

Utah Telehealth Study – 2016 Overview Update

Prepared by Pilot Healthcare Strategies

For the Utah Division of Occupational and
Professional Licensing

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Executive summary and overview

This update of 2014 Utah Telehealth Study is a high level, global overview of market, practice and regulatory environment developments in the five focus areas since completion of the 2014 study:

- Market developments and telehealth use by licensed health care professionals (scope of this update is physicians and mid-level practitioners who work with physicians);
- New stakeholder and interest group policy positions since completion of the 2014 study;
- State statutes and regulatory board rules
- Federal statutes and regulations (relative to Medicare and Medicaid providers)
- Notable court decisions related to delivery of services via telehealth by licensed health care professionals

Methodology

Google searches were conducted using the search phrases “telemedicine” and “telehealth” combined with the term “regulation” to identify relevant media accounts of developments since completion of the 2014 study in June, 2014. In addition, RSS Google and Yahoo news feeds, Lexology and JD Supra were reviewed for relevant content as well as the websites of the Center for Connected Health Policy and the National Conference of State Legislatures and selected LinkedIn discussion groups (American Telemedicine Association, Telemedicine & E-Health)

The websites of the following stakeholder groups were searched using the search terms “telemedicine” and “telehealth:”

- Federation of State Medical Boards (FSMB)
- American Medical Association (AMA)
- American Telemedicine Association (ATA)
- American Association of Nurse Practitioners (AANP)
- American Nurses Association (ANA)
- The Information Technology and Innovation Foundation (ITIF)
- Alliance for Connected Care

Given the limited scope of this overview, a comprehensive review of each state’s statutes and regulations was not conducted.

Updated market trends and projections since completion of 2014 Utah Telehealth Study

Various research groups project continued growth in the telehealth market since completion of the 2014 Utah Telehealth Study. The global video telemedicine market is projected to expand from its market value of \$559 million in 2013 to an estimated total of \$1.6 billion by the end of 2020. Based on the projections, the market is likely to develop at a remarkable 16.5 percent CAGR between 2014 and 2020.¹

ReportsnReports.com forecasts the global telehealth market growth at 18.88 percent CAGR during 2014-2019, with mobile and healthcare IT will driving this growth.²

An August 2014 Deloitte study calculated there would be 75 million virtual visits in North America in 2014 and that the potential exists for as many as 300 million visits a year.³

Despite the projected growth, consumer knowledge of and adoption of telehealth remains in the early stages. A March 2016 survey of 500 insured consumers who are also users of mobile health applications found nearly 40 percent have not heard of telemedicine while 42 percent have not used telemedicine and prefer an in-person physician visit instead. The survey also found:

- 28 percent don't know when it is appropriate to use telemedicine;
- 14 percent don't trust a telemedicine provider to diagnose and/or treat;
- 14 percent are not sure if telemedicine services are covered by health insurance.

Survey participants were also asked for which services they would consider using telemedicine:

- 44 percent for follow-up care for acute illness;
- 44 percent for symptom tracking/diagnosis;

¹ Video Telemedicine Market - Global Industry Analysis, Size, Share, Growth, Trends and Forecast 2014 – 2020, Transparency Market Research, December 19, 2014. <http://www.transparencymarketresearch.com/v-telemedicine-market.html>

² "Global Telehealth Market Growth to 2019 Driven by Mobile and Healthcare IT, says a New Research Report," ReportsnReports December 10, 2014. <http://www.prnewswire.com/news-releases/global-telehealth-market-growth-to-2019-driven-by-mobile-and-healthcare-it-says-a-new-research-report-285330051.html>

³ Darius Tahir, "Telehealth services surging despite questions about value," *Modern Healthcare*, February 21, 2015. <http://www.modernhealthcare.com/article/20150221/MAGAZINE/302219981/telehealth-services-surging-despite-questions-about-value>

- 44 percent for medication management/prescription renewal;
- 34 percent for follow-up care for a chronic condition;
- 31 percent for remote monitoring of vital signs;
- 24 percent for behavioral/mental health.

Another survey polled health care executives and health care clinicians regarding their views on the challenges and objectives of telemedicine programs. Almost 66 percent of survey participants indicate that telemedicine is their top priority or one of the highest priorities for their healthcare organizations. The top three telemedicine objectives are:

- Improved patient outcomes;
- Improved patient convenience;
- Increasing patient engagement and satisfaction.⁴

There was a marked rise in 2015 in the number of partnerships between U.S. health care providers and international institutions for U.S. physicians (particularly in certain orthopedic and oncology sub-specialty areas) to provide consultations to international physicians about their patient cases, as well as “second opinion” programs where U.S. physicians review the medical records and diagnostic tests of patients located abroad, and then render a second opinion to that patient. It is predicted that these international telemedicine arrangements will continue throughout 2016 as U.S. providers search for ways to expand their patient base and grow their brands internationally.⁵

Practitioner/provider adoption trends

A survey of more than 150 health care professionals in eight nations conducted in November 2015 found a majority believe telemedicine can deliver similar outcomes to in-person doctor visits.⁶

⁴ Rene Quashie, “Recent Telemedicine Surveys Make for Interesting Reading,” *Telehealth Perspectives* (blog), April 5, 2016. <http://www.techhealthperspectives.com/2016/04/05/recent-telemedicine-surveys-make-for-interesting-reading/>

⁵ Lisa Schmitz Mazur, “New Year, New Telehealth Opportunities,” *Of Digital Interest* (blog), February 12, 2016. <http://www.jdsupra.com/legalnews/new-year-new-telehealth-opportunities-15398/>

⁶ Aeris Survey of Healthcare Professionals Shows Telemedicine Is Mission Critical, Aeris (website), March 22, 2016. Accessed April 20, 2016. <http://www.aeris.com/news-post/aeris-survey-of-healthcare-professionals-shows-telemedicine-is-mission-critical/>

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In early 2015 the Robert Graham Center, the American Academy of Family Physicians (AAFP), and health insurer Anthem conducted a nationwide survey of more than 5,000 randomly selected family physicians on how they use telehealth in their practices. Physicians using telehealth are more likely rural, younger, in practice for fewer than 10 years, and were more likely to employ an electronic medical record than non-users.

Survey respondents noted a variety of barriers that must be overcome before telehealth services can become a routine tool for primary care clinicians, including creating guidelines for the use of telehealth services in clinical practice, definitions of quality, and measurable outcomes. Additionally, healthcare clinicians and users need assurance that the patient's privacy is protected and their health information is secure. Respondents reported barriers to adoption include a lack of billing codes, a lack of reimbursement mechanisms, licensing and credentialing barriers, and appropriate training in the use of telehealth services. Respondents called for national pilot and demonstration programs to create the knowledge base necessary to assure that telehealth services meet, or potentially exceed, the current standards of care for access and quality.⁷

Another survey in November and December 2015 of 390 healthcare executives, physicians, nurses and other professionals throughout the United States showed telemedicine continues to evolve from a specialty offering to a mainstream service. Nearly two-thirds of survey participants noted telemedicine as their top priority or one of their highest priorities for their healthcare organizations, a 10 percent increase from 2015. Patient-oriented objectives including improving patient outcomes, improving patient convenience and increasing patient engagement and satisfaction as the foremost objectives for telemedicine programs.⁸

Another survey of 276 healthcare decision makers and physician executives by the Healthcare Information and Management Systems Society issued in September 2015 found both familiarity with telemedicine and adoption increased from 2014. Seventy percent of respondents reported two-way video/webcam usage, making it the most utilized telemedicine communications choice. Other findings:

- 26 percent plan to expand their telemedicine programs to add other specialties in the near future;

⁷ Family Physicians and Telehealth: A First Look at Attitudes Surrounding Telehealth, Think Anthem (website), November 13, 2015. Accessed April 20, 2016. <http://thinkanthem.com/report/family-physicians-and-telehealth-first-look-attitudes-surrounding-telehealth>

⁸ Executive Summary of Telemedicine Industry Survey Findings. ReachHealth (website), March 23, 2016. Accessed April 20, 2016. <http://reachhealth.com/executive-summary-survey-findings>

- 34 percent are engaged in telemedicine primarily to develop a service that increases access and integrates care across rural areas;
- 22 percent are focused on developing a service that reduces overall costs for their organization;
- 18 percent are seeking to develop specialty services not otherwise available in the region.⁹

The 2014 Utah Telehealth Study reported Salt lake City–based Intermountain Healthcare was rolling out telemedicine infrastructure including all 2,800 hospital beds in its system, prioritizing emergency and intensive care units. Intermountain has launched three other initiatives in a smaller number of hospitals and was on track to roll them out throughout the Intermountain system by the end of 2015. One of those initiatives focuses on newborn intensive care. Eleven rural hospitals now have access to neonatologists through telehealth. About 60 consultations have taken place so far, and at least 18 babies who would have been transferred to a larger facility have been able to remain in their communities.

Another initiative focuses on stroke diagnosis in emergency departments and underscores the importance of speedy access to specialists. Telehealth makes a neurologist rapidly available to assess the situation, respond and deliver the required care. The fourth initiative addresses behavioral health, specifically crisis care support, in EDs. This program makes a social worker available hours faster than would normally be the case for patients in rural facilities.¹⁰

Role of payers and employer plans

Since public and private health insurance and employers pay for medical care, this update includes developments and trends in this space as drivers of telemedicine utilization. Among private payers, UnitedHealth Group reportedly offers the widest health insurance coverage yet of physician visits via telemedicine, offering access to three different medical care provider

⁹ U.S. Telemedicine Adoption. ABISA (blog), November 2015. Accessed April 20, 2016. <https://abisallc.wordpress.com/2015/11/23/u-s-telemedicine-adoption/>

¹⁰ Tara Larkin, “Telehealth Enhances Care in Rural Communities,” Hospitals & Health Networks (American Hospital Association), January 14, 2016. <http://www.hhnmag.com/articles/6833-telehealth-enhancing-care-in-rural-communities>

networks that connect physicians and patients via smart phone, tablet or computer. UnitedHealth is rolling out “virtual care doctor’s visits” to nearly 1 million health plan members in self-funded plans and expected to have 20 million members in UnitedHealth’s fully insured plans with access to the network by the start of 2016. “We got into this so people could get what they needed in the middle of the night,” Dr. Richard Migliori, executive vice president and chief medical officer, UnitedHealth Group said in an interview. “It helps people sort out their problems and get access to a live physician. It says, ‘let me solve that problem here and now.’”

