvement plan would not be appropriate if the issue you are addressing has no development component. For example, using TV streaming services on the practice's computer during work hours. In this case, you could document a conversation with the employee and clarify that the behavior is a policy violation and is unacceptable. If the behavior occurs again, you move ahead with the identified consequence, which could include termination. This brings me to another situation where a PIP would not be appropriate. If the supervisor has already decided that they are ready to terminate the employee, then putting a PIP in place creates false hope and delays the inevitable. Finally, if the issue at hand is so severe that you don't want to provide the employee an opportunity to change then a PIP is not appropriate. Examples of this might include if an employee acted very aggressively toward another employee, or if they exhibited behaviors that constituted harassment, according to your policies. Both of those instances are examples of behavior issues or policy violations vs. performance issues and thus, would be more conducive to corrective action rather than a PIP.

In summary, you want to choose the right communication tool to fit the circumstances. Start by first diagnosing the type of issue the employee is experiencing. Then, determine if there is a pattern to what you are seeing, taking into consideration how severe the issue is and if there is any indication that the employee has the capacity to change. The answers to these questions will help you determine your next steps and whether a PIP is an appropriate tool to use or whether coaching or corrective action will be more effective.

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MDHHS UPDATE

It's Time for Kindergarten Round Up in Michigan

Sarah de Ruiter, BSN, RN, MA, Immunization Nurse Educator,
Michigan Department of Health and Human Services, Division of Immunization

It's kindergarten round-up time again and many Michigan schools are actively enrolling the kindergarten class of 2023/2024. This is a crucial time when healthcare providers have the opportunity to communicate with families about the importance of adding routine childhood and COVID-19 vaccinations to their back-to-school checklist.

On October 20, 2022, the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP) recommended updates to the 2023 childhood and adult immunization schedules, which includes incorporating recommendations for COVID-19 vaccines. These updates ensure the 2023 schedules are consistent with all ACIP recommendations made during 2022. The 2023 schedules will become effective when published on the CDC website in February 2023.

During the COVID-19 pandemic, we saw a concerning drop in routine immunizations for children. On January 13, 2023, CDC reported that during the 2020–21 school year, national coverage with state-required vaccines among kindergarten students declined from 95% to approximately 94%. During the 2021–22 school year, coverage decreased again to approximately 93% for all state-required vaccines. The exemption rate remained low (2.6%). An additional 3.9% without an exemption were not up to date with measles, mumps and rubella vaccine. Despite widespread return to in-person learning, COVID-19–related disruptions have continued to affect vaccination coverage and assessment for the 2021–22 school year, preventing a return to coverage rates prior to the COVID-19 pandemic.

To get kids back on track, it is important for providers to assess immunization records at every visit to see which vaccines are needed to protect them and others from communicable disease. For the best protection, health care providers should vaccinate their pediatric patients from vaccine-preventable diseases according to the CDC recommended child and adolescent immunization schedule.

To get kids back on track, it is important for providers to assess immunization records at every visit to see which vaccines are needed to protect them and others from communicable disease.

Michigan requires all incoming kindergarteners and 4-6-year-old transfer students to have appropriate documentation of vaccines protecting against diphtheria, tetanus, pertussis, polio, measles, mumps, rubella, hepatitis B, and varicella. By vaccinating children according to the CDC schedule, your patients will receive all the vaccines required for school and daycare entry.

To help understand school and daycare vaccine requirements, the Michigan Department of Health and Human Services (MDHHS) has created easy-to-read handouts that target healthcare providers, schools and daycares, and parents. These documents are available on the MDHHS Immunization Information for Families and Providers website. As a reminder, patients requesting a non-medical waiver for school should be referred to their Local Health Department (LHD). Health care providers should only provide parents with a medical immunization waiver (i.e., true medical contraindication to vaccine(s)) when needed.

Remember to check the Michigan Care Improvement Registry (MCIR) for every patient at every well and sick child visit to determine which vaccines are needed to best protect them. All vaccines administered to persons less than 20 years of age, including flu and COVID-19 vaccines, are required to be entered into MCIR within 72 hours of vaccine administration. By protecting your patients with all ACIP-recommended vaccines, you are helping young Michiganders stay healthy and ready to learn.

Healthcare providers are trusted sources of information for parents and guardians. They can also help families make the informed decision to vaccinate. Here are some ways to help catch school-aged children up on vaccination.

- Prioritize ensuring everyone catches up on routine vaccination
- Identify individuals behind on their vaccinations
- Encourage vaccination catch-up through reminders, recall, and outreach
- Make strong vaccine recommendations
- Make vaccines easy for everyone to find and afford

Routine and catch-up vaccination will require efforts from healthcare systems, healthcare providers, schools, state and local governments, and families. Routine Immunizations on Schedule for Everyone (RISE) is part of a recently launched CDC initiative called "Let's RISE." This initiative provides actionable strategies, resources and data to support getting all Americans back on schedule with their routine immunizations. Applying CDC's strategies along with sharing facts and answering families' questions about routine and COVID-19 vaccines is an important step in ensuring everyone is protected from vaccine preventable disease and disability.

