Talking Points re S.37

David Herlihy to Senate Health & Welfare, scheduled for February 8, 2023

These comments are focused not on the concept of the bill, but rather how it is executed. Also, they are limited to Sections 1, 7, 10, and 14, as the other sections do not raise matters within the Board's regulatory authority.

Section 1 – Definitions

There are two points of concern with wording in the definitions. Both pertain to the definition of "legally protected health care activity."

The first is in the proposed 1 V.S.A. § 150(b)(1)(B). This 108-word clause, part of a longer sentence, would appear to say that "legally protected health care activity" includes a physician licensed and present in Vermont reaching out via telemedicine to another state were a patient is located.

The second is with the wording in the proposed 1 V.S.A. § 150 (b)(2), which provides that legally protected HCA "does not include any service rendered below an applicable professional standard of care or that would violate antidiscrimination laws of this State." That sentence should also include the phrase ", or rendered without appropriate licensure," inserted after "care" and before "or" on line 18 of page 3.

There are two problems that arise with the way that the proposed 1 V.S.A. § 150 addresses licensure.

First, the need to be licensed in a state to provide health care for individuals who are present in that state is universally recognized in the United States. All states, including Vermont, have the right to require licensure in order to practice in the state regardless of whether the health care professional is physically present in the state or practicing via telehealth. It is a matter of state sovereignty and comity. Vermont would be very upset if another state declared that their medical professionals could practice in Vermont via telehealth without holding a license in the state where the patient is located and declaring that the state would not sanction their providers for unlicensed practice in other states. That seems to be what S.37 does. The concept that a health care professional must be licensed in the state where the patient is located is very important because it allows Vermont to protect people within the state from inadequate and inappropriate care by unlicensed physicians reaching across our borders. In one case the Board dealt with there was a physician in another state who was illegally issuing prescriptions to individuals in Vermont. We were fortunate to have the cooperation of the other state in addressing that physician's illegal conduct to quickly and efficiently prosecute the offender. If that state had not addressed the activity, Vermont still would have needed the cooperation of the other state to extradite the offender. Declaring in Vermont law that unlicensed practice in other states by Vermont physicians is acceptable and will not be subject to action here, even for a limited subset of practice activities, would undermine the system of mutual respect among states for their sovereign rights.

The second issue is that absent language in 1 V.S.A. § 150(b)(2) addressing licensure there would be situations in which the Board might be prevented from exercising its disciplinary authority in situations that present clear unprofessional conduct and that are unrelated to the concerns prompting S.37. For

instance, if a Vermont licensee provided an abortion in another state where they do not hold a license (and where abortion is legal), and that other state prosecuted the unlicensed practice, the Board would be prohibited from addressing that unprofessional conduct. Criminal convictions constitute unprofessional conduct by a licensee, regardless of whether the conviction occurs in Vermont. A criminal conviction for unlicensed practice of medicine in another jurisdiction is clearly unprofessional conduct.

Section 7 – Unprofessional conduct

Section 7 would limit the Board's ability to address unprofessional conduct of licensees and applicants by adding a new subsection (d) to 26 V.S.A. § 1354, which pertains to unprofessional conduct. The new (d)(1) proposes to bar "disciplinary action by the Board solely for providing or assisting in the provision of legally protected health care activity." That is fine. A key word of that sentence is solely.

In contrast, the new (d)(2) uses the words "that arises from" rather than "solely for" in limiting the ability of the Board to consider out of-state actions when acting on applications. It reads: "The Board shall not take adverse action on an application for certification, registration, or licensure of a qualified health care provider based on a criminal or civil action or disciplinary action by a licensing board of another state that arises from the provision of or assistance in legally protected health care activity." That change would create the possibility that the Board could not consider unprofessional conduct that would be entirely unrelated to the policies underlying the bill. For instance, if a physician in another state engaged in systematic billing fraud for a large number of abortions, was prosecuted and convicted of crimes, and had their license suspended based on the conviction and the unprofessional conduct associated with fraudulent billing, as written the Board would not be able to consider that history and would have to issue a license.

For that reason, it is recommended that the wording of (d)(2) be changed to be consistent with (d)(1) by using "based solely on" instead of "that arises from."

Section 10 – BMP and OPR report on Interstate Compacts

The issues related to how disciplinary actions in different states are treated under interstate compacts that facilitate licensure in additional states are complex. It will take time to see how the issues come up and whether states pursue, or decline to pursue, legal actions regarding the way in which Vermont or other states treat out-of-state discipline. For those reasons the Board appreciates and supports the approach taken in Section 10.

Section 14 – Disclosure of Protected Health Information

Section 14 would create new standards with regard to limitations on use of protected health information relating to legally protected health care activities by amending 18 V.S.A. § 1881. In essence, it would bar the disclosure of such information absent explicit written consent, except for very limited circumstances. One circumstance allows for a covered entity to share records of a patient for

investigation of a complaint if the records are related to the complaint, as seen in the proposed 18 V.S.A. § 1881(d)(3). The Board appreciates the effort to maintain the Board's access to records to allow the Board to carry out its duty to protect patients. However, this exception is written too narrowly. It only applies to cases in which there is a complaint. Many cases arise from sources other than complaints, such as from malpractice information, reports of employer discipline, anonymous tips, or tips from other regulators or law enforcement agencies. In some cases patients actively oppose efforts to investigate and discipline unprofessional conduct by their physicians. The ability to address unprofessional conduct should not be contingent on the willingness of a patient to give consent to the release of protected health information to the Board. Also, it should be clear that the Board may use information as necessary in an administrative proceeding. The Board should be able to subpoena and obtain records so long as there is an investigation and the records are relevant to that investigation.