March 21, 2017
1:00pm – 5:00pm

Location: Goodwood Museum & Gardens
1600 Miccosukee Road
Tallahassee, FL 32308


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<tr>
<th>Time</th>
<th>Agenda Item</th>
<th>Presenter(s)</th>
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<tr>
<td>1:00 – 1:05</td>
<td>Roll Call, Welcome &amp; Introductions Review &amp; Approval of March Minutes</td>
<td>Chair Senior</td>
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<tr>
<td>1:05 - 1:15</td>
<td>Welcome and Opening Remarks Tallahassee Memorial Hospital</td>
<td>Lauren Faison</td>
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<td>1:15 – 1:30</td>
<td>Department of Health Physician Workforce Statistics</td>
<td>Steven Chapman, PhD</td>
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<td>1:30 – 1:45</td>
<td>Department of Health Medical Quality Assurance</td>
<td>Claudia Kemp, JD</td>
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<td>1:45 – 2:45</td>
<td>Florida Nurse Practitioner Network Florida ARNP Association Florida Association of Physician Assistants</td>
<td>Janet Dubois, ARNP Stan Whitaker, ARNP TBD</td>
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<tr>
<td>2:45 - 3:00</td>
<td>Break</td>
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<tr>
<td>3:00 - 4:00</td>
<td>Florida Medical Association Florida Osteopathic Medical Association Florida Pharmacy Association</td>
<td>Mary Thomas, JD Ronald Knaus, DO Michael Jackson, BPharm</td>
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<td>4:00 – 4:25</td>
<td>Public Comment</td>
<td>Chair Senior</td>
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<td>4:25 - 4:55</td>
<td>Member Discussion &amp; Next Steps</td>
<td>Council Members</td>
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<tr>
<td>4:55 – 5:00</td>
<td>Wrap Up &amp; Closing</td>
<td>Chair Senior</td>
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Meeting Materials and Information will be available at: [www.AHCA.myflorida.com/Telehealth](http://www.AHCA.myflorida.com/Telehealth)

Additional comments and information may also be sent to: [Telehealth@ahca.myflorida.com](mailto:Telehealth@ahca.myflorida.com)
Members Present
Justin M. Senior, Chair,
Dr. Celeste Philip
Dr. Ernest Bertha
Dr. Anne Burdick
Leslee Gross
Darren Hay
Dr. Kim Landry
William Manzie
Elizabeth Miller
Dr. Steven Selznick
Mike Smith
Matthew Stanton (virtual)
Monica Stynchula
Dr. Sarvam TerKonda

Members Absent
Dr. Kevin O’Neil (excused)

Staff Present
Nikole Helvey
Pam King

Others Present
Interested Parties (Attachment A)

Welcome and Opening Remarks
Chair Senior called the meeting to order at 8:05 a.m.

Roll Call
Chair Senior welcomed the group and directed Ms. Nikole Helvey to call the roll. A quorum was present.

Review and Approval of the Minutes
Dr. Anne Burdick requested a modification to the minutes, clarifying her suggestion that the Council consider whether their recommendation should include parity of payment for treatment via telehealth. Chair Senior noted some typographical errors. Mr. Mike Smith moved to approve the minutes as amended; the motion was seconded and carried unanimously.

Welcome and Opening Remarks
Mr. Ken Hetlage, Executive Vice President, Memorial Hospital, welcomed the Council and shared information on the current services they offer via telehealth. He also provided information on Memorial’s plans for use of telehealth to provide care at schools and businesses. Mr. Hetlage also noted his opinion that telehealth is crucial to population health.
Florida Blue Telehealth Presentation

Dr. Deborah Stewart, Medical Director, Florida Blue, shared information on their telehealth implementations. She informed the Council that Florida Blue had instituted a variety of pilots between 2009 and 2015 with providers in Florida. Dr. Stewart noted they began offering a direct-to-patient telemedicine model through Teladoc to self-funded employer groups; two employer groups purchased this benefit for 2016.

Dr. Stewart gave a brief summary of the results experienced, as well as the barriers to entry. She noted that utilization for new offerings is low and the providers with whom Florida Blue collaborated expressed technology setup is a barrier. Dr. Stewart stated Florida Blue’s focus is on gaining knowledge to find appropriate use cases for telehealth.

She also discussed Florida Blue’s reimbursements for telehealth, noting that they do not reimburse for telehealth outside of their pilots. She highlighted that Florida Blue believes the market demand should dictate the use and payment for telehealth services. She noted, as with other services, the ability to negotiate rates with providers for services is beneficial to their members. Dr. Stewart also shared that collaboration with provider partners has enabled pilot implementations without the need for regulation.

Council members asked clarifying questions of Dr. Stewart and provided suggestions on current studies, including Blue’s coverage of telehealth in other states, that may benefit them as they look at reimbursing for telehealth services in Florida.

Insurance Laws in Other States

Nathaniel Lacktman, Esq., Foley & Lardner, LLP, spoke to the Council about commercial insurance coverage of telehealth services. Mr. Lacktman provided information on the role of insurance in health care and the various payment models used by other states to cover services offered by telehealth. He also shared information from a 2016 Health Care Cost Institute Study.

The study shows there were 6,500 telehealth claims by primary care providers compared to 95.9 million non-telehealth claims. He reported that while non-telehealth service reimbursements increased every year, telehealth reimbursements began to decrease after 2011. The average reimbursement decreased from $68 to $38, which is 40% lower than identical non-telehealth claims. Mr. Lacktman also provided a state comparison with laws requiring commercial insurance reimbursement for telehealth, as well as other types of telehealth reimbursements covered. Mr. Lacktman gave a more specific description of the telehealth commercial insurance coverage laws in Texas, Georgia, and Michigan.

The Council members asked clarifying questions of Mr. Lacktman and requested copies of additional reports he noted were available.

Break

Member Discussion and Next Steps

The Council members discussed the importance of distinguishing types of telehealth modalities when discussing parity payment. Dr. Kim Landry specifically noted that the Council should be careful when comparing a Teladoc type visit to an emergency department visit related to payment parity.
Dr. Steven Selznick agreed that there should be a noted difference between one-time audio telehealth appointments and visual telehealth appointments. They suggested reviewing statutory language in states like Mississippi to establish model telehealth language for insurance reimbursement.

Mr. Smith questioned if the increase in bundle payment services may be an impetus for providers to use telehealth. Dr. Selznick noted that telehealth is vital to addressing the needs in long-term care facilities.

Dr. Burdick remarked that education of providers and the population should be included in the Council’s recommendations.

Chair Senior noted that the recommendations should include information discovered in the Council meetings. He reiterated that the Council could make recommendations that include suggestions for changes to rules, Medicare coverage, and statutes – including mandates or prohibitions. He advised that the recommendations should also provide guidance on program structure and best practices.

Dr. Sarvam TerKonda added that the Council’s recommendations should address health care coverage and payment. Ms. Leslee Gross requested that the Council obtain additional information from the Office of Insurance Regulation on the use telehealth by health plans.

Ms. Elizabeth Miller suggested the Council seek out an organization that is not in favor of telehealth in order to get a better picture of the barriers. Mr. Smith replied that a Florida Medical Association lobbyist spoke in opposition during a past legislative session. He also noted that the information Dr. Stewart shared from Florida Blue was helpful in learning the needs of the insurers. Dr. Burdick shared that the Florida Hospital Administration League does not advocate for telehealth.

Chair Senior asked the Council about reasonable caveats they have heard from stakeholders. Dr. Burdick noted the requirement for providers to have a State of Florida license. Dr. TerKonda mentioned that compacts for licensure could streamline the process for some providers licensed in other states.

Chair Senior reminded the group that everyone wants an ideal system, but the Council is to recommend the best approach to improve quality and access.

After much discussion about future potential speakers, Ms. Helvey reviewed the topics for the upcoming meeting. She explained that the topics for March will include licensure and scope of practice, April will focus on telehealth used by public entities, May will include information from various types of practitioners using telehealth, and June will include presenters from various facility settings. She added that staff would provide members with a list of topics and current anticipated presenters.

**Public Comment**

**Stanley H. Wilson, Nova Southeastern University** – Mr. Wilson, representing the Florida Physical Therapy Association, stated that it is critical to have allied health professionals at the discussion table. He opined that there was a great need to educate medical students with courses such as ethics and legalities. Mr. Smith stated that medical schools have not participated in the
telehealth conversation. The Council welcomes input on how to introduce telehealth into the curriculum. Mr. Wilson replied that Ms. Deborah Mulligan at Florida State University is working with Nova Southeastern University to add telehealth to their curriculum.

**Anna Baznik, CEO, IMPOWER** — Ms. Baznik shared that Impower is concerned with current legislation. House Bill 7011, filed by Representative Pignan, would reverse language in the Board of Medicine’s rule related to behavioral health providers. She reiterated prior comments that telehealth is not a service; it is a modality for providing health care. She noted that outcomes should be no different in telehealth delivery as in person.

Mr. Smith suggested the Council look at the impact of any telehealth proposals to ensure unintended consequences do not arise.

**Carolyn Grant, Director, Government Relations, Cardinal Health, Inc. & Adam Chesler, Director, Government Affairs** — Ms. Carolyn Grant and Mr. Adam Chesler spoke to the Council about telepharmacy efforts in other states. Cardinal Health’s goal is to find solutions for providers to make care cost effective. It is very important to look at all types of providers in order to expand access to care.

Mr. Darren Hay asked which states had specific regulations related to telepharmacy. Mr. Chesler responded that North Dakota, South Dakota, and Idaho have provisions around practicing telepharmacy. Mr. Chesler noted he would email the Idaho statutory language that includes pharmacists to the Council. Dr. Selznick commented that it was interesting that the states noted by Mr. Chesler do not have parity laws.

**Adjournment**

There being no further discussion, the Telehealth Advisory Council adjourned at 12:00 p.m.
Interested Parties Present:

Socrates Agury, Anthem; Anna Baznik, IMPOWER; Adam Chesler, Cardinal Health; Judy Cirafesi, UHC; Laura Cohen, PhD, Florida Psychological Association; Dave Freedman, Connectivity Leadership; Carolyn Grant, Cardinal Health; Jeff Marforana, Sunshine Health; Deb Stewart, MD, Florida Blue; Teresa West, Merck; and Stanley H. Wilson, Nova Southeastern University.
Trends in Florida’s Physician Workforce
Florida Telehealth Advisory Council
March 21, 2017

Licensed, Practicing Physicians by Specialty

Primary Care Physicians

Primary Care Physicians by Specialty
Pediatrics 15.3%
Family Medicine 40.7%
Internal Medicine 44.9%
Physicians Accepting New Medicaid or Medicare Patients

Between 2008-09 and 2015-16, the percentage of physicians accepting new Medicaid patients rose more than 4%, the percentage accepting new Medicare patients rose more than 9%.

Age Distribution of Physicians

Physician Workforce in Florida

- 55,000: Total fully licensed physicians in-state active in Florida**
- 6,362: Practicing physicians planning to retire in the next five years
- 1,630: Physicians planning to relocate in the next five years *
- 4,365: Average new physician licenses issued annually in the past five years **

* Florida Medical Association Annual Report 2016
** Florida Medical Association Annual Report
Primary Care Physician Rates per 100,000 by County Size

Trends in Total Physicians in Small Counties

Florida Projections Results

- HBSA (2016) estimates a national need of 23,640 additional primary care physicians by 2025, and 3,060 in Florida.
- Robert Graham Center (2013) projected the need for an additional 4,673 Florida primary care physicians by 2030.
- The 2013 Safety Net Report by IHS estimated a surplus of 1,066 primary physicians by 2025. They estimated a shortage of more than 900 family physicians which was masked by a surplus of pediatric physicians due to demographic shifts.
- The 2016 AAMC Report by IHS projects a shortage of between 14,300 and 35,600 primary care physicians by 2025 nationwide.
Specialties

- Projected Surplus
  - Pediatrics
  - Emergency Medicine
  - Internal Medicine
  - Dermatology
  - Geriatric Medicine

- Projected Deficit
  - Psychiatry
  - Family Practice
  - General Surgery
  - Radiology
  - Anesthesiology
  - Cardiology
  - OB/GYN
  - Hematology & Oncology
  - Pulmonology & CC

DOH Programs and Initiatives Strengthening Workforce Availability and Distribution

- J-1 Visa Conrad 30
- National Health Service Corps
- Physician Limited Licenses
- Physician Recruitment Assistance—3net.org
- Volunteer Health Services
- Valor Program—Military Veteran Licensure Fee Exemptions
- Temporary Certificates for Dentists

Strengthening the Physician Workforce: Pipeline and GME

- Florida is a net importer of medical school graduates
- Lack of graduate medical education—residency—slots
- Governor’s budget included $110 million for new slots, and almost $50 million in support for GME positions
- Almost 80% of Florida med school graduates who graduate from Florida GME programs stay here and practice
- Pipeline programs mentor middle- and high-school students who are interested in becoming physicians, especially targeting underserved populations
Strengthening the Physician Workforce: New Access Models

- Community Paramedicine Programs
- Telemedicine

Questions?

