REPORT 08 OF THE COUNCIL ON MEDICAL SERVICE (JUN-21)
Licensure and Telehealth
(Resolve 2, Items (b) and (d) of Alternate Resolution 203-Nov-2020)
Reference Committee A

EXECUTIVE SUMMARY

This report is the Council's second on licensure and telehealth in as many years and responds to elements (b) and (d) of the second Resolve of Alternate Resolution 203 that the House of Delegates referred during its November 2020 Special Meeting. Since the Council's previous report (Council Report 1-I-19, Established Patient Relationships and Telemedicine) was presented, the coverage and payment landscape for telehealth has changed considerably in response to the novel coronavirus (COVID-19) pandemic, enabling physicians to provide uninterrupted care to patients while adhering to social distancing. The surge in virtual visits across most practices and settings has been so significant that more than three-quarters of physicians reported using telehealth in 2020, up from one quarter in 2018. The Council anticipates that most physicians who increased their use of telehealth during the public health emergency will want to continue the practice after COVID-19 is under control, not as a replacement for in-person care but as part of a hybrid model in which physicians utilize both in-person and telehealth visits to support optimal care.

The Council acknowledges the breadth of existing American Medical Association (AMA) licensure and telehealth policy and the organization's long history of supporting solutions that make it easier for physicians to obtain licenses to practice medicine across state lines while protecting patients and preserving state oversight of the practice of medicine. The Council continues to support the Interstate Medical Licensure Compact as an important licensure solution and recommends reaffirmation of AMA policy supportive of the Compact and reduced application and licensure fees.

This report addresses a common frustration among physicians—that, outside of the temporary licensure flexibilities put in place during the public health emergency, they are prohibited by most states from using telehealth to provide longitudinal care to existing patients who may live across a state border, attend college in another state, or travel for work or seasonally. The Council believes that multiple pathways are available to states to facilitate interstate telehealth for continuity of care purposes, including exceptions to state licensing laws, reciprocity agreements, or possibly other solutions not yet proffered. Accordingly, the Council recommends that the AMA work with the Federation of State Medical Boards and other stakeholders to encourage states to allow an out-of-state physician to use telehealth to provide continuity of care to an existing patient if certain conditions are met.

The Council believes the recommendations in this report will increase physician and patient satisfaction with health care, reduce physician administrative burdens, help sustain physician practices as they continue to recover from the economic impacts of COVID-19, and address the needs of individuals with complex health conditions who lack access to specialty care locally and would benefit from virtual visits with out-of-state specialist physicians.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 08-JUN-21

Subject: Licensure and Telehealth
(Resolve 2, Items (b) and (d) of Alternate Resolution 203-Nov-2020)

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee A

At the November 2020 Special Meeting of the House of Delegates, four potential additions to the second Resolve of Alternate Resolution 203 were referred or referred for decision. The second Resolve of Alternate Resolution 203-I-20, which is now Policy D-480.963[2] asked:

> That our American Medical Association (AMA) advocate that the federal government, including the Centers for Medicare & Medicaid Services (CMS) and other agencies, state governments and state agencies, and the health insurance industry, adopt clear and uniform laws, rules, regulations, and policies relating to telehealth services that (1) provide equitable coverage that allows patients to access telehealth services wherever they are located; and (2) provide for the use of accessible devices and technologies, with appropriate privacy and security protections, for connecting physicians and patients.

The following additional elements were proposed for the second Resolve. Paragraphs a and b were referred. Paragraphs c and d were referred for decision.

> a) promote continuity of care by preventing payors from using cost-sharing or other policies to prevent or disincentivize patients from receiving care via telehealth from the physician of the patient's choice.
> b) ensure qualifications of physicians duly licensed in the state where the patient is located to provide such services in a secure environment.
> c) provide equitable payment for telehealth services that are comparable to in-person services.
> d) promote continuity of care by allowing physicians to provide telehealth services, regardless of current location, to established patients with whom the physician has had previous face-to-face professional contact.

The Board of Trustees asked the Council on Medical Service to address Paragraphs (a)-(d) in reports back to the House of Delegates at the 2021 June Special Meeting. This report is specifically responding to Paragraphs (b) and (d); Council on Medical Service Report 7, also being considered at this meeting, is addressing Paragraphs (a) and (c).

This report provides an overview of physician licensure and telehealth, describes exceptions to licensing laws authorized by states before and during the novel coronavirus (COVID-19) pandemic, summarizes relevant AMA policy, and makes policy recommendations. For the purposes of this report, the term "telehealth" refers to digital health solutions that connect patients and clinicians through real-time audio and video technology.

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BACKGROUND

In response to the spread of COVID-19, widespread stay-at-home orders, and federal and state policy changes instituted last spring, the use of telehealth by physicians and other health professionals expanded exponentially. Swift adoption of telehealth across most practices and settings enabled physicians to provide uninterrupted continuity of care while adhering to social distancing that protected patients and health professionals from exposure to the virus. The surge in telehealth is reflected in data from recent biennial AMA Physician Practice Benchmark Surveys, which are nationally representative samples of non-federal physicians who provide care to patients at least 20 hours per week. Benchmark Survey data show a substantial increase in the use of telehealth between 2018 and 2020, with 79 percent of physicians reporting use of telehealth in their practice in 2020, up from 25 percent in 2018.[1] Additionally, last summer more than 75 percent of respondents to the Telehealth Impact Physician Survey said that telehealth enabled them to provide quality care for COVID-19-related care, acute care, chronic disease management, hospital or emergency department follow-up, care coordination, preventive care, and mental or behavioral health.[2] Sixty percent of physicians reported that telehealth has improved the health of their patients, while 55 percent indicated that telehealth has improved their work satisfaction.[3] Payment (73 percent) and technology challenges for patients (64 percent) were cited by a majority of physicians as barriers to maintaining telehealth after the pandemic, while 18 percent of physicians cited licensure as a barrier.[4]

