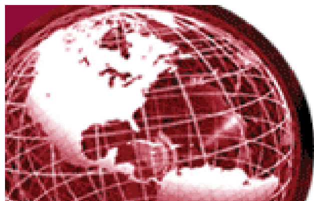

American Association of Osteopathic Examiners

AAOE OFFICERS

Barbara E. Walker, DO
President

Mary Jo Capodice, DO
Vice President

Michael Wieting, DO
Secretary-Treasurer

Anna Z. Hayden, DO
Immediate Past President

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ANNUAL BUSINESS MEETING

HILTON LAKE LAS VEGAS RESORT & SPA ▪ HENDERSON, NV

TUSCANY ROOM

January 26, 2019 ▪ 9:00 AM - 11:00 AM
Breakfast Available at 8:30 AM

BUSINESS MEETING AGENDA
(AAOE Fellows Only)

Barbara Walker, DO, President, Presiding

		TAB
I.	**AOA Update** William S. Mayo, DO — President, American Osteopathic Association (AOA)	
II.	**Call to Order**	
III.	**Approval of Agenda—Action Item**	
IV.	**July 19, 2018 Approved Minutes**	**1**
V.	**NBOME/COMLEX-USA Update** John Gimpel, DO — President & CEO, National Board Osteopathic Medical Examiners, Inc. (NBOME) Geraldine T. O'Shea, DO — Board Vice-Chair, NBOME Sandra Waters, MEM — Vice President for Collaborative Assessment & Initiatives, NBOME	
VI.	**Update: FSMB's "Artificial Intelligence in Health Care: The Role of Medical Boards" Seminar & Recent Activities** Humayun J. Chaudhry, DO, MS, MACP, MACOI — President and CEO, Federation of State Medical Boards	

Upcoming Meetings
AAOE Annual Meeting (FSMB)—April 26, 2019 *(tentative)*, Fort Worth, TX
Business Meeting (HOD)—July 25, 2019 *(tentative)*, Chicago, IL

VII. AOA State Government Affairs Update **2**

Raine Richards, JD — Director, AOA State Government Affairs

VIII. State Roundtable: Open Discussion of Issues Impacting Osteopathic Medical Regulation/Licensure

IX. Announcements

a. **New AAOE Representative on the AOA's Bureau of State Government Affairs**
   i. Jone Geimer-Flanders, DO, appointed to fill remainder of James Griffin's, DO, term expiring in 2021.

b. **Upcoming AAOE Meeting Dates**
   i. **AAOE Annual Business Meeting and Elections** will be held on **Friday, April 26th *(tentative)*** in conjunction with the FSMB Annual Meeting from April 24 – 27th in Fort Worth, TX.
   ii. **AAOE Summit Meeting** will be held on **Thursday, July 25th *(tentative)*** in conjunction with the AOA House of Delegates from July 22 – 28th in Chicago, IL.

c. **AAOE Elections**
   i. AAOE Officer Elections for the 2019-2021 term will be held during the AAOE Annual Business Meeting in April.
   ii. The deadline to submit nominations was December 14th, and the Nominating Committee will hold a ****closed meeting**** immediately following this meeting to review.

