

**BARRIERS**  
TO THE  
**INTERSTATE PRACTICE**  
OF  
**TELEMEDICINE**

Duke University Practicum  
with  
Verizon Connected Healthcare Solutions

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## EXECUTIVE SUMMARY

From early American literature to classic television shows, doctors have long been associated with house calls. In the era before large medical practices and nation-wide HMOs, doctors went directly to their patients. Telemedicine holds the promise of restoring this personal access to medicine—particularly in rural communities that are underserved by medical specialists. Whether these virtual doctors' visits take place at home, in a clinic, or in the nearest hospital, the nation's finest doctors can soon be available to help patients and local medical professionals treat rare or serious illnesses.

Unfortunately, because the medical infrastructure has developed organically for so long, obstacles have thus far prevented large-scale adoption of telemedicine. These obstacles include state-by-state licensure requirements and hospital-by-hospital credentialing and privileging requirements, tremendous variation in state liability and malpractice law, concerns about patient privacy, and uncertainty surrounding the payment system. For example, there are 69 different licensure jurisdictions in the United States, and each state's board of medical licensure uses slightly different guidelines for approving physicians.

Without a nation-wide standard for physicians and other medical personnel, telemedicine providers are subject to each state's differing regulations and standards. This forces companies promoting telemedicine to incur higher business costs to meet compliance, places burdensome requirements on practicing physicians, and hinders access to care for remote patients. State-based licensure schemes were logical before telemedicine because the diagnosis, treatment, and care of patients almost always occurred face-to-face. Twenty-first century medicine is no longer limited by the resources available within one community or state, but telemedicine is still constrained by these regulatory boundaries.

Despite the burdens, there are models that successfully facilitate the practice of telemedicine. For instance, some states have attempted to create new regulatory frameworks for themselves. Two-dozen states have joined a compact of mutual recognition for nursing licenses (which, like doctors' licenses, are regulated by the states) and pharmacist licenses have been standardized in all fifty states. On a national level, the Department of Veterans Affairs has broadly and successfully implemented a telemedicine program throughout its entire system of hospitals and clinics. Yet in order for these successes to be replicated in a way that provides access to the most patients in the most places, the states alone cannot fix the present piecemeal system.

Short-term solutions. The most immediate solutions will continue to be at the state level, with state medical boards agreeing to **mutual recognition** of out-of-state licenses and coalescing around **standardized applications** and a uniform electronic **license clearinghouse**. These

solutions have been in progress for more than a decade and will reduce the barriers to interstate telemedicine practice.

Long-term solutions. For telemedicine to reach its potential, Congress must act to create a national standard. This problem of collective action requires the uniformity that the states cannot meaningfully provide by themselves. A **national telemedicine license** could protect patients while allowing states to continue regulating traditional medicine. A less ambitious solution would limit the interstate practice to interstate provider networks, while a more ambitious approach would require state medical boards to accept out-of-state licenses just as states currently accept out-of-state drivers' licenses.

Telemedicine holds the promise of expanding access to the highest quality of medical care, reducing the impact of doctor shortages in rural communities, and building an entirely new high tech industry that reduces healthcare costs and creates jobs. For this promise to be realized, there must be a national standard that allows the private sector to create a successful telemedicine business model.

## INTRODUCTION

Earlier research catalogues the barriers that “prevent the full realization of the benefits of telemedicine.”<sup>1</sup> Obstacles impeding the implementation of telemedicine include: (1) state-based licensure requirements, (2) credentialing and privileging requirements, (3) liability and malpractice issues, (4) privacy of information, and (5) payment of services. This paper does not address the privacy and reimbursement issues that affect telemedicine; rather, it focuses on the legal barriers. First, the paper explores the history of the U.S. licensure systems and the problems these systems create for the practice of telemedicine. Next, the paper discusses how the current credentialing and privileging processes hinder the practice of telemedicine. Third, the paper explores the jurisdiction and malpractice issues associated with liability across state lines. Finally, the paper will explore some of the proposed solutions to the licensing barriers and the potential benefits and drawbacks from these proposals.

### **I. Licensing Issues for the Interstate Practice of Telemedicine**

It has been widely observed that the “overlapping and often inconsistent and inadequate regulatory frameworks and technical standards imposed by governments and professional medical organizations” constrain “the present and potential uses of telemedicine.”<sup>2</sup> In most cases, professionals must receive a license before they are allowed to practice. Licensure and re-licensure requirements vary by profession, but are conducted at the state-level. Differently, certification is provided by professional societies and boards, which acknowledge competence in a particular specialty and often require more in-depth knowledge than licensure. Credentialing occurs at the level of the health care organization and verifies that a health professional has received training up to the level required by the organization.

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<sup>1</sup> Volkert, Susan E. *Telemedicine: Rx for the Future of Health Care*. 6 Mich. Telecomm. & Tech. L. Rev. (2000), at 147-153.

<sup>2</sup> *Supra* note 1, at 156-157.

Professional licensure is a “legal process that allows physicians and other professionals to practice their profession in a particular state pursuant to certain limitations.”<sup>3</sup> While much of this discussion focuses on physicians, the myriad others who comprise the health professional workforce and play an integral role in the future of telemedicine (e.g., nurses, physician assistants, behavioral therapists) are also subject to state-by-state licensing rules.

