REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-I-19

Subject: Established Patient Relationships and Telemedicine (Resolution 215-I-18)

Presented by: W. Alan Harmon, MD, Chair

Referred to: Reference Committee J (, MD, Chair)

At the 2018 Interim Meeting, the House of Delegates referred Resolution 215-I-18, "Extending the Medical Home to Meet Families Wherever They Go," which was introduced by the American Academy of Pediatrics. The Board of Trustees assigned this item to the Council on Medical Service for a report back at the 2019 Interim Meeting. Resolution 215-I-18 asked that our American Medical Association (AMA) "develop model legislation to permit primary care physicians, who work in medical homes/primary care practices that satisfy the National Committee for Quality Assurance Patient-Centered Medical Home Recognition Program guidelines, and who have documented a face-to-face patient-care relationship, to provide telehealth services for the patient when the patient travels to any of the fifty states."

This report provides an overview of state-based medical licensure and telemedicine; describes the Interstate Medical Licensure Compact (the Compact); summarizes relevant AMA policy; and makes recommendations.

BACKGROUND

Telemedicine is a key health care delivery innovation that has the potential to improve access to care and reduce health care costs. The AMA advocates for policies that encourage the adoption of telemedicine, while strongly supporting the current state-based medical licensure structure and the ability of states to enforce their medical practice laws that are in place to protect patients.

Although technological developments have enabled the application of telemedicine across a range of care settings, including patient-centered medical home practices, barriers to its widespread use remain. The financial burden of implementing telemedicine was cited as one such barrier in a recent study, which found that 15.4 percent of physicians worked in practices utilizing telemedicine to interact with patients, and 11.2 percent worked in practices that used telemedicine for interactions between physicians and health care professionals.[1]

Referred Resolution 215-I-18 highlighted concerns historically raised by physicians that the state-based licensure process has served as an additional barrier for physicians trying to expand telemedicine practices. Unlike some countries that have national oversight of medical practice, states are responsible for regulating the practice of medicine in the US. State authority to protect the health of its citizens was granted in 1791 under the 10th Amendment of the US Constitution, with formal licensing of physicians through state medical boards dating back to the 1800s.[2] The primary goals of state medical boards are to protect patients, ensure quality health care, and foster the professional practice of medicine. The prevailing standard for state medical licensure found in

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1 the medical practice acts of each state affirms that the practice of medicine is determined to occur
2 where the patient is located, so that the full resources of the state are available for the protection of
3 that patient. Without such protection, a patient who receives services that fall short of the standard
4 of care would have limited recourse to seek redress and relief under the state's medical practice and
5 patient safety statutes and regulations.
6
7 Licensure requirements established by state medical boards vary with respect to telemedicine but,
8 according to the Federation of State Medical Boards (FSMB), 49 state boards—as well as the
9 medical boards of the District of Columbia, Puerto Rico, and the Virgin Islands—require
10 physicians practicing telemedicine to be licensed in the state in which the patient is located,[3]
11 consistent with AMA policy. Fourteen state medical boards issue a special purpose license,
12 telemedicine license or certificate, or license to practice medicine across state lines.[4]
13
14 Historically, the process of obtaining licenses to practice medicine in multiple states has been
15 burdensome and time-consuming for physicians, and some states formed interstate agreements to
16 practice medicine across state lines. The AMA has long supported solutions that make it easier for
17 physicians to obtain licenses to practice across multiple states, while preserving the ability of states
18 to protect patient health and oversee the care provided to patients within their borders. For many
19 years, the AMA urged policymakers to address the cost, time and paperwork burdens associated
20 with licensure, which were compounded when a physician sought licensure in more than one state.[5]
21 Accordingly, the AMA strongly supported development and implementation of the Compact as a
22 licensure solution that would make it easier and faster for physicians to obtain licenses to practice
23 in multiple states.[6]
24
25 *Interstate Medical Licensure Compact*
26
27 The Compact, developed over many years and officially launched in 2017, established a new
28 pathway to expedite the licensing of physicians already licensed to practice in one state, who seek
29 to practice medicine in one or more other states. This expedited process helps facilitate license
30 portability and allows physicians to practice medicine—including telemedicine—in a safe and
31 accountable manner that expands access to care without compromising patient protections. At the
32 time this report was prepared, the Compact was an agreement among the following 29 states, the
33 District of Columbia and the Territory of Guam: Alabama, Arizona, Colorado, Georgia, Idaho,
34 Illinois, Iowa, Kansas, Kentucky, Maine, Maryland, Michigan, Minnesota, Mississippi, Montana,
35 Nebraska, Nevada, New Hampshire, North Dakota, Oklahoma, Pennsylvania, South Dakota,
36 Tennessee, Utah, Vermont, Washington, West Virginia, Wisconsin, and Wyoming.[7]
37
38 The Compact provides a licensing option under which qualified physicians seeking to practice in
39 multiple states are eligible for expedited licensure in all states participating in the Compact.
40 Licensing fees vary and remain the purview of each state's medical board. For a state to join the
41 Compact, the state legislature must enact authorizing legislation. A license obtained through the
42 expedited procedure provided for by the Compact provides the same licensing currently provided
43 for physicians by state medical boards—the only difference is that the process of obtaining a
44 license is significantly streamlined. Physicians can apply for licenses through the Compact on the
45 Compact's website.
46
47 Importantly, the Compact creates another pathway for licensure and does not otherwise change a
48 state's medical practice act. Of priority to the AMA, facilitating expedited medical licensure
49 through the Compact ensures that states retain their roles in regulating the practice of medicine
50 and protecting patient welfare. The Compact adopts the prevailing standard that the practice of
51 medicine occurs where the patient is located at the time of the physician-patient encounter.