The Council anticipates that many physicians who increased their use of telehealth during the pandemic will want to continue the practice after COVID-19 is under control, not as a replacement for in-person care but as part of a hybrid model in which physicians utilize both in-person and telehealth visits to support optimal care. The AMA continues to study telehealth use to better understand the needs of patients and physicians as well as the overall impact of telehealth on care quality and patient outcomes. At the same time, the AMA engages in robust federal and state advocacy on telehealth, weighing in on a range of policy proposals including the temporary flexibilities put in place during the public health emergency as well as proposals that will shape the practice of telehealth post-pandemic.

Interstate licensure and telehealth were addressed in Council Report 1-I-19, Established Patient Relationships and Telemedicine, which highlighted concerns raised by physicians that the nation's state-based licensure system has impeded growth in telehealth use by medical homes and other physician practices, including those wishing to provide telehealth services to their regular patients when those patients travel to another state. In adopting the Council's 2019 report, the House of Delegates reaffirmed long-standing AMA policy maintaining that physicians delivering telemedicine services must be licensed in the state where the patient receives services (Policies H-480.946 and H-480.969). Additionally, by adopting the recommendations in the report, the House established Policy D-480.964, which directs the AMA to work with state medical associations to encourage states that are not part of the Interstate Medical Licensure Compact (IMLC) to consider joining; advocate for reduced application and state licensure(s) fees processed through the IMLC; and work with interested state medical associations to encourage states to pass legislation enhancing patient access to and proper regulation of telemedicine services.

Council Report 1-I-19 highlighted the rationale behind state oversight of the practice of medicine and the licensure of physicians to practice within a state's borders. State authority to protect the health, safety and general welfare of its citizens was granted in 1791 under the 10th Amendment of the US Constitution, with formal licensing of physicians through state medical boards dating back to the 1800s.[5] The primary goals of state medical boards are to protect patients, ensure quality health care, and foster the professional practice of medicine. In addition to issuing licenses, state

medical boards are authorized to investigate complaints and take disciplinary action against the licenses of those who violate state law. States also license a range of other health professionals, including physician assistants and nurses, and establish scope of practice parameters within the state to safeguard the practice of medicine.

The prevailing standard for medical licensure found in the medical practice acts of each state affirms that the practice of medicine is determined to occur where the patient is located. This standard enables states to ensure that health professionals adhere to that state's laws and regulations (e.g., licensing requirements and scope of practice parameters) and to protect the public from the unprofessional and improper practice of medicine. Because the standards and scope of telehealth services should be consistent with related in-person services (consistent with Policy H-480.946), most states similarly require physicians utilizing telehealth to be licensed in all jurisdictions where patients receive care. Licensure requirements established by state medical boards may vary but, according to the Federation of State Medical Boards (FSMB), 49 state boards—as well as the medical boards of the District of Columbia, Puerto Rico, and the Virgin Islands—require physicians practicing telehealth to be licensed in the state in which the patient is located.[6]

INTERSTATE LICENSURE

Recognizing the costs and burdens associated with obtaining physician licenses to practice medicine in multiple states, the AMA has long supported making it easier to obtain licenses to practice across state lines, and addressing the cost, time and administrative burdens while preserving the ability of states to oversee the care provided to patients within their borders. Advances in telehealth, and the potential to increase access to virtual care among people in rural and underserved communities, increasingly motivated stakeholders to seek solutions that would streamline licensure processes across state lines. Ultimately, these efforts culminated in the development of the IMLC.

Interstate Medical Licensure Compact

In 2017, the IMLC became operational establishing a new expedited pathway to licensure for qualifying physicians seeking to practice in multiple states. From the beginning, the AMA strongly supported the IMLC as a means of facilitating expedited licensure while ensuring that states retain the authority to regulate the practice of medicine and protect patient welfare. The IMLC adopts the prevailing standard that the practice of medicine occurs where the patient is located at the time of the physician-patient encounter. A physician practicing under a license facilitated by the IMLC is thus bound to comply with the statutes, rules, and regulations of each state wherein he/she chooses to practice medicine.

At the time this report was written, the IMLC was an agreement among the following 30 states, the District of Columbia and the Territory of Guam: Alabama, Arizona, Colorado, Georgia, Idaho, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Hampshire, North Dakota, Oklahoma, Pennsylvania, South Dakota, Tennessee, Utah, Vermont, Washington, West Virginia, Wisconsin, and Wyoming.[7] Compact authorizing legislation has been introduced in Missouri, New Jersey, New York, North Carolina, Ohio, Oregon, Rhode Island and Texas, with other states expected to introduce legislation during 2021 legislative sessions.[8]

Over 17,000 licenses have been issued by IMLC,[9] and the IMLC Commission estimates that 80 percent of physicians in Compact states meet the criteria for licensure.[10] However, physicians

practicing in several heavily populated states—e.g., California, Florida, Massachusetts, New York and Texas—are unable to apply for expedited licenses through the IMLC since those states have not passed authorizing legislation to join the Compact. Physicians practicing in Compact states are similarly unable to use the IMLC to obtain expedite licenses in these non-Compact states.