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- https://www.cdc.gov/mmwr/volumes/72/wr/mm7202a2.htm?s_cid=mm7202a2_w
- https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html
- https://www.michigan.gov/mdhhs/adult-child-serv/childrenfamilies/immunization/providerinfo/providered/immunization-waiver-information
- https://mcir.org/
- https://www.cdc.gov/vaccines/partners/routine-immunizations-lets-rise.html


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A NEW DAWN A NEW DAY *A New Lansing*

New Leadership at the Capitol

In some circles, it's still hard to believe—a Democratic supermajority in Lansing for the first time in nearly 40 years. Not only is one party in charge of the governorship and both houses of the Legislature, but just under half of the members of the state House are serving as lawmakers for the first time.

> **Nearly half in the Michigan House of Representatives—54 of 110 members—are serving for the first time.**

The slimmest of margins separate the caucuses that will lead the development and approval of new laws this year. A 56-54 House split means just one vote across party lines shifts the balance. In the Senate, the fault line also rests on one vote, as Democrats hold a 20–18 edge.

MSMS will pick up with many of the same policy challenges as last session, but with the additional burden of educating new lawmakers on the many complex issues affecting the practice of medicine. Scope infringement, staff shortages, Medicaid uplift and emerging public health threats will create the bulk of our advocacy work this year, and even that list is far from exhaustive.

All of these concerns are set against the backdrop of an unspent $9 billion surplus—yes, billion with a B—which means that MSMS has cultivated some budget-specific asks in addition to our list of legislative priorities.

Collectively and individually, physicians across the entire state must engage with lawmakers to protect and promote the policies that best serve patients. Working together, physician perspectives can help bring about the pragmatic, sensible policy changes that will benefit patients and public health alike.

Just look at all we've accomplished during the last year alone:

- **Prior Authorization Reform**

It's hard to believe it's been almost a year since we secured a hard-fought victory in prior authorization reform. As an organization, we knew the prior authorization process was broken, so we worked to craft legislative solutions that would reduce wait times and streamline how physician offices and payers interact. Our goal? Reducing endless paperwork and ultimately improving access to care for patients.

More than three years of lawmaker education and physician advocacy proved fruitful when Gov. Whitmer signed SB 247 on April 7, 2022. Many of the reforms take effect this June, when insurers will be required to make available a standardized electronic prior authorization request transaction process.

Under the new law, urgent requests are managed much more easily, with the prior authorization considered granted if the insurer fails to act within 72 hours of the original submission. Transparency, clinical validity, and fairness embedded in the reforms will ensure patients receive timely coverage decisions and life-changing care.

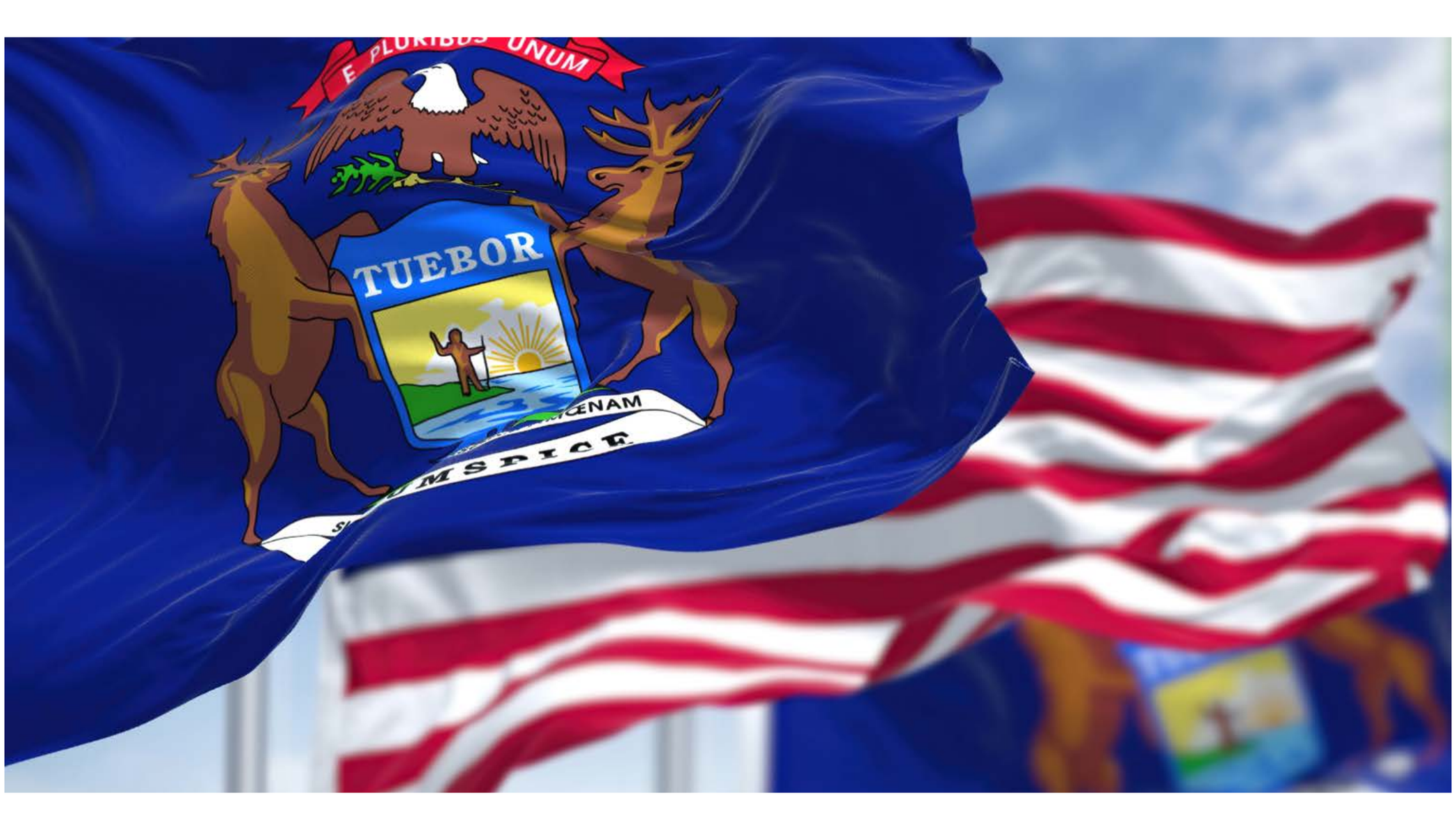
MSMS's work in this space is not done. Reduction of one administrative burden of practice frees up more time for patient care, but there are countless other encumbrances imposed by insurance companies that will require continued advocacy to reduce.