The federal Center for Medicare & Medicaid Services reported **a 27 percent increase in the number of Medicare fee for service telehealth services claims and a 25 percent increase in total payments for 2015 over the previous year.** “This reflects how providers are successfully integrating telehealth services into their traditional health care delivery approaches, and are better realizing payment opportunities both within the Medicare FFS program and in other sources of revenue,” wrote Nathaniel Lactman of Foley & Lardner LLP in a March 4, 2016 blog post.¹¹

Employers are also teaming up with health plans to offer telemedicine services to employees. Penske Truck Leasing is working with Aetna and Teladoc to offer virtual services to its 18,000 employees, 20 percent of whom have used them.¹²

Among health insurers, telemedicine is widely offered, promoted by health plans such as Cigna and startup Oscar Health. As many as 15 million people used the service in 2015, up 50 percent from 2013, according to the American Telemedicine Association. “The insurers have been adopting this at a really rapid rate because they see benefits from better access to care,” said Jason Gorevic, chief executive of Teladoc, a provider of telemedicine physicians. “It eliminates unnecessary visits to more expensive sites.” Teladoc is working with over 20 health plans, including Aetna, which plans to add virtual behavioral health consultations. In 2016, UnitedHealth Group will roll out services to employer-sponsored and individual plans through partnerships with Doctors on Demand, American Well and NowClinic. Oscar Health offers telehealth services at no cost for its 100,000 members. CEO Mario Schlosser says the move has paid off, with 91 percent of care cases resolved after the first virtual appointment.¹³

¹¹ Nathaniel Lactman, “Medicare Payments for Telehealth Increased 25 percent in 2015: What You Need to Know,” Health Care Law Today (blog), March 3, 2016. <https://www.healthcarelawtoday.com/2016/03/03/medicare-payments-for-telehealth-increased-25-in-2015-what-you-need-to-know/>

¹² Kylie Gumpert, “Telemedicine Gaining Acceptance Among Patients, Insurers,” *Insurance Journal*, December 27, 2015. <http://www.insurancejournal.com/news/national/2015/12/27/392987.htm>

¹³ Ibid.

An increasing number of employers—ranging from big to small—offered telemedicine as a benefit to employees in 2015 in an effort to reduce health care costs and as a means of improving employee health.¹⁴ According to a Towers Watson survey, 34 percent of employers are considering offering their employees telemedicine consultation services in 2016 or 2017 for non-emergency care. However, the employer survey reveals the disappointing statistic that at companies that offer this service, less than 10 percent of employees utilize it. A lack of awareness and education about the benefits and services may contribute to this number.¹⁵

Other studies suggest that nearly 70 percent of employers will offer telemedicine services as an employee benefit by 2017. Additionally, consumers are increasingly willing to visit retail medical clinics and pay out-of-pocket for the convenience and multiple benefits of telemedicine services when telemedicine is not covered by their insurance plans. Both CVS Health and Walgreens have publicly announced plans to incorporate telemedicine-based service components in their brick and mortar locations.¹⁶

Telepsychiatry has seen growth since the 2014 Utah Telehealth Study. Telepsychiatry has allowed hospital emergency departments to quickly place individuals in the appropriate level of care and improve their overall throughput. In 2015, the American College of Emergency Physicians has recognized telepsychiatry as a focus area.¹⁷

Amid health insurers' increasing use of narrow provider networks and a shortage of primary care physicians, a Robert Wood Johnson Foundation study of six states —Arkansas, Colorado, Illinois, Maine, Texas and Washington— found that insurers generally have not incorporated telemedicine providers into their networks. Interviewees said that telemedicine could expand access to primary care, as well as specialists including psychiatrists, cardiologists and endocrinologists, but that insurers are more likely to use it as a supplement and not a replacement for in-person services. In addition, insurers are reluctant to use telemedicine to meet state network requirements in part because they do not know how it will be viewed by

¹⁴ Mazur, "New Year, New Telehealth Opportunities."

¹⁵ "Current Telemedicine Technology Could Mean Big Savings," August 11, 2014. WillisTowersWatson (website) Accessed April 20, 2016. <https://www.towerswatson.com/en/Press/2014/08/current-telemedicine-technology-could-mean-big-savings>

¹⁶ "Five Telemedicine Trends Transforming Health Care in 2016," National Law Review, November 16, 2016. http://www.natlawreview.com/article/five-telemedicine-trends-transforming-health-care-2016?sthash_2Q5lVc4T_mjjo=#sthash.NjhaCmJ4.dpuf

¹⁷ Jim Varrell, "Major industry changes for telepsychiatry in 2015," January 20, 2015. Multibriefs (website), Accessed April 20, 2016. <http://exclusive.multibriefs.com/content/major-industry-changes-for-telepsychiatry-in-2015/mental-healthcare>

state regulators, the study found. They also often face opposition from local clinicians who think telemedicine could replace them, or be used as leverage against them in negotiations over reimbursement fees.¹⁸

Some industry leaders advocate for such use of telehealth, including the National Association of Insurance Commissioners and its recent model law for boosting provider networks. This law acknowledged the potential for telehealth to improve provider network adequacy.¹⁹

State and regulatory board activity since completion of the 2014 Utah Telehealth Study

The Interstate Medical Licensure Compact

A major new development with significant implications for physician use of telemedicine since the completion of the 2014 Utah Telehealth Study is the creation of an interstate expedited licensing compact for physicians by the Federation of State Medical Boards (FSMB) in July 2014. The Interstate Medical Licensure Compact creates a new pathway to expedite the licensing of physicians seeking to practice medicine in multiple states. States participating in the compact agree to share information with each other and work together in new ways to significantly streamline the licensing process. An explicit goal is to increase access to health care for individuals in underserved or rural areas and allow patients to more easily consult medical experts through the use of telemedicine technologies:

“Among the issues driving the need for a Compact are physician shortages, the expected influx of millions of new patients into the health care system as a result of the Affordable Care Act, and the growing need to increase access to health care for individuals in underserved or rural areas through the use of telemedicine. Proponents of telemedicine have often cited the time-consuming state-by-state licensure process for multiple-license holders as a key barrier to overcome in order for telemedicine to continue to grow and thrive. The Compact would make it easier and faster for physicians to obtain a license to

¹⁸ Ahn S, Corlette S, and Lucia K, “Can Telemedicine Help Address Concerns with Network Adequacy?” Urban Institute, April 2006. http://www.rwjf.org/en/library/research/2016/04/can-telemedicine-help-address-concerns-with-network-adequacy.html?cid=xem_other_unpd_ini:moni_percent20telemedicine_percent204.6_dte:20160406

¹⁹ Sara Heath, “Can Telehealth Fill Health Insurer’s Provider Network Gaps?” *mHealth Intelligence*, April 12, 2016. <http://mhealthintelligence.com/news/can-telehealth-fill-health-insurers-provider-network-gaps>

practice in multiple states, thus helping extend the impact and availability of their care at a time when demand is expected to grow significantly.”

Surveys estimate that nearly 80% of the physician population licensed in the United States could be eligible for expedited licensure via the compact process.

To be eligible for expedited licensure, physicians must:

- Possess a full and unrestricted license to practice medicine in a compact state
- Possess specialty certification or be in possession of a time unlimited specialty certificate
- Have no discipline on any state medical license
- Have no discipline related to controlled substances
- Not be under investigation by any licensing or law enforcement agency
- Have passed the USMLE or COMLEX (or equivalent) within 3 attempts
- Have successfully completed a graduate medical education (GME) program

Physicians who are ineligible for the expedited licensure process facilitated by the compact will still be able to seek additional licenses in those states where they desire to practice, using the traditional state-by-state licensure processes.²⁰

According to the FSMB, a dozen states had enacted the compact at the start of 2016 while additional states have introduced model Compact legislation, bringing the total number of state legislatures that have introduced the legislation since 2015 to 26. Additional introductions of the model Compact legislation are expected across the nation in early 2016.²¹

The Interstate Medical Licensure Compact is in the process of establishing its administrative process for expedited licensure. Expedited licensing is not yet available.²²

²⁰ “Frequently Asked Questions about the Interstate Medical Licensure Compact,” Interstate Medical Licensure Compact (website). Accessed April 21, 2016. <http://www.licenseportability.org/faq/>

²¹ “Six New States Introduce Interstate Medical Licensure Compact Legislation,” Federation of State Medical Boards (news release), January 21, 2016. https://www.fsmb.org/Media/Default/PDF/Advocacy/NewCompactIntroductions_Jan2016_FINAL.pdf

²² <http://www.licenseportability.org/> (Accessed April 21, 2016)

Revised nurse licensing compacts

As reported in the 2014 Utah Telehealth Study, the National Council of State Boards of Nursing (NCSBN) had adopted an interstate compact approach to facilitate the provision of care by telehealth across state lines. Some 25 states adopted the existing version of the Nurse Licensure Compact, which was launched in 1997 and doesn't specifically cover telemedicine services.