Costs associated with Compact licenses/renewals remain an additional barrier to increased licensing via the IMLC, since physicians who want to apply must pay an initial $700 fee plus cover the costs and renewal fees of the license(s) in Compact state(s) where the physician wants to practice.[11] Licensing fees in Compact states range from $75 in Alabama and Wisconsin to $790 in Maryland, with most states charging several hundred dollars. These costs may be beyond the budgets of many physician practices—particularly small practices—that continue to face COVID-19-related financial pressures. A nationwide physician survey conducted by the AMA in July-August 2020 found that practice revenue had dropped by a third, on average, and spending on personal protective equipment (PPE) had increased 57 percent.[12] Despite an increase in telehealth use, almost 70 percent of physicians were still providing fewer total visits (in-person plus telehealth) at the time of the survey than before the pandemic.[13]

Exceptions to State Licensing Laws Pre-COVID-19

Prior to the pandemic, physicians licensed by states that had not joined the IMLC or who wanted to practice in a non-Compact state were generally required to go through that state's traditional, often lengthy, licensure application process. Allowances for circumstances under which out-of-state physicians may practice in a state without being licensed vary by state and were predominantly limited pre-pandemic to physicians consulting with in-state physicians and physicians practicing in emergencies or responding to natural disasters. Although licensing requirements across states share many commonalities, each state has its own rules and exceptions to those rules. Colorado's Medical Practice Act [§ 12-240-107(3)(b)], for example, uniquely permits physicians licensed and lawfully practicing medicine in another state to provide "occasional services" in Colorado, provided they do not have a regular practice in Colorado and maintain malpractice insurance.[14]

Some states had licensure policies specific to interstate telehealth in place before the pandemic. According to FSMB, 12 state medical boards issue a special purpose license, telemedicine license or certificate, or license to practice medicine across state lines, while six state boards require physicians to register if they wish to practice across states.[15] Florida is an example of the latter. Despite opposition from the Florida Medical Association and other health providers, Florida enacted a law in 2019 allowing out-of-state health professionals to provide telehealth services in the state without a Florida license if they register with the state medical board.

The Uniform Emergency Volunteer Health Practitioners Act (UEVHP) allows properly registered out-of-state volunteer health professionals providing disaster relief in a state to provide services without having to seek a license in the state that has declared an emergency; however, participation is limited to the 18 states plus the District of Columbia that have enacted the Act.[16] Some states have enacted universal licensure recognition laws to allow people holding certain out-of-state occupational licenses to practice in that state, although these laws have generally been limited to emergencies and accommodations for military spouses.[17]

Physicians and other health professionals employed by the US Veterans Administration, the Indian Health Service and the US Department of Defense are generally permitted by these health systems to practice—including via telehealth—outside of the state where they are licensed. States also recognize the licenses of National Disaster Medical System physician team members. The Sports Medicine Licensure Clarity Act, passed by Congress in 2018, enabled sports medicine

professionals to provide medical care to athletes and team members while traveling with an athletic team in a state in which they are not licensed. Under this law, services provided by a sports medicine professional are deemed to have occurred in the professional's primary state of licensure. The law further extends medical professional liability insurance to cover the professional with respect to medical care provided while out of state with the team.[18]

Liability concerns are integral to licensure discussions because liability insurance policies vary in terms of coverage for care across state lines. Most insurers provide coverage for actions undertaken in any state, although the intent is to ensure coverage for one-off situations where a physician provides a limited amount of care outside the jurisdiction where they are licensed. Accordingly, it is important for physicians to speak to their insurers if they intend to treat patients in other states on a regular basis so the insurer can verify whether their coverage extends to those states.

Licensing Waivers in Response to COVID-19

COVID-19 led to a slew of federal and state temporary waivers of telehealth coverage and payment regulations intended to expand the scale and reach of telehealth, thereby meeting the increased demand for virtual medical care. Federal and state licensure requirements were also waived, enabling health care professionals to work across state lines and provide care in areas hardest hit by the pandemic without having to seek licenses in those states. After the President and US Department of Health and Human Services Secretary declared a public health emergency in March 2020, CMS used its 1135 waiver authority to temporarily waive requirements that out-of-state physicians and other health professionals be licensed in the state where they are providing services when they are licensed in another state. Licensing requirements were waived for physicians and other health professionals participating in the Medicare, Medicaid and Children's Health Insurance Program programs and meeting the following four conditions: 1) must be enrolled as such in the Medicare program; 2) must possess a valid license to practice in the state; 3) is furnishing services—whether in person or via telehealth—in a state in which the emergency is occurring in order to contribute to relief efforts in his or her professional capacity; and 4) is not affirmatively excluded from practice in the state or any other state that is part of the emergency area.[19]

CMS' actions did not waive state or local licensure requirements, which remain in effect unless also waived. Accordingly, for a physician or other health professional to avail him- or herself of the CMS waiver under the conditions described above, the state would also have to have modified its licensure requirements. Many states did so by implementing temporary changes that to varying degrees permit physicians licensed in other states to provide medical services during the public health emergency. Some states issued broad reciprocity waivers permitting physicians and other health professionals possessing an active license in good standing in another state to provide care without obtaining a license, temporary or otherwise, in that state. Other states required registration with or approval by the state medical board. Some waivers were more targeted, presumably based on a state's needs, and several states established emergency temporary licensure or certification processes that out-of-state providers must go through to seek permission to practice. A few states specified that telehealth could be used by out-of-state physicians to provide continuity of care to patients in that state, or by physicians in contiguous states that have existing patient relationships with state residents. At the time this report was written, a few states had already rescinded their temporary licensure waivers while Idaho's Governor, via executive order, had declared that all the state's waivers, including the change allowing out-of-state physicians to provide telehealth services to Idaho residents, be made permanent. States modifying licensure requirements for physicians in response to COVID-19, and states waiving telehealth licensure requirements, are tracked by FSMB.

