AMA AMERICAN MEDICAL ASSOCIATION

Advocacy Resource Center

Advocating on behalf of physicians and patients at the state level

State legislative wrap-up: August 2018

This year, states faced a flurry of legislation concerning the ever-present discussions surrounding the nation's opioid epidemic; telemedicine; physician-insurer relations; scope of practice; public health issues; and more. Out-of-network coverage was again a prominent issue across the country, as were Medicaid waivers. Additionally, ongoing debates over administrative hassles and insurer efforts to control utilization affected many states. Finally, the proposed CVS-Aetna and Cigna-Express Scripts mergers attracted extensive media attention, as federal and state regulators endeavored to understand the impact that those mergers would have on health care competition.

In the midst of these legislative, regulatory and private sector issues, medical societies continued to show their value and won more often than can be counted in a single document. In part, this was due to working with state legislatures on solutions, developing coalitions and seeking the best resources from around the country. The American Medical Association (AMA) Advocacy Resource Center has been pleased to contribute to the success of many state and national medical specialty society efforts, and we welcome the opportunity to share our expertise, reach out to our colleagues and enlist colleagues within the AMA on your behalf. This report provides an overview of many 2018 developments to date.

Please refer to the Advocacy Resource Center website for comprehensive resources relating to our state advocacy campaigns, detailed state legislative tracking information and for a list of Advocacy Resource Center attorneys and areas of expertise.

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CVS-Aetna and Cigna-Express Scripts mergers

Overview

CVS-Aetna announced their proposed merger on December 3, 2017, and Cigna-Express Scripts announced their intention to combine on March 8, 2018. The CVS-Aetna merger is a horizontal and a vertical merger. In horizontal mergers, two competitors combine, and CVS-Aetna are significant competitors in numerous Medicare Part D geographic markets. In many additional markets, the merger is "vertical" because Aetna is a buyer of inputs (such as PBM services and pharmacy) that CVS sells. The AMA has never opposed a vertical merger—it has only challenged horizontal mergers of health insurers, with varying degrees of success. Vertical mergers' impacts are much more difficult to determine than horizontal mergers'. Compared with horizontal mergers, very little economic research and legal guidance about vertical mergers exists. These factors make it difficult to determine whether or not opposition to a vertical merger can succeed.

2017-2018 Significant activity

The AMA began its comprehensive analysis of the proposed CVS-Aetna merger shortly after the CVS-Aetna made their announcement in December 2017. On February 28, 2018, the AMA submitted a statement to the House Judiciary Subcommittee on Regulatory Reform, Commercial and Antitrust Law in anticipation of a hearing entitled "Competition in the Pharmaceutical Supply Chain: The Proposed Merger of CVS Health and Aetna." In this document, the AMA stated that the CVS-Aetna merger had the potential to worsen competition in the following four markets: Medicare Part D; pharmacy benefit manager (PBM) services; local health insurance; and many local retail pharmacy markets. Activity since the filing includes:

- February 2018: The AMA formed and conducted the first of an ongoing series of calls with, an AMA-state and specialty society coalition formed to coordinate CVS-Aetna and Cigna-Express Scripts advocacy efforts.

- March 2018: In March, the AMA hired four nationally recognized antitrust experts to help evaluate the proposed CVS-Aetna merger and began building an evidence base needed to help AMA evaluate its position on the merger: (1) Lawton "Rob" Burns, PhD - Professor of Management and the Chairperson of the Health Care Management Department of The Wharton School of The University of Pennsylvania; (2) Richard Sheffler, PhD - Distinguished Professor of Health Economics and Public Policy, joint tenured appointments in School of Public Health and Goldman School of Public Policy, University of California, Berkeley; (3) Neraj Sood, PhD - Professor & Vice Dean for Research at the USC Sol Price School of Public Policy and Director of Research at the Leonard D. Schaeffer Center for Health Policy & Economics; and (4) Amanda Starc, PhD - Associate Professor of Strategy at the Kellogg School of Management and a Faculty Research Fellow at the National Bureau of Economic Research.