Steven F. Chapman, PhD
Division Director
Division of Public Health Statistics and Performance Management
Florida Department of Health
Steven.Chapman@flhealth.gov
Materials, Citations, and Resources for TELEHEALTH PRACTICES
A multi-state overview of Telehealth

Presentation to the Telehealth Advisory Council
March 21, 2017
Claudia Kemp, J.D.
Executive Director, Florida Board of Medicine
Florida Department of Health
Medical Quality Assurance
Executive Summary

The Federation of State Medical Boards is a national non-profit organization whose membership includes 70 medical licensing and disciplinary boards in the United States, and the U.S. territories. The Federation acts as a collective voice for its member medical boards in the continual improvement of the quality, safety, and integrity of health care standards for physician licensure and practice. Goals V and VIII of the Federation’s strategic plan (HOD April 2000) call for the Federation to support state medical boards (1) as primary vehicles of medical licensure and discipline and (2) in developing and using consistent standards, language, definitions and tools.

Reflecting these tenets, in April 2000, Federation President, George C. Barrett, MD, established the Special Committee on License Portability to explore mechanisms that could significantly improve the portability of state medical licensure. The committee was carefully selected to include broad representation from the medical regulatory and professional communities, including professional and public members of state medical boards and medical board staff. Robert E. Porter, MD, a former Federation president, was selected to chair this committee.

The Committee met over the course of two years, with the original intent to propose a licensure model that would result in true license portability. The Committee evaluated licensure models including the mutual recognition model utilized in Australia and proposed in Canada, as well as the licensure compact model developed by the National Council of State Boards of Nursing.

In its initial work product, the Committee proposed a “portable license cooperative system” that would have required significant statutory changes and the establishment of formal agreements among state medical boards. Based upon comments and concerns expressed by a variety of stakeholders, including board executives, committee members, and other interested parties, the Committee concurred that an incremental approach would be more widely accepted and practical to implement. Accordingly, the Committee reassessed its work product and developed recommendations based upon the existing processes of licensure by endorsement. The Committee believed this approach to be advantageous to state medical boards as the recommendations will (1) require little, if any, statutory amendment and (2) not require contracts or other formal agreements between jurisdictions.

The Committee’s report sets forth an expedited licensure process for physicians meeting identified and accepted standards and is dependent upon the development of a standard medical license application and acceptance of established standards for primary source verification of physician core credentials, including identity, medical education, postgraduate training, examination, and disciplinary history.

The Committee recommends state medical boards offer an expedited licensure by endorsement process to physicians meeting the following qualifications:

1. Full and unrestricted licensure (in all jurisdictions where a medical license is held);
2. Free of disciplinary history, license restrictions, or pending investigations (in all jurisdictions where a medical license is or has been held);
3. Graduation from an approved medical school or hold current Educational Commission for Foreign Medical Graduates (ECFMG) certification;
4. Passage of a licensing examination acceptable for initial licensure within three attempts per step/level and within a seven (7) year time period;
5. Completion of three (3) years of progressive postgraduate training in an accredited program; and/or,
6. Current certification from a medical specialty board recognized by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA). Lifetime certificate holders who have not passed a written specialty recertification examination must demonstrate successful completion of the Special Purpose Examination (SPEX), Comprehensive Osteopathic Medical Variable Purpose Examination (COMVEX), or applicable recertification examination.

The Committee recognizes that the recommendations, if implemented, will not allow all physicians applying for licensure by endorsement to qualify for the expedited process; however, over time the vast majority of physicians should be able to meet these core requirements.

The Committee distributed a draft of its recommendations to member medical boards and other interested parties in February 2002 for comment. Comments were carefully considered and some have been incorporated into the final document that follows. The Committee emphasizes that the recommendations set forth are not applicable to initial licensure but only apply to those applicants who have an unencumbered medical license and credentials profile permitting expedited movement to another jurisdiction. The Committee is aware that many states have requirements beyond those pertaining to education, training, examination, etc. that are jurisdictionally specific that may limit an expedited process. The Committee urges state medical boards to take an opportunity to review existing licensure requirements that are specific to their jurisdiction and evaluate them with regard to endorsement licensure.

Report of the Special Committee on License Portability

Section 1. Introduction

In April 2000, Federation President George C. Barrett, MD, established the Special Committee on License Portability to explore mechanisms that could significantly improve the portability of state medical licensure. Responding to changes in the delivery of health care over the last decade, the Federation has incrementally addressed the issue of license portability. The Ad Hoc Committee on Licensure by Endorsement (1995) identified the need for a centralized system for primary source verification and archiving of core physician credentials on behalf of state medical boards, as well as the need to address regulatory issues associated with telemedicine and barriers to license portability. The policy that resulted from the Ad Hoc Committee on Licensure by Endorsement led to the development of the Federation Credentials Verification Service (FCVS) and the policy, A Model Act to Regulate the Practice of Medicine Across State Lines. Recognizing that barriers exist that impede implementation of an expedient process for licensure by endorsement, the Special Committee on Uniform Standards and Procedures (1998) set forth recommendations to improve consistency of licensure requirements and disciplinary terminology and processes.

Administrative, regulatory, statutory and operational differences among medical licensing jurisdictions are key factors to be addressed in assessing states’ ability to improve license portability. Since its inception in 1912, the Federation has maintained its commitment to protecting the constitutional right of states to independently and exclusively regulate the practice of medicine within their respective jurisdictions in order to ensure that persons practicing medicine meet sufficient standards of education, training, competence, and ethics. However, current social, economic and political pressures threaten the state-based medical licensure system. The American Medical Association’s House of Delegates recently adopted policy calling for the AMA to examine license reciprocity between states in order to improve the ability of physicians to practice in other states and to ask the Federation of State Medical Boards to explore a standardized medical licensure application form. Additionally, Federal initiatives directed toward
improving access to telehealth services continue to identify state licensure as a barrier and encourage the adoption of provisions allowing for practitioner licensure across state lines. Medical boards have an obligation to take a proactive role in addressing concerns that have arisen as a result of physician mobility, the evolution of managed care, advancements in technology, and an expanding number of interstate multi-hospital systems.

Accordingly, the Special Committee on License Portability was charged as follows:

- To review the report of the Ad Hoc Committee on Licensure by Endorsement and identify areas for revision;
- To review and evaluate current state requirements for licensure by endorsement;
- To identify variances in licensure requirements and other statutory or system barriers to license portability and reasons for such variances;
- To evaluate the experiences of other countries utilizing a mutual recognition model for physician licensure; and
- To develop recommendations to state medical boards to enhance license portability while preserving a state-based licensure system and maintaining the high standards necessary to protect the public.

The Special Committee recognized that state-based licensure best serves the interests of public safety and any system to enhance license portability must protect both the state-based licensure system and high standards for physician licensure and practice. During its deliberations, the Committee evaluated potential licensure models and systems and concluded that building upon the existing processes of licensure by endorsement is the best option and most practical to implement. The Committee believed this approach to be most advantageous to state medical boards as (1) it will require little, if any, statutory amendment and (2) will not require contracts or other formal agreements between jurisdictions. The Committee strongly urges state medical boards to revise their processes for licensure by endorsement to improve the ability for qualified physicians to obtain licensure in subsequent jurisdictions while maintaining public protection.

The recommendations proposed are designed to significantly enhance the process of licensure by endorsement for physicians meeting identified and accepted standards. The standards recommended meet or exceed requirements for the practice of medicine in the majority of jurisdictions. Although the proposed standards are stringent, the majority of currently licensed physicians will qualify for licensure by endorsement under the proposed enhanced and expedited process. Until such time as all physicians practicing in the United States are eligible under the proposed standards, state medical boards should implement two distinct tracks for processing applications for licensure by endorsement: (1) the traditional track; and (2) an expedited track for physicians who qualify.

Section 2. Expedited Licensure by Endorsement

In 1995, the Ad Hoc Committee on Licensure by Endorsement defined licensure by endorsement as “process whereby a state issues an unrestricted license to practice medicine to an individual who holds a valid and unrestricted license in another jurisdiction. The license will be granted based upon (1) documentation of successful completion of an approved examination previously administered by another agency (2) acceptance of core documents which have been authenticated by an approved process and (3) completion of additional requirements which assess the applicant’s fitness to practice medicine in the new jurisdiction.”

Section 2(A). Basis for Recommendations

The Committee based its recommendations on the following:
• Only physicians who qualify will be eligible for licensure by endorsement via an expedited process. Physicians otherwise will be considered via traditional processes.
• State medical boards can enhance operational and administrative procedures required to expedite licensure by endorsement.
• The ultimate responsibility for assessing applicants’ fitness to practice is retained by each licensing jurisdiction.
• Physicians remain subject to the authority of each and every jurisdiction wherein they hold a license.
• Utilization of a standardized system of credentials verification, such as the Federation Credentials Verification Service, can provide consistent and timely verification of physician core credentials, including examination and disciplinary history.

Section 2(B). Qualifications

Physicians must meet the following qualifications in order to be considered eligible for licensure via an expedited licensure by endorsement process:

The applicant must provide documentation of—

• The identity of the applicant.
• All U.S. jurisdictions in which the applicant holds a full and unrestricted license.
• The applicant is free of disciplinary history, license restrictions, and, pending investigations in all jurisdictions.
• Graduation from an approved medical school
• Liaison Committee on Medical Education (LCME) or American Osteopathic Association (AOA) approved medical school; or
  o Fifth Pathway certificate;3 or
  o Educational Commission for Foreign Medical Graduates (ECFMG) certificate
• Passing one or more of the following examinations acceptable for initial licensure within three attempts per step/level
  o United States Medical Licensing Examination (USMLE) Steps 1-3 or its predecessor examinations (National Board of Medical Examiners (NBME) I-III or the Federation Licensing Examination (FLEX)
  o Examinations offered by the National Board of Osteopathic Medical Examiners (COMLEX-USA) Levels 1-3 or its predecessor examination(s)
  o Medical Council of Canada Qualifying Examinations (MCCQE) or its predecessor examination(s) offered by the Licentiate Medical Council of Canada.
• The applicant successfully completed the total examination sequence within seven (7) years, except when in combination with a PhD program.
• Successful completion of 3 years of progressive postgraduate training in a program accredited by the Accreditation Council on Graduate Medical Education (ACGME) or the AOA; and/or,
• Certification or recertification by a medical specialty board recognized by the American Board of Medical Specialties (ABMS) or the AOA within the previous ten (10) years. Lifetime certificate holders who have not passed a written specialty recertification examination must demonstrate successful completion of the Special Purpose Examination (SPEX), Comprehensive Osteopathic Medical Variable Purpose Examination (COMVEX), or applicable recertification examination.

Section 3. Verification of Credentials
Section 3(A). Verification of Core Credentials

Primary source verification of physician core credentials, including identity, medical education and training, examination and disciplinary history must be established. Enhancing license portability is dependent upon the assurance and trust that primary source verification of physicians’ core credentials has been conducted, such verified documents are securely maintained, and the credentials verification process is consistent among jurisdictions.

Physicians desiring an expedited process for licensure must utilize FCVS, or credentials verification meeting equivalent standards for verification of core credentials.