The AMA has supported the need for flexibilities to effectively respond to COVID-19 but does not currently support extending the CMS licensure waiver beyond the end of the public health emergency. To protect patients, the AMA has long advocated that physicians and other health professionals providing care via telehealth must be licensed or otherwise authorized to practice in the state where the patient is receiving care to ensure that state medical practice acts, informed consent, and scope of practice laws apply, and that the state has oversight of medical practice.

Providing telehealth services in a "secure environment"

Aside from licensure, the referred item (b) also specifies that telehealth services should be provided in a secure environment, which may be relevant to temporary changes to Health Insurance Portability and Accountability Act (HIPAA) privacy and security rules. To help physicians and other health professionals quickly adopt telehealth, the Office for Civil Rights (OCR) announced early in the pandemic that it would exercise discretion in enforcing violations of HIPAA privacy and security rules for physicians and hospitals who, in good faith, utilized telemedicine platforms and applications to connect with their patients. This policy allows health professionals and patients to use technologies that may not meet all HIPAA requirements, such as Skype, FaceTime and Google Hangouts, to provide care. The AMA supported this policy because it helped physicians quickly adopt telehealth without needing to first implement contracts and security reviews that are often complex and time-consuming. However, while HIPAA compliance may seem onerous and burdensome, it is a necessary ingredient to the successful use of telehealth over the long term.

HIPAA's requirements are intended to ensure that both health professionals and their business associates are accountable for the privacy and security of patient information, thereby fortifying the trust that is central to the patient-physician relationship. Accordingly, when the public health emergency ends, the AMA has urged OCR to not continue its enforcement discretion policy, but rather to establish a glide path to compliance with HIPAA obligations. This would mean that, if the emergency ends on September 30, rather than requiring physicians to be fully in compliance on October 1, OCR should instead allow providers to begin taking steps toward compliance (e.g., engage their vendors in discussions about business associate agreements and initiate or implement their security risk analysis of a new telehealth platform). Additionally, the AMA has advocated that OCR should ensure that physicians and other health professionals are held harmless for actions taken in good faith during the public health emergency.

RELEVANT AMA POLICY

A key safeguard included in Policy H-480.946, which was established through Council Report 7-A-14, Coverage and Payment for Telemedicine, stipulates that physicians and other health practitioners must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by the state's medical board. In addition, this policy requires physicians to abide by state licensure laws, state medical practice acts and other requirements in the state where the patient receives services and maintains that the delivery of telemedicine must be consistent with scope of practice laws. The full text of Policy H-480.946 and other relevant policies is appended.

Long-standing AMA policy maintains that state and territorial medical boards should require a full and unrestricted license in the state for the practice of telemedicine unless there are other appropriate state-based licensing methods (Policy H-480.969). This policy also delineates exemptions from such licensure requirements for "curbside consultations" that are provided without expectation of compensation, and in the event of emergent or urgent circumstances.

Policy D-480.999 opposes a single national federalized system of medical licensure. Policy H-480.974 states that our AMA will work with FSMB and the state and territorial licensing boards to develop licensure guidelines for telemedicine practiced across state boundaries. Policy D-480.969 states that our AMA will work with the FSMB to draft model state legislation to ensure telemedicine is appropriately defined in each state's medical practice statutes and its regulation falls under the jurisdiction of the state medical board. Policy D-275.994 supports the IMLC.

Policies H-275.978 and H-275.955 urge licensing jurisdictions to adopt laws and regulations facilitating the movement of licensed physicians between states. Policy D-480.963 directs the AMA to continue to advocate for the widespread adoption of telehealth services in the practice of medicine for physicians and physician-led teams post-pandemic.

Policy H-130.941 encourages physicians who are interested in volunteering during a disaster to register with their state's Emergency System for Advance Registration of Volunteer Health Professionals program, local Medical Reserve Corps unit, or similar registration systems capable of verifying that practitioners are licensed and in good standing at the time of deployment; and supports the Uniform Emergency Volunteer Health Practitioners Act. Policy H-275.922 encourages FSMB to develop model policy for state licensure boards to streamline and standardize the process by which a physician who holds an unrestricted license in one state may participate in physician volunteerism in another state.

The AMA has substantial scope of practice policy, including Policies D-160.995, H-270.958, and H-160.949. Principles for the supervision of nonphysician providers when telemedicine is used are outlined in Policy H-160.937. Code of Medical Ethics Opinion 1.2.12 states that physicians who provide clinical services through telemedicine must uphold the standards of professionalism expected in in-person interactions, follow appropriate ethical guidelines of relevant specialty societies and adhere to applicable law governing the practice of telemedicine. HIPAA is addressed by Policies H-478.997, D-190.983, and H-315.964.

AMA RESOURCES AND ADVOCACY

Consistent with AMA policy, AMA model state legislation provides a framework for a modern state medical practice act that facilitates physician adoption of telemedicine. The Telemedicine Act clarifies licensure requirements for physicians treating patients via telemedicine, ensuring that, with certain exceptions (e.g., curbside consultations, volunteer emergency medical care), physicians and other health professionals practicing telemedicine are licensed in the state where the patient receives services or are providing these services as otherwise authorized by that state's medical board. The model bill also outlines steps through which a physician can establish a relationship with a new patient via telemedicine and addresses informed consent and privacy.