#### **A. History of the current licensing system**

Since the Supreme Court’s 1889 ruling in *Dent v. West Virginia*, states have had “the authority to regulate health professionals who practice in their territories.”<sup>4</sup> Therefore, the federal government plays a limited role in medical licensure; its power does not “pre-empt [the] state power” granted in *Dent*.<sup>5</sup> Each state has its own statutes that govern the practice of medicine and require a physician to be licensed in the state in which the physician is practicing medicine.<sup>6</sup> Most states have a medical practice act that governs the practice of medicine and grants state medical boards the power to license physicians, investigate complaints, and discipline physicians. There are 69 different licensure jurisdictions in the United State, and each state’s board of medical licensure functions similarly but uses slightly different guidelines.<sup>7</sup> Most states require physicians to have graduated from an approved medical school, show physical and mental fitness, and lack a serious disciplinary history. Length of postgraduate training, type of credentials,

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<sup>3</sup> Ameringer, Carl F. *Symposium: Roundtable on Legal Impediments to Telemedicine: State-based Licensure of Telemedicine: the Need for Uniformity but not a National Scheme*. 14 J. Health Care L. & Pol’y (2011), at 55-62.

<sup>4</sup> See *Dent v. West Virginia*, 129 U.S. 114, 122-23 (1889), where the Supreme Court held that a state’s interest in protecting its citizens included the regulation of medical licensure.

<sup>5</sup> Gupta, Amar, and Deth Sao. *The constitutionality of current legal barriers to telemedicine in the United States: Analysis and future directions of its relationship to national and international health care reform*. Health Matrix 21, (2011), at 385-442.

<sup>6</sup> Fed’n of State Med. Bds. *The Role of the State Medical Board*. (2012). Available: [http://www.fsmb.org/m\\_grpol2.html](http://www.fsmb.org/m_grpol2.html).

<sup>7</sup> National Governors Association (NGA) Center for Best Practices. Available: <http://www.nga.org/files/live/sites/NGA/files/pdf/0809EHEALTHLICENSURE.PDF;jsessionid=C856816EA72DEEEB18B5BD533FA881EB>

continuing medical education requirements and timeline for re-licensure differ depending on the state.<sup>8</sup>

## **B. Barriers Posed by State Licensing Systems**

State laws present a “formidable hurdle” for the interstate practice of medicine.<sup>9</sup> A major problem that stems from this fragmented system is “overlapping, inconsistent, and inadequate” processes for licensing and re-licensing healthcare professionals.<sup>10</sup> In 2011, the Institute of Medicine wrote that the “delivery of telehealth services hasÉbeen complicated by variability in state regulations, particularly whenever online communications cross state lines.”<sup>11</sup> These variations include differences in the “definition of the practice of medicine; what constitutes the unlawful practice of medicine; and licensure and re-registration requirements.”<sup>12</sup>

Before the “advent of telemedicine,” state-based licensure schemes sufficed because the diagnosis, treatment, and care of patients almost always occurred face-to-face.<sup>13</sup> However, the state-based licensing framework results in “jurisdictional problems related to the interstate practice of medicine.”<sup>14</sup> Telemedicine providers are “subject to each state’s differing regulations and standards.”<sup>15</sup> Consequently, satisfying “different requirements in multiple jurisdictions can be quite burdensome for a practicing physician.”<sup>16</sup> State-specific requirements “force” a telemedicine provider to “incur higher business costs to meet compliance.”<sup>17</sup>

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<sup>8</sup> See Appendix A.

<sup>9</sup> Paul Spradley, *Telemedicine: The Law Is the Limit*, 14 Tul. J. Tech. & Intell. Prop. at 307-333.

<sup>10</sup> *Supra* note 5, at 393.

<sup>11</sup> Institute of Medicine, *The Future of Nursing: Leading Change, Advancing Health*, The National Academies Press, Washington, DC. (2011).

<sup>12</sup> *Supra* note 5, at 394.

<sup>13</sup> *Supra* note 3, at 57.

<sup>14</sup> *Id.* at 62.

<sup>15</sup> *Supra* note 5, at 392.

<sup>16</sup> *Supra* note 9, at 317.

<sup>17</sup> *Supra* note 5, at 392.



In 2010, the Federal Communications Commission (FCC) acknowledged the challenges posed by state licensure requirements: The state-by-state requirements “limit practitioners’ ability to treat patients across state lines. This hinders access to care, especially for residents of states that do not have needed expertise in-state.”<sup>18</sup> The American Telemedicine Association took the argument a step further, arguing that state-by-state licensing requirements are in place not only to assure quality of care and protect state rights, but also to protect in-state providers from outside competition.<sup>19</sup> Under this argument, state medical societies have an incentive to impose high costs of interstate business because doing so creates “a monopoly for in-state health care providers.”<sup>20</sup> Even the American Medical Association has acknowledged that state licensure requirements “may be used to protect the economic interests of local physicians.”<sup>21</sup> The AMA has written for instance, that telemedicine has “crystallized the tension between the states’ role in protecting patients from incompetent physicians and protecting in-state physicians from out-of-state competition.”<sup>22</sup>

## II. Credentialing and Privileging

Hospitals have a legal duty to evaluate the competency of physicians that provide medical services to patients. They do so through the credentialing and privileging processes. Credentialing is a process that ensures each physician possesses the necessary qualifications to provide medical services.<sup>23</sup> As part of this objective process, a hospital verifies that a physician

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<sup>18</sup> Federal Communications Commission. *Connecting America: The National Broadband Plan*. (March 2010). Available: <http://download.broadband.gov/plan/national-broadband-plan.pdf>

<sup>19</sup> American Telemedicine Association. *The Cost of Licensure*. (2012) Available: <http://americantelemed.blogspot.com/2012/02/cost-of-licensure.html>

<sup>20</sup> *Supra* note 5, at 394.

