Consensus Statement for Telehealth Licensure Reforms

We, the undersigned physicians, patients, health systems, academics, and advocates, urge prompt reform of physician licensure so that patients can obtain the telehealth services they require from the physicians they choose, regardless of which state they live in. Our proposed reforms will facilitate the continuity of care that all patients deserve.

Patients and Families Are Harmed by Restrictive State-Based Licensure

The current physician licensure system often stands in the way of patients getting the care they need (see text box). Emmett's frequent travel is a familiar experience for many cancer, pediatric, rare disease, and other specialty care patients across the country. Our state-based licensure system often necessitates burdensome and costly travel, even when telehealth could offer equally effective care. In some specialties such as pediatric oncology, only a handful of specialists in the country have the necessary expertise for a particular condition.[1] Treatments have also become increasingly complex, which limits the number of facilities that can provide state-of-the-art care. A single specialty medical center treats patients who live across the United States.

Emmett was diagnosed with a rare brain tumor when he was seventeen months old. His local oncologist had never treated this disease, so his parents sought care from experts at Massachusetts General Hospital and Boston Children's Hospital. This meant that for eight years, Emmett and his parents had to frequently travel from Albuquerque to Boston to receive medical care. Many consultations and conversations could have more easily been held over videoconferencing, but in our current system his physicians would have to be licensed in New Mexico to provide this follow-up care. This travel was a significant financial burden on Emmett's parents, required his siblings to travel with the family or be left behind in the care of others,

Moreover, treating patients with complex conditions requires regular and ongoing communication. Much of the care patients need occurs outside of examination rooms, such as addressing side effects, discussing new laboratory tests and scans, and managing dietary and physical treatment regimens. Effective care often requires phone calls, portal messages, email, and video visits with members of a patient's care team. Unfortunately, if a physician or other care team member is not licensed in the state where their patient is located, they cannot receive this follow-up care.

Patients have become victims of their geography. Two patients with the same disease equidistant from the same physician may have different access to care just because one lives across a state border.

Licensing Barriers to Providing Specialty Care Services

Historically, licensure laws have required physicians to be licensed in the state where the patient is physically located when providing medical care. Before the advent of telehealth, this regulatory requirement was uncontroversial because almost all care was delivered when the patient came to the physician's office, hospital or other facility. Telehealth creates the opportunity for patients to obtain care from a broader array of physicians and at a new collection of convenient locations, but the state-based physician licensure system has limited patients' abilities to take advantage of this opportunity.

Early in the pandemic, almost all states implemented temporary changes to allow patients located within their boundaries to receive care from physicians licensed in another state.[3] These changes fueled a surge in telehealth use. In April 2020, about 40% of all ambulatory visits occurred through telehealth and about 5% of all telehealth visits occurred between a patient and a physician located in different states.[4] Out-of-state telehealth was a critical component of care at academic medical centers and, in particular, children's hospitals and cancer centers.[5,6] This experience with out-of-state telehealth during the COVID-19 pandemic demonstrated that both patients and providers have a strong preference and rising comfort for telemedicine options .[2]

The end of both federal and state public health emergencies and the expiration of temporary licensure waivers, however, brought real frustration to physicians and patients and prevented many patients from getting the care they need.

Guiding Principles for Reforms of State Licensure

We believe that reforms must incorporate the following principles to be successful:

(1) Augmenting Patient Access to Care

The primary motivation for reforming our state-based physician licensure system is to facilitate patients' access to the care and providers they need. There are many reasons that patients may require or prefer care from out-of-state physicians; such needs may be particularly acute for patients who have medically complex conditions, such as rare disease, cancer and pediatric patients. Patients, and especially those with limited resources, should not be shut out of cutting-edge care or face challenges in maintaining continuity of care because of geography or ability to finance frequent trips to another state.

Improving access also helps local physicians and smaller hospitals. Specialty hospitals can connect with patients in rural communities to provide advice on whether a patient should travel to specialty centers for further input. A large West Coast academic medical center noted that in 80% of its telehealth consultations, patients are told that they are best served by continuing with their local physician's treatment. Improving the licensure system will help enable local physicians and hospitals to obtain the specialty care their patients need from specialists in other states.