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Vice President

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Secretary-Treasurer

Anna Z. Hayden, DO
Immediate Past President

SUMMIT MEETING

HILTON LAKE LAS VEGAS RESORT AND SPA ▪ HENDERSON, NV

January 26, 2019

List of Attendees

William S. Mayo, DO – AOA President
Mary Jo Capodice, DO – Vice President, AAOE; Wisconsin Medical Examining Board
Alexios Carayannopoulos, DO - Rhode Island Board of Medical Licensure and Discipline
Humayun Chaudhry, DO – President & CEO, Federation of State Medical Boards
Jone Geimer-Flanders, DO – Hawaii Medical Board
John Gimpel, DO, President & CEO, National Board of Osteopathic Medical Examiners
James Griffin, DO – Rhode Island Board of Medical Licensure and Discipline
Anna Hayden, DO –Immediate Past President, AAOE; Florida Board of Osteopathic Medicine
Gary Hill, DO – Alabama Board of Medical Examiners
Kim Kuman – Executive Assistant, AOA State Government Affairs
Geraldine O'Shea, DO – Board Vice Chair, National Board of Osteopathic Medical Examiners
Donald Polk, DO - Tennessee Board of Osteopathic Examination
Wayne Reynolds, DO – Virginia Board of Medicine
Raine Richards, JD - Director, AOA State Government Affairs
Joel Rose, DO – Florida Board of Osteopathic Medicine
Otto Sabando, DO – New Jersey State Board of Medical Examiners
Barbara Walker, DO President, AAOE; North Carolina Medical Board
Sandra Waters, MEM – Vice President, Collaborative Initiatives, National Board of Osteopathic Medical Examiners
J. Michael Wieting, DO – Secretary-Treasurer, AAOE, Tennessee Board of Osteopathic Examination
Joseph A. Zammuto, DO – President, Osteopathic Medical Board California

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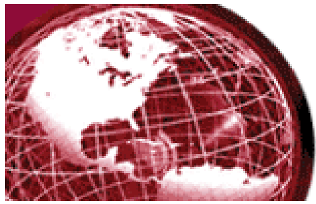

BUSINESS MEETING MINUTES

Thursday, July 19, 2018
Marriott Chicago Downtown Magnificent Mile - Addison Room, 4th floor
5:00 PM – 7:00 PM

Fellows Present:
Jimmy Adams, DO, West Virginia Board of Osteopathic Medicine
James Andriole, DO - Past President, AAOE
Mary Jo Capodice, DO – Vice President, AAOE; Wisconsin Medical Examining Board
Katherine Fisher, DO, Oregon Medical Board
Jone Geimer-Flanders, DO – Hawaii Medical Board
James Griffin, DO – Rhode Island Board of Medical Licensure and Discipline
Anna Hayden, DO –Immediate Past President, AAOE; Florida Board of Osteopathic Medicine
Veryl Hodges, DO – Arkansas State Medical Board
Lynn Mark, DO - New York State Board for Medicine
Nicholas Parise, DO - Illinois Medical Licensing Board
Joel Rose, DO – Florida Board of Osteopathic Medicine
Dana C. Shaffer, DO – Past President, AAOE; Board Chair, NBOME; Kentucky Board of Medical Licensure
Barbara Walker, DO President, AAOE; North Carolina Medical Board
J. Michael Wieting, DO – Secretary-Treasurer, AAOE, Tennessee Board of Osteopathic Examination
Andrew Yuan, DO – Connecticut Medical Examining Board Department of Public Health
Joseph A. Zammuto, DO – President, Osteopathic Medical Board California
Jan Zieren, DO, Tennessee Board of Osteopathic Examination

Non-Members/Observers Present:
Humayun Chaudhry, DO – President & CEO, Federation of State Medical Boards
John Gimpel, DO, President & CEO, National Board of Osteopathic Medical Examiners
Scott Steingard, DO, Chair-elect, Federation of State Medical Boards
Sandra Waters, MEM – Vice President, Collaborative Initiatives, National Board of Osteopathic Medical Examiners

AOA Leaders/Staff:
Mark Baker, DO – AOA President
Kim Kuman – Executive Assistant, AOA State Government Affairs
Raine Richards, JD - Director, AOA State Government Affairs