Such credentials include:

- Medical School Diploma
- Medical School Transcript
- Dean’s Certificate
- Examination history
- Disciplinary history
- Identity (photograph and certified birth certificate or original passport)
- ECFMG certificate, if applicable
- Fifth Pathway Certificate, if applicable
- Postgraduate training verification

3(B) Additional Verification

State medical boards should obtain supplemental documentation including, but not limited to: (1) criminal record check(s), (2) absence of current/pending investigation(s) (3) verification of specialty board certification, if not previously obtained through the ABMS, AOA, or other specialty board recognized by the state medical board and (4) professional experience.

4. Issuance of License

State medical boards should implement an abbreviated and expedient process for issuing a medical license based upon evidence of the aforementioned requirements and qualifications. The applicant should, at a minimum, satisfy the following requirements:

The applicant must:

- Submit a completed application form.
- Initiate the transmittal of an FCVS (or equivalent) physician information profile to the board.
- Expeditiously meet all other state board specific requirements, e.g. interviews, orientations
- Remit required fee(s).
- An individual meeting the requirements set forth above and who holds a valid, unrestricted license in at least one U.S. jurisdiction should be given every consideration for expedited issuance of a full and unrestricted license.

Section 5. Standardized Medical License Application
The Committee believes it is incumbent upon the Federation, in partnership with Administrators in Medicine, to develop a standardized license application, (electronic and/or paper) for use by state medical boards.

Section 6. Responsibility of the Applicant

Nothing in this document obviates the responsibility of applicants to be knowledgeable of the specific requirements of the jurisdiction in which they seek licensure, and to timely comply with those requirements.

Section 7. Implementation

With a sense of urgency, the Committee encourages state medical boards to implement systems to improve license portability that foster cooperation and consistency among the Federation’s member boards. License portability will only be achieved through commitment, cooperation, and trust between and among the Federation and its member boards.

The Committee encourages the Federation, in partnership with Administrators in Medicine, to develop an implementation plan that includes:

1. Developing and supporting a pilot program to assess the overall workability of expedited license by endorsement.
2. Providing assistance to state medical boards, including a standardized license application and other documentation supporting enhanced license portability.
3. Soliciting support from pertinent external stakeholder organizations in implementing the changes necessary to enhance license portability.
4. Identify problematic or deficient areas and outcomes; evaluate the success of this effort; and facilitate recommendations for future enhancements.

Section 8. Recommendations of the Special Committee on License Portability

The Special Committee on License Portability recommends that—

1. State medical boards work immediately and cooperatively to effect administrative and operational changes required to enhance and develop an expedited licensure by endorsement for physicians who qualify.
2. The Federation of State Medical Boards assist state medical boards in the implementation of an expedited licensure by endorsement process for physicians who qualify.
3. The Federation of State Medical Boards, in partnership with Administrators in Medicine, develop a standardized license application and other necessary documentation to assist state medical boards in facilitating license portability.
4. The Federation of State Medical Boards expand the Federation Credentials Verification Service primary source verification to include all jurisdictions in which licensure is held, specialty board certification status and implement other enhancements to expedite product delivery.
5. The Federation reaﬀirms its policy that medical boards share investigative information, at the early stages of complaint investigation, with other medical boards considering a licensure application.4
6. The Federation reaﬀirms its policy that all state medical boards conduct criminal record checks as part of the licensure application process.5

Special Committee on License Portability.6
A Fifth Pathway program is an academic year of supervised clinical education provided by a LCME-accredited medical school and is available to persons who meet all of the following conditions:

- Have completed, in an accredited US college or university, undergraduate premedical work of the quality acceptable for matriculation in an LCME-accredited US medical school;
- Have studied in a medical school located outside the United States, Puerto Rico, and Canada that is listed in the World Directory of Medical Schools and that requires an internship and/or social service after completing the school’s academic requirements and before receiving the final medical credential;
- Have completed all of the formal requirements of the non-US medical school except internship and/or social service.

Students who have completed the academic curriculum in residence at a non-US medical school and who meet the above conditions may be offered the opportunity to substitute, for an internship and/or social service required by a non-US medical school, an academic year of supervised clinical training in a medical school accredited by the LCME.

Special Committee on License Portability

Robert E. Porter, MD, Chair  
Past President  
Federation of State Medical Boards

Penny Angelo  
Board Member  
Texas State Board of Medical Examiners

George C. Barrett, MD  
Past President  
Federation of State Medical Boards  
Board Member  
North Carolina Medical Board

Edward David, MD, JD  
Board Chair  
Maine Board of Licensure in Medicine

William M. Lightfoot, MD  
Past Board Member  
Alabama State Board of Medical Licensure
Ira Lubell, MD  
Board Member  
Medical Board of California

Diane Meelheim, MSN, JD  
Assistant Executive Director  
North Carolina Medical Board

Barbara Schneidman, MD  
FSMB Past President  
American Medical Association  
Consultant:  
Ray Q. Bumgarner, JD  
Past Executive Director  
State Medical Board of Ohio

**FSMB Staff:**  
Lisa A. Robin  
Assistant Vice President  
Leadership and Legislative Services
Telemedicine Policies
Board by Board Overview

Document Summary:
- Forty-eight (48) state boards, plus the medical boards of District of Columbia, Puerto Rico, and the Virgin Islands, require that physicians engaging in telemedicine are licensed in the state in which the patient is located.
- Fifteen (15) state boards issue a special purpose license, telemedicine license or certificate, or license to practice medicine across state lines to allow for the practice of telemedicine.
- Four (4) state boards require physicians to register if they wish to practice across state lines.
- Twenty-eight (28) states, plus the District of Columbia, require both private insurance companies and Medicaid to cover telemedicine services to the same extent as face-to-face consultations.
- Eighteen (18) states currently require only Medicaid to cover telemedicine services.
- One (1) state requires only private insurance companies to reimburse for services provided through telemedicine.

<table>
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<tr>
<th>State</th>
<th>State License Required</th>
<th>Reimbursement Parity</th>
<th>Other Rules/Regulations (citation only)</th>
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<td>Ala. Admin. Code § 540-x-16</td>
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<td>Medicaid Only.</td>
<td>“Telehealth Statutes, Regulations &amp; Policy”</td>
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<td>AR State Med. Board Newsletter Fall 2012</td>
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1 √* denotes that a state may issue a special purpose license, telemedicine license or certificate, or license to practice medicine across state lines to allow for the practice of telemedicine.
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<th>State</th>
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|       |          |                     | “40-27: Guidelines for the Appropriate Use of Telehealth Technologies in the Practice of Medicine”
|       |          |                     | **Colorado Medical Board, Aug. 2015** |
| DE    | √        | Medicaid & Private. | **18 Del. C § 3370**
|       |          |                     | **24 Del. C § 1702**
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|       |          |                     | **Effective 1/1/16** |
| DC    | √        | Medicaid & Private. | **DC Code § 31-3861**
|       |          |                     | “Telemedicine Policy”
|       |          |                     | **DC Board of Medicine, Nov. 2014** |
| FL-M  | √        | Medicaid Only. | **Fla. Stat. § 456.023**
|       |          |                     | **Fla. Admin. Code § 64B8-9.0141** |
| FL-O  | √        | Medicaid Only. | **Fla. Admin. Code § 64B15-14.0081** |
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| GU    | #2       | --                  | **10 GCA § 12202(b)** |
| HI    | √        | Medicaid & Private. | **Haw. Rev. Stat. § 453-1.3** |
| ID    | √        | --                  | **Idaho Code Ann. § 54-5601** |
| IL    | √        | Medicaid & Private. | **225 ILCS 60/49.5** |
| IN    | √        | Medicaid & Private. | **Ind. Code 25-22.5-14**
|       |          |                     | **Ind. Code 12-15-5-11**
|       |          |                     | **844 IAC 5-8** |
| IA    | √        | Medicaid Only. | **IAC 653 – 13.11** |
| KS    | √        | Medicaid Only. | No unique laws regulating practice of telemedicine. |

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2 Guam Code, 10 GCA § 12202(b), requires only that physicians are licensed somewhere within the United States.
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<th>State</th>
<th>Medicaid &amp; Private</th>
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| ME-M  | √†                 | 32 MRSA § 3300-D  
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“Policy: Medical Practice Across State Lines”  
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| ME-O  | √                   | “Policy: Medical Practice Across State Lines”  
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| MD    | √^                 | Code of Maryland and Rules (COMAR)  
10.32.05  
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^ "√" denotes that Maryland Revised Statutes § 14-302 exempts physicians licensed in adjoining states from being required to obtain a Maryland license.
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<td>MN</td>
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<td>Minn. Stat. § 147.032 “Telemedicine Registration” Minnesota Board of Medical Practice</td>
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<td>NC</td>
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4 v* denotes that a state requires physicians to register if they choose to wish to practice medicine across state lines.
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| UT-O  | √    | Medicaid Only. | Same as UT-M |
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| VT-O  | √    | Medicaid & Private. | Same as VT-M |
| VI    | √    | --              | VI St. T. 27 § 16 |
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| WA-M  | √    | Medicaid Only. | RCW 18.71.030  
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| WA-O  | √    | Medicaid Only. | RCW 18.57.040 |
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| WI    | √    | Medicaid Only. | No unique laws regulating practice of telemedicine. |
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For informational purposes only: This document is not intended as a comprehensive statement of the law on this topic, nor to be relied upon as authoritative.

Non-cited laws, regulation, and/or policy could impact analysis on a case-by-case or state-by-state basis. All information should be verified independently.
MODEL POLICY FOR THE APPROPRIATE USE OF
TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF
MEDICINE

Report of the State Medical Boards’ Appropriate Regulation of
Telemedicine (SMART) Workgroup

*Adopted as policy by the Federation of State Medical Boards in April 2014*

INTRODUCTION

The Federation of State Medical Boards (FSMB) Chair, Jon V. Thomas, MD, MBA, appointed the State Medical Boards’ Appropriate Regulation of Telemedicine (SMART) Workgroup to review the “Model Guidelines for the Appropriate Use of the Internet in Medical Practice” (HOD 2002)\(^1\) and other existing FSMB policies on telemedicine and to offer recommendations to state medical and osteopathic boards (hereinafter referred to as “medical boards” and/or “boards”) based on a thorough review of recent advances in technology and the appropriate balance between enabling access to care while ensuring patient safety. The Workgroup was charged with guiding the development of model guidelines for use by state medical boards in evaluating the appropriateness of care as related to the use of telemedicine, or the practice of medicine using electronic communication, information technology or other means, between a physician in one location and a patient in another location with or without an intervening health care provider.

This new policy document provides guidance to state medical boards for regulating the use of telemedicine technologies in the practice of medicine and educates licensees as to the appropriate standards of care in the delivery of medical services directly to patients\(^2\) via telemedicine technologies. It is the intent of the SMART Workgroup to offer a model policy for use by state medical boards in order to remove regulatory barriers to widespread appropriate adoption of telemedicine technologies for delivering care while ensuring the public health and safety.

In developing the guidelines that follow, the Workgroup conducted a comprehensive review of telemedicine technologies currently in use and proposed/recommended standards of care, as well as identified and considered existing standards of care applicable to telemedicine developed and implemented by several state medical boards.

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\(^1\) The policy on the Appropriate Use of Telemedicine Technologies in the Practice of Medicine supersedes the Model Guidelines for the Appropriate Use of the Internet in Medical Practice (HOD 2002).

\(^2\) The policy does not apply to the use of telemedicine when solely providing consulting services to another physician who maintains the physician-patient relationship with the patient, the subject of the consultation.
MODEL POLICY FOR THE APPROPRIATE USE OF TELEROMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

Model Guidelines for State Medical Boards’ Appropriate Regulation of Telemedicine

Section One. Preamble

The advancements and continued development of medical and communications technology have had a profound impact on the practice of medicine and offer opportunities for improving the delivery and accessibility of health care, particularly in the area of telemedicine, which is the practice of medicine using electronic communication, information technology or other means of interaction between a licensee in one location and a patient in another location with or without an intervening healthcare provider. However, state medical boards, in fulfilling their duty to protect the public, face complex regulatory challenges and patient safety concerns in adapting regulations and standards historically intended for the in-person provision of medical care to new delivery models involving telemedicine technologies, including but not limited to: 1) determining when a physician-patient relationship is established; 2) assuring privacy of patient data; 3) guaranteeing proper evaluation and treatment of the patient; and 4) limiting the prescribing and dispensing of certain medications.