<sup>21</sup> *Supra* note 3, at 61.

<sup>22</sup> American Medical Association. *Physician Licensure: An Update of Trends*. (Sept. 11, 2010). Available: <http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/young-physicians-section/advocacy-resources/physician-licensure-an-update-trends.page>

<sup>23</sup> *Roundtable on Legal Impediments to Telemedicine, Legal Impediments to the Diffusion of Telemedicine*. U. Md. Sch. L. (April 16, 2010).

has completed training, is properly licensed in the state, and has no violations. Meanwhile, privileging assess the provider’s competence in a specific area of patient care.<sup>24</sup> This more subjective process often includes peer review and an evaluation of the physician’s past performance.

Credentialing and privileging are typically the responsibility of the hospital where the practicing physician is located. The question then becomes, “which hospital performs these functions?”<sup>25</sup> Any practitioner who provides telemedicine services from a remote site must be credentialed and obtain privileges from the facility where the patient is located.<sup>26</sup> Credentialing and privileging can be time consuming and expensive processes for physicians, particularly because—as with licensing—hospitals differ in their requirements. A physician practicing telemedicine could find herself spending countless hours ensuring her privileges are in place at various hospitals, each of which requires renewal on a different basis.

In July 2011, CMS proposed a rule to address the challenges posed by credentialing and licensing: *Credentialing and Privileging of Telemedicine Physicians and Practitioners*.<sup>27</sup> Before July 2011, the Joint Commission allowed Joint Commission-accredited hospitals to “utilize information from the distant-site hospital or other accredited telemedicine entity when making credentialing or privileging decisions for the distant-site physicians and practitioners.”<sup>28</sup>

However, the Medicare Conditions of Participation required the hospital’s governing body to make all privileging decisions based upon the recommendation of the hospital’s medical staff

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<sup>24</sup> *Id.*

<sup>25</sup> *Supra* note 9, at 321.

<sup>26</sup> Benesh, Katherine. *What’s New in Telemedicine: Legal and Regulatory Issues*. Presentation to the New Jersey State Bar Association, Health & Hospital Law Section (April 7, 2011).

<sup>27</sup> *Credentialing and Privileging of Telemedicine Physicians and Practitioners*, 75 Fed. Reg. 29,479 (proposed May 20, 2010) (to be codified at 42 C.F.R 482, 485).

<sup>28</sup> Zhani, Elizabeth Eaken. 2011. *The Joint Commission Applauds CMS’ Revised Telemedicine Requirements*. Available:

[http://www.jointcommission.org/the\\_joint\\_commission\\_applauds\\_cms\\_revised\\_telemedicine\\_requirements/](http://www.jointcommission.org/the_joint_commission_applauds_cms_revised_telemedicine_requirements/)

after individual consideration of a practitioner’s qualifications. Such individualized consideration was mandated even if the practitioner was a remote-site practitioner and was already credentialed in a distant-site facility.<sup>29</sup> This Medicare policy burdened hospitals and impeded the practice of telemedicine, but the Joint Commission has said the new rule “provide[s] more flexibility to hospitals and lessen[s] their regulatory burden. This is an especially positive step for improving access to care.”<sup>30</sup>

### **III. Liability and Malpractice Issues**

In addition to licensure issues, telemedicine faces additional legal barriers to entry and widespread adoption. Questions of jurisdiction and liability in the novel field of remote medicine are currently unresolved and variable by state. Two broad categories of potential uncertainty for physicians seeking to practice interstate telemedicine are outlined below, though this assessment of potential liability issues is not exhaustive.

#### **A. Jurisdiction**

Jurisdiction, venue, and choice of law all affect the scope of interstate telemedicine. A physician operating only in the state in which he is licensed will generally only be subject to the laws of his own jurisdiction, and any applicable federal laws. However, should physicians “treat” out-of-state patients via electronic means, the physician may open himself to liability in the state where the patient was treated, as well as federal court.<sup>31</sup> Generally, in an interstate transaction, an individual is potentially subject to the foreign state’s jurisdiction if he has the requisite “minimum contacts” with that state.<sup>32</sup> Further, tort law generally utilizes the state law where the

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<sup>29</sup> Delgado, Heather Fesko, and Mark E. Rust. 2011. *Final Rule on Telemedicine Credentialing and Privileging Process*. Barnes & Thornburg LLP.

<sup>30</sup> *Supra* note 28.

<sup>31</sup> 28 USC § 1332.

<sup>32</sup> See *International Shoe Co. v. Washington*, 326 U.S. 310 (1945).

injury occurred,<sup>33</sup> which may be defined as the patient’s state in a telemedical context. Certain states have proactively defined telemedicine as occurring at the site of the patient, and have enacted “long-arm” statutes to impose liability on out-of-state physicians.<sup>34</sup> However, not all states have expressed similar legislative intent.