I. Meeting called to order by Barbara Walker, DO, President, presiding at 5:05 PM (CDT).

II. Approval (unanimous) of minutes of April 27, 2018 meeting. Approval of agenda (unanimous).

III. Federation of State Medial Boards (FSMB) Update – Humayun Chaudhry, DO, President and CEO, FSMB

a) Acknowledged Scott Steingard, DO incoming FSMB chair, Anna Hayden, DO (FSMB Director) and others serving on FSMB committees and offices.
b) Concern regarding potential personal liability of licensing board members over actions taken – seeking federal legislation protection of board members – details upcoming.
c) New FSMB property purchased in Washington, D.C. for potential new building.
d) Interstate Medical Licensure Compact – over 1500 licenses issued already
e) Physician Wellness issue – a public health issue.
f) Artificial Intelligence – especially regarding mistakes/errors made by a machine – how to handle this on a state regulatory level. FSMB will sponsor a small invitational symposium to inform where to go in the future.
g) Social Media
    i. work group working on policy on its use by physicians
    ii. possibly need new/revised policies
    iii. recommendations for physicians
h) Sexual Boundary Issues – increasing complaints from patients, trainees, etc.
    i. What should state boards do? - a work group is working on this
i) COMs working with FSMB regarding access to data on licensed physicians who work with medical students
j) Internal task force to look at records of licensee discipline retrieval and if applicable to/useful for state boards.
k) IAMRA meeting in October 2018. Dr. Hayden will represent AAOE.

IV. American Osteopathic Association (AOA) Update - Mark Baker, DO, President, AOA

a) Welcomed group to Chicago
b) Working on improving AOA Board Certification Services

V. National Board of Medical Examiners (NBOME) Update – John Gimpel, DO, President and CEO, NBOME

a) Mission, leadership updates, and awards (including Dr. Walker)
b) Overview of National Faculty, Standard Setting Panels
c) COMLEX-USA pass rates and new passing standards
    i. Level 1 new passing standard
    ii. Level 2 CE, 2 PE
    iii. Level 3
d) COMLEX-USA Level 3 New Blueprint and new GME program director attestation for eligibility requirement.
e) Catalyst – continuous assessment and learning program
    i. Pilots with AOBP, AOBIM, AOBOG, and take-away results/feedback – positive for providing better care and recommend to colleagues
f) Single Accreditation System for GME
    i. NRMP Match results for 2018
g) ACGME acceptance rate of COMLEX (77%)
h) Initiatives to reach residency program directors

VI. State Legislative Update – Raine Richards, JD, Director, State Government Affairs, AOA

a) 46 states legislatures in session, all sent legislative communications
   i. Assistant physician licensure efforts
   ii. DMS licensure
   iii. Bureau of State Government Affairs policy revisions – regarding special licensing pathways for physicians, non-physician clinican policy
   iv. Opposition for creation of new medical license types
b) Osteopathic equivalency and distinctiveness especially in licensure, in legislation/regulation
c) Updating state legislative terminology
d) Insurance regulation issues, especially regarding care cost for patients
e) Prescription drug abuse/substance diversion

VII. Assistant Physician Update

a) No longer restricted to primary care
b) Level of supervision variations

VIII. Osteopathic Manual Practitioners

a) Former Canadian chiropractor has established self-accredited schools of "European style osteopathy" and calling themselves "DOs" after passing self-created board examination
b) They have created a Canadian and an international association
c) Cathopathi physician
   i. One has inquired about licensure in Hawaii

IX. Policy Development Preventing Physician Burnout – Scott Steingard, DO, Chair-elect, FSMB

a) Licensing issues and safe haven reporting
b) Initial discussion re: disruptive physicians
c) Realization that disruptive behavior often has roots in burnout
d) Focus on:
   i. professionalism Education
   ii. Research/evaluation
   iii. Collaboration
   iv. Stigma reduction
e) Surveyed state medical boards re: awareness of stigmas among licensees
f) Held Stakeholder Summit
   i. Many attendees didn't realize their role in physician burnout
g) License application question design
   i. Trigger point for many stakeholders
   ii. Balance between public and physician protection and transparency
   iii. Many questions on applications are against Federal law
   iv. Issues with licensing process and stigma inhibiting treatment and disclosure
h) <u>FSMB recommendations:</u>
   i. Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a completely ethical and professional manner?