A physician practicing under a license facilitated by the Compact is thus bound to comply with the statutes, rules and regulations of each Compact state wherein he/she chooses to practice medicine. The Compact serves as a leading alternative to proposals to change the site of practice from where the patient is located to where the physician is located for purposes of telemedicine, which would usurp state authority to regulate the practice of medicine.

AMA POLICY AND RESOURCES

The recommendations contained in Council on Medical Service Report 7-A-14 established Policy H-480.946, which outlines safeguards and standards to support the appropriate coverage of and payment for telemedicine services. In the report, the Council prioritized the need for AMA policy to support future innovation in the use of telemedicine while ensuring patient safety, quality of care and the privacy of patient information, as well as protecting the patient-physician relationship and promoting improved care coordination and communication with medical homes.

A key safeguard included in Policy H-480.946 stipulates that physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board. In addition, the policy requires physicians and other health practitioners delivering telemedicine services to abide by state licensure laws, state medical practice acts and other requirements in the state where the patient receives services, and maintains that the delivery of telemedicine services must be consistent with state scope of practice laws. The Council included these safeguards in the recommendations of its report because the Council believed that the key tenets in the delivery of in-person services hold true for the delivery of telemedicine services. Policy H-480.946 also states that a valid patient-physician relationship must be established before the provision of telemedicine services, through:

- A face-to-face examination, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine; or
- A consultation with another physician who has an ongoing patient-physician relationship with the patient. The physician who has established a valid physician-patient relationship must agree to supervise the patient's care; or
- Meeting standards of establishing a patient-physician relationship included as part of evidence-based clinical practice guidelines on telemedicine developed by major medical specialty societies, such as those of radiology and pathology.

Additionally, the policy maintains that prior to the delivery of any telemedicine service, physicians need to verify that their medical liability insurance covers telemedicine services, including telemedicine services provided across state lines, if applicable.

Long-standing AMA policy also maintains that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory (Policy H-480.969). The policy also states that this license category should adhere to the following principles:

- Application to situations where there is a telemedical transmission of individual patient data from the patient's state that results in either; (i) provision of a written or otherwise documented medical opinion used for diagnosis or treatment or; (ii) rendering of treatment to a patient within the board's state;

- Exemption from such a licensure requirement for traditional informal physician-to-physician consultations ("curbside consultations") that are provided without expectation of compensation;
- Exemption from such a licensure requirement for telemedicine practiced across state lines in the event of an emergent or urgent circumstance, the definition of which for the purposes of telemedicine should show substantial deference to the judgment of the attending and consulting physicians as well as to the views of the patient; and
- Application requirements that are non-burdensome, issued in an expeditious manner, have fees no higher than necessary to cover the reasonable costs of administering this process, and that utilize principles of reciprocity with the licensure requirements of the state in which the physician in question practices.

Policy D-480.999 opposes a single national federalized system of medical licensure. Policy H-480.974 directs our AMA to work with the FSMB and state and territorial licensing boards to develop licensure guidelines for telemedicine practiced across state boundaries. Policy D-480.969 states that our AMA will work with the FSMB to draft model state legislation to ensure that telemedicine is appropriately defined in each state's medical practice statutes and its regulation falls under the jurisdiction of the state medical board. Policies H-275.978 and H-275.955 urge licensing jurisdictions to adopt laws and regulations facilitating the movement of licensed physicians between states. Policy D-275.994 supports the Compact and directs the AMA to work with interested medical associations, the FSMB and other interested stakeholders to ensure expeditious adoption by the states of the Interstate Compact for Medical Licensure.

Policies H-480.974, H-480.968 and H-480.969 encourage national medical specialty societies to develop appropriate and comprehensive practice parameters, standards and guidelines addressing the clinical and technological aspects of telemedicine. Policy H-480.968 urges national private accreditation organizations to require that medical care organizations that establish ongoing arrangements for medical care delivery from remote sites require practitioners at those sites to meet no less stringent credentialing standards and participate in quality review procedures that are at least equivalent to those at the site of care delivery.

The AMA has substantial scope of practice policy, including Policies D-160.995, H-270.958, and H-160.949. Principles for the supervision of nonphysician providers when telemedicine is used are outlined in Policy H-160.937. This policy states that in all settings and circumstances, physician supervision is required when nonphysician providers deliver services via telemedicine, and the extent of supervision provided by the physician should conform to the applicable medical practice act in the state where the patient receives services. Policy H-160.937 further states that nonphysician providers who deliver services via telemedicine should do so according to the applicable nonphysician practice acts in the state where the patient receives such services. Code of Medical Ethics Opinion 1.2.12 states that physicians who provide clinical services through telemedicine must uphold the standards of professionalism expected in in-person interactions, follow appropriate ethical guidelines of relevant specialty societies and adhere to applicable law governing the practice of telemedicine.