The AMA has created numerous resources to help guide physician practices through the successful implementation of telehealth, including a Telemedicine Quick Guide, Telehealth Implementation Playbook, and Continuing Medical Education (CME) modules available on the AMA Ed Hub. The AMA has also developed HIPAA privacy and security resources to help walk physicians through what is needed to comply with the required HIPAA privacy and security rules. The AMA Physician Profile Service is used extensively by organizations that verify physician credentials directly (e.g., licensing boards, hospitals, group practices, managed care organizations and physician recruiters).

At the beginning of the pandemic, the AMA also made available a COVID-19 State Policy Guidance on Telemedicine, which outlined AMA policy recommendations for telemedicine on a

range of issues, including licensure, in response to COVID-19. As noted previously, the AMA engages in robust federal and state telehealth advocacy and routinely weighs in on a range of telehealth policy proposals related to licensure, payment, coverage, technology and equity. Federal legislation addressing licensure includes the Temporary Reciprocity to Ensure Access to Treatment Act or the TREAT Act (S 168/HR 708), which would provide nationwide temporary licensing reciprocity for telehealth and in-person care during the public health emergency and for 180 days thereafter. The AMA is neutral on this legislation because it specifies that health professionals providing care across state lines will be subject to the jurisdiction of the state in which the patient is located. The Equal Access to Care Act (S 155/HR 688) would allow health professionals in one state to provide telemedicine in states where they are not licensed during the public health emergency and for 180 days thereafter. The site of care in this legislation is considered to be the state where the health professional is located. More broadly, in response to the COVID-19 pandemic the AMA has:

- sought and secured broad telehealth coverage expansion and improved payments at the federal and state levels to increase access to care and provide patients with a safer way to receive care;
- secured introduction of legislation to make key telehealth policy changes permanent; and
- obtained permanent ability to use smart phones for Medicare telehealth services.

DISCUSSION

Once the COVID-19 pandemic was declared a public health emergency, many states quickly waived licensure requirements so that physicians licensed in one state could provide medical care—including via telehealth—to patients in another state. Scores of executive orders and regulatory actions that expanded coverage for and payment of telehealth led to a substantial surge in virtual services, enabling physicians to provide uninterrupted continuity of care amidst stay-at-home orders and helping to ease physician shortages in areas hardest hit by COVID-19. The AMA continues to hear success stories from patients and physicians who view the expansion of telehealth positively and are more comfortable with telehealth than ever before. The Council encourages continued assessment of the experiences of physicians who have used licensing flexibilities to provide telehealth across state lines as well as the impact of virtual services on care quality and patient outcomes. The Council also understands the challenges facing physician practices trying to compete with corporate telehealth entities—including those contracting with payers to provide telehealth—and how these challenges may increase post-pandemic.

The Council is mindful that physicians hold strong, divergent opinions about interstate telehealth and whether the licensure flexibilities put in place during the public health emergency should be made permanent. Some proponents want to abandon the prevailing standard that physicians must be licensed in the state where the patient is located and move toward national licensure and/or federal oversight of interstate telehealth. Other physicians prefer to uphold the state-based licensing structure—which dates to the 1800s and is embedded in state authority granted by the 10th Amendment—and continue treating the location of the patient (originating site) as the site of service. The Council continues to believe that patient safety should remain the primary consideration and that licensure of physicians and other health professionals should remain within the purview of each state. Proposals to change which state is responsible for overseeing the physician from the state where the patient is located to the physician's home state would likewise change which state's medical practice and scope laws apply to the care rendered. Such proposals would interfere with states' investigative and disciplinary authorities and also raise enforcement concerns since states are generally unable to investigate incidents that happen in another state.[20] Similarly, states cannot take action against the license of a physician in another state.

Considering the differing views among physicians and the issues raised in paragraphs (b) and (d) of the second Resolve of Alternate Resolution 203-Nov-20, the Council focused its deliberations on helping physicians, practices and patients by allowing physicians to treat existing patients wherever they are, thereby preserving those patient relationships, ensuring continuity of care, and permitting specialist care for complex patients and the seriously ill. Consistent with Policy H-480.969, the Council affirmed in its 2019 report that, where there is an established patient relationship, a physician should be able to use telemedicine to provide quality emergent or urgent care for a patient's existing condition when that patient is traveling in another state. In this report, the Council suggests broadening the scope of that statement and address a frustration common among physicians—that they are prohibited by most states from using telehealth to provide longitudinal care to existing patients whom they have seen in the office but who may live across a state border, attend college in another state, or travel for work or seasonally. The Council believes that multiple pathways are available to states to facilitate interstate telehealth for continuity of care purposes, including exceptions to state licensing laws, reciprocity agreements, or possibly other solutions not yet proffered. Accordingly, the Council recommends that the AMA work with FSMB, state medical associations and other stakeholders to encourage states to allow an out-of-state physician to use telehealth to provide continuity of care to an existing patient if certain conditions are met. The Council further recommends amending Policy H-480.969 by addition to codify the previous recommendation in AMA telehealth licensure policy. Because Policy H-480.969 currently prohibits the use of telehealth to provide medical opinions and e-consults between physicians in different states, the Council recommends additional amendments by deletion to update this policy to reflect current practice.