> **"Today's action by Gov. Whitmer to sign this overwhelmingly bipartisan legislation will directly help patients across Michigan," said state Senator Curt VanderWall, R-Ludington. "This new law reforms the prior authorization process, which has created barriers and inefficiencies with access and quality of care in the health care system. It will promote transparency of practices used by insurers, allowing enrollees and health care providers to be fully informed while making coverage and care decisions." – April 2022**

- **Approval of bills to reduce administrative practice burdens is a huge success for physicians, but last term MSMS also successfully batted back several measures that would have interfered on scope of practice and overly burdensome Continuing Medical Education (CME) requirements.**

A Senate bill was introduced to allow nurse practitioners to practice independently, including prescribing authority for opioids and other medications. The bill was referred to the Senate Committee on Health Policy and Human Services but did not receive a hearing. While the independent practice legislation was thwarted, we anticipate the possibility of similar bills being reintroduced this session. Advocating for a physician-led health care model is the top public policy priority for MSMS. Protecting the scope of practice is critical if we are serious as a state about providing quality, safe accessible and affordable care for patients. Whether it is nurse practitioners, anesthesia care or another infringement that eradicates the core work of a physician, MSMS must continue to diligently protect the work physicians are trained to do better than anyone else.

Legislation that would have required all physicians to take a course to identify and treat lead poisoning in children as part of their continuing education for license renewal did not move forward, but we also expect a lead remediation bill package to be introduced again, with the CME requirement just one part of it. MSMS opposes any attempt to introduce compulsory content of mandated CME in the state of Michigan.



2023: Expect the Unexpected

New lawmakers, new leadership, and a majority that's reached the pinnacle of power for the first time in 40 years—an unrelenting legislative session has begun. Public health is certain to be a priority, as are emerging public health issues, such as gun control. The MSMS legislative advocacy team is preparing for nearly every proposal imaginable, including the sleeping giant of health policy: tort reform.

The Scope of the Scope

While independent practice for NPs didn't move toward the finish line last year, MSMS is aware that this legislation is likely to see another push this term.

Advocacy efforts must emphasize the critical importance of physician-led, team-based health care for Michigan patients and oppose independent prescriptive authority by non-physicians.