- April-June 2018: The AMA, worked with its experts (and other independent outside experts) to analyze the CVS-Aetna merger. This analysis also began taking into account the proposed Cigna-Express Scripts transaction.

- May 2018: In May, based on the evolution of the work with national experts, AMA filed a statement with the California Department of Managed Health Care (DMHC), asking the DMHC to closely scrutinize the CVS-Aetna merger in PBM services, health insurance markets, retail pharmacy markets, Medicare Part D *and* specialty pharmacy.

- May-June 2018: AMA experts completed reports and concluded that the CVS-Aetna merger is likely to substantially lessen competition in PBM services, health insurance, retail pharmacy, Medicare Part D and specialty pharmacy.

- June 2018: Working closely with the California Medical Association (CMA), the AMA and CMA secured a hearing–on June 19–by the California Department of Insurance (CA DOI) on the CVS-Aetna merger. On June 19, the AMA and a number of its experts testified before the CA DOI and California Insurance Commissioner David Jones. AMA formally announced its opposition to the CVS-Aetna merger at this hearing.

  On June 29, AMA filed a comprehensive statement, along with an exhibit containing the experts' reports from Drs. Burns, Scheffler, Sood, and Starc, with the CA DOI, describing in detail why the AMA opposed the merger and urged the CA DOI to recommend that the DOJ oppose the merger. The AMA also sent copies of the statement and exhibit to the DOJ and the National Association of Attorneys General.

- July 2018: AMA experts Drs. Sood and Burns filed supplemental statements with the CA DOI rebutting claims made in documents filed with the CA DOI by CVS and Aetna after the June 19 hearing. Diana Moss, PhD, President, American Antitrust Institute also submitted a statement that countered claims made by CVS and Aetna, as did Tim Greaney, Visiting Scholar, University of California, Hastings College of Law, the nation's leading antitrust legal scholar.

The AMA continues to develop legal theories and evidence to further support its opposition to the CVS-Aetna merger. The AMA is working with state medical associations and national medical specialty societies to identify other opportunities to further its opposition to the CVS-Aetna merger, e.g., state attorneys general and insurance departments. Finally, the AMA also continues to press its merger opposition with the DOJ and the nation's attorneys general.

For more information on AMA merger-related advocacy, please visit ama-assn.org/advocacy-resource-center or contact Wes Cleveland, JD, Senior Attorney, at wes.cleveland@ama-assn.org or (312) 464-4503, or Henry Allen, JD, Senior Attorney, at henry.allen@ama-assn.org or (312) 464-4271.

Medicaid

Overview

This year the Medicaid conversation often turned from expanding coverage to restricting eligibility in new ways. After being given license from the federal government in January to experiment with new flexibilities, states are increasing looking at ways to trim their Medicaid rolls with features like work requirements, lock-out periods, time limits, and invoking "personal responsibility" among beneficiaries by increasing premiums and cost-sharing requirements. In some states, these restrictions represent a necessary compromise to begin or continue Medicaid expansion programs. In others, expanding Medicaid budgets are forcing reconsideration of all aspects of their programs, including prescription drug spending and payment initiatives, in hopes of identifying new savings mechanisms.

2018 Significant activity

Work requirements

Since the Centers for Medicare and Medicaid Services (CMS) announced it would permit states to require certain Medicaid beneficiaries to work or engage in other work-related activities as a condition of Medicaid eligibility, four states (AR, KY, IN and NH) have secured federal approval to do so and eight (AZ, KS, ME, MS, NC, OH, UT and WI) have waiver proposals pending. Alabama and South Dakota have released – but not yet submitted to CMS – waiver proposals that include work requirements as well. Some 30 state legislatures debated work requirement bills this year, with legislation passing in four states (MI, TN, UT and VA). To date, only Arkansas has begun implementing its work requirements. A legal challenge struck down Kentucky's work requirements, though the litigation has not slowed other states from pursing similar work requirements.