In 2015, the NCSBN updated the Nurse Licensure Compact (NLC) and the Advanced Practice Registered Nurse Compact (APRNC). The revised compacts allow nurses to hold one multistate license with a privilege to practice in other compact states. "Influenced by the growing need for nurse mobility and clarification of the authority to practice for many nurses currently engaged in telenursing or interstate practice, boards of nursing have worked over the past several years to revise the NLC to ensure it reflects best practices and provides for continued high standards of public protection," the NCSBN stated in announcing the revised compact model law.²³

Like the Interstate Medical Licensure Compact for physicians, the nurse compacts establish an interstate commission and set guidelines for uniform licensing requirements and criminal background checks. As of April 2016, six states -- Wyoming, Virginia, South Dakota, Idaho, Florida and Tennessee -- have approved the new compacts, and nine other states are considering legislation. NCSBN rules stipulate that the new compact will take effect upon adoption by 26 states or at the end of 2018, whichever comes first.²⁴

State statutes and rules since completion of 2014 Utah Telehealth Study

State activity relative to regulation of telehealth practice by licensed health care professionals picked up considerably since the completion of the 2014 Utah Telehealth Study in June 2014. Twenty-one states enacted statutes and rules in this subject area since then as detailed below. A third of those put in place comprehensive statutes or medical board rules and legislatures in four of those states (Tennessee, Louisiana, Indiana, West Virginia) acted in response to or to

²³ "NCSBN Delegate Assembly Adopts Revised Nurse Licensure Compacts," (News release), May 4, 2015.
<https://www.ncsbn.org/7320.htm>

²⁴ Eric Wicklund, "Nurses' Group Lobbies for Telemedicine Licensure," *mHealth Intelligence*, April 4, 2016,
<http://mhealthintelligence.com/news/nurses-group-lobbies-for-telemedicine-licensure>

preempt state medical board actions on telemedicine. There were more than 200 telehealth-related bills introduced in 42 states in 2015.²⁵ More were introduced in 2016.

The American Telemedicine Association (ATA) issued an analysis of physician practice standards and licensure in January 2016. The analysis concludes since the ATA's first assessment in September 2014, states have become more prescriptive in their requirements for patient Informed consent and the types of modalities permitted for appropriate clinical practice when using telemedicine when reassessed in December 2015. In 2015, more than half the states considered proposals to revise health professional standards and licensure requirements when using telemedicine.²⁶

Arkansas

Statutory definition of telemedicine: Arkansas enacted legislation effective July 1, 2016 defining telemedicine as “the medium of delivering clinical healthcare services by means of real-time two-way electronic audio-visual communications, including without limitation the application of secure video conferencing, to provide or support healthcare delivery that facilitates the assessment, diagnosis, consultation, or treatment of a patient’s health care while the patient is at an originating site and the healthcare professional is at a distant site.”

Authority: *AR Code 23-79-1601(5).*

Regulation of certain drugs to induce abortions: Legislation enacted February, 2015 requires that when any drug or chemical (including mifepristone) is used to induce an abortion, the initial administration of the drug must occur in the same room and in the physical presence of the physician who prescribed, dispensed or provided the drug. The law does not affect telemedicine practice that does not involve abortion-inducing drugs.²⁷

²⁵ “Telehealth Policy Trends and Considerations,” National Conference of State Legislatures.
<http://www.ncsl.org/documents/health/telehealth2015.pdf>

²⁶ “State Telemedicine Gaps Analysis,” American Telemedicine Association, January 2016.
http://www.americantelemed.org/docs/default-source/policy/2016_50-state-telehealth-gaps-analysis-md-physician-practices-licensure.pdf?sfvrsn=2

²⁷ “State Telehealth Laws and Medicaid Program Policies: A Comprehensive Scan of the 50 States and District of Columbia,” Center for Connected Health Policy, July 2015.
<http://cchpca.org/sites/default/files/resources/STATE%20TELEHEALTH%20POLICIES%20AND%20REIMBURSEMENT%20REPORT%20FINAL%20%28c%29%20JULY%202015.pdf>

Arkansas State Medical Board rules: Arkansas Code 17-80-117, enacted in April 2015, and Regulation No. 2(8) of the Arkansas State Medical Board, requires an initial in-person encounter to establish a valid physician-patient relationship. The board circulated draft rules in October 2015 which if enacted would improve the practice environment by allowing a doctor to establish a relationship with a patient “using a face-to-face real-time audio and visual technology” in certain situations.²⁸

California

Effective September 2014, new legislation revised the informed consent requirements relating to the delivery of health care via telehealth by permitting consent to be made verbally or in writing. It also repeals the requirement that the health care provider who obtains the consent be at the originating site where the patient is physically located. The statute requires the health care provider to document the consent.²⁹

Colorado

Statutory definition of telehealth: Effective January 1, 2017, telehealth means a mode of delivery of healthcare services through telecommunications systems, including information, electronic, and communication technologies, to facilitate the assessment, diagnosis, consultation, treatment, education, care management, or self-management of a covered person’s health care while the covered person is located at an originating site and the provider is located at a distant site. The term includes synchronous interactions and store-and forward transfers. Telehealth does not include the delivery of health care services via telephone, facsimile machine or electronic mail.

Authority: CO Revised Statutes 10-16-123(2) (h) (4) (e) (I & II) (2015).³⁰

²⁸ “Arkansas Prepares New Telemedicine Practice Rules,” *Health Care Law Today* (blog), February 16, 2016. <https://www.healthcarelawtoday.com/2016/02/16/arkansas-prepares-new-telemedicine-practice-rules/>

²⁹ “Practicing Medicine through Telehealth Technology,” Medical Board of California. (website). Accessed April 21, 2016. <http://www.mbc.ca.gov/Licensees/Telehealth.aspx>

³⁰ “State Telehealth Laws and Medicaid Program Policies: A Comprehensive Scan of the 50 States and District of Columbia,” Center for Connected Health Policy, July 2015

Connecticut

Effective October 1, 2015, new legislation broadly defines telehealth as “the mode of delivering health care or other health services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient’s physical and mental health, and includes (A) interaction between the patient at the originating site and the telehealth provider at a distant site, and (B) synchronous interactions, asynchronous store and forward transfers or remote patient monitoring.”³¹

Effective October 1, 2015, at the time of the telehealth interaction, the provider shall provide information to the patient treatment information, limitations of the telehealth platform, and obtain consent from the patient to provide telehealth services and disclose to the patient’s primary care provider records of the telehealth interaction.

Authority: CT Public Act No. 15-88 (2015); SB 467.³²

Public Act 15-88 is the first comprehensive law in Connecticut to address telemedicine and to establish regulatory requirements for providing telehealth services. Under the new law, any of the following licensed professionals acting within their scope of practice and in accordance with applicable standards of care can provide services via telehealth: physicians, physical therapists, chiropractors, naturopaths, podiatrists, occupational therapists, optometrists, advanced practice registered nurses, physician assistants, psychologists, marital and family therapists, clinical or master social workers, alcohol and drug counselors, professional counselors, and certified dietician-nutritionists.

Telehealth services must be conducted using real-time, interactive two-way communication technology and/or transmitting images and data recorded with a camera or other technology from the patient to the remote provider. The definition of telehealth expressly excludes the use of fax, audio-only telephone, text messaging, and e-mail. Telehealth providers must have access to or knowledge of the patient’s medical history, as provided by the patient, and the patient’s health record, including the name and address of the patient’s primary care provider. Health care services rendered via telehealth must conform to the standard of care applicable to the provider’s profession that would be expected for in-person care and, if the relevant standard requires the use of certain tests or a physical exam, such tests or exam may be carried out using

³¹ “States Begin 2016 with the Expansion of Telehealth Services,” *Of Digital Interest* (blog), January 6, 2016. <http://www.ofdigitalinterest.com/2016/01/states-begin-2016-with-the-expansion-of-telehealth-services/>

³² “State Telehealth Laws and Medicaid Program Policies: A Comprehensive Scan of the 50 States and District of Columbia,” Center for Connected Health Policy, July 2015.

appropriate peripheral devices. Providers are prohibited from prescribing schedule I, II, or III controlled substances via telehealth.

The new requirements include certain patient protections. During the first telehealth interaction, providers must inform their patients about the treatment methods and limitations of providing treatment via telehealth and obtain the patient’s consent to using telehealth, to be documented in the patient’s health record. At the time of each telehealth interaction, telehealth providers must request patient consent to disclose records relating to the telehealth session to the patient’s primary care provider. If the patient does consent, such records shall be shared with the patient’s primary care provider. The provision of telehealth services and maintenance and disclosure of related records must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended. Telehealth providers must provide patients with their license number and contact information. The legislation is clear that it should not be construed to prohibit (1) a provider from providing on-call coverage or consulting with another provider regarding a patient’s care or (2) orders of health care providers for hospital outpatients or inpatients.³³

Delaware

On July 7, 2015, Delaware enacted a comprehensive statute amending numerous provisions in Title 24 (health care professions and occupations) of the Delaware Code to account for changes to telemedicine and telehealth scope of practice. The Delaware telemedicine law includes separate, but complementary, definitions for telehealth and telemedicine. Key provisions:

- **Telehealth** is defined as “the use of information and communications technologies consisting of telephones, remote patient monitoring devices or other electronic means which support clinical health care, provider consultation, patient and professional health-related education, public health, health administration, and other services as described in regulation.”
- **Telemedicine** is defined as “a form of telehealth which is the delivery of clinical health care services by means of real time two-way audio, visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care

³³ “Connecticut Enacts Act concerning the facilitation of telehealth,” *Data Privacy + Security Insider* (blog), July 2, 2015. https://www.dataprivacyandsecurityinsider.com/2015/07/connecticut-enacts-act-concerning-the-facilitation-of-telehealth/?utm_source=feedburner&utm_medium=feed&utm_campaign=Feed%3A+DataPrivacyAndSecurityInsider+%28Data+Privacy+and+Security+Insider%29

management and self-management of a patient's health care by a health care provider practicing within his or her scope of practice as would be practiced in-person with a patient, and legally allowed to practice in the state, while such patient is at an originating site and the health care provider is at a distant site."

The legislation amends Delaware's Medical Practice Act (Title 24, Chapter 17) including a new section 1769D governing the physician practice of telemedicine. The law includes the following highlights:

Creating a valid doctor-patient relationship. A valid doctor-patient relationship established through telehealth includes, but is not limited to, the following seven elements:

1. Fully verifying and authenticating the location and, to the extent possible, identifying the requesting patient;
2. Disclosing and validating the provider's identity and applicable credential(s);
3. Obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including informed consents regarding the use of telemedicine technologies;
4. Establishing a diagnosis through the use of acceptable medical practices, including patient history, mental status examination, physical examination (unless not warranted by the patient's mental condition), and appropriate diagnostic and laboratory testing to establish diagnoses, as well as identify underlying conditions or contra-indications, or both, to treatment recommended or provided;
5. Discussing with the patient the diagnosis and the evidence for it, the risks and benefits of various treatment options;
6. Ensuring the availability of the distant site provider or coverage of the patient for appropriate follow-up care; *and*
7. Providing a written visit summary to the patient.