Immunization Administration

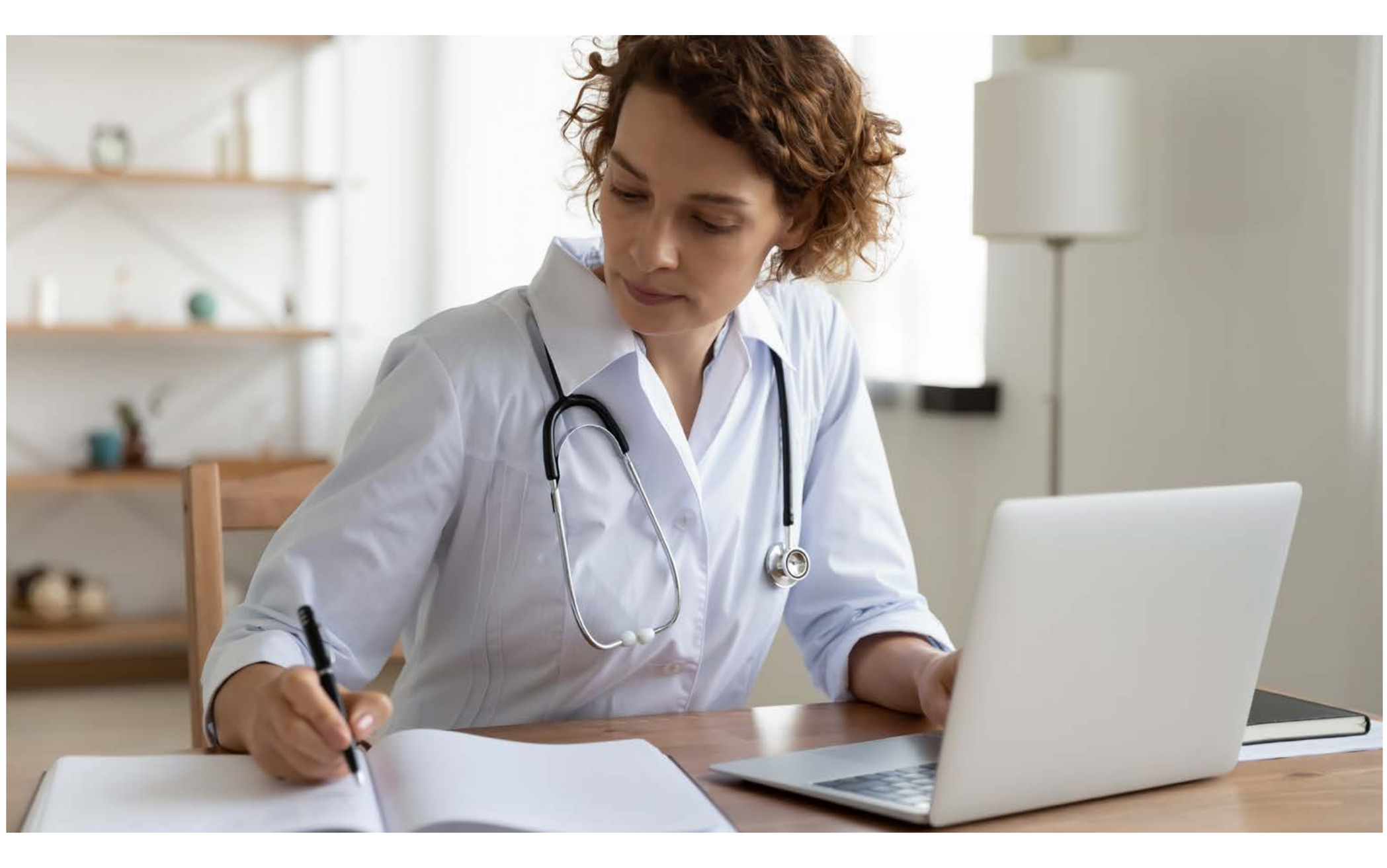
The immunization of children and adults as prophylaxis against infectious diseases is best performed at the direction of physicians involved in continuing care of the individual, considering the risks and benefits accruing to that individual. Guidelines and schedules produced by scientific groups and/or governmental agencies, while often helpful, should not be regarded as overriding the exercise of informed decision-making by the physician where the welfare of his or her patient is involved.

> **"With the new majority in Lansing, we predict a larger focus on public health threats, such as lead remediation, other chemical contaminants such as PFAS, and gun violence. While partnering with legislators on these issues, it's also incumbent upon us as an organization to raise up the voices of physicians who will emphasize the critical importance of physician-led care and individualized patient relationships." – Kate Dorsey, Manager of Federal and State Government Relations, MSMS**

Step Therapy

We're halfway there! With prior authorization reform going into effect this year, we've reduced some of the lengthy red tape that obstructs and delays physician-recommended patient care. The next frontier of policy that reduces barriers in patient care is step therapy reform. Currently, insurance companies require a "fail first" approach to formulary treatments, harming patients and undercutting the physician-patient relationship. If we as physicians are to emphasize clinical expertise over cost-first policies, we must preserve and protect our rights as health care providers to make treatment decisions that favor the patient, not the payer.

MSMS favors reforms to the step therapy process that are based on well-developed scientific standards and administered in a flexible manner that considers the individual needs of patients. Any new state policy should require health insurers to base step therapy protocols on appropriate clinical practice guidelines or published peer reviewed data developed by independent experts with knowledge of the condition or conditions under consideration.



Telehealth

One of few positive benefits of the COVID-19 pandemic has been the move toward telehealth as a mainstream medical practice. Telehealth has proven to be an important care delivery method for improving access in underserved communities, particularly rural areas, areas with physician shortages, and areas with limited access to primary care services. The accessibility afforded by this technology benefits not just individual patients, but also scores points in public health generally through the elimination of barriers.

To ensure continuity of care and minimize the spread of COVID-19, physician practices quickly adopted telehealth during the pandemic. Payers also temporarily removed some of the regulatory and administrative barriers that were limiting telehealth use and payment of telehealth services, including payment at in-person rates during the public health crisis. However, payments are now reverting to pre-pandemic rates, and MSMS believes the time is right to make these equitable policies permanent given that telehealth is, and will continue to be, an effective method of health care delivery.