Expansion

After little successful legislative activity in 2017, 2018 was a big year for Medicaid expansion. Most notably, in June, Virginia became the 33rd state to adopt Medicaid expansion under the Affordable Care Act. Also, last November, Maine became the first state to expand Medicaid through a voter referendum. Voters in Maine overwhelmingly approved the measure with nearly 60 percent of the vote, though, to date, Maine's Governor refused to implement the program. Following Maine's example, three other states (ID, NE and UT) are pursuing Medicaid expansion via ballot initiative in 2018. In addition, Montana is seeking to reauthorize and fund its existing Medicaid expansion program by ballot. Legislatures in Arkansas and New Hampshire also reauthorized Medicaid expansion this year.

Medicaid buy-ins

A handful of states are considering allowing non-Medicaid beneficiaries to buy into the program as a public option alternative to Marketplace and other coverage options. State goals and approaches to this option vary widely. Massachusetts and New Mexico have authorized studies on whether and how buy-in proposals might lower costs and expand coverage options. Similar study bills were debated in Colorado and Connecticut. In addition, a work group has been formed in Nevada to explore additional options after the Governor vetoed legislation that would have established a public option in 2017.

For more information on this Advocacy Resource Center campaign, please visit ama-assn.org/advocacy-resource-center or contact Annalia Michelman, JD, Senior Legislative Attorney, at annalia.michelman@ama-assn.org or (312) 464-4788.

Medical liability reform

Overview

The AMA and our state and specialty society partners continue to advance medical liability reform (MLR) at the state level. State legislatures in 2018 considered bills that promoted a variety of reforms, including expert witness guidelines, affidavit of merit requirements, collateral source reform and bills that established structures such as pretrial screening panels or health court systems. A handful of states also considered and defeated attempts to raise caps on non-economic damages.

2018 Significant activity

Legislative activity this year includes the successful defeat of legislation to eliminate or raise caps on non-economic damages in Florida, Kansas, Louisiana, Maryland, and Washington. The AMA was pleased to submit testimony in opposition to several of these pieces of legislation. In proactive legislative efforts, Maine and Washington enacted the Uniform Emergency Volunteer Health Practitioners Act, with Maine overriding the governor's veto to do so.

For more information on medical liability reform or to pursue any of the liability reforms discussed above, please visit ama-assn.org/go/liability or contact Kristin Schleiter, JD, Senior Legislative Attorney, at kristin.schleiter@ama-assn.org or (312) 464-4783.

Reversing the nation's opioid epidemic

Overview

Similar to previous state legislative sessions, there were more than 2,000 individual pieces of legislation concerning prescription drug misuse, overdose and death in 2017-2018. As in previous years, the increasing death toll and media focus on opioid-related mortality has caused legislators and other policymakers to demand solutions. The most common solutions proposed continue to be new—or more restrictive—mandates for physicians to use prescription drug monitoring programs (PDMPs), restrictions on opioid prescribing, mandates for continuing medical education and increased access to naloxone through standing orders and Good Samaritan protections. Considerably less focus has been paid to policies to expand access to multidisciplinary pain care, including non-opioid alternatives or policies to increase access to medication assisted treatment.

2018 Significant activity

State medical associations also continue to play a constructive role in shaping state legislation. Currently, nearly 40 states have some type of PDMP mandate; at least 30 have an opioid prescribing restriction; and more than 20 have a continuing medical education (CME) mandate. Notably, every state now provides for increased access to naloxone, with most allowing for a standing order prescription.

Earlier this year, the AMA Opioid Task Force released a report quantifying what physicians have done with respect to several different policies. In short:

- Opioid prescriptions declined 22.2 percent between 2013 and 2017;
- PDMP use increased 389 percent between 2014 and 2017 to more than 300 million queries in 2017;
- More than 549,000 physicians took CME on opioid prescribing and related areas in 2017 (view state- and specialty-specific resources at end-opioid-epidemic.org);
- Naloxone prescriptions more than doubled in 2017, from approximately 3,500 to 8,000 naloxone prescriptions dispensed per week; and
- More than 15,000 physicians became certified to provide in-office buprenorphine to treat substance use disorders in the past year.