In-Person Examination Requirement and Exceptions. Physicians using telemedicine technologies to provide medical care to patients located in Delaware must, prior to a diagnosis and treatment provide one of the following:

- An appropriate examination in-person;
- Have another Delaware-licensed practitioner at the originating site with the patient at the time of the diagnosis;
- The diagnosis must be based using both audio and visual communication; *or*
- The service meets standards of establishing a patient-physician relationship included as part of evidenced-based clinical practice guidelines in telemedicine developed by major medical specialty societies, such as those of radiology or pathology.

The legislation provides treatment and consultation recommendations made in an online setting, including issuing a prescription via electronic means, are held to the same standards of appropriate practice as those in traditional in-person settings. Without a prior and proper doctor-patient relationship, providers are prohibited from issuing prescriptions solely in response to an Internet questionnaire, an Internet consult, or a telephone consult. Prescriptions made through telemedicine under a valid doctor-patient relationship may include controlled substances (subject to any limitations as set by the Board of Medicine).

Record Keeping. The physician treating a patient through telemedicine must maintain a complete record of the patient’s care which must follow all applicable state and federal statutes and regulations for recordkeeping, confidentiality, and disclosure to the patient.

Exceptions. Telemedicine services may be performed without a doctor-patient relationship under the following exceptions:

1. Informal consultation performed by a physician outside the context of a contractual relationship and on an irregular or infrequent basis without the expectation or exchange of direct or indirect compensation;
2. Furnishing of medical assistance by a physician in case of an emergency or disaster if no charge is made for the medical assistance; or
3. Episodic consultation by a medical specialist located in another jurisdiction who provides such consultation services on request to a person licensed in this state.

The law requires that the definition of telemedicine must include, at such time is feasible and when appropriate, utilizing the Delaware Health Information Network (DHIN) in connection with the practice of telemedicine. Presumably, this will be a subject of implementing regulations.

In addition to physician practice, the Act empowers the following Delaware professional licensing boards to issue regulations regarding telehealth and telemedicine: psychologists, physician assistants, nurses, pharmacists, genetic counselors, chiropractors, respiratory care practitioners, podiatrists, dentists, occupational therapists, optometrists, mental health counselors and chemical dependency professionals, dietitians and nutritionists, and clinical social workers.³⁴

³⁴ Nathaniel Lacktman, “Telemedicine Practice and Remote Prescribing in Delaware,” *Health Care Law Today* (blog), July 10, 2015. <https://www.healthcarelawtoday.com/2015/07/10/delawares-new-telemedicine-scope-of-practice-law/>

Florida

Florida’s Board of Medicine implemented a new rule to permit physicians to prescribe controlled substances via telemedicine exclusively for the treatment of psychiatric disorders, effective March 4, 2016. Specifically, the amended regulation provides that controlled substances may not be prescribed through the use of telemedicine, “except for the treatment of psychiatric disorders.”³⁵

Idaho

Idaho Telehealth Access Act enacted in 2015 defines telehealth as a mode of delivering health care services that uses information and communication technologies to enable the diagnosis, consultation, treatment, education, care management and self-management of patients at a distance from health providers. Telemedicine is defined as the use of medical information exchanged from one site to another via electronic communications to improve a patient's health status. Patient-provider relationships can be established without an in-person visit using two-way audio and video and maintained using electronic communications. A provider offering telehealth services must act within the scope of the provider's license and according to all applicable laws and rules and the community standard of care.

If provider does not have an established provider-patient relationship with a person seeking such services, the provider shall take appropriate steps to establish a provider-patient relationship by use of two-way audio and visual interaction; provided however that the applicable Idaho community standard of care must be satisfied. The new law also created the Idaho Telehealth Council to coordinate and develop a comprehensive set of standards, policies, rules and procedures for the use of telehealth and telemedicine in Idaho.^{36 37}

Indiana

New law taking effect July 1, 2016 (with the sunset of the 2015 legislation establishing a telehealth services pilot program) implements telemedicine practice standards and remote prescribing rules. The new statute may potentially require the board of medicine to rewrite some of its current telemedicine regulations to the extent the prior regulations conflict with the controlling provisions of the statute. Key provisions:

³⁵ “2016 Is Ramping Up For Telemedicine Developments.” *Benesch Health Law* (blog), February 26, 2016. <https://beneschhealthlaw.com/2016/02/26/2016-is-ramping-up-for-telemedicine-developments/#page=1>

³⁶ <http://telehealthcouncil.idaho.gov/> (Accessed April 22, 2016)

³⁷ Idaho Telehealth Access Act. www.legislature.idaho.gov/legislation/2015/H0189.pdf

- Telemedicine is defined as the delivery of health care services using electronic communications and information technology between a provider in one location and a patient in another location, including: 1) secure videoconferencing; 2) interactive audio-using store and forward technology; or 3) remote patient monitoring technology. Telemedicine does not include the use of the following: 1) audio-only communication; 2) a telephone call; 3) electronic mail; 4) an instant messaging conversation; 5) facsimile; 6) internet questionnaire; 7) telephone consultation; or 8) internet consultation.
- **Physician-Patient Relationship.** Physicians utilizing telemedicine must establish a proper physician-patient relationship by, among other things, conducting an appropriate examination. The examination does not require an in-person visit. However, the examination must at a minimum include the following eight elements:
 - Obtain the patient’s name and contact information and: 1) a verbal statement or other data from the patient identifying the patient’s location; and 2) to the extent reasonably possible, the identity of the requesting patient.
 - Disclose the provider’s name and disclose whether the provider is a physician, physician assistant, advanced practice nurse, or optometrist.
 - Obtain informed consent from the patient.
 - Obtain the patient’s medical history and other information necessary to establish a diagnosis.
 - Discuss with the patient the: 1) diagnosis; 2) evidence for the diagnosis; and 3) risks and benefits of various treatment options, including when it is advisable to seek in-person care.
 - Create and maintain a medical record for the patient and, subject to the consent of the patient, notify the patient’s primary care provider of any prescriptions the provider has written for the patient if the primary care provider’s contact information is provided by the patient. (This requirement does not apply when the provider is using an electronic health record system that the patient’s primary care provider is authorized to access.)
 - Issue proper instructions for appropriate follow-up care.
 - Provide a telemedicine visit summary to the patient, including information that indicates any prescription that is being prescribed.
- **Standard of Care.** A provider who provides health care services through telemedicine is held to the same standards of appropriate practice as those in traditional in-person settings.
- **Remote Prescribing.** Remote prescribing is permitted, subject to certain conditions. A provider may issue a prescription to a patient who is receiving services via telemedicine without any prior in-person exam if the following five conditions are met:

- The provider has satisfied the applicable standard of care in the treatment of the patient.
 - The issuance of the prescription by the provider is within the provider's scope of practice and certification.
 - The prescription is not for a controlled substance (defined in IC 35-48-1-9).
 - The prescription is not for an abortion-inducing drug (defined in IC 16-18-2-1.6).
 - The prescription is not for an ophthalmic device, including: 1) glasses; 2) contact lenses; or 3) low vision devices.
- **Informed Consent.** Informed consent to telemedicine services is required.
 - **Patient Records.** A patient record must be created for every telemedicine visit. The maintenance and confidentiality of the records must be consistent with state and federal law. Subject to the consent of the patient, the telemedicine provider must notify the patient's primary care provider of any prescriptions the provider has written for the patient if the primary care provider's contact information is provided by the patient.
 - **Other Health Care Professionals.** In addition to physicians, the law empowers the following Indiana licensed professionals to provide services via telemedicine: physician assistants, advanced practice nurses, and optometrists. A provider who is physically located outside Indiana is engaged in the provision of health care services in Indiana when he or she: 1) establishes a provider-patient relationship via telemedicine with; or 2) determines whether to issue a prescription via telemedicine for; an individual who is located in Indiana. Such a provider may not establish a provider-patient relationship via telemedicine or issue a prescription for an individual located in Indiana unless the provider and the provider's employer or the provider's contractor have certified in writing to the Indiana professional licensing agency (e.g., the Board of Medicine), in a manner specified by that agency, that the provider and the provider's employer or provider's contractor agree to be subject to: 1) the jurisdiction of the courts of law of Indiana; and 2) Indiana substantive and procedural laws; concerning any claim asserted against the provider, the provider's employer, or the provider's contractor arising from the provision of health care services via telemedicine to an individual located in Indiana at the time the services were provided.
 - The filing of the certification constitutes a voluntary waiver by the provider, the provider's employer, or the provider's contractor of any respective right to avail themselves of the jurisdiction or laws other than those in Indiana concerning the claim.
 - A provider that practices predominately in Indiana is not required to file the certification. The statute does not define what it means to practice predominately in

Indiana.

- A provider shall renew the certification at the time the provider renews his or her license. A provider's employer or contractor is required to file the certification only at the time of initial certification.
- A provider who violates these rules is subject to disciplinary action, and a provider's employer or contractor that violates these rules commits a Class B infraction for each act in which a certification is not filed as required.³⁸

Iowa

The Iowa Board of Medicine adopted a new rule effective June 3, 2015 establishing standards of medical practice via telemedicine. Telemedicine is defined to include practicing medicine "using electronic audio-visual communications and information technologies...including interactive audio with asynchronous store-and-forward transmission" between a patient and physician and does not include providing medical services through audio-only phone, email, fax, or mail.

Physicians using telemedicine to treat a patient in Iowa must have an active Iowa medical license and will be held to the same standards of care and professional ethics as required of in-person care. A prior in-person examination is not required if telemedicine technology is sufficient to provide an informed diagnosis. Additionally, the Rule provides standards for physicians practicing telemedicine regarding patient consent, follow-up care, coordination of care, emergency services, and patient feedback.³⁹

The regulations also state that "[a] licensee who uses telemedicine shall utilize evidence-based telemedicine practice guidelines and standards of practice, to the degree they are available, to ensure patient safety, quality of care, and positive outcomes."