The biggest barrier to long term implementation of telemedicine services by providers is costs. Telehealth parity will encourage the growth of telemedicine and allow physicians to make investments to offer telemedicine services to patients.

With payers returning to pre-pandemic rates, legislation is needed that will require insurers to cover and reimburse telehealth services the same as if the service were provided in-person.

MSMS will pursue bills that:

- Require payment parity for telemedicine services as compared to the same service provided in person.
- Prohibit annual or lifetime limits on coverage for telemedicine.
- Prohibit prior authorization requirements on telemedicine that exceed requirements for the same in-person service.
- Prohibit insurers from placing certain restrictions/requirements on telemedicine services and providers.
- Allow insurers to require telemedicine services comply with the same coding, documentation, and other requirements necessary for payment as in-person service.
- Require that telemedicine services conform to the standards of care applicable to the provider's profession and specialty.

A State Budget with Solutions

The latest figures on Michigan's state budget surplus show that the balance of federal funding remains in the billions. Deciding how to allocate this immense amount of funding in ways that directly improve the lives of Michigan residents will be among the foremost challenges facing legislative leadership this year.

One of the budget goals identified by MSMS has a proven track record of success: Medicaid uplift. When the Affordable Care Act required states to increase Medicaid payments for primary care services to match Medicare payments at 100 percent, the increased payment rates improved access to care according to data from that time period. One study showed the availability of primary care appointments for Medicaid patients increased by 7.7 percentage points after Medicaid payments were raised.

The COVID-era policy that created the temporary Medicaid uplift helped alleviate the financial instability of physician practices that provide essential care to Medicaid patients.

Medicaid reimbursement rates remain far below Medicare and private insurance. These low rates, combined with increasing Medicaid enrollment, exacerbate the financial instability of physician practices that provide essential care to Medicaid patients. Primary care services and wellness checks contribute greatly to not just overall patient health, but cost savings in these programs for the state and federal governments.

MSMS has suggested budget language that states: the department shall provide Medicaid reimbursement rates for primary care services at the greater of either the actual rates paid during the previous fiscal year or at least 95 percent of the Medicare rate received for those services on the date the service is provided.

Staffing Shortages

As the health care community is aware, the staffing shortage in Michigan is reaching acute levels. State government can play a part in alleviating a care crisis by creating a physician practice staff recruitment and training grant program. MSMS will seek funds from existing federal COVID funding grants to allocate to physician-owned practices in the acute, post-acute and behavioral health care space. Additionally, MSMS will seek opportunities for further uplifts in the Medicaid space, similar to the one secured for primary care services.

Senate Health Policy Chair: Sen. Kevin Hertel (D-St. Clair Shores), previously served 3 terms in the House of Representatives and worked in legislative affairs at Blue Cross Blue Shield.

House Health Policy Chair: Rep. Julie M. Rogers (D-Kalamazoo), a practicing physical therapist.

Spotlight issues: Lead poisoning prevention, reproductive freedom, Medicaid work requirements repeal.

The Democratic majority also announced the addition of the new Health Policy Behavioral Health Subcommittee, chaired by state Rep. Felicia Brabec (D-Pittsfield). Brabec is a practicing clinical psychologist with a master's degree in clinical social work, with over two decades of experience.

Senate Appropriations Chair: Sen. Sarah Anthony (D-Lansing), previously served 2 terms in the House of Representatives.

House Appropriations Chair: Rep. Angela Witwer (D-Delta Township), in her third term in the House of Representatives, worked for 22 years at Sparrow Health System in clinical health care and then community relations.

The Frontlines of Public Health: Gun Violence

As gun violence increasingly becomes part of our everyday lives and less of an isolated occurrence, the MSMS Board has reviewed the role of physicians and MSMS in addressing violence prevention. The Board last year hosted robust discussion on violence as a public health issue and emphasized the importance of promoting evidence-based solutions to understand what factors protect people or put them at risk for experiencing or perpetrating violence. The Board also reviewed the extensive policy on firearm safety adopted by the MSMS House of Delegates over the years.

With Democrats fully in charge of enacting new laws, it's certain a gun control bill package will see legislative action this year. In Governor Whitmer's State of the State address on January 26, she stated: "Let's enact universal background checks for people who want to buy firearms. Let's enact safe storage laws so we can make sure firearms are stored safely at home. And let's enact extreme risk protection orders, so we can keep guns out of the hands of those who might represent a danger to themselves or others."

The following are existing MSMS policies on gun violence and firearm safety issues:

- Education and training on gun safety, including requirements for firearm safety certifications.
- Strategies to increase firearm safety and prevent firearm injury and death.
- Evidence-based research on gun-related injuries and deaths.
- Bans on look-alike toy guns and the sale of assault weapons and large-capacity ammunition magazines.
- Policies prohibiting acquisition of firearms by high-risk person and limits on the ownership and use of assault weapons.
- Effective controls on the assembly, manufacture, distribution, and possession of handguns.

The exact parameters of any proposals are yet to be seen. MSMS's Government Affairs team will closely monitor movement of the legislation and send key updates to our membership.