Given the uncertainty of jurisdiction in this novel field of medicine, any federal legislation defining the site or jurisdiction of telemedicine should consider the policy implications of such a definition. Defining the practice as occurring where the physician is located and licensed would seemingly mitigate the need for physicians to stay abreast of malpractice laws in multiple states, and would reduce confusion of whether malpractice insurance in the physician’s home state is applicable. However, attempting to limit the “practice” of telemedicine to the physician’s state may run counter to the traditional “minimum contacts” analysis. In a telemedical encounter where a physician renders a diagnosis and charges a fee, a court would likely find that the physician has “purposefully availed” himself of the patients in another state and thus has the requisite minimum contacts for jurisdiction. However, an infrequent telemedical encounter between an out-of-state physician and a patient that was initiated by a physician in the patient’s state for purposes of a consultative examination may not meet the “minimum contacts” threshold.

Thus, absent statutory intervention, the potential telemedicine practitioner would need to be familiar with the governing law, standard of care, and state medical board practice of each state in which he wishes to treat telemedicine patients. A forum selection clause integrated into any telemedicine contract with a patient may reduce the uncertainty of jurisdiction. However,

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<sup>33</sup> Restatement (Second) of Conflict of Laws, § 146.

<sup>34</sup> See N.C. Gen. Stat. Ann. § 90-21.12A;

not all courts recognize forum selection clauses and may void them as against public policy in the public health context.

Further, without federal authorization via statute or a national licensing system, or a state compact with reciprocity, physicians practicing telemedicine in a state without prior authorization also potentially open themselves up to criminal sanctions and penalties under state statutes. The majority of states have statutes forbidding the practice of medicine without a license, with many states categorizing the act as a felony.<sup>35</sup> The monetary penalties for practicing medicine without a license range from a \$50 fine in Vermont to a \$50,000 fine in South Carolina.<sup>36</sup> For states imposing imprisonment on violators, the sentences range from ten days in Louisiana to five years in Georgia.<sup>37</sup>

Therefore, the governing standard of conduct is significantly more uncertain in a telemedical encounter. Further statutory guidance is likely necessary to incentivize the full utilization of telemedicine.

## **B. Malpractice**

The elements of a malpractice claim mirror a negligence claim in traditional tort law. Thus, a plaintiff must show that a physician owed him a duty, the physician breached that duty, an injury occurred, and the physician's breach was the proximate cause of that duty. In the medical malpractice context, the physician's duty is established when the physician-patient relationship commences. The physician's breach of the duty is determined by the applicable standard of care.

In a traditional medical relationship, the touchstone of liability is the physician-patient relationship. In the telemedicine context, the exact genesis of this crucial relationship is not

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<sup>35</sup> See, e.g., N.C. Gen Stat. § 90-18(a).

<sup>36</sup> See generally Medical Practice Acts of Vermont and South Carolina.

<sup>37</sup> See generally Medical Practice Acts of Louisiana and Georgia.

necessarily certain. However, it is clear that a physician-patient relationship can be established via electronic means, regardless of whether a physician has ever physically examined the patient.<sup>38</sup> Thus, while telemedicine interactions that resemble traditional consultations, wherein one medical professional consults another professional, are unlikely to trigger liability, a telemedicine encounter that includes a physician examining a patient or a patient's records and recommending a treatment via electronic means will likely suffice to establish the requisite relationship and potential liability.<sup>39</sup> A court will likely look to outside indicia to determine exactly when a physician-patient relationship began, such as reliance by the patient or the existence of a contract between the parties.

Insofar as a physician-patient relationship is established via a telemedicine encounter, the governing standard of negligence may also vary by state. States are divided on the determination of the appropriate medical standard of care, with some states deferring to a standard based on the local or community practice, and other states adopting a national standard.<sup>40</sup> A national standard of care as it relates specifically to telemedical practice would be ideal, and could be adopted both at the state and federal level without undermining existing standards of care for physical encounters. However, absent statutory or contractual guidance on the governing standard of care in a telemedical encounter, physicians bear the risk of uncertainty as to what defines negligence across state lines. This state-by-state or variation may have substantial impact on the definition of "negligence." For example, in *Brown v. Belifante*, a Georgia

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<sup>38</sup> See, e.g., *Bienz v. Central Suffolk Hospital* (physician-patient relationship established over the phone); *Dougherty v. Gifford*, 826 S.W.2d 668, 673-75 (Tex. App. – Texarkana 1992, no writ) (finding a physician-patient relationship between a pathologist and a patient where the pathologist never reviewed the patient's records nor met the patient).

<sup>39</sup> See, e.g., *Greenberg v. Perkins*, 845 P.2d 530 (Colo. 1993); *Wheeler v. Yettie Kersting Memorial Hospital*, 866 S.W.2d 32, 37-40 (Tex.App. B Houston [1st Dist] 1993, no writ).

<sup>40</sup> Compare *Barham v. Hawk*, 163 N.C. App. 708, 600 S.E.2d 1 (2004) (disallowing an expert physician from testifying because he was not familiar with the local community standards), with *Morrison v. MacNamara*, 407 A.2d 555 (D.C. 1979) (finding that the locality or community standard is outdated and a national standard of care is appropriate).

appellate court found that a dentist performing procedures outside the scope of the Dental Practice Act was *negligence per se*, despite the actual care provided to the patient.<sup>41</sup>

Further, should the national standard of care become more widely adopted, physicians in states that do not adopt telemedicine practices will also have to assess their potential liability in not providing telemedicine services. Insofar as telemedicine is found to be a “best practice” in certain medical situations, a physician choosing not to utilize a similar practice could be found in breach of this newly established national standard of care.