(2) Clarity and Uniformity

The current licensure regime's ambiguity is problematic. The definitions and parameters of what constitutes "providing medicine" vary, and each state imposes its own rules. For example, Virginia

defines an established relationship as one in which the physician has seen the patient within the last year, whereas the Centers for Medicare and Medicaid Services defines it as the physician having seen the patient within the last three years. Nonetheless, physicians are expected to comply with the laws of each state. Reforms to the state licensure regime should prioritize uniformity, clarity, and harmonization across states whenever possible. Advancing uniformity – in both the substance of state licensure rules and the procedures in obtaining licenses – would reduce compliance challenges and encourage specialty physicians to provide cutting-edge services and treatments to Americans across the country.

(3) Administrative Burden and Cost

Modern medicine has saddled physicians with cumbersome administrative burdens; state licensure regimes should not amplify this problem. Streamlining processes for application, registration, renewal, and maintenance of state licensure will help reduce burdens. For example, while continuing medical education is important, varying requirements across states make it difficult for a physician to be licensed in more than a handful of states.

Licensure costs are also a key consideration. While the licensing fee for a physician for a single state is not a barrier, the costs add up especially quickly for physicians treating patients from across the country; it is estimated that a physician seeking to be licensed in all fifty states would spend $90,000 on fees.[7] For the average hospital system in the US, licensing their 1,536 physicians in twenty states using the Interstate Medical Licensure Compact (IMLC) would cost roughly $14 million upfront along with recurring renewal costs.

(4) Expedience

Physicians often do not have advance notice that they will be caring for a patient from another state. A person might be diagnosed with a rare condition and suddenly be in the office that week. The patient might return home in another state and require guidance the week after. Physicians want to be attentive to patients and initiate prompt follow-up communications, but waiting months for a state license is not practical. Patients also often need care while traveling for work or pleasure. To ensure access for patients who would benefit from care across state lines, state licensure regimes should ensure that physicians appropriately licensed in one state can provide care in a timely manner.

Pathways to Greater Access to Telehealth Specialty Care

We advocate two reforms that reflect the above principles and help patients access the specialty care they need.

(1) Standard Exceptions to State-Based Licensure Requirements

There is growing recognition of the benefits of authorizing out-of-state physicians to provide in-state care on a limited basis without having to obtain a license. Many states, the Federation of State Medical Boards,[8] the Uniform Law Commission,[9] and the American Medical Association[10] have all encouraged states to offer certain time-limited exceptions to licensure requirements.

We believe that, under the following situations, physicians should be able to provide interstate telehealth services under their primary state license, assuming they are in good standing, without being required to hold an additional license with state in which their patient is located:

- **<u>Follow-up Care for Established Patient Relationships</u>**: We propose an exception to provide care via telehealth to patients with whom physicians have an established physician-patient relationship. To promote national uniformity, we propose using CMS guidance to define an "established physician-patient relationship." But, in general, a physician-patient relationship would be established by meeting with a patient in-person in a state where the physician is licensed or meeting with a patient via telehealth when the patient is located in a state in which the physician is licensed. To reflect how modern medicine is provided, follow-up care through this exception could be provided by the physicians on the care team responsible for the patient's care. All care under this exception must be provided in compliance with state laws where the patient is located.
- **<u>Screening for Specialty Referrals</u>:** We propose an exception to licensure requirements to allow patients to be screened and assessed so that a recommendation can be made as to whether they should travel to a specialty care center. This exception would apply to any orders for necessary workup (e.g., laboratory testing, imaging) needed to support the screening or in preparation for a consultation but would not cover any treatment (e.g., prescribing of medications). Physicians who screen patients under this exception and then seek to deliver treatment must be appropriately licensed in the patient's location. Any screening and assessment under this exception must be provided in compliance with state laws where the patient is located.
- **<u>Care Incident to Existing Care Plan</u>:** We propose an exception to facilitate care guided by an existing care plan. Physicians often develop a care plan for a patient which is then implemented in partnership with a local primary or specialty care physician. For example, a local oncologist might administer the chemotherapy recommended by another oncologist in another state. Care provided under this exception must be done in collaboration with a local licensed physician or in a peer-to-peer consultation with a local licensed physician.
- **<u>Care in the Context of Clinical Trials</u>:** We propose an exception to licensure requirements for care and services provided in the context of clinical trials. Many conditions are rare, and in order to recruit enough subjects' trials may involve patients in many states. Clinical trial protocols may require care for trial participants. Under this exception, physicians licensed in another state in good standing could provide care and services to patients enrolled in a clinical trial.