Other Items We're Screening:

Torts: The Michigan Legislature has enacted four waves of tort reform legislation over the past four decades: 1986, 1993, 1995, and 2013. With full Democratic control of the Legislature, it's a definite possibility that tort reform could be revisited. It's likely that such a proposal would seek to increase the cap on non-economic damages plaintiffs can receive from providers. MSMS will work with lawmakers and other stakeholders to preserve Michigan's existing tort reforms and retain existing legislative intent to ensure Michigan physicians may continue practicing medicine without fear of significant economic loss.

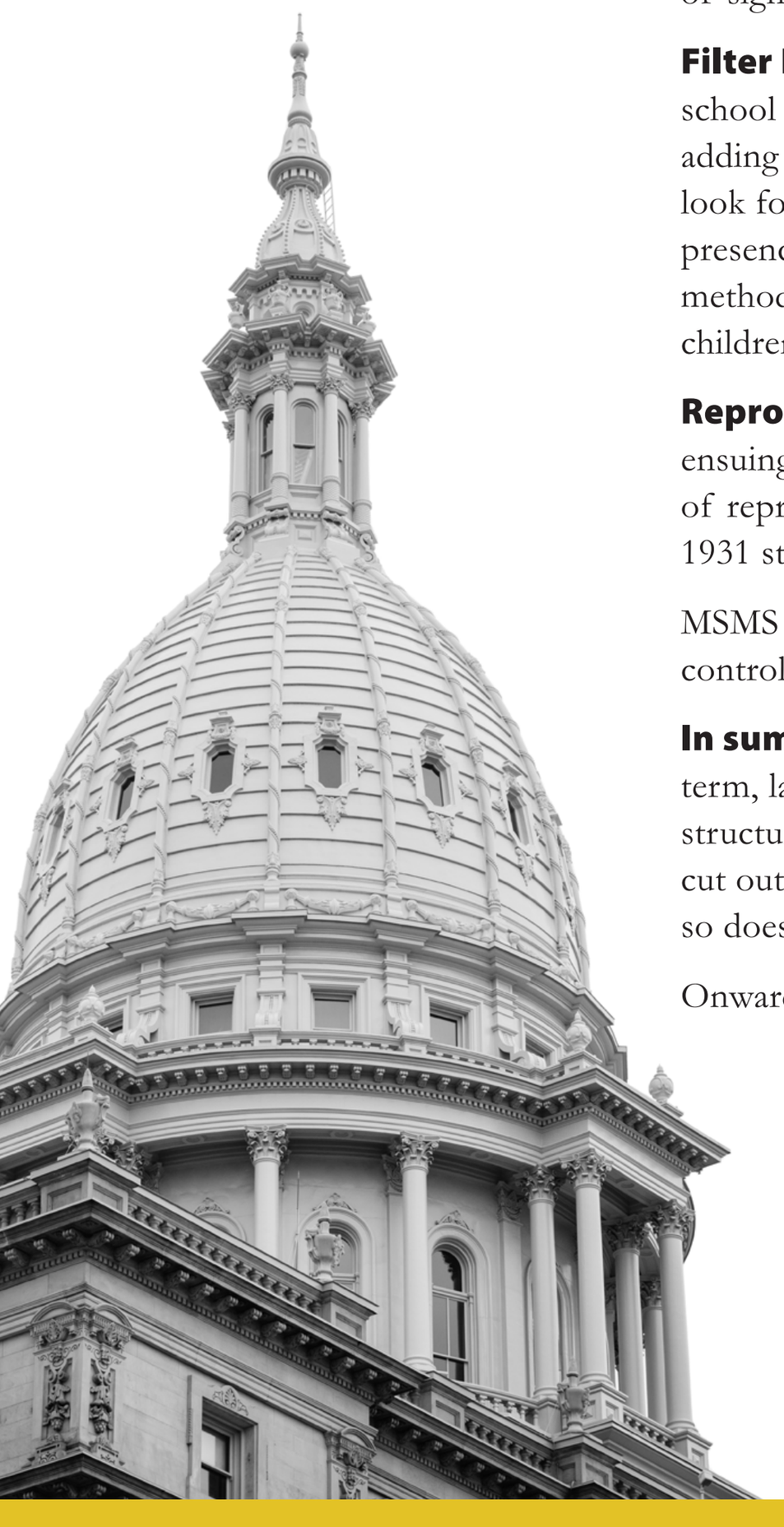
Filter First: We will continue to push for filter installation on daycare and school drinking fountains, negating the need to test and replace before adding filters. Presently, Michigan relies on the "test and tell" method to look for the presence of lead in drinking water, which only confirms the presence of lead without reducing exposure. Bypassing this inefficient method by simply installing filtered water drinking stations will ensure children have cleaner drinking water, sooner.

Reproductive health care: As during the overturn of *Roe v. Wade* and the ensuing political battles, MSMS will continue to oppose any criminalization of reproductive health treatments or procedures, and support repeal of the 1931 statute that criminalizes such medical treatment.

MSMS also supports collaboration with pharmacists to offer hormonal birth control over the counter.