The Council believes these recommendations will increase physician and patient satisfaction with health care, reduce physician licensure-related costs and administrative burdens, help sustain physician practices as they continue to recover from the economic impacts of COVID-19, and address the needs of individuals with disabilities or complex health conditions who lack access to specialty care locally and would benefit from virtual visits with out-of-state specialist physicians. Additionally, as discussed in Council on Medical Service Report 7-JUN-21, these recommendations have the potential to address long-standing health inequities among marginalized and minoritized communities.

The Council is aware of efforts at the state level to streamline or otherwise facilitate interstate licensure through reciprocity or other means. To ensure that our AMA can support such efforts if they align with existing policy, the Council recommends continued support for state efforts to expand physician licensure recognition across state lines in accordance with the standards and safeguards outlined in Policy H-480.946. The Council continues to support the IMLC as an important licensure solution and hopes that the states that have not joined the Compact elect to do so. Accordingly, the Council recommends that Policy H-480.946 be reaffirmed. Finally, the Council recommends reaffirmation of Policy H-480.946, which delineates standards and safeguards that should be met for the coverage and payment of telemedicine.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolve 2, Items (b) and (d) of Alternate Resolution 203-Nov-20, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) amend Policy H-480.969[1] by addition and deletion as follows:

   The Promotion of Quality Telemedicine H-480.969

(1) It is the policy of the AMA that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory. This license category should adhere to the following principles:
~~(a) application to situations where there is a telemedical transmission of individual patient data from the patient's state that results in either (i) provision of a written or otherwise documented medical opinion used for diagnosis or treatment or (ii) rendering of treatment to a patient within the board's state~~;
(~~b~~a) exemption from such a licensure requirement for ~~traditional informal~~ physician-to-physician consultations ~~("curbside consultations") that are provided without expectation of compensation~~;
(~~c~~b) exemption from such a licensure requirement for telemedicine practiced across state lines in the event of an emergent or urgent circumstance, the definition of which for the purposes of telemedicine should show substantial deference to the judgment of the attending and consulting physicians as well as to the views of the patient; and
(c) allowances, by exemption or other means, for out-of-state physicians providing continuity of care to a patient, where there is an established ongoing relationship and previous in-person visits, for services incident to an ongoing care plan or one that is being modified.
(d) application requirements that are non-burdensome, issued in an expeditious manner, have fees no higher than necessary to cover the reasonable costs of administering this process, and that utilize principles of reciprocity with the licensure requirements of the state in which the physician in question practices. (Modify Current AMA Policy)

2. That our AMA continue to support state efforts to expand physician licensure recognition across state lines in accordance with the standards and safeguards outlined in Policy H-480.946, Coverage and Payment for Telemedicine. (New HOD Policy)

3. That our AMA reaffirm Policy D-480.964, which directs the AMA to work with state medical associations to encourage states that are not part of the Interstate Medical Licensure Compact to consider joining the Compact; advocate for reduced application and state licensure(s) fees processed through the Interstate Medical Licensure Compact; and work with interested state medical associations to encourage states to pass legislation enhancing patient access to and proper regulation of telemedicine services. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-480.946, which delineates standards and safeguards that should be met for the coverage and payment of telemedicine, including that physicians and other health practitioners must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by the state's medical board. (Reaffirm HOD Policy)

Fiscal Note: Less than $6,000

REFERENCES

[1] Kane, C. Key Findings from the AMA 2012-2020 Physician Practice Benchmark Surveys.
[2] COVID-19 Healthcare Coalition. Telehealth Impact: Physician Survey Analysis. Last updated Nov. 2020. Available online at: https://c19hcc.org/static/catalog-resources/telehealth-physician-survey-analysis-c19hcc.pdf.
[3] *Ibid*.
[4] *Ibid*.
[5] Federation of State Medical Boards. Understanding Medical Regulation in the United States. Available online at: https://www.fsmb.org/siteassets/education/pdf/best-module-text-intro-to-medical-regulation.pdf.
[6] Federation of State Medical Boards. Telemedicine Policies: Board by Board Overview. July 2020. Available online at: https://www.fsmb.org/siteassets/advocacy/key-issues/telemedicine_policies_by_state.pdf.
[7] The Interstate Medical Licensure Compact website: https://imlcc.org/.
[8] *Ibid*.
[9] Federation of State Medical Boards. Advocacy Network News. April 1, 2020.
[10] The Interstate Medical Licensure Compact website: https://www.imlcc.org/information-for-states/
[11] The Interstate Medical Licensure Compact website: https://www.imlcc.org/what-does-it-cost/
[12] American Medical Association. COVID-19 Physician practice financial impact survey. 2020. Available online at: https://www.ama-assn.org/system/files/2020-10/covid-19-physician-practice-financial-impact-survey-results.pdf
[13] *Ibid*.
[14] Colorado's Medical Practice Act [§ 12-240-107(3)(b)]
[15] Federation of State Medical Boards. Telemedicine Policies: Board by Board Overview. July 2020. Available online at: https://www.fsmb.org/siteassets/advocacy/key-issues/telemedicine_policies_by_state.pdf.
[16] Uniform Law Commission. Emergency Volunteer Health Practitioners Act. Available online at: https://www.uniformlaws.org/committees/community-home?CommunityKey=565933ce-965f-4d3c-9c90-b00246f30f2d
[17] National Conference of State Legislatures. Universal Licensure Recognition. March 2, 2021. Available online at: https://www.ncsl.org/research/labor-and-employment/universal-licensure-recognition.aspx
[18] Sports Medicine Licensure Clarity Act of 2018. Available online at: https://www.congress.gov/bill/115th-congress/house-bill/302?q=%7B%22search%22%3A%5B%22Sports+Medicine+Licensure+Clarity+Act%22%5D%7D&r=1
[19] Centers for Medicare & Medicaid Services. COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers. Available online at: https://www.cms.gov/files/document/covid19-emergency-declaration-health-care-providers-fact-sheet.pdf
[20] Mehrotra A, Nimgaonkar BA and Richman B. Telemedicine and Medical Licensure — Potential Paths for Reform. *New England Journal of Medicine*, Feb. 25, 2021. Available online at: https://www.nejm.org/doi/full/10.1056/NEJMp2031608?query=TOC