The [Name of Board] recognizes that using telemedicine technologies in the delivery of medical services offers potential benefits in the provision of medical care. The appropriate application of these technologies can enhance medical care by facilitating communication with physicians and their patients or other health care providers, including prescribing medication, obtaining laboratory results, scheduling appointments, monitoring chronic conditions, providing health care information, and clarifying medical advice.

These guidelines should not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law. In fact, these guidelines support a consistent standard of care and scope of practice notwithstanding the delivery tool or business method in enabling Physician-to-Patient communications. For clarity, a physician using telemedicine technologies in the provision of medical services to a patient (whether existing or new) must take appropriate steps to establish the physician-patient relationship and conduct all appropriate evaluations and history of the patient consistent with traditional standards of care for the particular patient presentation. As such, some situations and patient presentations are appropriate for the utilization of telemedicine technologies as a component of, or in lieu of, in-person provision of medical care, while others are not.

The Board has developed these guidelines to educate licensees as to the appropriate use of telemedicine technologies in the practice of medicine. The [Name of Board] is committed to assuring patient access to the convenience and benefits afforded by telemedicine technologies, while promoting the responsible practice of medicine by physicians.

It is the expectation of the Board that physicians who provide medical care, electronically or otherwise, maintain the highest degree of professionalism and should:

- Place the welfare of patients first;
- Maintain acceptable and appropriate standards of practice;

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4 Id.

MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

- Adhere to recognized ethical codes governing the medical profession;
- Properly supervise non-physician clinicians; and
- Protect patient confidentiality.

Section Two. Establishing the Physician-Patient Relationship

The health and well-being of patients depends upon a collaborative effort between the physician and patient.6 The relationship between the physician and patient is complex and is based on the mutual understanding of the shared responsibility for the patient’s health care. Although the Board recognizes that it may be difficult in some circumstances to precisely define the beginning of the physician-patient relationship, particularly when the physician and patient are in separate locations, it tends to begin when an individual with a health-related matter seeks assistance from a physician who may provide assistance. However, the relationship is clearly established when the physician agrees to undertake diagnosis and treatment of the patient, and the patient agrees to be treated, whether or not there has been an encounter in person between the physician (or other appropriately supervised health care practitioner) and patient.

The physician-patient relationship is fundamental to the provision of acceptable medical care. It is the expectation of the Board that physicians recognize the obligations, responsibilities, and patient rights associated with establishing and maintaining a physician-patient relationship. A physician is discouraged from rendering medical advice and/or care using telemedicine technologies without (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); and (3) obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including any special informed consents regarding the use of telemedicine technologies. An appropriate physician-patient relationship has not been established when the identity of the physician may be unknown to the patient. Where appropriate, a patient must be able to select an identified physician for telemedicine services and not be assigned to a physician at random.

Section Three. Definitions

For the purpose of these guidelines, the following definitions apply:

“Telemedicine” means the practice of medicine using electronic communications, information technology or other means between a licensee in one location, and a patient in another location with or without an intervening healthcare provider. Generally, telemedicine is not an audio-only, telephone conversation, e-mail/instant messaging conversation, or fax. It typically involves the application of secure videoconferencing or store and forward technology to provide or support healthcare delivery by replicating the interaction of a traditional, encounter in person between a provider and a patient.7

“Telemedicine Technologies” means technologies and devices enabling secure electronic communications and information exchange between a licensee in one location and a patient in another location with or without an intervening healthcare provider.

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7 See Ctel.
Section Four. Guidelines for the Appropriate Use of Telemedicine Technologies in Medical Practice

The [Name of Board] has adopted the following guidelines for physicians utilizing telemedicine technologies in the delivery of patient care, regardless of an existing physician-patient relationship prior to an encounter:

Licensure:
A physician must be licensed, or under the jurisdiction, of the medical board of the state where the patient is located. The practice of medicine occurs where the patient is located at the time telemedicine technologies are used. Physicians who treat or prescribe through online services sites are practicing medicine and must possess appropriate licensure in all jurisdictions where patients receive care.\(^8\)

Establishment of a Physician-Patient Relationship:
Where an existing physician-patient relationship is not present, a physician must take appropriate steps to establish a physician-patient relationship consistent with the guidelines identified in Section Two, and, while each circumstance is unique, such physician-patient relationships may be established using telemedicine technologies provided the standard of care is met.

Evaluation and Treatment of the Patient:
A documented medical evaluation and collection of relevant clinical history commensurate with the presentation of the patient to establish diagnoses and identify underlying conditions and/or contra-indications to the treatment recommended/provided must be obtained prior to providing treatment, including issuing prescriptions, electronically or otherwise. Treatment and consultation recommendations made in an online setting, including issuing a prescription via electronic means, will be held to the same standards of appropriate practice as those in traditional (encounter in person) settings. Treatment, including issuing a prescription based solely on an online questionnaire, does not constitute an acceptable standard of care.

Informed Consent:
Evidence documenting appropriate patient informed consent for the use of telemedicine technologies must be obtained and maintained. Appropriate informed consent should, as a baseline, include the following terms:

- Identification of the patient, the physician and the physician’s credentials;
- Types of transmissions permitted using telemedicine technologies (e.g. prescription refills, appointment scheduling, patient education, etc.);
- The patient agrees that the physician determines whether or not the condition being diagnosed and/or treated is appropriate for a telemedicine encounter;
- Details on security measures taken with the use of telemedicine technologies, such as encrypting data, password protected screen savers and data files, or utilizing other reliable authentication techniques, as well as potential risks to privacy notwithstanding such measures;
- Hold harmless clause for information lost due to technical failures; and
- Requirement for express patient consent to forward patient-identifiable information to a third party.

MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

Continuity of Care:
Patients should be able to seek, with relative ease, follow-up care or information from the physician [or physician’s designee] who conducts an encounter using telemedicine technologies. Physicians solely providing services using telemedicine technologies with no existing physician-patient relationship prior to the encounter must make documentation of the encounter using telemedicine technologies easily available to the patient, and subject to the patient’s consent, any identified care provider of the patient immediately after the encounter.

Referrals for Emergency Services:
An emergency plan is required and must be provided by the physician to the patient when the care provided using telemedicine technologies indicates that a referral to an acute care facility or ER for treatment is necessary for the safety of the patient. The emergency plan should include a formal, written protocol appropriate to the services being rendered via telemedicine technologies.

Medical Records:
The medical record should include, if applicable, copies of all patient-related electronic communications, including patient-physician communication, prescriptions, laboratory and test results, evaluations and consultations, records of past care, and instructions obtained or produced in connection with the utilization of telemedicine technologies. Informed consents obtained in connection with an encounter involving telemedicine technologies should also be filed in the medical record. The patient record established during the use of telemedicine technologies must be accessible and documented for both the physician and the patient, consistent with all established laws and regulations governing patient healthcare records.

Privacy and Security of Patient Records & Exchange of Information:
Physicians should meet or exceed applicable federal and state legal requirements of medical/health information privacy, including compliance with the Health Insurance Portability and Accountability Act (HIPAA) and state privacy, confidentiality, security, and medical retention rules. Physicians are referred to “Standards for Privacy of Individually Identifiable Health Information,” issued by the Department of Health and Human Services (HHS). Guidance documents are available on the HHS Office for Civil Rights Web site at: www.hhs.gov/ocr/hipaa.

Written policies and procedures should be maintained at the same standard as traditional face-to-face encounters for documentation, maintenance, and transmission of the records of the encounter using telemedicine technologies. Such policies and procedures should address (1) privacy, (2) health-care personnel (in addition to the physician addressee) who will process messages, (3) hours of operation, (4) types of transactions that will be permitted electronically, (5) required patient information to be included in the communication, such as patient name, identification number and type of transaction, (6) archival and retrieval, and (7) quality oversight mechanisms. Policies and procedures should be periodically evaluated for currency and be maintained in an accessible and readily available manner for review.

Sufficient privacy and security measures must be in place and documented to assure confidentiality and integrity of patient-identifiable information. Transmissions, including patient e-mail, prescriptions, and laboratory

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results must be secure within existing technology (i.e. password protected, encrypted electronic prescriptions, or other reliable authentication techniques). All patient-physician e-mail, as well as other patient-related electronic communications, should be stored and filed in the patient’s medical record, consistent with traditional record-keeping policies and procedures.

Disclosures and Functionality on Online Services Making Available Telemedicine Technologies:
Online services used by physicians providing medical services using telemedicine technologies should clearly disclose:

- Specific services provided;
- Contact information for physician;
- Licensure and qualifications of physician(s) and associated physicians;
- Fees for services and how payment is to be made;
- Financial interests, other than fees charged, in any information, products, or services provided by a physician;
- Appropriate uses and limitations of the site, including emergency health situations;
- Uses and response times for e-mails, electronic messages and other communications transmitted via telemedicine technologies;
- To whom patient health information may be disclosed and for what purpose;
- Rights of patients with respect to patient health information; and
- Information collected and any passive tracking mechanisms utilized.

Online services used by physicians providing medical services using telemedicine technologies should provide patients a clear mechanism to:

- Access, supplement and amend patient-provided personal health information;
- Provide feedback regarding the site and the quality of information and services; and
- Register complaints, including information regarding filing a complaint with the applicable state medical and osteopathic board(s).

Online services must have accurate and transparent information about the website owner/operator, location, and contact information, including a domain name that accurately reflects the identity.

Advertising or promotion of goods or products from which the physician receives direct remuneration, benefits, or incentives (other than the fees for the medical care services) is prohibited. Notwithstanding, online services may provide links to general health information sites to enhance patient education; however, the physician should not benefit financially from providing such links or from the services or products marketed by such links. When providing links to other sites, physicians should be aware of the implied endorsement of the information, services or products offered from such sites. The maintenance of preferred relationships with any pharmacy is prohibited. Physicians shall not transmit prescriptions to a specific pharmacy, or recommend a pharmacy, in exchange for any type of consideration or benefit form that pharmacy.
Prescribing:
Telemedicine technologies, where prescribing may be contemplated, must implement measures to uphold patient safety in the absence of traditional physical examination. Such measures should guarantee that the identity of the patient and provider is clearly established and that detailed documentation for the clinical evaluation and resulting prescription is both enforced and independently kept. Measures to assure informed, accurate, and error prevention prescribing practices (e.g. integration with e-Prescription systems) are encouraged. To further assure patient safety in the absence of physical examination, telemedicine technologies should limit medication formularies to ones that are deemed safe by [Name of Board].

Prescribing medications, in-person or via telemedicine, is at the professional discretion of the physician. The indication, appropriateness, and safety considerations for each telemedicine visit prescription must be evaluated by the physician in accordance with current standards of practice and consequently carry the same professional accountability as prescriptions delivered during an encounter in person. However, where such measures are upheld, and the appropriate clinical consideration is carried out and documented, physicians may exercise their judgment and prescribe medications as part of telemedicine encounters.

Section Five. Parity of Professional and Ethical Standards
Physicians are encouraged to comply with nationally recognized health online service standards and codes of ethics, such as those promulgated by the American Medical Association, American Osteopathic Association, Health Ethics Initiative 2000, Health on the Net and the American Accreditation HealthCare Commission (URAC). There should be parity of ethical and professional standards applied to all aspects of a physician’s practice. A physician’s professional discretion as to the diagnoses, scope of care, or treatment should not be limited or influenced by non-clinical considerations of telemedicine technologies, and physician remuneration or treatment recommendations should not be materially based on the delivery of patient-desired outcomes (i.e. a prescription or referral) or the utilization of telemedicine technologies.
MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

REFERENCES


Colorado Board of Medical Examiners. Policy Statement Concerning the Physician-Patient Relationship.

The Department of Health and Human Services, HIPPA Standards for Privacy of Individually Identifiable Health Information. August 14, 2002.