ii. Consider offering "safe haven non-reporting" to applicants for licensure who are receiving appropriate treatment for mental health or addiction
iii. Work with safe legislature to ensure that the personal health information of licensees related to an illness/diagnosis is not publicly disclosed as part of a board's process
1. Goals of recommendation of FSMB
a. Encourage physician to seek help early
b. Remove stigma associated with acknowledging need for help
c. Improve physician well being
d. Change perception of licensing board role as always punitive
e. Promote understanding of "duty to report" to assist in earlier intervention
f. Improve equality of care delivered to patients
g. Support public protection efforts of state medical boards

i) Future considerations
i. Encourage self-care without fear of repercussion against license
ii. State medical boards duty to protect the public includes a responsibility to support physician wellness

X. Report on Special Legislative Commission to Examine the Advisability of Rhode Island Joining the Interstate Medical Licensure Compact – James Griffin, DO

a) Opponents often misinformed
b) Often legislative action needed
c) Input from government officials, state medical associations
d) Opposition by the medical society to proposed legislation by compact components; hospitals and medical staffs need to act as self governing entities, including determination of eligibility criteria for medical staff privileges
e) Recommend licensing board members be involved with these legislative issues, make contact with elected officials, be a resources to legislators
f) Expertise of Rick Masters, on licensure compacts

XI. AAOE Nominating Committee and Elections

a) 2 years terms end April 2019
b) Nominating Committee needs to begin its work
c) Slate presented at Jan. 2019 meeting and election will be in April 2019

XII. Osteopathic Medical Regulation/Licensure Roundtable

a) North Carolina - one position required to be a DO on the licensing board
b) California - already dealing with osteopathic manual practitioner issue
c) Oregon - currently two DO's also hold officer positions
d) Issues with incorrect calculation of buprenorphine prescribing amounts using morphine equivalents
e) Maine – has considered merging two licensing boards into one
f) New Mexico – likely merging of two licensing boards into one composite board
g) Florida – limitations on number of days for opioid prescriptions and requiring documented PDMP inquiry

h) Florida and Pennsylvania_– considering no longer requiring AOA internship for licensure

XIII. Next Meetings

a) January 24-27, 2019 (Las Vegas)
b) April 25-27, 2019 (Fort Worth)

Therefore, being no further business, meeting adjourned by Dr. Walker at 6:47 p.m. (CDT) after motion to adjourn.

Respectfully submitted,
Michael Wieting, DO
AAOE Secretary-Treasurer

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AOA STATE GOVERNMENT AFFAIRS UPDATE

Raine Richards, JD
Director, State Government Affairs

Kim Kuman
Executive Assistant, State Government Affair

The AOA Department of Public Policy continues to monitor and respond to new developments as they arise, working closely with state and specialty affiliates to promote the policies and positions of the AOA at the state and federal levels. A list of 2019 state and federal public policy priorities is included at the end of this report.

Scope of practice and the creation of new licensure types continue to be major issues, as does protecting and promoting the practice of osteopathic medicine. Advocacy around state health insurance regulations and Medicaid expansion is also a growing trend in our efforts. This report highlights legislation that has been introduced since the start of 2019 that is relevant to our state policy priorities, and we anticipate taking action on many of these bills once they start moving.

Scope of Practice Partnership

The AOA continues its partnership with the American Medical Association and state and specialty societies as a steering committee member in the Scope of Practice Partnership (SOPP). In the fall of 2018, the Pennsylvania Osteopathic Medical Association (POMA) became the second osteopathic affiliate (after Oklahoma) to receive grant funding from the SOPP. The SOPP approved a $75,000 grant request submitted jointly by POMA and the Pennsylvania Medical Society for a comprehensive public affairs campaign to combat a legislative push for independent practice by certified registered nurse practitioners. The campaign includes op-eds, a media kit, social media posts, billboards and digital media advertising which will be used to educate legislators and the public about the importance of physician involvement in patient care.