A portion of the standard of care involves informed consent. In a telemedical context, courts may find that a higher degree of consent is a necessary part of the standard of care, to show that a patient understood the benefits and risks presented by telemedical treatment. For example, California’s Informed Consent Procedure requires an additional, telemedicine-specific written consent from a patient before any telemedicine services can be rendered.<sup>42</sup>

State requirements of a physical examination prior to certain types of treatment also pose a significant barrier to telemedicine. Specifically, states often prohibit a physician from prescribing drugs to a patient without first obtaining a face-to-face physical examination.<sup>43</sup> Moreover, many courts have held that online prescriptions violate state and federal laws. Thus, the current case law suggests that telemedicine providers who advise a course of treatment that is paired with a physical examination requirement in the patient’s state will face significant liability unless another physician licensed in the patient’s state is involved in treatment.

Additionally, where the patient has an existing treating physician in his home state, the question of liability for a telemedicine provider will also turn on which physician was the

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<sup>41</sup> *Brown v. Belinfante*, 557 S.E.2d 399 (2001)

<sup>42</sup> California Telemedicine & eHealth Center. *Telemedicine Reimbursement Handbook*, p. 8-9, available at <http://www.nrtc.org/wp-content/uploads/Telemedicine-Reimbursement-Handbook1.pdf>.

<sup>43</sup> See, e.g., *United States v. Valdivieso Rodriguez*; *Holzhauser v. State Med. Bd. of Ohio*.

proximate cause of the patient's injury. Consulting physicians may be shielded from liability, particularly when the consultation is formal and adheres to the standard of care based on their specialty.<sup>44</sup> However, if a consulting physician's judgment is directly enacted on the patient or significantly influences the primary treating physician's treatment of the patient, the consulting physician may be liable.<sup>45</sup> This distinction could likely vary significantly depending on the nature of the telemedicine encounter and the availability of a local physician.

Therefore, questions of the both the appropriate standard of care and the extent of liability for a telemedicine provider are still unanswered. This uncertainty provides a significant barrier to widespread adoption of interstate telemedicine.

#### **IV. Interstate Medicine in Other Medical Specialties**

Though the interstate practice of telemedicine presents novel challenges, the issue of multi-state licensing in the medical profession has been previously addressed. The examples of nursing, pharmacy, and the Veteran's Health Administration provide some guidance on the potential of telemedicine providers operating across state lines.

##### **A. Nursing: A Mutual-Recognition Model**

Recognizing the need for fluidity and portability in nursing practices, in 1996 the National Council of State Boards on Nursing investigated the possibility of nurses practicing in multiple states without obtaining multiple state licenses. The proposed solution was a multi-state compact that establishes mutual recognition of a nurse's license in a home state, with the condition that a nurse practicing in a foreign state consents to the foreign state's jurisdiction and

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<sup>44</sup> See *Elias v. Bash*, 54 A.D.3d 354 (2d Dep't 2008) lv. den. 11 N.Y.3d 711 (2008) (finding that consulting cardiologist had a limited duty to the patient and treating physician's failure to follow-up with patient did not impose liability on consulting physician).

<sup>45</sup> See *Campbell v. Haber*, 274 A.D.2d 946 (4<sup>th</sup> Dep't 2000) (denying a motion to dismiss claim against cardiologist who reviewed patient's symptoms via telephone and opined that patient's symptoms were not cardiac in nature).



laws. Additionally, the compact established a centralized licensee information system called NURSYS to promote efficiency in applications and information sharing.<sup>46</sup>

In 1999, Utah and Arkansas enacted the first model compact.<sup>47</sup> As of 2012, 24 states have joined the mutual-recognition nursing compact.<sup>48</sup> The National Council of State Boards on Nursing note many benefits of the compact, including continuity of care for patients via telenursing, improved efficiency, and information sharing.<sup>49</sup>

### **B. Pharmacy – A Standardization Model**

Similar to the traditional state medical boards, every state has an established Board of Pharmacy tasked with regulating pharmacists, pharmacies, and prescription drugs within the state. The state pharmacy boards of all fifty states also belong to the National Association of Boards of Pharmacy, which acts as a unifying and standardizing force for licensing guidelines throughout the states. Moreover, the NABP has instituted the Electronic Licensure Transfer Program, which facilitates efficiency in a licensed pharmacist becoming licensed in a different state<sup>50</sup>. The move toward standardization of licensure requirements at a national level and the reduction of administrative inefficiencies are keys to the success of this interstate licensure system.

### **C. The Veteran’s Health Administration: A Network Model**

Finally, the Veteran’s Health Administration utilizes telemedicine nationally within their network without interstate restrictions. The federal government authorizes Veteran’s Administration physicians to practice telemedicine by limiting licensure requirements to a

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<sup>46</sup> Center for Telemedicine Law. *Telemedicine Licensure Report*, (June 2003).

<sup>47</sup> [https://www.ncsbn.org/2010\\_NLCA\\_factsheet\\_FINAL.pdf](https://www.ncsbn.org/2010_NLCA_factsheet_FINAL.pdf)

<sup>48</sup> *Id.*

<sup>49</sup> *Id.*

<sup>50</sup> Center for Telehealth and e-Health Law. *Analysis of Licensure Laws, Rules and Procedures as they Relate to e-Health and Telehealth*, (August 24, 2007).

medical degree, an eligible internship, and a valid license in one state.<sup>51</sup> Thus, under the VHA system, a physician can obtain one state license where state boards can maintain regulatory control, and the VHA network is tasked with maintaining uniformity of standards of care throughout the network.