Consistent with AMA policy, AMA model state legislation ensures that, with certain exceptions (eg, curbside consultations, volunteer emergency medical care), physicians and other health practitioners practicing telemedicine are licensed in the state where the patient receives services or are providing these services as otherwise authorized by that state's medical board. A Continuing Medical Education (CME) module, "Adopting Telemedicine in Practice," outlines steps physicians should take before adopting telemedicine into practice and is available on the AMA Ed Hub.

DISCUSSION

The Council appreciates the intent of referred Resolution 215-I-18 and understands the frustrations of the authors. It is increasingly challenging for physician practices to compete with large commercial entities that are contracting with payers to provide telemedicine services, including primary care services. Commercial direct-to-consumer telemedicine enables patients to receive care from their homes, offices or mobile devices; however, these encounters are provided outside of a patient's medical home and can lead to fragmented care. Where there is an established patient relationship, a physician should be able to use telemedicine to provide quality emergent or urgent care for a patient's existing condition when that patient is traveling in another state.

The Council also discussed potential unintended consequences of the model legislation requested via referred Resolution 215-I-18, which would create an exception for primary care physicians who work in accredited patient-centered medical homes and would ultimately be very disruptive to existing laws and regulations. The Council is concerned that such legislation, if implemented, could result in national oversight of telemedicine provided across state lines, and that any national oversight would be subject to influence by a variety of stakeholders including physicians, but also commercial telemedicine providers and retail health clinics. Additionally, the Council believes it would be difficult to limit the suggested exception to primary care physicians. It is possible that direct-to-consumer telemedicine providers would be able to become medical homes, which could in turn lead to other unintended consequences, such as the overprescribing of antibiotics.[8]

The Council believes that patient safety must remain a primary consideration during discussions of proposals to enhance patient access to care through telemedicine, and that maintaining AMA policy in support of state licensing boards having authority over medical services where patients are located prioritizes patient protections. The Council notes that treating physicians not licensed by the state where a patient is located may not receive public health department alerts, including notice of local outbreaks such as measles or food borne illness.

The Council discussed the concerns raised by referred Resolution 215-I-18 and believes that the Compact is a sensible and viable approach to facilitating multistate licensure without undermining state jurisdiction over medical practice and patient health. The Council acknowledges that the licensing option available under the Compact is not yet available to all physicians because not all states have become members of the Compact. However, within two years after its official launch, over half of all states joined the Compact and it was used by more than 3,000 physicians to secure more than 5,400 medical licenses in Compact member states.[9] The Council recognizes the importance of persuading remaining states to join the Compact, which will ultimately facilitate multistate licensure for most physicians who want it, and recommends that our AMA work with state medical associations to encourage states that are not part of the Compact to consider joining it as a means of enhancing patient access to and proper regulation of telemedicine services.

With respect to the travel considerations raised in referred Resolution 215-I-18, the Council discussed the ability of physicians to provide telemedicine services to their patients while they are traveling to another state and points to the practical exemptions from state licensure requirements already encompassed in AMA policy—for emergent or urgent circumstances and "curbside consultations." Physicians who wish to provide telemedicine services to patients in a state where they are not licensed are encouraged to direct inquiries to that state's medical board.

Finally, the Council believes that state-based exceptions and carve-outs of not only AMA telemedicine policy, but also state licensure laws, will further complicate oversight and regulation

and could potentially diminish the standards and patient safeguards that are centerpieces of AMA policy. Accordingly, the Council also recommends reaffirming Policies H-480.946 and H-480.969.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 215-A-18, and the remainder of the report be filed:

1. That our American Medical Association (AMA) work with state medical associations to encourage states that are not part of the Interstate Medical Licensure Compact to consider joining the Compact as a means of enhancing patient access to and proper regulation of telemedicine services. (Directive to Take Action)

2. That our AMA reaffirm Policy H-480.946, which delineates standards and safeguards that should be met for the coverage and payment of telemedicine, including that physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-480.969, which maintains that state medical boards should require a full and unrestricted license in that state for the practice of telemedicine, with no differentiation by specialty, unless there are other appropriate state-based licensing methods, and with exemptions for emergent or urgent circumstances and "curbside consultations." (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy D-480.969, which supports coverage for telemedicine-provided services comparable to coverage for in-person services. (Reaffirm HOD Policy)

5. That our AMA advocate to the Interstate Medical Licensure Compact Commission and Federation of State Medical Boards for reduced application fees and secondary state licensure(s) fees processed through the Interstate Medical Licensure Compact. (Directive to Take Action)

6. That our AMA work with interested state medical associations to encourage states to pass legislation enhancing patient access to and proper regulation of telemedicine services, in accordance with AMA Policy H-480.946, Coverage and Payment for Telemedicine. (New HOD Policy)

Fiscal Note: Less than $500.

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