Appendix: Relevant AMA Policy

Policy H-480.946, “Coverage of and Payment for Telemedicine”
1. Our AMA believes that telemedicine services should be covered and paid for if they abide by the following principles:
a) A valid patient-physician relationship must be established before the provision of telemedicine services, through:
- A face-to-face examination, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine; or
- A consultation with another physician who has an ongoing patient-physician relationship with the patient. The physician who has established a valid physician-patient relationship must agree to supervise the patient’s care; or
- Meeting standards of establishing a patient-physician relationship included as part of evidence-based clinical practice guidelines on telemedicine developed by major medical specialty societies, such as those of radiology and pathology.
Exceptions to the foregoing include on-call, cross coverage situations; emergency medical treatment; and other exceptions that become recognized as meeting or improving the standard of care. If a medical home does not exist, telemedicine providers should facilitate the identification of medical homes and treating physicians where in-person services can be delivered in coordination with the telemedicine services.
b) Physicians and other health practitioners delivering telemedicine services must abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services.
c) Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state’s medical board.
d) Patients seeking care delivered via telemedicine must have a choice of provider, as required for all medical services.
e) The delivery of telemedicine services must be consistent with state scope of practice laws.
f) Patients receiving telemedicine services must have access to the licensure and board certification qualifications of the health care practitioners who are providing the care in advance of their visit.
g) The standards and scope of telemedicine services should be consistent with related in-person services.
h) The delivery of telemedicine services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes.
i) The telemedicine service must be delivered in a transparent manner, to include but not be limited to, the identification of the patient and physician in advance of the delivery of the service, as well as patient cost-sharing responsibilities and any limitations in drugs that can be prescribed via telemedicine.
j) The patient’s medical history must be collected as part of the provision of any telemedicine service.
k) The provision of telemedicine services must be properly documented and should include providing a visit summary to the patient.
l) The provision of telemedicine services must include care coordination with the patient’s medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and treating physicians and providing to the latter a copy of the medical record.
m) Physicians, health professionals and entities that deliver telemedicine services must establish protocols for referrals for emergency services.
2. Our AMA believes that delivery of telemedicine services must abide by laws addressing the privacy and security of patients’ medical information.

3. Our AMA encourages additional research to develop a stronger evidence base for telemedicine.
4. Our AMA supports additional pilot programs in the Medicare program to enable coverage of telemedicine services, including, but not limited to store-and-forward telemedicine.
5. Our AMA supports demonstration projects under the auspices of the Center for Medicare and Medicaid Innovation to address how telemedicine can be integrated into new payment and delivery models.
6. Our AMA encourages physicians to verify that their medical liability insurance policy covers telemedicine services, including telemedicine services provided across state lines if applicable, prior to the delivery of any telemedicine service.
7. Our AMA encourages national medical specialty societies to leverage and potentially collaborate in the work of national telemedicine organizations, such as the American Telemedicine Association, in the area of telemedicine technical standards, to the extent practicable, and to take the lead in the development of telemedicine clinical practice guidelines. (CMS Rep. 7, A-14; Reaffirmed: BOT Rep. 3, I-14; Reaffirmed in lieu of Res. 815, I-15; Reaffirmed: CME Rep. 06, A-16; Reaffirmed: CMS Rep. 06, I-16; Reaffirmed: Res. 111, A-17; Reaffirmation: A-18; Reaffirmed: CMS Rep. 1, I-19)

Policy D-480.964, “Established Patient Relationships and Telemedicine”
Our AMA will: (1) work with state medical associations to encourage states that are not part of the Interstate Medical Licensure Compact to consider joining the Compact as a means of enhancing patient access to and proper regulation of telemedicine services; (2) advocate to the Interstate Medical Licensure Compact Commission and Federation of State Medical Boards for reduced application fees and secondary state licensure(s) fees processed through the Interstate Medical Licensure Compact; and (3) work with interested state medical associations to encourage states to pass legislation enhancing patient access to and proper regulation of telemedicine services, in accordance with AMA Policy H-480.946, “Coverage of and Payment for Telemedicine.” (CMS Rep. 1, I-19)