In April 2012, the Department of Veteran's Affairs (VA) announced that it was fast-tracking a proposal to eliminate patient co-pays for in-home video telehealth consultations, relying on its Home Based Primary Care Program (HBPC).<sup>52</sup> This program was established in 1972 to help serve patients with chronic conditions. Last year the VA announced at the National Health Policy Forum that, by reducing the number of hospitalized days and long-term care days, this program has reduced healthcare costs for the VA by 24%. This technology allows in-home, real-time video teleconferencing between a veteran and a provider, and has proven effective for interactions that do not require a physical exam, including wound management, psychiatric or psychotherapeutic care, exercise plans, and medication management. The VA has already seen a direct return on investment in its telehealth program. According to VA officials servicing the northwest region, they saved \$742,000 in 2011 through direct use of telehealth, allowing for the reduction of more than 23,000 patient encounters. One provider alone in Oregon was able to shift 3,200 encounters to telehealth, and saved more than \$88,000.<sup>53</sup>

## **V. Potential Solutions to Reduce the Barriers to Interstate Telemedicine**

Although the current state-by-state licensing systems complicate widespread implementation of telemedicine, a number of alternative frameworks have been proposed. Some

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<sup>51</sup> Hatzakis, Michael, Jr., M.D., et. al., *Telemedicine and the delivery of health services to veterans with multiple sclerosis*, Journal of Rehabilitation Research and Development Vol. 40, No. 3, p. 278 (May/June 2003)

<sup>52</sup> Wickland, Eric. [MHIMMS. VA fast-tracks proposal to eliminate co-pays for telehealth consults](http://www.mhimss.org/news/va-fast-tracks-proposal-eliminate-co-pays-telehealth-consults), available at <http://www.mhimss.org/news/va-fast-tracks-proposal-eliminate-co-pays-telehealth-consults>

<sup>53</sup> Wicklund, Eric. *VA to eliminate co-pays for telehealth consultations*, Healthcare IT News, Contributing Editor, April 13, 2012

of these, such as state-by-state exceptions for telemedicine are already implemented to some degree, whereas others, such as a national licensure system, would require a complete overhaul of existing systems. This paper does not recommend one “fix”, rather, the paper discusses numerous proposed solutions from least to most dramatic, as well as other potential policy incentives.

## **A. Direct Licensing Solutions**

### **1. Endorsement and Reciprocity Agreements**

Many states allow various forms of endorsement, mutual recognition, and reciprocity. State Boards with an endorsement policy may grant full, unrestricted licenses to health professionals who have been licensed in another state with equivalent standards. All but one state has a current endorsement policy in place, as a means to fast-track the licensure process. Additionally, “consultation exceptions” allow an out-of-state provider to practice in “very limited situations” without a state-specific license.<sup>54</sup> Similarly, most states provide limited exceptions for medical students, physicians with academic appointments, and physicians who are federal employees.<sup>55</sup> For example, New Mexico allows licensure by endorsement if the physician meets New Mexico’s state-based Medical Practice Act requirements,<sup>56</sup> and South Dakota and Tennessee allow reciprocity if the other state’s requirements are not less stringent.<sup>57</sup>

Most states that have explicitly addressed telemedicine in legislation or regulations have forbade out-of-state providers from utilizing telemedicine to treat in-state patients. Between the states, there are three general categories of licenses offered for the practice of telemedicine: (1) a Special Telemedicine License, (2) a Full License, and (3) a Full License with Exceptions for

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<sup>54</sup> *Supra* note 5, at 394.

<sup>55</sup> *Supra* note 3, at 57.

<sup>56</sup> N.M. Stat. Ann § 61-6-13 (LexisNexis 2008).

<sup>57</sup> S.D. Codified Laws § 36-4-19 (2010); Tenn. Code Ann. § 63-6-211(a) (West 2010).

consultations. The exceptions are provided for consultations, infrequent consultations, or emergency care. As identified in Appendix B, many of these laws regulating telemedicine require out-of-state physicians to obtain a full license from the state in which the service is being provided (i.e., the state in which the patient is located).<sup>58</sup>

Hawaii is one of the few states that has explicitly permitted out-of-state licensed physicians to engage in “actual consultation, including electronic, telephonic, fiber-optic, or other telemedicine consultation.”<sup>59</sup> Others allow out of state consultations however limit consultations to an infrequent (some define this as a certain number or duration of consultation), emergent basis or other include another form of restriction. For example, Washington permits out-of-state physicians to consult with in-state providers provided they do not open an office, designate a meeting place for patients, or receive calls in-state.<sup>60</sup> Ten states hold full licensure exceptions for out-of state consultations without limitations, but do not explicitly recognize telemedicine as a means by which the consultation could be provided.

The state-by-state regulations could facilitate out-of-state physicians utilizing telemedicine to work with or offer services at the request of an in-state physician.<sup>61</sup> That said, these forms of endorsement, mutual recognition, and reciprocity usually require consultations to be infrequent and that the in-state physician make the final medical decision.<sup>62</sup> Few states have proactively or positively “address[ed] the interstate and global nature of telemedicine.”<sup>63</sup> Given the large number of states that have issued legislation explicitly prohibiting telemedicine without

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<sup>58</sup> *Supra* note 5, at 394.