While these are positive signs, it is clear that there is much more work to do. The nation's opioid-related death toll continues to rise, and it is increasingly being fueled by heroin and illicit fentanyl. To address this, the AMA Advocacy Resource Center continues to work with dozens of state and national medical specialty societies on this issue in both the state legislative and regulatory arenas. In addition, the Advocacy Resource

Center presented national updates and analysis to numerous state and specialty society executive committees, task forces and conference panels.

New partners in support of increasing access to comprehensive treatment—both for pain and for substance use disorders—are being sought in the National Association of Attorneys General, American Association of State and Territorial Health Officials, National City and County Health Officials, Partnership for Drug-Free Kids and other key stakeholders. A new model bill to support partial fills of opioid prescriptions is available for state use and the AMA Opioid Task Force launched a new microsite (end-opioid-epidemic.org) to further support state and specialty society efforts to educate their members.

The Advocacy Resource Center also has a new model bill—"The Ensuring Access to High Quality Care for the Treatment of Substance Use Disorders Act"—that we believe can make an immediate impact in removing barriers to Medication Assisted Treatment as well as providing regulators with needed information to evaluate and enforce state mental health and substance use disorder parity laws.

AMA support, including background, analysis and technical support, has been a part of the effort to enact new laws, amend negative provisions (and defeat others) relating to prescription drug monitoring programs, continuing medical education, treatment and naloxone/Good Samaritan protections in at least 25 states (AZ, AL, CA, CO, DE, FL, GA, IA, IL, IN, MA, ME, MD, MS, NJ, NV, OH, OK, OR, PA, RI, SD and TN, TX and UT).

One key question that the AMA continues to ask focuses on the outcomes and evaluation of the plethora of new laws being enacted. The AMA is urging many groups to undertake this important work, including the stakeholders noted above as well as the National Governors Association, the National Safety Council, the Federation of State Medical Boards, National Association of Boards of Pharmacy, National Association of State Controlled Substance Authorities, National Alliance for Model State Drug Laws, National Association of Counties, National League of Cities, the Partnership for Drug Free Kids, National Academy of Medicine and others.

For more information about the Task Force and any other areas mentioned above, please contact Daniel Blaney-Koen, JD, Senior Legislative Attorney, at daniel.blaney-koen@ama-assn.org or (312) 464-4954.

Private payer reform

Overview

The way in which patients and physicians experience the private health care system can be frustrating to say the least. The Advocacy Resource Center continues to work with state and national medical specialty societies to enact state legislation that helps support physicians and patients in all aspects of their relationships with health insurers and other third party payers. Several states had success this year enacting important reforms. Others continued the fundamental process of laying the groundwork and educating lawmakers about the importance of simplifying, streamlining and increasing the transparency of physician-payer interactions for the benefit of all stakeholders.

In addition to supporting state legislative efforts, the AMA also continued its work with the National Association of Insurance Commissioners, National Conference of Insurance Legislators (NCOIL) and other national groups to promote changes to the way commercial health insurers interact with patients and their physicians.

2018 Significant activity

Balance billing

State and specialty societies continue to work through legislative proposals addressing anticipated out-of-network bills or "surprise" bills. Twenty-one states had proposals on the table this year.

While most bills were problematic in that they would have banned balance billing while establishing an insufficient minimum payment standard to out-of-network physicians, there were several states where progress seems to be happening. Some medical societies attempted to address the issue proactively, including Georgia and Kentucky, with legislation that would use charge data as the minimum payment standard in exchange for a ban on balance billing–a proposal that would protect patients and incent fair contracting between payers and physicians. Ultimately, none of these proposals passed.