2017 State Level Advocacy

Forty-six states held regular legislative sessions last year, and all fifty are in session this year. The AOA Public Policy department is monitoring and responding to proposed legislation and regulations across the country on topics important to osteopathic medicine.

Scope of Practice and New Provider Types

AANP's "We Choose NPs" Campaign

Last summer, the American Association of Nurse Practitioners (AANP), which represents the nearly 250,000 NPs in the United States, announced a $2 million advocacy campaign to push for independent practice rights in the 28 states that do not currently allow NPs to practice without physician supervision. The campaign lauds NPs as critical providers who bring expanded access to primary care to millions of Americans and the related blog targets a diverse audience with public health tips.

While the AOA values the unique contributions of all members of the health care team, our policy supports a "team-based" approach to medical care because the physician-led medical model ensures that professionals with complete medical education and training are adequately involved in medical decisions and

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patient care. We are concerned that granting independent practice rights to non-physician clinicians could create a two-tier health care system whereby geographic location and type of insurance could determine whether a patient can access and afford care from physicians or be treated by health care providers with far less education and training.

We also support truth in advertising legislation that requires all members of the health care team to clearly state their credentials and professional degrees in all advertisements (including verbally and via name badge during patient encounters), and refrain from using the title "doctor" or "physician" unless they are a US-trained DO or MD.

The AOA Public Policy department worked with the Communications team to develop an article in The DO as well as a press release to provide a counter-narrative to the AANP campaign. We are also working to create materials which can be used to educate lawmakers and the public on the differences in physician and non-physician training, and the need for alternative solutions (increased funding for graduate medical education, medical school scholarships and loan forgiveness tied to providing care in underserved areas/populations) to ensure that all patients are able to access a fully trained and licensed physician regardless of geographic or financial barriers.

Advanced Practice Registered Nurses (APRNs)

In 2019 so far, Indiana has introduced legislation (IN SB 343 / HB 1097 / SB 394) to allow Advanced Practice Registered Nurses (APRNs) with prescriptive authority who have been practicing under a practice agreement with a "practitioner," who may be another APRN, for one year to practice without one.

Texas introduced TX HB 927, which authorizes APRNs in shortage areas to order, perform and interpret diagnostic tests, formulate primary and differential diagnoses, prescribe controlled substances under certain circumstances, serve as primary care providers of record and perform other acts that are "commensurate with their education and demonstrated competencies."

New Jersey SB 1961 deletes the current joint APRN-physician protocol requirement and allows APRNs to order medications after completing six hours of continuing professional education in pharmacology, and ten additional hours every biennial licensing period. APRNs who have completed less than 12 years or 2,400 hours in an initial role shall have a formal agreement with a collaborating "provider," who may be another APRN.

Physician Assistants and the "Optimal Team Practice" (OTP) Model

In 2014, the American Academy of Physician Assistants (AAPA) decided to eliminate use of the term "physician assistant," and make "PA" the preferred terminology for the organization. According to the AAPA, the shift reflects the fact that PAs "practice medicine."

In 2017, the organization adopted a new OTP model, which professes to reaffirm the team-based model of care but in reality supports eliminating of any legal or regulatory requirements that PAs must collaborate with a physician and creates a roadmap to independent PA practice.

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Specifically, the OTP policy:

- Replaces the title "physician assistant" with "PA;"
- Supports the elimination of provisions in laws or regulations that require a physician assistant to have a supervisory or collaborative relationship with a physician in order to practice;
- Advocates for the establishment of independent state boards, with a voting membership comprised of a majority PAs, to license, regulate, and discipline PAs (in most states, PA practice is currently regulated by the medical board);
- Removes the concept that physician assistant scope of practice is determined by physician delegation, instead allowing physician assistants to provide "any legal medical service for which they have been prepared by their education, training and experience and are competent to perform;" and
- Removes the concept that the physician assistant is considered the agent of the physician, except when acting on a specific directive from a physician.