FSMB. A Model Act to Regulate the Practice of Medicine Across State Lines. April 1996.


MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

SMART WORKGROUP

Kenneth B. Simons, MD, Chairman
Chair, State of Wisconsin Dept of Safety & Professional Services

Michael R. Arambula, MD, PharmD
Member, Texas Medical Board

Michael J. Arnold, MBA
Member, North Carolina Medical Board

Ronald R. Burns, DO
Chair, Florida Board of Osteopathic Medicine

Anna Earl, MD
Immediate Past President, Montana Board of Medical Examiners

Gregory B. Snyder, MD
President, Minnesota Board of Medical Practice

Jean Rawlings Sumner, MD
Past Chair & Current Medical Director, Georgia Composite Medical Board

SUBJECT MATTER EXPERT

Elizabeth P. Hall
WellPoint, Inc.

Alexis S. Gilroy, JD
Jones Day LLP

Sherilyn Z. Pruitt, MPH
Director, HRSA Office for the Advancement of Telehealth

Roy Schoenberg, MD, PhD, MPH
President & CEO, American Well Systems

EX OFFICIOS

Jon V. Thomas, MD, MBA
Chair, FSMB

Donald H. Polk, DO
Chair-elect, FSMB

Humayun J. Chaudhry, DO, MACP
President & CEO, FSMB

STAFF SUPPORT

Lisa A. Robin, MLA
Chief Advocacy Officer, FSMB

Shiri Hickman, JD
State Legislative & Policy Manager, FSMB

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FLORIDA ADMINISTRATIVE CODE-Rules that use or define the term “telemedicine.”

Rule 59G-1.057, Telemedicine. (Agency for Health Care Administration)

(1) This rule applies to any person or entity prescribing or reviewing a request for Florida Medicaid services and to all providers of Florida Medicaid services that are enrolled in or registered with the Florida Medicaid program.

(2) Definition. Telemedicine – The practice of health care delivery by a practitioner who is located at a site other than the site where a recipient is located for the purposes of evaluation, diagnosis, or treatment.

(3) Who Can Provide. Practitioners licensed within their scope of practice to perform the service.

(4) Coverage. Florida Medicaid reimburses for telemedicine services using interactive telecommunications equipment that includes, at a minimum audio and video equipment permitting two-way, real time, interactive communication between a recipient and a practitioner.

(5) Exclusion. Florida Medicaid does not reimburse for:

(a) Telephone conversations, chart review(s), electronic mail messages, or facsimile transmissions.

(b) Equipment required to provide telemedicine services.

(6) Reimbursement. The following applies to practitioners rendering services in the fee-for-service delivery system:

(a) Florida Medicaid reimburses the practitioner who is providing the evaluation, diagnosis, or treatment recommendation located at a site other than where the recipient is located.

(b) Providers must include modifier GT on the CMS-1500 claim form, incorporated by reference in Rule 59G-4.001, F.A.C.

Rulemaking Authority 409.919 FS. Law Implemented 409.905 FS. History–New 6-20-16.

Rule 64C-8.001, Definitions Used in the Child Protection Team Rule. (Department of Health, Division of Children’s Medical Services)

For the purpose of this rule chapter, the following definitions will apply:

(1) “Case” – an individual child referred to and accepted by a child protection team for assessment services as a result of a report of alleged abuse or neglect made to the central abuse hotline as set forth in Section 39.201, F.S.

(2) “Case Coordinator” – a member of the child protection team professional staff who provides or directs the activities on behalf of clients to complete team assessment services.

(3) “Medical Consultation” – a Child Protection Team medical opinion based on oral or written information obtained by the team when the child was not physically examined by a team medical provider.

(4) “Team Coordinator” – the person in charge of managing the day to day operation of a Child Protection Team.

(5) “Telemedicine” – the use of telecommunication and information technology to provide clinical care to individuals at a distance and to transmit the information needed to provide that care.

Rulemaking Authority 39.3031 FS. Law Implemented 39.303 FS. History–New 3-2-93, Amended 5-7-96, Formerly 10J-10.002, 65C-7.001, Amended 4-30-08, 12-2-15.
Rule 64C-8.003, Child Protection Team Services (Department of Health, Division of Children’s Medical Services).

(1) A Child Protection Team physician or Advanced Registered Nurse Practitioner and a case coordinator must be available 24 hours a day, seven days a week for consultation. On-site services will be provided as deemed necessary for child safety.

(2) Child Protection Team services are provided in cases of suspected abuse or neglect without regard to income. All children, reported as being abused or neglected by an adult caretaker and accepted by the Florida Abuse Hotline for protective investigation, are eligible for Child Protection Team services.

(3) Medical diagnosis and evaluation can be conducted in person or through the use of telemedicine technology. Use of telemedicine requires the presence of a CMS approved physician or Advanced Registered Nurse Practitioner at the hub site and a Registered Nurse at the remote site to facilitate the evaluation.

Rulemaking Authority 39.3031 FS. Law Implemented 39.303 FS. History–New 3-2-93, Amended 5-7-96, Formerly 10J-10.007, 65C-7.003, Amended 4-30-08, 12-2-15.

Rule 64B8-9.0141, Standards for Telemedicine Practice (Board of Medicine).

(1) “Telemedicine” means the practice of medicine by a licensed Florida physician or physician assistant where patient care, treatment, or services are provided through the use of medical information exchanged from one site to another via electronic communications. Telemedicine shall not include the provision of health care services only through an audio only telephone, email messages, text messages, facsimile transmission, U.S. Mail or other parcel service, or any combination thereof.

(2) The standard of care, as defined in Section 456.50(1)(e), F.S., shall remain the same regardless of whether a Florida licensed physician or physician assistant provides health care services in person or by telemedicine.

(3) Florida licensed physicians and physician assistants providing health care services by telemedicine are responsible for the quality of the equipment and technology employed and are responsible for their safe use. Telemedicine equipment and technology must be able to provide, at a minimum, the same information to the physician and physician assistant which will enable them to meet or exceed the prevailing standard of care for the practice of medicine.

(4) Controlled substances shall not be prescribed through the use of telemedicine except for the treatment of psychiatric disorders. This provision does not preclude physicians or physician assistants from ordering controlled substances through the use of telemedicine for patients hospitalized in a facility licensed pursuant to Chapter 395, F.S.

(5) Prescribing medications based solely on an electronic medical questionnaire constitutes the failure to practice medicine with that level of care, skill, and treatment which is recognized by reasonably prudent physicians as being acceptable under similar conditions and circumstances, as well as prescribing legend drugs other than in the course of a physician’s professional practice.

(6) Physicians and physician assistants shall not provide treatment recommendations, including issuing a prescription, via electronic or other means, unless the following elements have been met:

(a) A documented patient evaluation, including history and physical examination to establish the diagnosis for which any legend drug is prescribed.
(b) Discussion between the physician or the physician assistant and the patient regarding treatment options and the risks and benefits of treatment.

(c) Maintenance of contemporaneous medical records meeting the requirements of Rule 64B8-9.003, F.A.C.

(7) The practice of medicine by telemedicine does not alter any obligation of the physician or the physician assistant regarding patient confidentiality or recordkeeping.

(8) A physician-patient relationship may be established through telemedicine.

(9) (a) Nothing contained in this rule shall prohibit consultations between physicians or the transmission and review of digital images, pathology specimens, test results, or other medical data by physicians or other qualified providers related to the care of Florida patients.

(b) This rule does not apply to emergency medical services provided by emergency physicians, emergency medical technicians (EMTs), paramedics, and emergency dispatchers. Emergency medical services are those activities or services to prevent or treat a sudden critical illness or injury and to provide emergency medical care and prehospital emergency medical transportation to sick, injured, or otherwise incapacitated persons in this state.

(c) The provisions of this rule shall not apply where a physician or physician assistant is treating a patient with an emergency medical condition that requires immediate medical care. An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention will result in serious jeopardy to patient health, serious impairment to bodily functions, or serious dysfunction of a body organ or part.

(d) The provisions of this rule shall not be construed to prohibit patient care in consultation with another physician who has an ongoing relationship with the patient, and who has agreed to supervise the patient’s treatment, including the use of any prescribed medications, nor on-call or cross-coverage situations in which the physician has access to patient records.

Rulemaking Authority 458.331(1)(v) FS. Law Implemented 458.331(1)(v), 458.347(4)(g) FS. History—New 3-12-14, Amended 7-22-14, 10-26-14, 3-7-16.

64B15-14.0081 Standards for Telemedicine Practice (Board of Osteopathic Medicine).

(1) “Telemedicine” means the practice of medicine by a licensed Florida physician or physician assistant where patient care, treatment, or services are provided through the use of medical information exchanged from one site to another via electronic communications. Telemedicine shall not include the provision of health care services only through an audio only telephone, email messages, text messages, facsimile transmission, U.S. Mail or other parcel service, or any combination thereof.

(2) The standard of care, as defined in Section 456.50(1)(e), F.S., shall remain the same regardless of whether a Florida licensed physician or physician assistant provides health care services in person or by telemedicine.

(3) Florida licensed physicians and physician assistants providing health care services by telemedicine are responsible for the quality of the equipment and technology employed and are responsible for their safe use. Telemedicine equipment and technology must be able to provide, at a minimum, the same information to the physician and physician assistant which will enable them to meet or exceed the prevailing standard of care for the practice of medicine.

(4) Controlled substances shall not be prescribed through the use of telemedicine except for the treatment of psychiatric disorders. This provision does not preclude physicians or physician assistants
from ordering controlled substances through the use of telemedicine for patients hospitalized in a facility licensed pursuant to Chapter 395, F.S.

(5) Prescribing medications based solely on an electronic medical questionnaire constitutes the failure to practice medicine with that level of care, skill, and treatment which is recognized by reasonably prudent physicians as being acceptable under similar conditions and circumstances, as well as prescribing legend drugs other than in the course of a physician’s professional practice.

(6) Physicians and physician assistants shall not provide treatment recommendations, including issuing a prescription, via electronic or other means, unless the following elements have been met:

(a) A documented patient evaluation, including history and physical examination to establish the diagnosis for which any legend drug is prescribed.

(b) Discussion between the physician or the physician assistant and the patient regarding treatment options and the risks and benefits of treatment.

(c) Maintenance of contemporaneous medical records meeting the requirements of Rule 64B15-15.004, F.A.C.

(7) The practice of medicine by telemedicine does not alter any obligation of the physician or the physician assistant regarding patient confidentiality or recordkeeping.

(8) A physician-patient relationship may be established through telemedicine.

(9)(a) Nothing contained in this rule shall prohibit consultations between physicians or the transmission and review of digital images, pathology specimens, test results, or other medical data by physicians or other qualified providers related to the care of Florida patients.

(b) This rule does not apply to emergency medical services provided by emergency physicians, emergency medical technicians (EMTs), paramedics, and emergency dispatchers. Emergency medical services are those activities or services to prevent or treat a sudden critical illness or injury and to provide emergency medical care and prehospital emergency medical transportation to sick, injured, or otherwise incapacitated persons in this state.

(c) The provisions of this rule shall not apply where a physician or physician assistant is treating a patient with an emergency medical condition that requires immediate medical care. An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention will result in serious jeopardy to patient health, serious impairment to bodily functions, or serious dysfunction of a body organ or part.

(d) The provisions of this rule shall not be construed to prohibit patient care in consultation with another physician who has an ongoing relationship with the patient, and who has agreed to supervise the patient’s treatment, including the use of any prescribed medications, nor on-call or cross-coverage situations in which the physician has access to patient records.