Complex balance billing reforms did pass in four states (ME MO, NH and NJ). Very broadly:

- Maine's new law uses average in-network rates as a payment standard in exchange for a ban for unanticipated out-of-network care (excluding emergency care);
- New Hampshire prohibits balance billing for pathology, anesthesiology, radiology and emergency services, setting the minimum payment at "a commercially reasonable value;"
- Missouri now bans balance billing for emergency care and requires a "reasonable reimbursement" while allowing for an arbitration process when the physician declines the payer's offer; and
- New Jersey prevents balance billing by out-of-network providers and establishes "baseball" arbitration to resolve payment disputes. The new law also allows self-funded ERISA plans to "opt-in," meaning employers can essentially choose to protect their employees from balance bills by opening themselves up to arbitration when a payment is disputed by a physician. If an employer, does not opt-in, then the patient is offered an arbitration process.

MA and PA continue to debate balance billing language in their legislatures.

Prior authorization and step therapy

There continues to be every indication that utilization review requirements are increasing and expanding. Physician are troubled and frustrated by the overstepping of insurers into the clinical decision making process and with the time, money and energy spent on ensuring their patients can access covered drugs and services. The AMA released a survey earlier this year looking at prior authorization, and of the practicing physicians surveyed:

- 64% report waiting at least one business day for PA decision;
- 92% report that PA delays access to necessary care;
- 78% report that PA can at least sometimes lead to treatment abandonment; and
- 92% report that PA can have a negative impact on patient clinical outcomes.

Seventeen states attempted (or are still attempting) to legislatively address the prior authorization process this year (including AZ, DE, FL, IL, IN, LA, KY, MD, ME, MN, NJ, NY, PA, UT, VT, WA and WV). Of those states, Indiana, Maine and West Virginia were all able to pass legislation aimed at improving access to care, reducing the burden, and/or streamlining the process. Unfortunately, the bills in Maine and West Virginia were both vetoed for different reasons.

Step-therapy legislation was also a priority for many states this year, and the enactment of several bills shows the power behind coalition work at the state level. Thirteen states (FL, HI, GA, IA, KS, MA, ME, MN, NM, NJ, OH, RI and VA) all had legislation this year, and bills passed in New Mexico and Minnesota this year. Very generally, most bills introduced are based on a coalition-backed model that would require an exception processes for patients who are stable on their current medication, have tried and failed the indicated medication before or for whom the medication would be contraindicated.

Pharmacy benefit managers

This year, Arkansas was able to pass legislation aimed at regulating pharmacy benefit managers (PBMs). Among other provisions, this legislation would place PBMs in the jurisdiction of the insurance commissioner, allowing the commissioner to promulgate rules relating to PBM practices such as rebates, market conduct, solvency, data reporting, compensation, utilization review, and networks. The new law also prevents gag clauses in pharmacists' contracts and prohibits mail-order pharmacies from being included to create adequate networks.

NCOIL is working the Arkansas law through its committees in order to make it a model bill. The AMA has supported this effort while urging NCOIL legislators to add provisions into the draft model on harmful utilization management protocols employed by PBMs, as well as conflicts of interest associated with P&T Committee members.

Efforts to address retroactive denials of emergency care

In many states this year, insurers have been busy implementing and defending policies that prevent access to covered care. For example, in six states (GA, OH, MO, IN, NH and KY) Anthem established policies that would retroactively deny coverage for care received in an emergency room if it determined by the payer to be non-emergent, based on the diagnosis. Other payers (e.g. UnitedHealthcare, BCBSTX) are starting to implement similar policies. In close collaboration with ACEP, state medical societies have taking different approaches to addressing this emergency care policy. Missouri lawmakers enacted legislation this year that would require that medical records be reviewed (by a licensed physician of the same specialty) before any denials, while New Hampshire recently established a prudent layperson requirement in state law. Meanwhile, several states are working with regulators to address the policy and its impact on patients. And, just this month, MAG and ACEP filed a lawsuit in Georgia against Anthem, alleging violation of the prudent layperson standard. With all the advocacy, media attention, and even inquiries from U.S. Senators, Anthem made minor changes to the policy earlier this year that may have relieved some of the impact, but the insurer seem to be committed to the broader policy in the states were is has been implemented.