In 2019, South Carolina became the first state to introduce OTP legislation via House Bill 3399 and Senate Bill 132. Together these bills replace the term "physician assistant" with "PA." They also change the definition of 'PA' from "a health care professional licensed to assist in the practice of medicine with a physician supervisor" to someone "who meets the qualifications provided in this article and is licensed to practice medicine as provided in this article."

The bills further remove physician supervision requirements and replace them with a requirement that PAs develop a "scope of practice," meaning "a written agreement developed by a PA and a physician or medical staff who agrees to work with and support the PA." "The scope of practice must establish the medical aspects of care to be provided by the PA, including the prescribing of medications and must contain mechanisms that allow the physician to ensure that quality of care and patient safety is maintained."

The bills establish that PAs may provide "legal medical services for which they are qualified by their education, training, and experience and are competent to perform as determined by the physician-PA team and stated within the scope of practice."

These services may include:

1) Evaluating, diagnosing, managing, and providing medical treatment;
2) Ordering, performing, and interpreting diagnostic studies and therapeutic procedures;
3) Issuing medical orders for physical therapy, medical equipment and hospice services;
4) Pronouncing death, certifying cause of death, and executing death certificates;
5) Authenticating any document that may be authenticated by a physician.

The bills also delete current requirements that PAs must have six months of clinical experience with a supervising physician before practicing off-site and remove the restriction that PAs may only prescribe a 72-hour supply of medication before the patient must be seen by a physician.

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Assistant/Graduate Physicians

In 2018, the AOA successfully opposed the creation of an Assistant Physician (AP) license, which would have allowed medical school graduates who did not match into a residency to provide care under limited supervision by a fully licensed physician, in four states. Similar legislation has been introduced this year in two states so far:

New Hampshire HB 509 creates the Graduate Physician (GP) Pilot Program, which licenses the first five applicants each year who graduate from a medical or osteopathic medical school and pass Steps 1 and 2 of the USMLE "or equivalent" to practice in medically underserved areas under limited physician supervision. HB 509 defers to the Board of Medicine to adopt rules related to the GP's scope (including prescriptive authority), supervision requirements and standards related to the GP's education and training.
NOTE: The AOA, the New Hampshire Osteopathic Association, the American College of Osteopathic Family Physicians and the American College of Osteopathic Internists sent a letter of opposition on 1/23/2019. The bill was voted Inexpedient to Legislate (DEAD) on 1/29/2019.

Hawaii HB 39 establishes a three-year pilot program to create a new category of professional licensure for APs to allow them to provide primary care in medically underserved areas.

Physical Therapists (PTs)

Indiana HB 1197 grants the authority to regulate PTs to a newly established independent Indiana Board of Physical Therapy, created from the Physical Therapy Committee, which currently exercises specific functions under the direction of the Medical Licensing Board. The bill also replaces the physician representative who currently services on the Committee with two PTs.

Missouri HB 410 and Wyoming HB 6 create direct-access physical therapy and only require PTs to refer patients to another "health care provider" if the PT determines that that patient's condition is beyond the scope of practice of physical therapy.

Naturopaths

Mississippi SB 2060 and New Mexico SB 135 license naturopathic "physicians" (MS) or "doctors" (NM). Mississippi's bill allows "naturopathic physicians under the general supervision of a physician" to order and perform clinical lab tests and diagnostic imaging studies, prescribe substances "determined by the Naturopathic Formulary Council" and barrier contraception.

New Mexico's bill allows naturopaths to prescribe hormones, hormonal and pharmaceutical contraceptives, and or "other physiologic substances." It also establishes a scope of practice to include the practice of primary care "in collaboration with an MD or DO," and allows them to order and take action on imaging studies. After passing a pharmacy exam, it also allows them to prescribe all legend drugs, testosterone and all Schedule III – V drugs except opioids and benzodiazepines. It only requires naturopaths to refer patients to a physician if the naturopath determines that the patient's condition is beyond the scope of their training.

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Psychologists
Several states have proposed legislation related to prescriptive authority for psychologists.