Policy H-480.969, “The Promotion of Quality Telemedicine”
(1) It is the policy of the AMA that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory. This license category should adhere to the following principles:
(a) application to situations where there is a telemedical transmission of individual patient data from the patient’s state that results in either (i) provision of a written or otherwise documented medical opinion used for diagnosis or treatment or (ii) rendering of treatment to a patient within the board’s state;
(b) exemption from such a licensure requirement for traditional informal physician-to-physician consultations (“curbside consultations”) that are provided without expectation of compensation;
(c) exemption from such a licensure requirement for telemedicine practiced across state lines in the event of an emergent or urgent circumstance, the definition of which for the purposes of telemedicine should show substantial deference to the judgment of the attending and consulting physicians as well as to the views of the patient; and
(d) application requirements that are non-burdensome, issued in an expeditious manner, have fees no higher than necessary to cover the reasonable costs of administering this process, and that utilize principles of reciprocity with the licensure requirements of the state in which the physician in question practices.
(2) The AMA urges the FSMB and individual states to recognize that a physician practicing certain forms of telemedicine (e.g., teleradiology) must sometimes perform necessary functions in the licensing state (e.g., interaction with patients, technologists, and other physicians) and that the

interstate telemedicine approach adopted must accommodate these essential quality-related functions.
(3) The AMA urges national medical specialty societies to develop and implement practice parameters for telemedicine in conformance with: Policy 410.973 (which identifies practice parameters as "educational tools"); Policy 410.987 (which identifies practice parameters as "strategies for patient management that are designed to assist physicians in clinical decision making," and states that a practice parameter developed by a particular specialty or specialties should not preclude the performance of the procedures or treatments addressed in that practice parameter by physicians who are not formally credentialed in that specialty or specialties); and Policy 410.996 (which states that physician groups representing all appropriate specialties and practice settings should be involved in developing practice parameters, particularly those which cross lines of disciplines or specialties). (CME/CMS Rep., A-96; Amended: CME Rep. 7, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: CME Rep. 6, A-10; Reaffirmed: CME Rep. 6, A-12; Reaffirmed in lieu of Res. 805, I-12; Reaffirmed: BOT Rep. 22, A-13; Reaffirmed in lieu of Res. 920, I-13; Reaffirmed: CMS Rep. 7, A-14; Reaffirmed: BOT Rep. 3, I-14; Reaffirmed: CMS Rep. 1, I-19)

Policy D-480.969, "Insurance Coverage Parity for Telemedicine Service"
1. Our AMA will advocate for telemedicine parity laws that require private insurers to cover telemedicine-provided services comparable to that of in-person services, and not limit coverage only to services provided by select corporate telemedicine providers.
2. Our AMA will develop model legislation to support states' efforts to achieve parity in telemedicine coverage policies.
3. Our AMA will work with the Federation of State Medical Boards to draft model state legislation to ensure telemedicine is appropriately defined in each state's medical practice statutes and its regulation falls under the jurisdiction of the state medical board. (Res. 233, A-16; Reaffirmed: CMS Rep. 1, I-19)

Policy H-480.974, "Evolving Impact of Telemedicine"
Our AMA:
(1) will evaluate relevant federal legislation related to telemedicine;
(2) urges CMS, AHRQ, and other concerned entities involved in telemedicine to fund demonstration projects to evaluate the effect of care delivered by physicians using telemedicine-related technology on costs, quality, and the physician-patient relationship;
(3) urges professional organizations that serve medical specialties involved in telemedicine to develop appropriate practice parameters to address the various applications of telemedicine and to guide quality assessment and liability issues related to telemedicine;
(4) encourages professional organizations that serve medical specialties involved in telemedicine to develop appropriate educational resources for physicians for telemedicine practice;
(5) encourages development of a code change application for CPT codes or modifiers for telemedical services, to be submitted pursuant to CPT processes;
(6) will work with CMS and other payers to develop and test, through these demonstration projects, appropriate reimbursement mechanisms;
(7) will develop a means of providing appropriate continuing medical education credit, acceptable toward the Physician's Recognition Award, for educational consultations using telemedicine;
(8) will work with the Federation of State Medical Boards and the state and territorial licensing boards to develop licensure guidelines for telemedicine practiced across state boundaries; and
(9) will leverage existing expert guidance on telemedicine by collaborating with the American Telemedicine Association (www.americantelemed.org) to develop physician and patient specific content on the use of telemedicine services--encrypted and unencrypted. (CMS/CME Rep., A-94; Reaffirmation A-01; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed in lieu of

Res. 805, I-12; Appended: BOT Rep. 26, A-13; Modified: BOT Rep. 22, A-13; Reaffirmed: CMS Rep. 7, A-14; Reaffirmed: CME Rep. 06, A-16; Reaffirmation: A-18)

State Authority and Flexibility in Medical Licensure for Telemedicine D-480.999
Our AMA will continue its opposition to a single national federalized system of medical licensure. (CME Rep. 7, A-99; Reaffirmed and Modified: CME Rep. 2, A-09; Reaffirmed in lieu of Res. 920, I-13; Reaffirmed: BOT Rep. 3, I-14)

Policy D-275.994, "Facilitating Credentialing for State Licensure"
Our AMA: (1) encourages the Federation of State Medical Boards to urge its Portability Committee to complete its work on developing mechanisms for greater reciprocity between state licensing jurisdictions as soon as possible; (2) will work with the Federation of State Medical Boards (FSMB) and the Association of State Medical Board Executive Directors to encourage the increased standardization of credentials requirements for licensure, and to increase the number of reciprocal relationships among all licensing jurisdictions; (3) encourages the Federation of State Medical Boards and its licensing jurisdictions to widely disseminate information about the Federation's Credentials Verification Service, especially when physicians apply for a new medical license; and (4) supports the FSMB Interstate Compact for Medical Licensure and will work with interested medical associations, the FSMB and other interested stakeholders to ensure expeditious adoption by the states of the Interstate Compact for Medical Licensure and creation of the Interstate Medical Licensure Compact Commission. (Res. 302, A-01; Reaffirmed: CME Rep. 2, A-11; Reaffirmed: CME Rep. 6, A-12; Appended: BOT Rep. 3, I-14)