For more information on the Advocacy Resource Center's private payer reform campaign, please visit ama-assn.org/go/arc or contact Emily Carroll, JD, Senior Legislative Attorney, at emily.carroll@ama-assn.org or (312) 464-4967.

Public health

Overview

As with most years, 2018 was an active year for public health with states taking up a wide range of bills to legislate the public health, public safety and the patient-physician relationship.

2018 Significant activity

Women's health

Iowa enacted a measure to prohibit abortion once a fetal heartbeat can be detected – often around six weeks of a pregnancy. The new law permits an abortion to be provided only when a woman's life is endangered or she is at risk of serious, irreversible physical impairment. Iowa's law was immediately challenged in court and a temporary injunction was granted halting the law. Louisiana and Mississippi also adopted new time limits, banning abortions after 15 weeks. Five states (AZ, ID, IN, MS and TN) also passed laws expanding burdensome and intrusive reporting requirements related to abortion procedures.

Several states are also taking proactive measures to address maternal mortality rates (CT, DC, IN, KS, KY, LA, MD, NY, OR, PA and WV) such as by establishing maternal mortality review committees to review maternal deaths and develop recommendations to address disparities.

Firearms

Five states (KS, LA, MD, OR and VT) enacted laws restricting access to firearms for individuals who have been convicted of domestic violence or subject to a domestic violence restraining order. Four states (FL, IL, MD and VT) also passed laws establishing gun violence restraining orders, which allow family members, intimate partners, household members and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence. Six states (CT, FL, MD, NJ, VT and WA) also banned bump stocks and Vermont strengthened its background check requirements.

Tobacco

This year, Maine and Oregon raised the age to purchase tobacco products to 21, joining California, Hawaii and New Jersey, which had passed such laws in prior years.

Public safety

Four states (CO, IN, MD and OK) passed legislation allowing schoolchildren to possess and use sunscreen without a prescription in schools and camps. Georgia passed comprehensive legislation toughening its distracted driving laws.

LGBTQ patients

Five states (DE, HI, MD, NH and WA) passed laws prohibiting so-called conversion therapy, bringing the total number of states that prohibit the harmful practice to 15 (CA, CT, DC, DE, HI, IL, MD, NV, NH, NJ, NM, OR, RI, VT and WA).

For more information on this Advocacy Resource Center campaign, please visit ama-assn.org/go/arc or contact Annalia Michelman, JD, Senior Legislative Attorney, at annalia.michelman@ama-assn.org or (312) 464-4788.

Scope of practice

Overview

State legislatures in 2018 considered over 1,000 bills seeking to eliminate team-based care models of health care delivery and/or expand the scope of practice of non-physician health care professionals. These included the usual range of scope bills — optometrists seeking surgical authority; naturopaths seeking prescriptive authority; psychologists and pharmacists seeking prescriptive authority; and so on. With tough fights in all cases, most bills that threatened passage were defeated, often with the support of the Advocacy Resource Center and – as is often the case with scope bills – a coordinated state and specialty effort.

Very few, if any, major scope of practice bills passed this year. Rather, most scope of practice bills were defeated. No state adopted legislation granting optometrists injectable or surgical authority (though bills remain pending in IL, MA and PA). No psychologist prescribing bills passed (though attention should be kept on Iowa as the medical and psychology board continue to draft regulations implementing legislation adopted in 2016). No state passed "assistant physician" legislation that would create a new license category to allow medical school graduates that have not undertaken a residency to practice and prescribe under physician supervision.