³⁸ Nathaniel M. Lacktman, "Key Takeaways from Indiana's New Telemedicine Law," *Health Care Law Today* (blog), March 28, 2016. <https://www.healthcarelawtoday.com/2016/03/28/key-takeaways-from-indianas-new-telemedicine-law/>

³⁹ Alexis S. Gilroy, Maureen Bennett, Soleil E. Teubner, Kevin D Lyles, Cristiana Spontoni and Stephen E. Gillette, "What Does the Interstate Medical Licensure Compact Mean for Telemedicine? Jones Day Digital Health Law Update, Vol. 1, Issue 3, June 2015. http://thewritestuff.jonesday.com/rv/ff001fba93988792fb6901396749bb38b75b5399?utm_source=Mondaq&utm_medium=syndication&utm_campaign=View-Original

The regulations further require the licensee to perform “a physical examination, when medically necessary, sufficient for the diagnosis and treatment of the patient.” The rule bars physicians from inducing an abortion by providing an abortion-inducing drug unless the physician has first performed a physical examination and is physically present with the woman at the time the abortion-inducing drug is provided.⁴⁰

Louisiana

In late 2014, Louisiana Medical Board adopted regulations specific to telemedicine placing limitations on telemedicine, including restricting the prescribing of controlled substances via telemedicine. In response to those regulations, the Louisiana legislature issued House Concurrent Resolution No. 4 on May 21, 2015, expressing its intent for previously passed telemedicine legislation, HB 1280, that the standard of care for telemedicine services be equal to the standard of care applied generally for medical services and that medical board actions should not exceed the scope of the legislative authority.⁴¹

Key provisions of the regulations:

1. **Telemedicine.** Telemedicine remains defined as the practice of health care delivery, diagnosis, consultation, treatment, and transfer of medical data by a physician using interactive telecommunications technology that enables a physician and patient at two locations separated by distance to interact via two-way video and audio transmissions simultaneously. A telephone-only conversation or electronic messaging between a physician and a patient do not meet the definition of telemedicine for purposes of the regulations. Only secure communication technology can be used for telemedicine. At a minimum, the technology must comply with all state and federal laws and regulations for medical information privacy and security.
2. **In-State Physician Licensure.** A physician with an unrestricted Louisiana medical license and who maintains a “physical practice location” in Louisiana can provide medical services via telemedicine to patients in Louisiana. “Physical practice location” means a “clinic facility, office or other location physically located in [Louisiana], where the physician spends the majority of his or her time practicing medicine.” The old rule had a similar definition in the term “primary practice site,” but the new rules add that no physician can use telemedicine to provide care to a patient physically located *outside* of

⁴⁰ *Planned Parenthood of the Heartland, Inc. & Jill Meadows v. Iowa Board of Medicine, Case No. 14-1415*, (June 19, 2015; Amended August 18, 2015) <http://cchpca.us9.list-manage.com/track/click?u=c9fa99b7520aedfca5c453103&id=2f795d15d9&e=c6df81e7d8>

⁴¹ Gilroy et al, “What Does the Interstate Medical Licensure Compact Mean for Telemedicine?”

Louisiana, unless the physician has authority to do so by the licensing authority in the state in which the patient is located.

3. **Out-of-State Physician Permit.** If a physician does not maintain a “physical practice location” in Louisiana, he or she cannot practice telemedicine in Louisiana unless he or she holds a telemedicine permit issued by the Board. A physician seeking a telemedicine permit must: 1) possess the qualifications for medical licensing (*e.g.*, age and character and medical degree requirements), 2) possess a medical license in another state, and 3) complete a board-approved application and fee. In addition, the application for a telemedicine permit now requires an affirmation that the applicant has an arrangement with one or more physicians who maintain a physical practice location in Louisiana to accept patients for referral and follow-up care.
4. **Consultations.** Louisiana has a peer-to-peer consultation exception to licensing, and it also applies to telemedicine-based consults. The Louisiana physician receiving the opinion of the unlicensed consulting doctor must remain personally responsible to the patient for the primary diagnosis and any testing and treatment provided.
5. **Physician-Patient Relationship.** Physicians utilizing telemedicine must establish a proper physician-patient relationship by, among other things, conducting an appropriate examination. The examination does not require an in-person visit if the technology is sufficient to provide the physician the pertinent clinical information reasonably necessary to practice at an acceptable level of skill and safety.
6. **Standard of Care and Remote Prescribing.** The practice of medicine by telemedicine including issuance of any prescription via electronic means is held to the same prevailing and usually accepted standards of medical practice as those in traditional in-person settings. An online, electronic or written mail message or a telephonic evaluation by questionnaire or otherwise, does not satisfy the standards of appropriate care. If required by the standard of care in an in-person setting, a physician must be able to utilize peripherals; obtain diagnostic testing; if necessary in the physician’s judgment, access a patient-side tele-presenter to assist with the encounter; and conduct an in-person examination or refer the patient to another physician for an in-person examination.
7. **Controlled Substances.** In most instances, the Board believes an in-person visit is required prior to prescribing any controlled substance. However, provided the physician can conduct a patient examination via telemedicine sufficient to make a diagnosis, controlled substances can be prescribed if: 1) the physician has had at least one in-person visit with the patient at a physical practice location in Louisiana within the past

year; 2) the prescription is issued for a legitimate medical purpose; 3) the prescription is in conformity with the same standard of care applicable to an in-person visit; and 4) the prescription is permitted by and in conformity with all applicable state and federal laws and regulations. The Board may grant an exception to these limitations in individual cases. Prescribers must also comply with the Ryan Haight Act, though provider-friendly changes are in the works due in part to efforts by members of the American Telemedicine Association and its [letter to the DEA](#).

8. **Disclosures.** The regulations require certain disclosures to the patient prior to providing telemedicine services: 1) the name, Louisiana medical license number and the contact information of the physician, 2) the physician's specialty or area of practice, 3) how to receive follow-up and emergency care; 4) how to obtain copies of medical records and/or insure transmission to another medical provider; 5) how to receive care in the event of a technology or equipment failure; and 6) notification of privacy practices. These disclosures were not required under the old rules.
9. **Informed Consent.** Informed consent to telemedicine services is required. A physician must notify a patient of the relationship between the physician and patient and the respective role of any other health care provider with respect to management of the patient and that the patient may decline to receive medical services by telemedicine at any time.
10. **Patient Records.** A patient record must be created for every telemedicine visit according to the same standard of care as an in-person visit. The maintenance and confidentiality of the records must be consistent with state and federal law. Records must be made available to the patient or a physician to whom the patient may be referred within a reasonable amount of time. A physician providing telemedicine services must also have access to the patient's medical record.⁴²

Maine

The Maine Board of Licensure in Medicine enacted new guidelines governing the practice of telemedicine and the use of technology to deliver health care services effective June 2014. Key provisions:

⁴² Nathaniel M. Lacktman and Jacqueline N. Acosta, "Louisiana Telemedicine Practice Rules: What Providers Need to Know," *Health Care Law Today* (blog), March 21, 2016. <https://www.healthcarelawtoday.com/2016/03/21/louisiana-telemedicine-practice-rules-what-providers-need-to-know/>

- **Maine License Required:** A Maine medical license is required for the practice of telemedicine with patients located in Maine, as the practice of medicine occurs at the location of the patient.
- **Practice Standards:** The same standards of practice for physician interaction, treatment, recommendations, and prescribing apply, regardless of whether the physician provides services via telemedicine or traditional in-person encounters. The telemedicine interaction must include all the recognized components of a patient-physician encounter required to establish a diagnosis and treatment.
- **In-Person Examinations:** Maine does not require an in-person examination prior to the telemedicine encounter. A valid doctor-patient relationship may be created via telemedicine. However, physicians offering primary care via telemedicine, other than acute episodic care, are required to conduct a “face-to-face” visit with their patient at least once a year.
- **Remote Prescribing:** Under the guidance, physicians may conduct remote prescribing without the need for an in-person exam. Remote prescribing is at the discretion of the prescribing physician and is held to equivalent standards for in-person encounters. Where proper measures are followed, and the appropriate clinical consideration is carried out and documented, physicians may exercise their judgment and prescribe medication as part of telemedicine encounters. Providers may not engage in internet prescribing. The guidance is silent on remote prescribing of controlled substances.
- **Accessibility of Medical Records:** Medical records are expected to satisfy Maine’s medical record standards and confidentiality rules, and must be maintained at the distant site. Records must be accessible to local health care providers and facilities upon request.
- **Informed Consent:** Maine’s consent requirements are more onerous than other states. Patient consent to the use of telemedicine technologies must be obtained, and should include:
 - Patient and physician identification
 - Types of telemedicine interactions/transmissions permissible such as prescriptions, refills, education, diagnosis, and appointment scheduling
 - Security measures taken with use of telemedicine such as password protection, encryption and notification of potential risk to privacy and sensitive information even with such measures
 - Possibility of transmission failure or loss of information due to technical reasons

- Information regarding emergency care and after-hours contacts
- **Emergency Care:** The physician providing services through telemedicine is required to provide to the patient with an emergency plan when a hospital emergency department or an acute care facility is needed. A plan of next steps to be taken by the patient must be provided to the patient by the physician providing telemedicine care when that care indicates the need for an acute care facility or hospital emergency department, including after-hours emergency treatment instructions.
- **Technology Considerations:** The guidelines require telemedicine to use either real-time audio and visual communications, or store & forward technology, provided the technology offers the same information to the provider as if the encounter had occurred in person. The technology must also verify the identity and location of the patient, and disclose the physician's identity and credentials.
- **Other Communications:** Audio only, telephone conversation, e-mail/instant messaging or fax are not acceptable methods for the practice of medicine in Maine with the following exceptions:
 - Providers covering their own practice or that of another licensee where an established patient-physician relationship exists.
 - Providers who initiate treatment of a patient/partner for sexually transmitted disease.
 - Distant site provider who provides consultation to a licensee who has primary responsibility for the care and treatment of the patient.⁴³

Minnesota

In 2015, Minnesota enacted legislation effective January 1, 2016 defining telemedicine as the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between licensed health care providers that consists solely of a telephone conversation, e-mail, or facsimile transmission does not constitute telemedicine consultations or services. A communication between a licensed health care provider and a patient that consists solely of an e-mail or facsimile transmission does not constitute telemedicine consultations or services.