<sup>59</sup> Haw. Rev. Stat. § 453-2 (West 2010) (permitting a telemedicine exception provided the out-of-state physician does “not open an office, or appoint a place to meet patients in th[e] State, or receive calls within the limits of the state.”)

<sup>60</sup> Wash. Rev. Code § 18.71.030(6) (2010).

<sup>61</sup> Gobis, Linda. *An Overview of State Laws and Approaches to Minimize Licensure Barriers*. Telemedicine Today (Dec. 1997) at 14-15.

<sup>62</sup> Martin, Laura Keidan. *Not So Fast, It's Regulated: Some Warnings for the E-Health Biz*. Bus. L. Today (Sept.-Oct. 2000) at 10.

<sup>63</sup> *Supra* note 5, at 392.

first obtaining full licensure, it seems unlikely that in the absence of provider demand or federal pressure other states will follow the lead of these proactive states.

## 2. Special Licenses

In 1996, the Federation of State Medical Boards (FSMB)<sup>64</sup> issued a Model Act to Regulate the Practice of Medicine Across State Lines (1996).<sup>65</sup> The Model Act, which states could choose to adopt, proposed a full and unrestricted “special-purpose” license that would allow physicians to practice in all jurisdictions. The special license was intended for physicians who practice medicine across state lines, and license holders would be subject to the jurisdiction of the medical board in the state of issuance. In 2009, FSMB received a three-year grant from the U.S. Department of Health and Human Services’ Health Resources and Services Administration (HRSA) to work on license portability initiatives, including the Model Act. In addition to the FSMB Model Act, scholars have proposed a national license for the practice of telemedicine.<sup>66</sup> The primary goal of a national telemedicine license would be to “standardize” licensing review, “maintain a central repository of information on telemedicine-related malpractice claims and verdicts, and to develop and enforce uniform standards for the practice of telemedicine.”<sup>67</sup>

Only ten state medical boards presently have a special purpose telemedicine license: Alabama, Louisiana, Minnesota, Montana, Nevada, New Mexico, Ohio, Oregon, Tennessee and Texas.<sup>68</sup> However, the notion of a special license for telemedicine poses several challenges. Each state that is a party to the Model Act would retain the authority to determine its own fees

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<sup>64</sup> The FSMB is a national nonprofit association that represents state medical licensing and disciplinary boards.

<sup>65</sup> Fed’n of State Med. Bds. *Report of the Ad Hoc Committee on Telemedicine, Federal of the State Medical Boards of the United States, A Model Act to Regulate the Practice of Medicine Across State Lines* (1996). Available: [http://www.fsmb.org/pdf/1996\\_grpol\\_Telemedicine.pdf](http://www.fsmb.org/pdf/1996_grpol_Telemedicine.pdf)

<sup>66</sup> Jacobson, Peter D. and Elizabeth Selvin. *Licensing Telemedicine: The Need for a National System*. 6 *Telemedicine J. & e-Health* 429 (2000), at 431-432.

<sup>67</sup> *Id.* at 435.

<sup>68</sup> See Appendix B.

and requirements for issuance, thereby perpetuating state-by-state variation.<sup>69</sup> For example, Alabama, which has adopted the Model Act, will only issue a special license to physicians located in states that allow Alabama-based physicians to practice medicine across state lines. Conversely, Minnesota, which has also adopted the Model Act, does not have a similar reciprocity requirement.<sup>70</sup> In addition, states may impose additional standards on physicians seeking special purpose telemedicine licenses. For example, candidates for telemedicine licenses may be required to have no history of revoked or suspended licenses, to appear for an additional interview,<sup>71</sup> or to complete a more vigorous continuing medical education requirement.<sup>72</sup> Furthermore, few states have adopted the Model Act<sup>73</sup> and the American Medical Association (AMA) opposes it.<sup>74</sup>

As discussed *supra* in Section III, the special license could also exacerbate jurisdictional issues. Complete federalization is unlikely and a joint federal-state system is more feasible.<sup>75</sup> In such a system, Bashshur proposes federal authorities “would focus on competency” and state authorities “would focus on policing professional misconduct.”<sup>76</sup> This, however, could further complicate licensing systems because the regulations would need to address which state’s scope of practice laws would apply to providers who possess national licenses for telemedicine. While “federal preemption of system scope of laws could be considered in the context of a federal license for telemedicine,” preemption might “exacerbate present conditions.”<sup>77</sup> Separate national

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<sup>69</sup> *Supra* note 5, at 396.

<sup>70</sup> Ala. Admin. Code 540-X-16-.02 (7)(a); Minn. Stat. § 147.032 (2008).

<sup>71</sup> See Appendix B, Louisiana

<sup>72</sup> See Appendix B. For example, Ohio requires over 50 hours per year.

<sup>73</sup> As of 2010, the states included Alabama, Minnesota, Montana, New Mexico, Nevada, Oregon, Tennessee, and Texas.

<sup>74</sup> *Supra* note 22.

<sup>75</sup> Bashshur, Rashid. *Telemedicine and State-based Licensure in the United States, Revisited*. 14 *Telemedicine & e-Health* (2008) at 310-311. See also, *supra* Jacobson & Selvin.

<sup>76</sup> *Id.* at 311.