Hawaii SB 819, Montana SB 106 and New York S 409 authorize psychologists to prescribe drugs customarily used in the diagnosis and treatment of mental or emotional disorders, including some controlled substances.

New Mexico SB 9 expands supervision of prescribing psychologists from physicians to nurses.

Insurance Regulations

In light of Congress' failure to repeal the Affordable Care Act (ACA), in the last year the Trump administration has taken numerous steps to dismantle and roll back key provisions. These actions threaten the viability of many state health insurance markets by driving up insurance premiums and creating opportunities for (typically) young and healthy individuals to exit the individual and small group markets.

Some of the most significant federal actions that have been taken include removing the individual mandate for insurance coverage, the passage of the final rule on short-term, limited duration insurance plans in May 2018, changes to essential health benefits, and the Centers for Medicare and Medicaid Services' approval of Section 1115 demonstration waivers to allow states to impose work requirements, lock-out provisions, and other modifications to their Medicaid programs.

These federal actions have led states to begin moving to stabilize their insurance markets and protect access to coverage for their residents. As a result, the AOA is tracking and considering action in support of state insurance market stability packages, which usually include reinsurance programs, limitations on the sale of short-term, limited-duration insurance and state Medicaid expansion efforts.

In the November midterm elections, Nebraska, Idaho and Utah voted to expand Medicaid under the ACA via ballot initiatives. Voters in Montana elected not to make their Medicaid expansion permanent, and legislators will decide whether to continue funding the program in 2019.

In late 2018, the AOA and the Alabama Osteopathic Medical Association submitted a comment letter opposing a Section 1115 demonstration waiver proposal by the state to impose work requirements on the non-expansion Parent and Caretaker Relative population. We anticipate more state action on Medicaid this year and will continue to work to support access to affordable, high-quality health care for all individuals regardless of income or geographic location.

In 2019, Florida, Oklahoma, South Carolina, Texas have introduced legislation to expand Medicaid under the ACA.

Physician Workforce Issues

The AOA supports incentives to attract and retain primary care physicians in shortage areas, and we support proposals introduced in several state so far this year.

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New Mexico SB 21 creates a "Physician Excellence Fund" in the treasury to support awards established through the Health Professional Loan Repayment Act to primary care physicians who practice in underserved areas of New Mexico.

New York S 1182 creates the Medical Professionals Across Rural New York State student loan repayment fund pilot program for physicians who commit to practice for two years in rural areas.

West Virginia SB 80 establishes a tax credit for recent physician graduates who commit to practice medicine in West Virginia for at least six years.

Washington SB 5319 increases payment rates for physicians who participate in Medicaid to match Medicare payment rates.

Interstate Medical Licensure

Virginia HB 2128/ SB 1124 allow MDs and DOs who are licensed and in good standing with jurisdictions that are contiguous with the state to provide services to patients located in Virginia through telemedicine.

Georgia SB 16, Kentucky SB 22, North Dakota SB 2173, New Mexico SB 97, Oklahoma HB 2351 and South Carolina H 3101 / S 320 enact the Interstate Medical Licensure Compact.

Dual Boards

Oklahoma HB 1445 reauthorizes the Oklahoma State Board of Osteopathic Examiners until 2025.

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2019 FEDERAL PRIORITIES

STRENGTHENING PHYSICIAN WORKFORCE:

Enact a multi-year reauthorization of the Teaching Health Center Graduate Medical Education (THCGME) program to support training for primary care physicians in our nation's rural and underserved communities.

Support enactment of legislation that increases physician workforce through increased graduate medical education funding and expanded student loan repayment programs.

Educate Congress on the importance of funding a physician-led health workforce.

ACCESS AND AFFORDABILITY:

Preserve essential benefits coverage, consumer and benefit protections, and ensure that currently insured individuals not unwillingly lose health insurance coverage as a result of any action or inaction by policymakers.

Promote network adequacy to ensure patients have access to covered services, including specialty and subspecialty services, and policies that prevent surprise billing for portions of services which are out of network.