⁴³ Nathaniel M. Lacktman, "Maine Welcomes Telemedicine with New Board Guidelines," *The National Law Review*, August 3, 2015. <http://www.natlawreview.com/article/maine-welcomes-telemedicine-new-board-guidelines#sthash.AkqzKSC.JV4Z8gT2.dpuf>

Telemedicine may be provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.

Authority: MN Senate File 1458 (2015). MN Statute Sec 256B.0622, subdivision 8.⁴⁴

Montana

In 2015, Montana enacted legislation defining telemedicine as the practice of medicine using interactive electronic communication information technology, or other means between a licensee in one location and a patient in another location with or without an intervening health care provider. Telemedicine typically involves the application of secure videoconferencing or store-and-forward technology and does not mean an audio-only telephone conversation, an e-mail or instant messaging conversation, or a message sent by facsimile transmission.

Authority: MT Code Sec. 37-3-102.⁴⁵

Nebraska

In 2015, Nebraska revised its 2014 statutory definition of telehealth. Under new definition, telehealth means “the use of medical information electronically exchanged from one site to another, whether synchronously or asynchronously, to aid a health care practitioner in the diagnosis or treatment of a patient. Telehealth includes services originating from a patient’s home or any other location where such patient is located, asynchronous services involving the acquisition and storage of medical information at one site that is then forwarded to or retrieved by a health care practitioner at another site for medical evaluation, and telemonitoring.

Authority: NE Rev. Statute, 71-8503. (LB 1076) & LB 257 (2015).⁴⁶

⁴⁴ “State Telehealth Laws and Medicaid Program Policies: A Comprehensive Scan of the 50 States and District of Columbia,” Center for Connected Health Policy, July 2015.

⁴⁵ “State Telehealth Laws and Medicaid Program Policies: A Comprehensive Scan of the 50 States and District of Columbia,” Center for Connected Health Policy, July 2015.

⁴⁶ Ibid.

New Mexico

Effective July 1, 2016, **the** Board of Osteopathic Medicine will issue a telemedicine license.

Authority: NM Statute Chapter 61, Article 10, Sec. 19. (SB 78)⁴⁷

New Hampshire

In 2015, New Hampshire enacted law stipulating that a physician-patient relationship requires an in-person exam that may take place via a face-to-face via 2-way real time interactive communication. The statute bars prescribing drugs to individuals without a physician-patient relationship except when writing admission orders for a newly hospitalized patient, the patient of another provider for whom the prescriber is taking call, a prescription for a patient who has been examined by a physician assistant, nurse practitioner, or other licensed practitioner; medication on a short-term basis for a new patient prior to the patient's first appointment; and when providing limited treatment to a family member in accordance with the American Medical Association Code of Medical Ethics.

The law makes it unlawful to prescribe through telemedicine a controlled drug classified in schedule II through IV. Prescriptions of a non-opioid controlled drug classified in schedule II through IV via telemedicine are be limited to certain practitioners and who are treating patients at a state designated community mental health center or a Substance Abuse and Mental Health Services Administration-certified state opioid treatment program, and shall require an initial in-person exam by a practitioner licensed to prescribe the drug.

Authority: NH Revised Statutes Annotated, Sec. 329:1-c.
NH Bill SB 84 (2015).⁴⁸

Tennessee

Effective July 1, 2015, Tennessee enacted legislation establishing an equal standard of care among services provided by both telemedicine and traditional in-person methods. The law prohibits any health care board or licensing entity from establishing a more restrictive standard of professional practice for services furnished by telehealth.⁴⁹

⁴⁷ Ibid.

⁴⁸ Ibid.

⁴⁹ Gilroy et al., "What Does the Interstate Medical Licensure Compact Mean for Telemedicine?"

The legislation is in response to the Tennessee Board of Medical Examiners' attempt to issue rules governing telemedicine in 2014. Those proposed rules contained several controversial elements, including a requirement that physicians must conduct a face-to-face examination prior an initial telehealth encounter. In addition, the proposed rules allowed only real-time patient encounters and mandated follow-up, in-person visits at least every fourth encounter or annually.

The statute defines “telehealth” or “telemedicine” broadly to mean “the use of real-time audio, video, or other electronic media and telecommunications that enable interaction between the healthcare provider and the patient, or also store-and-forward telemedicine services . . . for the purpose of diagnosis, consultation, or treatment of a patient in another location where there may be no in-person exchange.”⁵⁰

Texas

In April 2015, the Texas Medical Board adopted rules requiring an in-person, co-located examination to establish a physician-patient relationship, and this defined physician-patient relationship is required before a physician can prescribe medications. These examinations can only be performed at certain established medical sites that meet the strict requirements of the Board's regulations.⁵¹

The rule allows telemedicine without a prior visit if a patient is at a health facility, such as a hospital, clinic or even a pharmacy, and has another healthcare professional with them. Mental health visits are excluded from the rule.⁵²

In December 2015, a U.S. District Court Judge Robert Pitman permitted a legal challenge of the rule by Teladoc to proceed in a law and motion ruling, finding Teladoc's claims that board was violating terms of the U.S. Constitution's Commerce Clause were substantial enough to be addressed in court and that the board did not have state actor immunity to antitrust lawsuits.⁵³

⁵⁰ Angela Youngberg, “April Showers Brought Changes to Telehealth Laws,” Waller Healthcare Blog, May 5, 2015. <http://www.wallerlawblog.com/posts/75/April-Showers-Brought-Changes-to-Telehealth-Laws>

⁵¹ Andrea Musker, “Telemedicine Providers Need to Keep Up with State Laws,” *JD Supra*, April 17, 2015. http://www.jdsupra.com/legalnews/telemedicine-providers-need-to-keep-up-w-57413/?utm_source=JD-Supra-eMail-Digests

⁵² Markian Hawryluk, “Texas Medical Board votes to curtail telemedicine,” *Houston Chronicle*, April 10, 2015. <http://www.chron.com/houston/article/Texas-Medical-Board-votes-to-curtail-telemedicine-6191806.php>

⁵³ Eric Wicklund, “Teladoc Wins another Skirmish in Texas Telemedicine Tussle,” *mHealth Intelligence*, December 16, 2015. <http://mhealthintelligence.com/news/teladoc-wins-another-skirmish-in-texas-telemedicine-tussle>

Virginia

In 2015, the Virginia Board of Medicine published telemedicine guidelines. Key provisions:

- **Telemedicine.** The guidelines incorporate the language from the statute, and define telemedicine services as "the use of electronic technology or media, including interactive audio, or video, for the purpose of diagnosing or treating a patient or consulting with other health care providers regarding a patient's diagnosis or treatment." Telemedicine services do not include an audio-only telephone, electronic mail message, facsimile transmission, or online questionnaire.
- **Licensure.** The practitioner must be licensed by both the regulatory board of the state where the patient is located and the state where the practitioner is located.
- **Practitioner-Patient Relationship.** A physician may establish a valid doctor-patient relationship via telemedicine without the need for an in-person examination. To do so, the practitioner must:
 - Meet the standard of care;
 - Adhere to Virginia law, and the law in any state where a patient is receiving services, that defines the patient-practitioner relationship;
 - Verify and authenticate the patient's location and identity;
 - Disclose the practitioner's identity and credentials; and
 - Obtain appropriate consent after disclosures regarding the delivery methods or limitations, including any special informed consents regarding the use of telehealth technologies.
- **Telehealth Consultations and Treatment.** Treatment and consultation recommendations, including remote prescribing, are held to the same standards of appropriate practice as those in traditional settings. Virginia's standards include a documented medical evaluation and relevant clinical history to establish a diagnosis, as well as identifying contra-indications to care and underlying conditions prior to providing treatment. Treatment, including issuing a prescription, based solely on an online questionnaire does not constitute an acceptable standard of practice.
- **Remote Prescribing & Controlled Substances.** Virginia physicians may prescribe medications via telemedicine (i.e., remote prescribing). Doing so is at the discretion of the physician, provided the prescribing is consistent with standards of care and lists the direct contact information of the prescriber (or prescriber's agent) on the prescription itself. Regarding controlled substances, prescriptions must comply with requirements

set forth in Va. Code §§ 54.1-3408.01 and 54.1 -3303(A). Physicians may prescribe Schedule VI medication via telemedicine when a doctor-patient relationship is established using face-to-face, two-way real-time communications services or store-and-forward technologies when all of the following conditions are met:

- The patient has provided a medical history that is available for review by the prescriber;
 - The prescriber obtains an updated medical history at the time of prescribing;
 - The prescriber makes a diagnosis at the time of prescribing;
 - The prescriber conforms to the standard of care expected of in-person traditional exams including the use of diagnostic testing or physical examination, via condition-appropriate peripheral devices;
 - The prescriber is licensed in Virginia and authorized to prescribe;
 - If the patient is enrolled in a health plan, the prescriber is credentialed by the health plan as a participating provider and the prescribing meets the plan's qualifications for reimbursement; and
 - Upon request, the prescriber provides medical records from the consultation to patients or their primary care physicians in a timely manner.
- **Informed Consent.** Patient consent to the use of telemedicine technologies must be obtained, documented, and maintained. The consent should include:
 - Identification of the patient, the practitioner, and the practitioner's credentials;
 - Types of telemedicine interactions/transmissions permissible such as prescriptions, refills, education, diagnosis, and appointment scheduling;
 - Agreement by the patient that it is the role of the practitioner to determine whether or not the condition being diagnosed and/or treated is appropriate for a telemedicine encounter;
 - Security measures taken with use of telemedicine such as password protection, encryption and notification of potential risk to privacy and sensitive information even with such measures;
 - Hold harmless clause for information loss due to technical failures; and
 - Requirement for express patient consent to forward patient information to a third party.
 - **Medical Records.** The practitioner must maintain a medical record in connection with the utilization of telemedicine services that is accessible to both the practitioner and the patient and consistent with established laws and regulations pertaining to patient health records.
 - **Privacy and Security.** Telemedicine providers should establish written policies and procedures that address the following factors: privacy; health care personnel who will

process messages; hours of operation; types of transactions that will be permitted electronically; required patient information to be included in the communication; archiving and retrieval; and quality oversight mechanisms. These protocols must be periodically evaluated for currency and readily available for review.⁵⁴

Washington

New law effective January 1, 2017 defines telemedicine as “the delivery of health care services through the use of interactive audio and video technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment. Telemedicine does not include the use of audio-only telephone, facsimile, or email.