So, what did pass? Maryland modified comprehensive 2015 legislation to license certified professional midwives to clarify the circumstances under which a midwife must consult with a health care practitioner, as well as the circumstances in which a midwife is prohibited from assuming or continuing to take responsibility for a patient's pregnancy. A few states slightly tweaked laws related to naturopaths (CO and NH) and New Hampshire now allows pharmacists to prescribe hormonal contraceptives subject to a standing order. Idaho expanded the practice of physical therapist to include dry needling, and Utah now allows physical therapists to order plain radiographs and MRIs in coordinating with a physician (a topic certain to come up in more states). Wisconsin now allows physician assistants to practice under the supervision of a podiatrist, and South Carolina clarified that podiatrists who enjoy privileges in ambulatory surgery centers must have graduated from a three-year residency program. Legislation relating to advanced practice nurses and physician assistants are described below.

2018 Significant activity

Advanced practice registered nurses

This year over 200 bills were filed to expand the scope of practice of advance practice registered nurses (APRNs). Many of these bills chip around the edges of state laws, notably laws regarding certification of a disability or cause of death, authorization of involuntary commitment, and so on. Fighting these types of bills–which often simply add "and nurse practitioners" throughout state laws–continue to be a challenge. Still other bills seek APRN practice independent of physician supervision, collaboration or oversight. State medical associations continue to feel pressure from legislators to compromise with APRNs on independent practice. 2019 may thus bring compromises from several states, potentially turning on a "transition to independence," allowing independent practice after a defined number of hours or years of clinical practice.

Medicine has been largely successful so far this year in preventing APRN independent practice laws from passing. Bills were defeated or significantly amended in six states (GA, LA, MS, NY, OK and VT), for example. A notable victory in New York led to withdrawal of a provision in the governor's budget that would have authorized nurse anesthetists to practice independently.

Only South Carolina and Virginia saw movement on APRN practice laws. In South Carolina, legislation impacting three types of APRN (CNM, CNS and NP) replaced a requirement for a supervision agreement with a physician with a requirement for a practice agreement with physicians or medical staff that can stipulate that the relationship with the physician or medical staff be collaborative or supervisory. The legislation also removed mileage restrictions, modified ratio requirements for MDs to NPs to 1:6 at any given time, expanded APRN signature authority, and authorized APRNs to practice and prescribe via telemedicine.

Legislation adopted in Virginia eliminated the requirement for a practice agreement with a patient care team for a nurse practitioner who has completed the equivalent of at least five years of full-time clinical experience and submitted an attestation to the Board of Medicine and Board of Nursing from the patient care team physician stating (i) that the patient care team physician has served with the nurse practitioner pursuant to a practice agreement; (ii) what while party to such a practice agreement, the physician routinely practiced in a patient population and practice area included within the category for which the nurse practitioner was licensed and certified; and (iii) the period of time for which the physician practiced with the nurse practitioner under such a practice agreement. The requirement that an APRN complete five years of full-time clinical practice on a physician-led team before gaining the authority to practice independently is the most substantial of any state "transition to practice" requirement.

The Advocacy Resource Center continues to work with state and specialty medical societies to address APRN issues and physician-led, team-based care.

APRN Multistate Licensure Compact

The National Conference of State Boards of Nursing (NCSBN) recently launched a revised APRN Multistate Licensure Compact (APRN Compact). The ARC has worked with medical associations in every state that has seen or expects to see APRN Compact legislation introduced, submitting extensive testimony in Nebraska highlighting the true impact of the APRN Compact on scope of practice. In 2018, this engagement led to the defeat of every APRN Compact bill–even in states where some APRNs already have the authority to practice independently.

In May, the AMA sent a letter joined by over 80 medical associations to NCSBN, urging removal of the problematic language from the APRN Compact. Unless and until they do so, the Advocacy Resource Center will continue to support state medical association advocacy against APRN Compact legislation and educate policymakers about the true impact of the APRN Compact.

Physician assistants

The American Academy of PAs (AAPA) continued developing its new policy in support of independent practice in 2018, releasing model legislation and regulation that eliminates provisions in laws or regulations that require a physician assistant to have a supervisory or collaborative relationship with a physician in order to practice. The legislative and regulatory measures would also:

- Remove 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;"
- Support the establishment of independent Physician Assistant regulatory boards to license, regulate and discipline Physician Assistants;
- Support Physician Assistants being able to directly bill insurers and be reimbursed for care at physician rates;
- Prohibit insurers from imposing practice, education, or collaboration requirements that are more restrictive than state law; and

- Continue the movement towards changing the title of "physician assistants" to just "PA".