In sum, the legislative agenda is packed. Just months into the new term, lawmakers are making major budget allocations, changing the tax structure, and looking at education reforms. At MSMS, we have our work cut out for us. As the complex issues before us grow in nature and number, so does our commitment to our advocacy work.

Onward we go, with a united voice, to lift up physician-led care.



To register or to view full course details, please visit:
msms.org/OnDemandWebinars

MSMS FOUNDATION

The MSMS Foundation has a library of over 30 on-demand webinars available, many of which are free, making it easy for physicians to participate at their convenience to meet their educational needs.

2023 Conference Schedule

Grand Rounds

Date(s): March 8, April 5, May 10, June 14, September 6, October 4, November 8, and December 13, 2023

Time: 12:00 – 12:45 pm

Location: Virtual Conference

Intended for: Physicians and all other health care professionals

Contact: Email Beth Elliott or call 517/336-5789.

Practice Management

Date(s): March 8, April 4, May 10, June 14, September 6, October 4, November 8, and December 13, 2023

Time: 1:00 – 2:00 pm

Location: Virtual Conference

Intended for: Physicians and all other health care professionals

Contact: Email Beth Elliott or call 517/336-5789.

Implicit Bias

Date(s): March 15, 2023, April 23, May 24, June 21, July 19, August 16, September 13, October 11, November 15, December 6, 2023

Time: 12:00 – 1:00 pm

Location: Virtual Conference

Intended for: Physicians and all other health care professionals

Contact: Email Carrie Wheeler or call 517/336-5723.

A Day of Board of Medicine Renewal Requirements

Date: March 10 and May 5, 2023

Time: 8:30 am – 4:15 pm

Location: March 10 – In-Person, Doubletree by Hilton, Grand Rapids Airport

Virtual Conference: May 5

Intended for: Physicians and all other health care professionals

Contact: Email Beth Elliott or call 517/336-5789.

Annual Scientific Meeting

Date: February 27, March 27, April 24, May 22, June 26, August 28, September 18, October 23, November 27, and December 19, 2023

Time: 6:00 – 8:00 pm

Location: Virtual Conference

Intended for: Physicians and all other health care professionals

Contact: Email Brenda Marenich or call 517/336-7580.

27th Annual Conference on Bioethics

Date: November 10, 2023

Time: 8:45 am – 4:00 pm

Location: Hybird – In-Person location, Sheraton Ann Arbor

Intended for: Physicians and all other health care professionals

Contact: Email Beth Elliott or call 517/336-5789.

For more information, or to register, please visit: MSMS.org/EO
Questions? Email Beth Elliott or call 517/336-5789.

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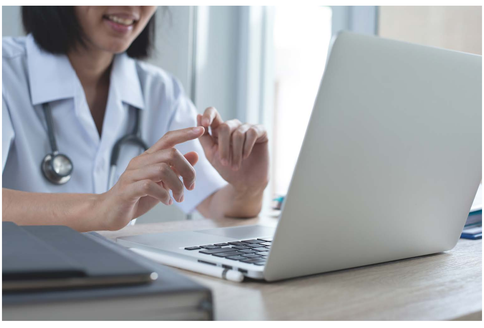
Interstate Licensure for Telehealth Can Fuel Practice Growth

Chad Anguiln, Vice President, In-Practice Technology, Medical Advantage;
David L. Feldman, MD, MBA, FACS, Chief Medical Officer, The Doctors Company and TDC Group, and Senior Vice President, Healthcare Risk Advisors;
Remi Stone, JD, Regional Director, Government Relations, The Doctors Company



When using telehealth to treat patients out of state, most healthcare professionals are mindful about licensure issues. But some are not aware that practicing without a license in a given state is not just malpractice, it is a criminal offense.

Licensing restrictions were eased to facilitate care during the COVID-19 pandemic, and the new normal of greater state-to-state cooperation for access to care may endure in the coming years. Many restrictions still apply, however, and understanding them can help reduce risk.

First-Time Visits vs. Established Patients

When discussing interstate licensure, we are less concerned about a one-time interaction with an established patient who happens to be traveling. One example: a practitioner has recently examined a patient or performed a procedure. The patient later calls with a question or a problem from another state while traveling. In this scenario, the practitioner can simply address the patient's concerns by a phone conversation, a telehealth visit, or a recommendation to go to the nearest emergency room, according to their best clinical judgment.

Caution is required, however, when planning for ongoing interactions with patients who will be across state lines from the practitioner as their regular routine, or when booking an initial interaction via telehealth with a new patient who is in another state. Most states require practitioners to be licensed in the state where the patient is located, and some may require a pre-existing relationship with the patient prior to a telehealth visit. To ensure compliance, check state licensure and telehealth requirements for these scenarios.

For practices interested in growing their patient base, the easing of restrictions related to licensure and place of service provides an opportunity to approach a national telehealth platform. If properly implemented, interstate telehealth care can fuel practice growth. Healthcare providers have an incentive to understand both the risks and the benefits of practicing across state lines.