Rulemaking Authority 459.015(1)(z) FS. Law Implemented 459.015(1)(z), 459.022(4)(f) FS. History—New 3-12-14, Amended 7-22-14, 12-9-14, 5-24-16.
Shows how many states have Medicaid coverage for telemedicine. Twenty-eight (28) states, plus the District of Columbia, require private insurance companies and Medicaid to cover telemedicine services to the same extent as face-to-face consultations. Eighteen (18) states currently require only Medicaid to cover telemedicine services. One (1) state requires only private insurance companies to reimburse for services provided through telemedicine. (FSMB)
Shows how many states have Medicaid coverage for store and forward. Most common issue for not covering store and forward was that store and forward did not meet the state’s legal definition of telemedicine/telehealth. When it is allowed the most common use is for radiology and dermatology. Store and forward involves the acquisition and storing of clinical information (e.g. Data, image, sound, video) that is then forwarded (or retrieved by) another site for clinical evaluation.
Shows how many states have Medicaid coverage for Remote Patient Monitoring (RPM). In most states it was not considered necessary or did not meet the state’s legal definition of telemedicine/telehealth.
Shows how many states chose to implement policies about online prescribing via telemedicine. “Unclear about physical” means states have laws requiring a “proper patient/physician relationship be established” but do not clearly state how that relationship needs to be established. The most common drugs that are not allowed to be prescribed with telemedicine are controlled substances and abortion drugs.
Shows the different ways states got around the cross-state licensing issue that arises with telemedicine. The FSMB compact is expected to grow by 8 states in the near future making it the most common method of tackling the cross-state licensing issue.

Another interesting note is only 11 states specifically listed “dentistry” as a profession that provides telehealth or has policies regarding teledentistry.
Additional Facts

- 16 States have some sort of reimbursement for store and forward. Hawaii and Missouri just passed legislation allowing for reimbursement.
- 19 states have reimbursement for remote patient monitoring (RPM) in Medicaid. Hawaii, Kentucky, and Missouri just added RPM to their Medicaid programs. All states have restrictions on which conditions can be reimbursed for RPM (e.g. diabetes, heart failure, and COPD). RPM is defined as a type of remote healthcare where patients use mobile medical devices to share their condition with care providers.
- 29 states have some sort of informed consent requirement in their statutes. Degree of specificity varies greatly from state to state but most require verbal and/or written consent.
- 48 states have coverage for mental/behavioral health services via telehealth.
There was new legislation passed in several states last year (2016).

- Legislation in Alaska allows for online prescribing without a physical if the physician can follow up with the patient and receives all medical files.
- Arkansas and Colorado made a similar adjustment to eliminate the need for an in-person physical for prescribing via telemedicine.
- Idaho now allows for online prescribing via telemedicine without a physical, but absolutely no controlled substances can be prescribed.
- Louisiana passed legislation allowing online prescribing without a physical for authorized physicians only.
- Connecticut, Vermont, Washington and Hawaii passed legislation for Medicaid coverage for telemedicine, basically introducing telemedicine to their states.
- Maryland and Kentucky started exploring Medicaid reimbursement for RPM.
- New Hampshire and Kansas recently entered into the FSMB interstate medical licensure compact.
- North Dakota added telehealth coverage to those in the public employee retirement system.
- Oklahoma changed the definition of telemedicine to include “real-time communication.”
- South Carolina changed their laws to say a physician/patient relationship cannot be established if a physical examination is needed, implying that a physical is not always needed.
- Tennessee changed their laws to include store and forward and eliminate special telemedicine licenses.
- Texas included store and forward under telemedicine.
- Virginia is generally expanding telemedicine coverage.
- West Virginia passed legislation to include “treatment education” under telemedicine.
Citations and Resources

- Rule 59G-1.057, Telemedicine, F.A.C.
- Rule 64C-8.001, Definitions Used in the Child Protection Team Rule, F.A.C.
- Rule 64C-8.003, Child Protection Team Services, F.A.C.
- Rule 64B8-9.0141, Standards for Telemedicine Practice, F.A.C.
- Rule 64B15-14.0081, Standards for Telemedicine Practice, F.A.C.
- Telehealth Resource Centers http://www.telehealthresourcecenter.org/
ARNPs and Telehealth

Janet DuBois, DNP, ARNP, FNP-BC, FAANP, FNAP
President
Florida Nurse Practitioner Network

American Telemedicine Association: Public Policy Objectives

• Eliminate artificial government barriers to telehealth, such as geographic discrimination and restrictions on the use of telehealth in managed care;
• Prevent new barriers to telemedicine, such as practice rules that impose higher standards for telehealth services than in-person care;
• Encourage use of telehealth to reduce health delivery problems, such as provider shortages;
• Promote payment and service models to increase consumer and payer value using telemedicine; and
• Increase patient choice, outcomes, convenience, and satisfaction.

Telehealth in Florida

• Telehealth Advisory Council (2016)
• 615 designated Health Professional Shortage Areas in Florida
• Primary care provider shortage
• No definition (HB7087, 2014)
Practice

- Need innovative models of practice to:
  - Reduce costs
  - Improve care
  - Decrease use of ERs and Urgent care centers
  - Increase access
- ARNPs can fill the gaps

Florida Licensure

- ARNPs are under physician supervision
- Florida BOM Telehealth Rules (2014)
  - Allows physicians and PAs to engage in Telehealth
  - Includes a brief definition
  - Existing "Standards of Care" applies

Practice Barriers

- New licensure changes should not be added/required for clinicians
- Location Restrictions:
  - Hub and Spoke model for MC & MK
  - Specific designations
- Only MCO care plans utilize telehealth
Practice Barriers (cont)

- Reimbursement of NPs: Lack of empaneling
  - 3rd Party payers and government
- HIPPA
- Lack of standard regulations
- No standard definition of Telehealth

References

Reference Materials:

- National Council of State Boards of Nursing and Telehealth Policy Statement
- Federation of State Medical Boards Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine
- Center for Connected Health Policy: Policy Brief – Model Language Analysis – Federation of State Medical Boards Interstate Medical Licensure Compact Language
National Council of State Boards of Nursing (NCSBN®)

- NCSBN® is an independent, nonprofit association comprising 59 boards of nursing from across the U.S., the District of Columbia and four U.S. territories.
- Boards of nursing are responsible for licensure, practice and discipline of the 3.2 million nurses (RNs, LPNs/VNs and APRNs) in the U.S. with active licenses.
- Boards of nursing are also responsible for the approval of prelicensure nursing education programs in the U.S.
- NCSBN was created to bring boards of nursing together to act and counsel with one another and lessen the burden of state government.
- The mission of NCSBN is to provide education, service, and research through collaborative leadership to promote evidence-based regulatory excellence for patient safety and public protection.
- One of the critical resources that NCSBN provides for boards of nursing, employers and the public is Nursys®, the only national database currently available for verification of nurse licensure and discipline for RNs, LPNs/VNs and APRNs. Nursys allows access to the status of a nurse’s license and provides information about any history of discipline.

NCSBN Telehealth Policy

- NCSBN understands and supports efforts to expand telehealth as a model of care delivery. We recognize that technological advances can both reduce the cost of care and increase patient access to care across the country.
- NCSBN recognizes the growing need for providers to be able to practice across state lines; however, a policy of one single interstate license that bases licensure on the location of the provider overlooks important public protection needs.
- NCSBN believes that licensure should be based on the location of the patient as dictated by current law.
- Moving licensure to the site of the provider will create confusion for nurses, patients and boards of nursing, not to mention the fact that it will be in direct conflict with states’ constitutional rights.
- Patients need to be able to seek recourse in the event that something goes wrong. If a provider is not located in their state, that process can often be complicated due to jurisdictional issues.
- Our goal at NCSBN is to work with Congress and telehealth advocates to resolve concerns about licensure being a barrier to the expansion of telehealth services.
Telehealth and the Nurse Licensure Compact (NLC)

- In 2000, NCSBN launched a new initiative to expand the mobility of nurses as part of our nation's health care delivery system. The NLC is an interstate compact that allows a nurse to have one multistate license (in his or her state of residency) and to practice in other states (both physically and electronically), subject to each state's practice laws and regulation.
- Under the NLC, when a nurse is disciplined, he or she loses multistate practice privileges.
- States participating in the NLC are legally required to report disciplinary actions in Nursys.
- NLC states must also flag when a nurse is under investigation prior to any disciplinary action being taken. This information is shared with other NLC states.
- Several organizations have endorsed the NLC, including the American Telemedicine Association and the Center for Telehealth & e-Health Law.
- Almost half of U.S. states have already adopted the NLC, and that number is expected to grow in the coming years.
- The NLC is undergoing revision to address concerns raised by states that have not yet joined the NLC, a process that will encourage new states to join.
MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

Report of the State Medical Boards' Appropriate Regulation of Telemedicine (SMART) Workgroup

Adopted as policy by the Federation of State Medical Boards in April 2014

INTRODUCTION

The Federation of State Medical Boards (FSMB) Chair, Jon V. Thomas, MD, MBA, appointed the State Medical Boards' Appropriate Regulation of Telemedicine (SMART) Workgroup to review the “Model Guidelines for the Appropriate Use of the Internet in Medical Practice” (HOD 2002)\(^1\) and other existing FSMB policies on telemedicine and to offer recommendations to state medical and osteopathic boards (hereinafter referred to as “medical boards” and/or “boards”) based on a thorough review of recent advances in technology and the appropriate balance between enabling access to care while ensuring patient safety. The Workgroup was charged with guiding the development of model guidelines for use by state medical boards in evaluating the appropriateness of care as related to the use of telemedicine, or the practice of medicine using electronic communication, information technology or other means, between a physician in one location and a patient in another location with or without an intervening health care provider.

This new policy document provides guidance to state medical boards for regulating the use of telemedicine technologies in the practice of medicine and educates licensees as to the appropriate standards of care in the delivery of medical services directly to patients\(^2\) via telemedicine technologies. It is the intent of the SMART Workgroup to offer a model policy for use by state medical boards in order to remove regulatory barriers to widespread appropriate adoption of telemedicine technologies for delivering care while ensuring the public health and safety.

In developing the guidelines that follow, the Workgroup conducted a comprehensive review of telemedicine technologies currently in use and proposed/recommended standards of care, as well as identified and considered existing standards of care applicable to telemedicine developed and implemented by several state medical boards.

\(^1\) The policy on the Appropriate Use of Telemedicine Technologies in the Practice of Medicine supersedes the Model Guidelines for the Appropriate Use of the Internet in Medical Practice (HOD 2002).

\(^2\) The policy does not apply to the use of telemedicine when solely providing consulting services to another physician who maintains the physician-patient relationship with the patient, the subject of the consultation.
MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

Model Guidelines for State Medical Boards’ Appropriate Regulation of Telemedicine

Section One. Preamble

The advancements and continued development of medical and communications technology have had a profound impact on the practice of medicine and offer opportunities for improving the delivery and accessibility of health care, particularly in the area of telemedicine, which is the practice of medicine using electronic communication, information technology or other means of interaction between a licensee in one location and a patient in another location with or without an intervening healthcare provider. However, state medical boards, in fulfilling their duty to protect the public, face complex regulatory challenges and patient safety concerns in adapting regulations and standards historically intended for the in-person provision of medical care to new delivery models involving telemedicine technologies, including but not limited to: 1) determining when a physician-patient relationship is established; 2) assuring privacy of patient data; 3) guaranteeing proper evaluation and treatment of the patient; and 4) limiting the prescribing and dispensing of certain medications.

The [Name of Board] recognizes that using telemedicine technologies in the delivery of medical services offers potential benefits in the provision of medical care. The appropriate application of these technologies can enhance medical care by facilitating communication with physicians and their patients or other health care providers, including prescribing medication, obtaining laboratory results, scheduling appointments, monitoring chronic conditions, providing health care information, and clarifying medical advice.

These guidelines should not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law. In fact, these guidelines support a consistent standard of care and scope of practice notwithstanding the delivery tool or business method in enabling Physician-to-Patient communications. For clarity, a physician using telemedicine technologies in the provision of medical services to a patient (whether existing or new) must take appropriate steps to establish the physician-patient relationship and conduct all appropriate evaluations and history of the patient consistent with traditional standards of care for the particular patient presentation. As such, some situations and patient presentations are appropriate for the utilization of telemedicine technologies as a component of, or in lieu of, in-person provision of medical care, while others are not.

The Board has developed these guidelines to educate licensees as to the appropriate use of telemedicine technologies in the practice of medicine. The [Name of Board] is committed to assuring patient access to the convenience and benefits afforded by telemedicine technologies, while promoting the responsible practice of medicine by physicians.