Authority: Revised Code of WA Sec. 41.05, 48.43, 74.09, & 70.41.020).⁵⁵

West Virginia

West Virginia enacted legislation effective June 11, 2016 implementing telemedicine practice standards and remote prescribing rules. West Virginia's Medical Board previously issued a Telemedicine Position Statement in November 2014.⁵⁶ Key provisions of the new law:

Telemedicine. The law separates the definition of telemedicine into three parts:

- Telemedicine is defined as the practice of medicine using tools such as electronic communication, information technology, store and forward telecommunication, or other means of interaction between a physician in one location and a patient in another location, with or without an intervening healthcare provider.

⁵⁴ Nathaniel M. Lacktman and Thomas B. Ferrante, “Virginia Telehealth Law: What You Need to Know,” *Health Care Law Today* (blog), April 12, 2016.

https://www.healthcarelawtoday.com/2016/04/12/4419/?utm_source=feedburner&utm_medium=feed&utm_campaign=Feed%3A+HealthCareLawToday+%28Health+Care+Law+Today%29?utm_source=Mondaq&utm_medium=syndication&utm_campaign=LinkedIn-integration

⁵⁵ “State Telehealth Laws and Medicaid Program Policies: A Comprehensive Scan of the 50 States and District of Columbia,” Center for Connected Health Policy, July 2015.

⁵⁶ “Position Statement on Telemedicine,” West Virginia Board of Medicine, Adopted November 3, 2014. www.mondaq.com/redirection.asp?article_id=480428&company_id=19711&redirectaddress=https://www.healthcarelawtoday.com/wp-content/uploads/sites/15/2016/03/WV-telemedicine-statement-2014.pdf

- "Telemedicine technologies" means technologies and devices which enable secure electronic communications and information exchange in the practice of telemedicine, and typically involve the application of secure real-time audio/video conferencing or similar secure video services, remote monitoring, or store and forward digital image technology to provide or support healthcare delivery by replicating the interaction of a traditional in-person encounter between a physician and a patient.
 - "Store and forward telemedicine" means the asynchronous computer-based communication of medical data or images from an originating location to a physician at another site for the purpose of diagnostic or therapeutic assistance.
- **Licensure.** The practice of medicine occurs where the patient is located at the time the telemedicine technologies are used, and the physician must be appropriately licensed in West Virginia.
- **Second Opinions.** The licensing requirement does not apply to "an informal consultation or second opinion, at the request of a physician who is licensed to practice medicine in this state, provided that the physician requesting the opinion retains authority and responsibility for the patient's care."
- **Physician-Patient Relationship.** Physicians utilizing telemedicine must establish a proper physician-patient relationship by, among other things, conducting an appropriate examination. Depending on the technology used, an in-person exam is not required. A physician-patient relationship may not be established through:
 - Audio-only communication;
 - Text-based communications such as e-mail, internet questionnaires, text-based messaging or other written forms of communication; or
 - Any combination thereof.
- If an existing physician-patient relationship does not exist prior to the utilization to telemedicine technologies, or if services are rendered solely through telemedicine technologies, a physician-patient relationship may only be established:
 - Through the use of telemedicine technologies which incorporate interactive audio using store and forward technology, real-time videoconferencing or similar secure video services during the initial physician-patient encounter; or
 - For the practice of pathology and radiology, a physician-patient relationship may be established through store and forward telemedicine or other similar technologies.

- Once a physician-patient relationship has been established, either through an in-person encounter or in accordance with the requirements above, the physician may use any telemedicine technology that meets the standard of care and is appropriate for the particular patient presentation.
- **Audio-Only or Text-Based Communications.** The law does not prohibit the use of audio-only or text-based communications by a physician who is:
 - Responding to call for patients with whom a physician-patient relationship has been established through an in-person encounter by the physician;
 - Providing cross coverage for a physician who has established a physician-patient relationship with the patient through an in-person encounter; or
 - Providing medical assistance in the event of an emergency situation.
- **Telemedicine Examinations.** A physician using telemedicine technologies to practice medicine must observe the following rules:
 - Verify the identity and location of the patient;
 - Provide the patient with confirmation of the physician's identity and qualifications;
 - Provide the patient with the physician's physical location and contact information;
 - Establish (or maintain) a physician-patient relationship that conforms to the standard of care;
 - Determine whether telemedicine technologies are appropriate for the patient's particular condition;
 - Obtain the patient's consent for telemedicine;
 - Conduct all appropriate evaluations and history of the patient consistent with traditional standards of care for the patient's particular condition; and
 - Create and maintain healthcare records for the patient which justify the course of treatment.
 - Note: These eight requirements do not apply to the practice of pathology or radiology medicine through store and forward telemedicine.
- **Standard of Care.** A physician who delivers healthcare services through telemedicine is held to the same standards of appropriate practice as those in traditional in-person settings. Treatment, including issuing a prescription, based solely on an online questionnaire, does not constitute an acceptable standard of care.
- **Remote Prescribing.** Remote prescribing without a prior in-person exam is permitted, including prescriptions for controlled substances, subject to certain limitations.

- A physician who practices medicine to a patient solely through the utilization of telemedicine technologies may not prescribe to that patient any Schedule II controlled substances.
- A physician may not prescribe any pain-relieving controlled substance listed in Schedules II through V as part of a course of treatment for chronic non-malignant pain solely based upon a telemedicine encounter.
- **Informed Consent.** The physician must obtain the patient's informed consent to telemedicine services.
- **Patient Records.** A patient record must be created for every telemedicine visit. The maintenance and confidentiality of the records must be consistent with state and federal law. A physician solely providing services using telemedicine technologies must make the records "easily available" to the patient, and subject to the patient's consent, to any identified care provider of the patient.⁵⁷

Federal policy actions relative to use of telehealth

This section reports on recently enacted federal policy that became effective since the completion of the 2014 Utah Telehealth Study.

Medicare Access and CHIP Reauthorization Act

The Medicare Access and CHIP Reauthorization Act signed into law on April 16, 2015 recognizes telehealth and remote patient monitoring in the definition of clinical practice improvement activities along with care coordination, population health management and monitoring of health conditions. The act requires the Government Accountability Office to conduct studies on telehealth and remote patient monitoring in the Medicare program by no later than April 2017. The objective is to review the definition of telehealth across various federal programs and inform the use of telehealth in the Medicare program.⁵⁸ The new legislation also creates the

⁵⁷ Nathaniel M. Lacktman, "West Virginia's New Telemedicine Practice Standards & Remote Prescribing Laws," *Health Care Law Today* (blog), April 6, 2016. https://www.healthcarelawtoday.com/2016/04/04/west-virginias-new-telemedicine-practice-standards-remote-prescribing-laws/?utm_source=Mondaq&utm_medium=syndication&utm_campaign=View-Original

⁵⁸ Nathaniel M. Lacktman, "Does the 'Doc Fix' Bill Help Telemedicine and Telehealth?" *Health Care Law Today* (blog) April 20, 2015. <https://www.healthcarelawtoday.com/2015/04/20/does-the-doc-fix-bill-help-telemedicine-and-telehealth/>

potential for providers to receive incentives for coordinating care through remote monitoring or telehealth despite the fact that Medicare reimbursement may not otherwise be available.⁵⁹

CMS expands telehealth reimbursement

In late 2014, the federal Center for Medicare & Medicaid Services (CMS) announced under its 2015 Physician Fee Schedule, providers would be able to receive Medicare reimbursement for a new group of services under the telehealth benefit.⁶⁰

Home telehealth authorized for military patients

On February 3, 2016, Assistant Secretary of Defense for Health Affairs Jonathan Woodson issued a memorandum allowing a patient's home or other patient location deemed appropriate by the treating provider to serve as an originating site for the receipt of telemedicine services from providers located in military treatment facilities (MTFs). Previously, patients were required to be physically present at an MTF or other designated facility in order to receive telemedicine services. The memo defines telemedicine as the provision of healthcare services using an interactive telecommunications system between a healthcare provider and patient in a different location.

Woodson's memo put in place several conditions, including:

- The patient's medical or psychological condition must be able to be safely and effectively treated in the home via telemedicine;
- A Department of Defense approved health information technology platform that meets HIPPA standards must be used. Equipment used by the patient must meet minimum technology standards;
- There must be a mutually agreed upon back up plan between the patient and provider in case the secure telemedicine connection fails;
- The Defense Health Agency (with the Military Health System Telehealth Working Group) is to provide additional guidance for utilizing telehealth in the patient's location, including coding practices and reporting requirements.⁶¹

⁵⁹ Angela Youngberg, "April Showers Brought Changes to Telehealth Laws," *Waller Healthcare Blog* (blog), May 5, 2015. <http://www.wallerlawblog.com/posts/75/April-Showers-Brought-Changes-to-Telehealth-Laws>

⁶⁰ Jennifer Bresnick, "CMS Offers Expanded Telehealth Coverage for Providers," *EHR Intelligence*, November 20, 2014. <https://ehrintelligence.com/news/cms-offers-expanded-telehealth-coverage-providers/>

Notable actions in the courts

This section reports on notable actions in the courts relative to use of telehealth by licensed health care professionals subsequent to the completion of the 2014 Utah Telehealth Study.