Support enactment of legislation that expands access to high value services and prescription drugs that manage chronic conditions.

Support enactment of legislation that expands the coverage of Health Savings Account when partnered with high deductible health plans.

Support enactment of legislation that promote opioid alternatives for pain management, funds research and treatment, and promotes greater access to substance abuse treatment.

ENTITLEMENT REFORM:

Ensure continued and sufficient federal funding to support Medicare benefits and Medicaid expansion as currently available. Potential changes in federal policy and funding for these programs should not erode benefits, eligibility, or coverage compared to current law.

FUNDING PRIORITIES:

Support funding for public health and physician workforce programs in fiscal year (FY) 2020 that promote a strong physician workforce, supports for preventive services, and research to develop the new and better ways to prevent and treat disease and help people live healthier lives.

Support funding for the National Institutes of Health and other agencies that will help facilitate greater support for osteopathic physician-researchers, and help build research capacity and infrastructure at osteopathic institutions.

Support funding for research on reducing firearm violence.

REGULATORY REFORM:

Support regulatory changes to reduce administrative burden that detract from patient care and interfere with the patient-physician relationship.

Support regulatory changes that provide greater flexibility in service delivery, and ensure the transition from a volume-based to value-based health care system provides adequate reimbursement, particularly for physicians in small and independent practices.

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2019 STATE PRIORITIES

SCOPE OF PRACTICE & NEW LICENSURE TYPES:

Support legislation that promotes the physician-led, team-based model of health care delivery, which values each member of the patient care team while protecting patient safety through appropriate physician involvement. Support uniform, evidence-based licensure pathways for physicians, as well as non-physician clinicians, based upon scope of practice.

OSTEOPATHIC EQUIVALENCY AND RECOGNITION:

Ensure that legislation appropriately recognizes osteopathic physicians, residents and students, as well as osteopathic examinations and board certifications, as equivalent to their allopathic counterparts. Educate legislators about currently accepted osteopathic terminology and the distinctive philosophy and practice of osteopathic medicine, including osteopathic manipulative treatment (OMT). Support the licensure and regulation of osteopathic physicians by osteopathic medical boards in dual board states.

TRUTH IN ADVERTISING:

Support legislation that requires all health care providers to affirmatively communicate their degrees and licensure type to patients. This helps to reduce patient confusion and protect patient safety by preventing fraud and deceptive practices, and enables patients to make informed decisions about who is providing their care. Support advertisements of physician board certification only if the board possesses legitimate training and testing requirements.

PHYSICIAN WORKFORCE:

Support enactment of legislation that increases the physician workforce through increasing funding for graduate medical education and expanding financial incentives to attract physicians to rural and underserved areas/populations.

TELEMEDICINE:

Support the delivery of appropriate health care services, including the prescription of controlled substances, through telemedicine and other communications-based technologies. Advocate for payment parity between these services and similar services delivered in-person.

PRESCRIPTION DRUG MISUSE, ABUSE AND DIVERSION:

Support a cautious, evidence-based approach to this issue that balances the need to curb prescription drug misuse while ensuring access to timely, appropriate health care for patients with legitimate pain care needs. Support legislation that promotes non-opioid alternatives for pain management, including OMT, and provides funding for research and treatment.

INSURANCE REGULATIONS AND ACCESS TO CARE:

Support state insurance regulations that require insurers to maintain adequate in-person provider networks and improve network transparency. Support physicians' right to voluntarily contract with insurers and set their own out-of-network rates, which allows them to continue to provide care to patients. Support legislation to stabilize state health insurance exchanges.

INTERSTATE MEDICAL LICENSURE COMPACT (COMPACT):

Support enactment of the Compact, which provides a voluntary, expedited pathway to physician licensure in multiple states. The Compact also increases access to health care for patients in underserved or rural areas by allowing them to more easily connect with medical experts through the use of telemedicine and other communications-based technologies.