It is the expectation of the Board that physicians who provide medical care, electronically or otherwise, maintain the highest degree of professionalism and should:

- Place the welfare of patients first;
- Maintain acceptable and appropriate standards of practice;

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4 Id.
MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

• Adhere to recognized ethical codes governing the medical profession;
• Properly supervise non-physician clinicians; and
• Protect patient confidentiality.

Section Two. Establishing the Physician-Patient Relationship

The health and well-being of patients depends upon a collaborative effort between the physician and patient. The relationship between the physician and patient is complex and is based on the mutual understanding of the shared responsibility for the patient’s health care. Although the Board recognizes that it may be difficult in some circumstances to precisely define the beginning of the physician-patient relationship, particularly when the physician and patient are in separate locations, it tends to begin when an individual with a health-related matter seeks assistance from a physician who may provide assistance. However, the relationship is clearly established when the physician agrees to undertake diagnosis and treatment of the patient, and the patient agrees to be treated, whether or not there has been an encounter in person between the physician (or other appropriately supervised health care practitioner) and patient.

The physician-patient relationship is fundamental to the provision of acceptable medical care. It is the expectation of the Board that physicians recognize the obligations, responsibilities, and patient rights associated with establishing and maintaining a physician-patient relationship. A physician is discouraged from rendering medical advice and/or care using telemedicine technologies without (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); and (3) obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including any special informed consents regarding the use of telemedicine technologies. An appropriate physician-patient relationship has not been established when the identity of the physician may be unknown to the patient. Where appropriate, a patient must be able to select an identified physician for telemedicine services and not be assigned to a physician at random.

Section Three. Definitions

For the purpose of these guidelines, the following definitions apply:

“Telemedicine” means the practice of medicine using electronic communications, information technology or other means between a licensee in one location, and a patient in another location with or without an intervening healthcare provider. Generally, telemedicine is not an audio-only, telephone conversation, e-mail/instant messaging conversation, or fax. It typically involves the application of secure videoconferencing or store and forward technology to provide or support healthcare delivery by replicating the interaction of a traditional, encounter in person between a provider and a patient.

“Telemedicine Technologies” means technologies and devices enabling secure electronic communications and information exchange between a licensee in one location and a patient in another location with or without an intervening healthcare provider.


7 See Ctel.
MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

Section Four. Guidelines for the Appropriate Use of Telemedicine Technologies in Medical Practice

The [Name of Board] has adopted the following guidelines for physicians utilizing telemedicine technologies in the delivery of patient care, regardless of an existing physician-patient relationship prior to an encounter:

Licensure:
A physician must be licensed, or under the jurisdiction, of the medical board of the state where the patient is located. The practice of medicine occurs where the patient is located at the time telemedicine technologies are used. Physicians who treat or prescribe through online services sites are practicing medicine and must possess appropriate licensure in all jurisdictions where patients receive care.¹

Establishment of a Physician-Patient Relationship:
Where an existing physician-patient relationship is not present, a physician must take appropriate steps to establish a physician-patient relationship consistent with the guidelines identified in Section Two, and, while each circumstance is unique, such physician-patient relationships may be established using telemedicine technologies provided the standard of care is met.

Evaluation and Treatment of the Patient:
A documented medical evaluation and collection of relevant clinical history commensurate with the presentation of the patient to establish diagnoses and identify underlying conditions and/or contra-indications to the treatment recommended/provided must be obtained prior to providing treatment, including issuing prescriptions, electronically or otherwise. Treatment and consultation recommendations made in an online setting, including issuing a prescription via electronic means, will be held to the same standards of appropriate practice as those in traditional (encounter in person) settings. Treatment, including issuing a prescription based solely on an online questionnaire, does not constitute an acceptable standard of care.

Informed Consent:
Evidence documenting appropriate patient informed consent for the use of telemedicine technologies must be obtained and maintained. Appropriate informed consent should, as a baseline, include the following terms:

- Identification of the patient, the physician and the physician’s credentials;
- Types of transmissions permitted using telemedicine technologies (e.g. prescription refills, appointment scheduling, patient education, etc.);
- The patient agrees that the physician determines whether or not the condition being diagnosed and/or treated is appropriate for a telemedicine encounter;
- Details on security measures taken with the use of telemedicine technologies, such as encrypting data, password protected screen savers and data files, or utilizing other reliable authentication techniques, as well as potential risks to privacy notwithstanding such measures;
- Hold harmless clause for information lost due to technical failures; and
- Requirement for express patient consent to forward patient-identifiable information to a third party.

MODEL POLICY FOR THE APPROPRIATE USE OF TELERECORDS TECHNOLOGIES IN THE PRACTICE OF MEDICINE

Continuity of Care:
Patients should be able to seek, with relative ease, follow-up care or information from the physician (or physician’s designee) who conducts an encounter using telemedicine technologies. Physicians solely providing services using telemedicine technologies with no existing physician-patient relationship prior to the encounter must make documentation of the encounter using telemedicine technologies easily available to the patient, and subject to the patient’s consent, any identified care provider of the patient immediately after the encounter.

Referrals for Emergency Services:
An emergency plan is required and must be provided by the physician to the patient when the care provided using telemedicine technologies indicates that a referral to an acute care facility or ER for treatment is necessary for the safety of the patient. The emergency plan should include a formal, written protocol appropriate to the services being rendered via telemedicine technologies.

Medical Records:
The medical record should include, if applicable, copies of all patient-related electronic communications, including patient-physician communication, prescriptions, laboratory and test results, evaluations and consultations, records of past care, and instructions obtained or produced in connection with the utilization of telemedicine technologies. Informed consents obtained in connection with an encounter involving telemedicine technologies should also be filed in the medical record. The patient record established during the use of telemedicine technologies must be accessible and documented for both the physician and the patient, consistent with all established laws and regulations governing patient healthcare records.

Privacy and Security of Patient Records & Exchange of Information:
Physicians should meet or exceed applicable federal and state legal requirements of medical/health information privacy, including compliance with the Health Insurance Portability and Accountability Act (HIPAA) and state privacy, confidentiality, security, and medical retention rules. Physicians are referred to “Standards for Privacy of Individually Identifiable Health Information,” issued by the Department of Health and Human Services (HHS). Guidance documents are available on the HHS Office for Civil Rights Web site at: www.hhs.gov/ocr/hipaa.

Written policies and procedures should be maintained at the same standard as traditional face-to-face encounters for documentation, maintenance, and transmission of the records of the encounter using telemedicine technologies. Such policies and procedures should address (1) privacy, (2) health-care personnel (in addition to the physician addressee) who will process messages, (3) hours of operation, (4) types of transactions that will be permitted electronically, (5) required patient information to be included in the communication, such as patient name, identification number and type of transaction, (6) archival and retrieval, and (7) quality oversight mechanisms. Policies and procedures should be periodically evaluated for currency and be maintained in an accessible and readily available manner for review.

Sufficient privacy and security measures must be in place and documented to assure confidentiality and integrity of patient-identifiable information. Transmissions, including patient e-mail, prescriptions, and laboratory

MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

results must be secure within existing technology (i.e. password protected, encrypted electronic prescriptions, or other reliable authentication techniques). All patient-physician e-mail, as well as other patient-related electronic communications, should be stored and filed in the patient's medical record, consistent with traditional record-keeping policies and procedures.

Disclosures and Functionality on Online Services Making Available Telemedicine Technologies:
Online services used by physicians providing medical services using telemedicine technologies should clearly disclose:

- Specific services provided;
- Contact information for physician;
- Licensure and qualifications of physician(s) and associated physicians;
- Fees for services and how payment is to be made;
- Financial interests, other than fees charged, in any information, products, or services provided by a physician;
- Appropriate uses and limitations of the site, including emergency health situations;
- Uses and response times for e-mails, electronic messages and other communications transmitted via telemedicine technologies;
- To whom patient health information may be disclosed and for what purpose;
- Rights of patients with respect to patient health information; and
- Information collected and any passive tracking mechanisms utilized.

Online services used by physicians providing medical services using telemedicine technologies should provide patients a clear mechanism to:

- Access, supplement and amend patient-provided personal health information;
- Provide feedback regarding the site and the quality of information and services; and
- Register complaints, including information regarding filing a complaint with the applicable state medical and osteopathic board(s).

Online services must have accurate and transparent information about the website owner/operator, location, and contact information, including a domain name that accurately reflects the identity.

Advertising or promotion of goods or products from which the physician receives direct remuneration, benefits, or incentives (other than the fees for the medical care services) is prohibited. Notwithstanding, online services may provide links to general health information sites to enhance patient education; however, the physician should not benefit financially from providing such links or from the services or products marketed by such links. When providing links to other sites, physicians should be aware of the implied endorsement of the information, services or products offered from such sites. The maintenance of preferred relationships with any pharmacy is prohibited. Physicians shall not transmit prescriptions to a specific pharmacy, or recommend a pharmacy, in exchange for any type of consideration or benefit form that pharmacy.
MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

Prescribing:
Telemedicine technologies, where prescribing may be contemplated, must implement measures to uphold patient safety in the absence of traditional physical examination. Such measures should guarantee that the identity of the patient and provider is clearly established and that detailed documentation for the clinical evaluation and resulting prescription is both enforced and independently kept. Measures to assure informed, accurate, and error prevention prescribing practices (e.g. integration with e-Prescription systems) are encouraged. To further assure patient safety in the absence of physical examination, telemedicine technologies should limit medication formularies to ones that are deemed safe by [Name of Board].

Prescribing medications, in-person or via telemedicine, is at the professional discretion of the physician. The indication, appropriateness, and safety considerations for each telemedicine visit prescription must be evaluated by the physician in accordance with current standards of practice and consequently carry the same professional accountability as prescriptions delivered during an encounter in person. However, where such measures are upheld, and the appropriate clinical consideration is carried out and documented, physicians may exercise their judgment and prescribe medications as part of telemedicine encounters.

Section Five. Parity of Professional and Ethical Standards
Physicians are encouraged to comply with nationally recognized health online service standards and codes of ethics, such as those promulgated by the American Medical Association, American Osteopathic Association, Health Ethics Initiative 2000, Health on the Net and the American Accreditation HealthCare Commission (URAC). There should be parity of ethical and professional standards applied to all aspects of a physician’s practice. A physician’s professional discretion as to the diagnoses, scope of care, or treatment should not be limited or influenced by non-clinical considerations of telemedicine technologies, and physician remuneration or treatment recommendations should not be materially based on the delivery of patient-desired outcomes (i.e. a prescription or referral) or the utilization of telemedicine technologies.
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Colorado Board of Medical Examiners. Policy Statement Concerning the Physician-Patient Relationship.

The Department of Health and Human Services. HIPPA Standards for Privacy of Individually Identifiable Health Information. August 14, 2002.

FSMB. A Model Act to Regulate the Practice of Medicine Across State Lines. April 1996.


MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

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Chair, State of Wisconsin Dept of Safety & Professional Services

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Donald H. Polk, DO
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Humayun J. Chaudhry, DO, MACP
President & CEO, FSMB

STAFF SUPPORT

Lisa A. Robin, MLA
Chief Advocacy Officer, FSMB

Shiri Hickman, JD
State Legislative & Policy Manager, FSMB

SUBJECT MATTER EXPERT

Elizabeth P. Hall
WellPoint, Inc.

Alexis S. Gilroy, JD
Jones Day LLP

Sherilyn Z. Pruitt, MPH
Director, HRSA Office for the Advancement of Telehealth

Roy Schoenberg, MD, PhD, MPH
President & CEO, American Well Systems

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Introduction

On September 5, 2014, the Federation of State Medical Boards (FSMB) released the final version of their proposal of interstate medical licensure compact (Compact) language. The FSMB should be commended on their efforts in directly addressing the licensure issue, which they have noted “could compound patient access problems associated with the national shortage of physicians.” While not specifically directed at telehealth, the FSMB has acknowledged that the advances in health care delivery and practice patterns would necessitate consideration of creating pathways for licensure that do not currently exist. The goals of the compact are “to develop a comprehensive process that complements existing licensing and regulating authority of state boards, ensures the safety of patients and enhance the portability of a medical license, while providing a streamlined process that allows physicians to become licensed in multiple states.”