No state has seen legislation attempting to implement AAPA's new model legislation or regulation, called "optimal team practice." Nonetheless, medical associations should be prepared for "optimal team practice" proposals in future legislative sessions.

In 2018, only one state (TN) considered a "doctor of medical science" bill, which would establish a new category of licensure for physician assistants with additional training. The bill was ultimately withdrawn.

For more information on these and other scope of practice legislative activity, including the Scope of Practice Partnership, please visit ama-assn.org/about/scope-practice or contact Kristin Schleiter, JD, Senior Legislative Attorney, at kristin.schleiter@ama-assn.org or (312) 464-4783.

Telemedicine

Overview

Following release of AMA model telemedicine legislation in 2014, states saw a flurry of activity in the area, with dozens of laws and regulations proposed to address telemedicine licensure, reimbursement, and practice standards. While most attention was given to debates over how to establish a patient-physician relationship via telemedicine–in person, face-to-face or over the phone–states continue to make gains in passage of coverage parity laws, ensuring that physicians will be compensated for treating their patients via telemedicine. Many of these laws were based on the Advocacy Resource Center's model legislation, "The Telemedicine Act," which addresses these and other issues related to telemedicine.

In the 2018 legislative session, 44 states introduced over 160 telehealth-related pieces of legislation. Many bills address different aspects of reimbursement regarding both private payers and Medicaid, with some bills making changes to existing reimbursement laws. Many states also proposed legislation directing licensure boards to establish standards for the practice of telehealth within their given profession. The AMA was pleased to see that many of these bills were either based on the AMA Telemedicine Act, or were amended to incorporate language from the model bill.

2018 Significant activity

This year, several states took steps to increase access to telemedicine, including DC, Kentucky, Missouri and Utah, which expanded Medicaid coverage of telemedicine, and Iowa, Kansas, Kentucky and Washington, which expanded private payer coverage of telehealth. Still other states established committees to study telemedicine reimbursement and report back to their respective legislature. Specifically, New Hampshire established a study committee to report back on reimbursement for telemedicine, and Washington established a collaborative to study the concept of telemedicine payment parity and develop recommendations on reimbursement issues, including whether to reimburse for store and forward technology at the same rate as in-person care for certain conditions.

In addition, three states (Kansas, Nebraska and Oklahoma) adopted comprehensive legislation that, among other things, confirmed that a patient-physician relationship can be formed via telemedicine and that a physician must hold a license to practice medicine in the state to treat the patients of that state. Finally, Connecticut expanded the authority for telemedicine providers to prescribe controlled substances.

Interstate Medical Licensure Compact

The newly released Interstate Medical Licensure Compact (the Compact) made tremendous gains in 2018, with Maryland, Vermont, the District of Columbia and Guam passing legislation to join the Compact. This brings the total number of states in the Compact to 24 (AL, AZ, CO, ID, IA, IL, KS, MD, ME, MN, MS, MT, NE, NV, NH, PA, SD, TN, UT, VT, WA, WI, WV and WY), plus DC and Guam.

The Compact was officially launched in 2017 and started accepting applications for licensure at imlcc.org. Currently, 20 of Compact member states can serve as the primary state of licensure and source of verification. The remaining states are setting the groundwork for the ability to conduct background checks. Legislation to enable or reaffirm this authority is moving quickly.

The Advocacy Resource Center will be working to ensure that the Compact continues to gain steam in 2019, as the Compact's promise of license portability will best be realized if every state and territory are members. For more information on telemedicine and the Compact, please visit ama-assn.org/practice-management/improving-digital-health or contact Kristin Schleiter, JD, Senior Legislative Attorney, at kristin.schleiter@ama-assn.org or (312) 464-4783.