State Laws vs. Insurer Requirements

In addition to distinguishing established patients from first-time patients and distinguishing one-time interactions from ongoing care plans, it is important to separate the restrictions imposed by state laws from the restrictions imposed by a professional liability carrier.

At The Doctors Company, our professional liability coverage follows members wherever they practice in the U.S., provided they are acting within the scope of the law—including state licensure requirements (which is where legal restrictions on state-to-state practice and insurance coverage overlap). Other insurers may have specific limitations about practicing in another state, independent of any legal restrictions.

Many insurance companies require a healthcare provider's coverage and practice to be in the state where the provider is physically located, whether the provider is treating the patient through telehealth encounters or in-person visits.

Interstate Licensure Compacts

The Interstate Medical Licensure Compact Commission (IMLCC) makes it easier for physicians to obtain a license to practice in more than one state. The compact, which is an agreement between states, requires the passage of legislation in any new state that wants to join. It currently includes 39 states and territories. The IMLCC does not permit a physician with a license in one state to automatically obtain licensure in another, but it makes obtaining licensure easier. Even though physicians still need to gather documents and pay fees, the IMLCC streamlines the process.

Launched in 2017, the IMLCC had already issued more than 50,000 licenses by fall 2022. The great value of the IMLCC has been proved by the pandemic, and as telemedicine usage increases, we can expect to see even more physicians requesting licenses in multiple states.

In addition to making the licensing process easier for physicians, the IMLCC may improve healthcare access for patients in rural areas, for example, with more specialists available via telemedicine.

Similar compacts exist for registered and licensed practical/vocational nurses, physical therapists, and audiologists/speech language pathologists. The intended goal of the compacts is to increase access to healthcare, reduce costs, and facilitate ease of licensure and telehealth practice where authorized. Occupational therapists will be able to access their compact privileges in late 2023 or early 2024, once the Occupational Therapy Licensure Compact Commission finalizes the infrastructure necessary for operation. Advanced practice registered nurses (APRNs) will enjoy access to an APRN compact once seven states enact legislation to enable it. An interstate compact for dentists and dental hygienists has been developed and is expected to be available for state adoption in 2023. Other provider specialties are likely to pursue similar authority in coming years.

Prescribing Across State Lines

Additional caution is required when prescribing is involved. During the first wave of the pandemic in the spring of 2020, many states temporarily waived various requirements affecting remote prescribing and state-to-state licensure. This includes, in many states, the common requirement that a provider see a patient in person first before prescribing remotely. Many of those waivers have ended. The Federation of State Medical Boards provides a list of states with telehealth waivers.

Controlled substances require particular caution when prescribing remotely or outside the state of licensure. In spring 2020, the Drug Enforcement Administration (DEA) temporarily lifted some restrictions around prescribing controlled substances by remote visit to patients the prescriber had not met in person. The key word here is "temporarily," as this DEA policy will expire at the end of the public health emergency.

Just as we lived within a patchwork of state-to-state restrictions before the pandemic, we can now expect those restrictions to return in a non-synchronized fashion. One state may restore restrictions next week, another not until later. To avoid the potential for surprise DEA charges, consider contacting your local health authority and/or specialty association to inquire about its tracking activities as states lift or reinstate restrictions.

Recent Federal Action

At the end of December 2022, Congress passed a $1.7 trillion omnibus appropriations bill (HR 2617, the Consolidated Appropriations Act, 2023), funding the federal government through September 30, 2023. The bill extends and expands several telehealth provisions through December 31, 2024. These provisions expand the originating site to cover any site at which the patient is located, including the patient's home. It also includes occupational therapists, physical therapists, speech-language pathologists, and audiologists as eligible practitioners who can furnish telehealth services; extends the ability to use telehealth services to meet the face-to-face recertification requirement for hospice care; extends the ability for federally qualified health centers and rural health clinics to furnish telehealth services; extends coverage and payment for audio-only telehealth services; and delays the six-month in-person requirement for mental health services furnished through telehealth.

Additionally, on November 1, 2022, CMS released the 2023 Physician Fee Schedule, solidifying access to telehealth and behavioral health services. The Physician Fee Schedule clarifies that chronic pain management services via telehealth will require the initial visit to be in-person. It also provides the regulatory framework to support the above-referenced Congressional actions.

Meanwhile, commercial reimbursement rates are tightening on visit types deemed telehealth appropriate. As conditions continue to change, keep a watchful eye on your major payers to ensure compliance.

Looking Ahead

Although professional and legal risks remain when practicing across state lines, risks may be mitigated by administrative efforts that include complying with licensing requirements, keeping abreast of regulatory changes, and following reimbursement rules. The rewards for doing so can be substantial and range from the personal—such as enjoying the ease and satisfaction of being able to provide care from the comfort of (perhaps) a home office—to the business rewards of being able to offer telehealth in multiple states. The latter is especially appealing given that some of the telehealth-friendly reimbursement rates introduced during the pandemic have persisted.

Find information on additional telehealth topics in our Telehealth Resource Center or contact the Department of Patient Safety and Risk Management at 800/421-2368 or patientsafety@thedoctors.com.

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