These exceptions to licensure requirements will facilitate timely provision of the specialty care many patients need and establish conditions under which out-of-state physicians can better support local physicians and hospitals. To minimize compliance burdens, they should be made as uniform as possible through either federal legislation or state coordination.

(2) Create Another Interstate Compact Specific to Telehealth Registrations

We support the IMLC's goal of expediting licensure for qualified physicians. Unfortunately, in its current form, the IMLC does not follow the guiding principles outlined above; it has therefore had limited

uptake, with only 19,350 physicians (<2% of practicing physicians in the US) using the IMLC to obtain a license from 2017-2021.[11] A physician still must obtain an individual full license in a state to provide telehealth, and each license obtained subjects physicians to additional fees and training requirements. There also are substantial administrative burdens; for example, physicians must obtain fingerprints repeatedly. While the IMLC has accelerated the licensing process, the time required to obtain a license in another state via the IMLC may still be substantial.

Many states have created telehealth registrations (sometimes called telehealth-only licenses) that authorize an out-of-state physician to provide telehealth to individuals in the state. This type of registration was a key component of the Uniform Law Commission's recommendations for reform.[9] Again, we value this type of reform as it decreases the administrative burden of obtaining additional full medical licenses. However, telehealth registrations also have had limited impact because of the financial costs, inconsistency in requirements, and lack of timeliness. Just as is the case with full licenses, costs can rapidly accumulate if multiple telehealth registrations are required for each individual physician within an organization. Nuances in the application can increase the administrative burden. For example, Florida requires registered out-of-state physicians to "have a designated registered agent, who has an address in Florida." It also is unclear whether these registries allow physicians to obtain permission to provide telehealth within the timeframe that their patients require.

To improve upon the IMLC and the telehealth registration systems of individual states, we propose a second compact, the "Interstate Medical Telemedicine Registration Compact" (IMTRC). The goal would be to harmonize state requirements for telehealth registrations, ideally using the Uniform Law Commissions template, along with compliance requirements such as by establishing a standardized continuing medical education requirement. The IMTRC would have a single application and serve as a one-stop application portal that would allow a physician to pursue a telehealth registration in multiple states. Ideally the IMTRC would have a small, fixed fee to support general processing costs along with an additional fee per state that could go back to the states. The IMLTC should be designed with the goal of faster, almost immediate, application processing.

Summary

We believe that our proposed reforms, with their focus on uniformity, timeliness, and lower administrative burdens and costs, would facilitate physicians' efforts to serve patients wherever the patients are located and improve patient access to complex, specialized care that they need.

Signatories

1. Center for Health Law and Policy Innovation (CHLPI) at Harvard Law School
2. Petrie-Flom Center for Health Law Policy, Biotechnology, and Bioethics at Harvard Law School
3. St. Jude Children's Research Hospital
4. Alliance for Connected Care
5. Association of American Medical Colleges (AAMC)

6. NORD
7. Mass General Brigham
8. Talkiatry
9. Johns Hopkins University
10. Fawaz Al Ammary, Associate Professor of Clinical Medicine, University of California Irvine
11. Tara Sklar, Professor and Faculty Director Health Law & Policy Program, University of Arizona

Sign-On

Please use this link to sign-on to this Consensus Statement: https://forms.office.com/r/D9mJeyyEAG

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