<sup>77</sup> *Supra* note 3, at 70-71.

and state jurisdictions, “one for the practice of telemedicine and one for the practice of medicine,” would create “choice of law issues that would delay and potentially impair disciplinary action.”<sup>78</sup> A national licensure process for only telemedicine would fragment disciplinary processes in place at the state level and would require states to enforce national standards that may differ from the state’s own licensure schemes.<sup>79</sup> “As a practical matter, few boards would have the capacity to handle” a dual-jurisdictional arrangement. “Relatively small units of state government, medical boards have limited resources.”<sup>80</sup>

### **3. National licensing system**

A national licensure system would “alter the current state-based scheme” whereas the other proposed solutions would retain the existing framework.<sup>81</sup> Because telemedicine is, by nature, cross-jurisdictional, several scholars have concluded that “the establishment of a uniform set of standards and regulations is necessary to realize telemedicine’s full potential.”<sup>82</sup> In 2011, the University of Maryland School of Law held a “Roundtable on the Legal Impediments to Telemedicine.” In a journal article of the symposium’s proceedings, Ameringer wrote: “Just as railroads and other large business enterprises at the turn of the nineteenth century sought federal protection from myriad state laws and regulations, so today’s for-profit and nonprofit systems for delivering health care seek uniform standards to operate more effectively and more efficiently across state lines.”<sup>83</sup>

Such a system would ideally facilitate “full free movement,” in a way similar to how the European Union (EU) “guarantee[s] the quality of the entrants to the profession” by requiring

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<sup>78</sup> *Id.* at 71-72.

<sup>79</sup> *Id.* at 71.

<sup>80</sup> *Id.* at 79.

<sup>81</sup> *Id.* at 62.

<sup>82</sup> *Supra* note 1, at 158-159.

<sup>83</sup> *Supra* note 3, at 55.

member states to recognize the degrees and qualifications of physicians trained in other member states as long as these diplomas and certifications meet the minimum training requirements listed in the EU's "Doctor's Directive."<sup>84</sup> Moreover, insofar as the desire to retain licensing revenues is a barrier presented by state medical boards, the revenues generated by any fees assessed on a national license could be distributed pro rata among participating states. The potential for additional revenue may incentivize promotion of telehealth services by state medical boards.

However, Ameringer, among other scholars, posits that a national licensing scheme would be "unwieldy and difficult to implement."<sup>85</sup> Furthermore, a national license could undermine the traditional framework of state boards. As described above, the state boards are "uniquely responsible" for protecting patients from physicians who "represent a clear danger to the health and safety of their patients, their colleagues, and the integrity of the medical profession."<sup>86</sup> In performing this duty, boards interact with hospitals, payers, government agencies, and other medical boards to license, re-license, and discipline providers. Developing these relationships on a national scale would introduce a host of logistical issues.

## **B. Other Legislative Incentives**

Short of direct licensing solutions, other legislation incentives may help to reduce the barriers to entry for telemedicine providers. First, in considering any new legislation regarding patients' rights to access, Congress should consider language that expands access to the best care possible without physical proximity barriers. An expressed Congressional purpose in increasing access to the best medical care for patients, particularly those in medically underserved areas, may incentivize states to accelerate consideration of the aforementioned proposed solutions.

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<sup>84</sup> Council Directive 93/16/EEC of the Council of the European Communities of 5 April 1993 to Facilitate the Free Movement of Doctors and the Mutual Recognition of Their Diplomas, Certificates, and Other Evidence of Formal Qualifications, (1993) O.J. (L 165).

<sup>85</sup> *Supra* note 3, at 62.

<sup>86</sup> *Id.* at 75.



Second, a more aggressive legislative step would be to define the act of telemedicine as “occurring” in the practicing physician’s state. As discussed in III-A supra, defining telemedicine as occurring in the physician’s state for the purposes of jurisdiction may reduce the burden on physician’s to be aware of multiple standards of care. However, there is a question of whether federal preemption would be valid in light of the presumed power of states to regulate medical licensure.<sup>87</sup> The federal government is certainly entitled to a degree of regulation of the unique market of interstate telemedicine transactions via the Commerce Clause.<sup>88</sup> Moreover, a colorable argument could be made that state’s practicing “economic isolationism” by favoring in-state physician’s economic interests at the expense of out-of-state physicians, and thus may be preempted under the Dormant Commerce Clause.<sup>89</sup> However, how a court would rule on this given the unique market of telemedicine is uncertain.

Third, efforts should be made to reduce uncertainty in physician liability. A direct licensing solution would almost certainly reduce questions of applicable law, because standards of care and forum selection could be addressed directly through contract, waivers as a condition for licensing, or reciprocity agreements. However, one alternative proposal that may incentivize treatment of rural, poor, or medically underserved populations would be to provide malpractice insurance for charitable treatment. As of 2009, 43 states have enacted some form of protection for volunteer physicians working in non-profit, non-emergency situations like free clinics.<sup>90</sup> Similarly, a federal program providing additional malpractice insurance coverage specifically for telemedicine services may incentivize volunteer or recently-retired physicians to become involved.

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<sup>87</sup> See supra note 4.

<sup>88</sup> Goehring, Lindsey. *H.R. 2068: Expansion of Quality or Quantity in Telemedicine in the Rural Trenches of America?* North Carolina Journal of Law and Technology, 11 N.C.J.L & Tech. On. 99 (2009).

<sup>89</sup> *Id.*

<sup>90</sup> Orłowski, Anna. Medical Board of California. *Report to Address Assembly Bill 2342*, (December 31, 2008).