As use of telemedicine grows and state medical boards develop rules to regulate its use, a U.S. Supreme Court decision in *N.C. State Bd. of Dental Examiners vs. FTC*, No. 13-534 (Feb. 25, 2015) could have implications for these boards. In that case, the high court held that the North Carolina Dental Board was not immune from federal antitrust liability under the state action doctrine when it engaged in anticompetitive conduct to restrain non-dentists from performing teeth whitening services. The Supreme Court reaffirmed that state action antitrust immunity for professional board regulatory actions has two prerequisites: 1) the actions must be conducted under active state supervision and; 2) they must follow a clearly articulated state policy to displace competition.

As the following analysis indicates, the ruling has implications for state medical boards governing telehealth in instances such as the previously referenced Teladoc challenge of the Texas Medical Board rules requiring an in-person examination to establish a physician-patient relationship. Teladoc asserts on antitrust grounds that the rule is designed to protect Texas licensed physicians from potential competition from multistate telehealth providers like Teladoc. (On December 14, 2015, the United States District Court for the Western District of Texas refused to dismiss Teladoc’s action against the board)⁶² In January 2016, the Texas Attorney General’s Office filed a notice of appeal in the case, seeking review by the Fifth Circuit U.S. Court of Appeal.

“The upshot of the case is that anticompetitive regulation will be scrutinized carefully by the courts before state action immunity is approved,” stated the analysis. It added the ruling leaves open questions in assessing the construct of state regulatory boards, including what percentage of members of a board constitute control by active market participants, who counts as an active market participant, how to define the market in which they participate, and who qualifies as a supervisor of a board’s or agency’s decisions. “Those open questions notwithstanding, this case provides a potentially useful weapon to organizations offering

⁶¹ Assistant Secretary of Defense Memorandum, “Provision of Telemedicine at a Patient’s Location.” February 3, 2016. <http://cchpca.us9.list-manage1.com/track/click?u=c9fa99b7520aedfca5c453103&id=d6201aaf70&e=c6df81e7d8>

⁶² “The Teladoc Case: Court Ruling Confirms Antitrust Vulnerabilities for State Licensing Boards,” Manatt Health Update (website), January 21, 2016. <https://www.manatt.com/health-law/The-Megatrends-Reshaping-Healthcare-Managing-Change-and.aspx#Article5>

innovative services that might not be well received by state boards of competitors who are wedded to the status quo and look to preserve their economic place in it,” the analysis concludes.⁶³

Use of telehealth in drug-induced abortion procedures

In 2015, the Iowa Supreme Court in *Planned Parenthood of the Heartland, Inc. & Jill Meadows v. Iowa Board of Medicine, Case No. 14-1415* struck down an Iowa Board of Medicine rule requiring a physician conduct an in-person examination and be physically present during the administration of an abortion inducing drug and at the follow-up visit, finding the rule unconstitutional. The court held the rule places an undue burden on a woman’s right to terminate her pregnancy as defined under the United States and Iowa constitutions.⁶⁴

⁶³ Stuart M. Gerson, Patricia M. Wagner, Daniel C. Fundakowski, Selena M. Brady, M. Brian Hall, IV, “No State Action Antitrust Immunity for North Carolina Dental Board: Implications for the Health Care Sector,” Epstein Baker Green (website), March 17, 2015. <http://www.ebglaw.com/news/no-state-action-antitrust-immunity-for-north-carolina-dental-board-implications-for-the-health-care-sector/>

⁶⁴ *Planned Parenthood of the Heartland, Inc. & Jill Meadows v. Iowa Board of Medicine, Case No. 14-1415*, (June 19, 2015; Amended August 18, 2015) <http://cchpca.us9.list-manage.com/track/click?u=c9fa99b7520aedfca5c453103&id=2f795d15d9&e=c6df81e7d8>

Stakeholder group policy positions

This section reviews stakeholder and interest group policy positions relative to those mentioned in the 2014 Utah Telehealth Study to identify any revised positions as well as those of other stakeholder groups that have been issued since completion of the study in June 2014.

The ERISA Industry Committee (ERIC)

The ERISA Industry Committee (ERIC), a Washington, D.C.-based trade association that advocates for employee benefit and compensation benefits for the nation’s largest employers, is seeking consistency in state regulation and minimization of barriers to health care services delivered by telehealth. ERIC’s telehealth policy position focuses on five principles:

1. Be technology-neutral, so that a telehealth platform can adopt whatever tools it needs to maintain a consistent standards of care;
2. Enable interstate telehealth so that providers – no matter where they’re located – can deliver care to that state’s residents;
3. Don’t restrict telehealth to specific sites or regions, so that residents can access care wherever they’re located;
4. Avoid excessive requirements or regulations, especially anything that isn’t required of in-person visits; and
5. Consider the needs of patients to have better access to care that can be provided via telemedicine, through either a telemedicine visit or remote monitoring of health conditions.⁶⁵

Federation of State Medical Boards (FSMB) Interstate Medical Licensure Compact

According to the Federation of State Medical Boards, some 31 state medical and osteopathic boards have expressed support for the compact, as have the American Medical Association and American Osteopathic Association. On January 12, 2016, the National Stroke Association added

⁶⁵ Eric Wicklund, “Large Employer Trade Group Pushes for Better State Telehealth Legislation.” *mHealth Intelligence*, January 20, 2016. <http://mhealthintelligence.com/news/large-employer-trade-group-pushes-for-better-state-telehealth-legislation>

its endorsement of the compact, saying it would ease barriers to the fast-growing network of telestroke programs.⁶⁶

Interstate access to care for Medicare beneficiaries

The American Telemedicine Association and 20 other national associations and businesses are supporting expanded interstate access to care for Medicare beneficiaries. The Telemedicine for Medicare Act (S. 1778 and H.R. 3081) would allow Medicare physicians licensed in one state to treat Medicare patients in another state without having to obtain an additional license for each state.⁶⁷

Health care providers call on Congress to prioritize telehealth

In late 2014, a group of healthcare industry associations including the American Telemedicine Association, the Continua Health Alliance, ACT/The App Association, the Alliance for Home Dialysis, the RCHN Community Health Foundation, the Telecommunications Industry Association, Christus Health, Qualcomm, Intel, Panasonic, Philips and Baxter International called on Congress to prioritize telehealth and remote monitoring based on the following principles.

1. Authorize the use of telehealth in all accountable care and bundled payment programs;
2. Use remote monitoring to assist patients with chronic obstructive pulmonary disease and congestive heart failure, as well as those with diabetes who are patients of federally qualified health centers, and include the flexibility to expand monitoring to those with other chronic conditions;
3. Authorize the use of telehealth payments for population health management at all critical access hospitals and Federally Qualified Health Centers; and
4. Enable Medicare patients to use video visits and remote monitoring.⁶⁸

⁶⁶ Eric Wicklund, "On Telehealth License Portability, Each State Follows its Own Path," mHealth Intelligence, January 28, 2016. <http://mhealthintelligence.com/news/on-telehealth-license-portability-each-state-follows-its-own-path>

⁶⁷ "ATA Supports Medicare Licensing Bill to Reduce Barriers to Health Care," American Telemedicine Association (website) Accessed April 23, 2016. <http://www.americantelemed.org/news-landing/2015/08/13/ata-supports-medicare-licensing-bill-to-reduce-barriers-to-health-care#.Vxve9vhf23->

⁶⁸ Eric Wicklund, "Industry groups to Congress: 4 ways to prioritize telehealth," Government HealthIT (website), October 2, 2014. <http://m.govhealthit.com/news/industry-groups-congress-4-ways-prioritize-telehealth>

The American College of Physicians (ACP)

The American College of Physicians (ACP) published policy positions and recommendations on the use of telemedicine in primary care in early September 2015. The policy states telemedicine is best utilized when it is between a patient and physician with an established ongoing relationship based on the following principles:

- A patient-physician relationship can be established through real-time audiovisual technology as long as the same standard of care is maintained as an in-person visit or the distant site physician consults with another physician who does have a relationship with the patient and oversees their care;
- Telehealth activities should not disenfranchise financially disadvantaged populations or those with low technologic literacy;
- Physicians should be proactive in protecting themselves against liability by ensuring their medical coverage includes the provision of telemedicine services;
- Streamlining medical licensure process to provide telemedicine services across state lines;
- Lifting geographic site restrictions in the Medicare program limiting reimbursement to areas outside of metropolitan statistical areas and rural health professional shortage areas.⁶⁹

American Academy of Pediatrics (AAP)

On June 29, 2015, the American Academy of Pediatrics (AAP) published a policy statement supporting the use of telemedicine in the practice of pediatrics as long as telemedicine technologies are used “in support of and integrated with” the patient-centered medical home (PCMH) – not in place of it.

In its first statement on telemedicine, the AAP’s Committee on Pediatric Workforce expressed concern related to the increased use of telemedicine by virtual providers who provide healthcare services to patients via smart phone, laptop or video-consultations without a previous physician-patient relationship, previous medical history, or hands-on physical examination. As noted by the committee members, such telemedicine services can undermine

⁶⁹ “Policy Recommendations to Guide the Use of Telemedicine in Primary Care Settings: An American College of Physicians Position Paper,” *Annals of Internal Medicine*, Vol. 163, No. 10, November 17, 2015.
http://annals.org/article.aspx?articleid=2434625&utm_source=Telehealth+Enthusiasts&utm_campaign=78bc264de-Issue+in+Focus+ACP+Policy+Rcmnds+9+21+15&utm_medium=email&utm_term=0+ae00b0e89a-78bc264dde-267651945

the basic principles of the PCMH model and thus there is a greater need for regulatory action on telemedicine from states and local governments.⁷⁰

⁷⁰ Carrie Roll, “American Academy of Pediatrics Recommends Limits on Telemedicine,” Health Law and Policy Matters (blog), July 14, 2015. <https://www.healthlawpolicymatters.com/2015/07/14/american-academy-of-pediatrics-recommends-limits-on-telemedicine/>