Below is a summary of some of the highlights of the Compact and the potential impact it could have on telehealth. This paper is meant for information purposes only and is not meant as an endorsement or criticism of the language. The full document is available on the FSMB's website at:

http://fsmb.org/state-medical-boards/interstate-model-compact/

Compact Legislation

A minimum of seven states must agree to participate in the compact and enact into law the proposed language, as is, before it could go into effect. Once that has happened, an “Interstate Medical Licensure Compact Commission” would be created by the member states. Each member state would have two voting representatives who would serve as Commissioners. A state will be able to leave the Compact by repealing applicable changes related to their membership. The Interstate Commission would administer the Compact. Among the duties assigned to the Commission would be promulgating rules; issue advisory opinions concerning the interpretation of the Compact, its bylaws, rules and actions; enforcement of the Compact’s provisions; and other duties.

The Interstate Commission is authorized to develop rules regarding the application process and issuance of an expedited license. The Commission is also authorized to develop rules regarding fees for expedited licenses. (NOTE: In addition, the member state issuing an expedited license may impose a fee for a license issued or renewed through the Compact). The Commission may levy an annual assessment from each member state to cover its costs.
Application and Issuance of Expedited License

The FSMB was clear when crafting the Compact that it would focus more on streamlining the process of obtaining a medical license as opposed to having one license for multiple states, such as the Nurse Licensure Compact. Under this Compact, a physician must designate a state of principal license to register for an expedited license. The physician would file an application with the board of that principal license state.

That principal license state board will evaluate whether the physician is eligible for expedited licensure and issue a letter of qualification that would either verify or deny the physician's eligibility. This letter will go to the Interstate Commission. Static qualifications such as verification of medical education and results of any medical or licensing examination are not subject to additional primary source verification if they have already been verified by the principal license state.

Applicants will need to complete the registration process that the Interstate Commission establishes to receive a license in another state that is a member of the Compact and pay all applicable fees. After verification of eligibility, a criminal background check and receipt of fees, the board of the member state the application is made to will issue an expedited license.3

The physician is subject to all laws, rules and regulations of the issuing member board and member state. The expedited license may be terminated if the physician does not maintain a license in the principal state without re-designating a new state of principal licensure.

Coordinated Information

The Interstate Commission will establish a data base of all physicians licensed or who have applied for licensure through the Compact. Member boards must report any public action, disciplinary or investigatory information deemed necessary and proper by the Commission or complaints against physicians who have applied or received an expedited license through the Compact. Complaint and disciplinary information may be shared between member boards upon request. Information provided to the Interstate Commission is confidential.

Joint Investigations and Discipline

Participation in the Compact would open a physician up to investigations and discipline in multiple jurisdictions for an act that occurred in one state. For example:

- Member boards may participate in joint investigations of physicians.
- A subpoena issued by a member state is enforceable in other member states.
- Any disciplinary action taken by any member board against a physician licensed through the Compact may be subject to discipline by other member boards.
- If a physician's principal state license is revoked, surrendered or relinquished, all licenses issued to that physician by member boards are automatically placed, without further action necessary by any member board, on the same status. If the principal state license is reinstated, the other state licenses will remain encumbered until that state member board takes action to reinstate.
- If disciplinary action is taken against a physician by a member board that is not in the state of principal license, any other member board may deem the action conclusive as to matter of law and fact decided.
- If a license granted to a physician by a member board is revoked, surrendered or relinquished in lieu of discipline, or suspended for an indefinite period of time, any license(s) issued to the physician by any other member board(s) shall be suspended, automatically and immediately without further action necessary by the other member board(s), for ninety (90) days upon entry of the order by the disciplining board, to permit the member board(s) to investigate the basis for the action. 

**Potential Impact on Telehealth**

One of the major barriers around licensure for telehealth providers is how long the process takes to receive a license in another state. The Compact would help expedite the process by allowing static information such as medical education, results of examinations, etc., not have to have primary source verification again if they have already been primary source verified by the principal state of license. This does appear to help streamline some of the repetitive aspects of applying for a license, however the current basic structure outlined by the Compact language indicates the process would include several applications and entities:

[Diagram of the process]

It appears that two applications would still need to be completed by the physician in this proposed format. Depending on what is involved, the process could still be more streamlined than what a physician currently needs to do. However, it should also be noted that in this process, there is also the potential that two fees will need to be paid, one to the Interstate Commission and one to the member board to whom the physician is applying for a license. It is also unclear whether a physician would need to repeat this process for each state board he or she wishes to obtain a license from or whether one application (and thus one fee paid) through the Interstate Commission would be sufficient for multiple licenses. These are details that would need to be considered by any Interstate Commission that is formed.
Due Process

Other areas that could raise questions are the joint investigations and discipline sections. Under the Compact language, if a physician has his or her license revoked in one state, other Compact member states may do the same, without further notice. If the revoked license is reinstated, the licenses in other states will remain encumbered until those state boards take action. If disciplinary action is taken by a member board not in the state of principal license, any other board “may deem the action conclusive as to the matter of law and fact decided, and:

(i) impose the same or lesser sanction(s) against the physician;
(ii) or pursue separate disciplinary action against the physician under its respective medical practice act, regardless of the action taken in other member states.”

Such language indicates that a physician may have no recourse in disciplinary actions as the finding in one state is “conclusive as to the matter of law and fact decided.” Additionally,

“If a license granted to a physician by a member board is revoked, surrendered or relinquished in lieu of discipline, or suspended for an indefinite period of time, any license(s) issued to the physician by any other member board(s) shall be suspended, automatically and immediately without further action necessary by the other member board(s), for ninety (90) days upon entry of the order by the disciplining board, to permit the member board(s) to investigate the basis for the action. A member board may terminate the automatic suspension of the license it issued prior to the completion of the ninety (90) day suspension period.”

States would need to take into consideration whether these sections and other parts of the compact may conflict with their existing state laws and practices. Several unknowns remain as the Commission would need to create actual policy and processes once it has been formed. For example, while the process outlined in the Compact language appears to require two applications and has the potential for two fees involved, the process may be quicker and less expensive than what currently occurs. Though some may feel the FSMB did not go far enough with their Compact language, progress has been made. How much progress remains to be seen.

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2 Federation of State Medical Boards, Interstate Medical Licensure Compact, Section 1. Purpose, p. 1.
3 Ibid, Section 5, Application and Issuance of Expedited Licensure, p. 6.
5 Ibid, Section 6, Fees for Expedited Licensure, p. 6.
6 Ibid, Section 10, Disciplinary Actions, p. 9-10.
7 Ibid, Section 10, Disciplinary Actions, p. 10.
Commercial Insurer Innovation

By J. Scott Ashwood, Ateev Mehrotra, David Cowling, and Lori Uscher-Pines

Direct-To-Consumer Telehealth May Increase Access To Care But Does Not Decrease Spending

Abstract The use of direct-to-consumer telehealth, in which a patient has access to a physician via telephone or videoconferencing, is growing rapidly. A key attraction of this type of telehealth for health plans and employers is the potential savings involved in replacing physician office and emergency department visits with less expensive virtual visits. However, increased convenience may tap into unmet demand for health care, and new utilization may increase overall health care spending. We used commercial claims data on over 300,000 patients from three years (2011-13) to explore patterns of utilization and spending for acute respiratory illnesses. We estimated that 12 percent of direct-to-consumer telehealth visits replaced visits to other providers, and 88 percent represented new utilization. Net annual spending on acute respiratory illness increased $45 per telehealth user. Direct-to-consumer telehealth may increase access by making care more convenient for certain patients, but it may also increase utilization and health care spending.

Direct-to-consumer telehealth companies such as Teladoc, American Well, and Doctor on Demand offer patients with minor illnesses around-the-clock access to a physician via telephone or videoconferencing on their smartphone, tablet, or laptop. The growth in direct-to-consumer telehealth appears to be accelerating. There were a reported 1.25 million direct-to-consumer telehealth visits in 2015, and Teladoc reported that in that year it provided roughly 600,000 visits—a volume almost double that of the previous year. A recent survey of large employers indicated that 90 percent of them plan to offer a direct-to-consumer telehealth option to their employees in 2017.

One of the key attractions of direct-to-consumer telehealth for employers is the potential cost savings. Direct-to-consumer companies argue that they save money for health plans, employers, and patients by replacing costly visits to physician offices and emergency departments (EDs) with a $40–$50 telehealth visit. Furthermore, patients who use direct-to-consumer telehealth can avoid time and travel costs, including time off from work, that are associated with seeking in-person care. However, the impact of direct-to-consumer telehealth on spending has not been rigorously assessed until now.

While it is clear that the reimbursement for a direct-to-consumer telehealth visit is lower than that for a physician office or ED visit, there are two potential concerns. The first is that if the direct-to-consumer telehealth visit is more likely to result in follow-up appointments, testing, or prescriptions, compared to similar visits to other settings, direct-to-consumer telehealth could increase spending. For example, given liability concerns, direct-to-consumer telehealth physicians may be more likely to recommend that patients have a subsequent in-person visit with a provider. Therefore, although the telehealth visit is less costly, the per episode cost of a direct-to-consumer telehealth visit could be great-
er than that of a visit in other settings.

The second concern is that the convenience of direct-to-consumer telehealth may drive many patients to seek care for an illness who would not have sought care if telehealth had not been available. Instead of saving money by substitution (that is, replacing more expensive visits to physician offices or EDs), direct-to-consumer telehealth may increase spending by new utilization (that is, increasing the total number of patient visits).

Building on previous methods used to assess the impact on spending of innovations in health care delivery, we addressed these two concerns in this study. We studied medical claims data for beneficiaries of the California Public Employees' Retirement System (CalPERS), a large California public employee benefit organization, which began offering Teladoc to selected members in 2012. We compared the per episode cost of visits to Teladoc and the cost of visits to physician offices and EDs. We also estimated what fraction of Teladoc visits for low-acuity conditions represented substitution versus new utilization.

### Study Data And Methods

**DATA** We used claims and enrollment data for the period 2011–13 for approximately 300,000 enrollees in the CalPERS Blue Shield of California health maintenance organization plan. That plan started covering telehealth visits in April 2012. We focused on visits for acute respiratory infections because they are the most common conditions for which patients seek direct-to-consumer telehealth treatment. These conditions, identified by the primary International Classification of Diseases, Ninth Revision (ICD-9), diagnosis code, were otitis media, bronchitis, bronchiolitis, pneumonia, sinusitis, pharyngitis, tonsillitis, laryngitis, tracheitis, nasopharyngitis, and mastoiditis (for the diagnosis codes, see the online Appendix).

**STUDY COHORTS** We identified all enrollees who had an acute respiratory infection visit at any time in the period April 2012–November 2013. These enrollees were divided into two cohorts based on whether or not they sought care via a direct-to-consumer telehealth visit.

To address potential selection bias, we selected a subset of the nonuser cohort who were similar to users on characteristics that we could observe in our data. These were age, sex, ZIP code median household income, and health status. We used propensity score matching to find two nonusers who were similar to each user. This allowed us to minimize selection bias by comparing populations with similar propensities to use direct-to-consumer telehealth (more details on our matching approach appear in the Appendix).

**MEASURING PER EPISODE COSTS** To address differences in testing or follow-up visits across settings, an episode of care was defined as the initial visit (to Teladoc, a physician's office, or an ED) plus all claims on the day of the visit and the following two days. We used procedure codes and revenue codes (for hospital-based claims) to classify services into five categories: evaluation and management, pharmacy, imaging, testing, and other. We further divided evaluation and management claims into claims for the initial visit and claims for follow-up visits.

**NEW UTILIZATION VERSUS SUBSTITUTION** We tracked the utilization and spending associated with acute respiratory infection visits among our two sets of enrollees, users and nonusers of direct-to-consumer telehealth, in 2011–13.

Because of how the set of direct-to-consumer telehealth users was created, by definition, the use of telehealth increased in that group between 2011 and 2013. We determined whether telehealth visits represented substitution or new utilization by focusing on the change in non-telehealth visits (those to physicians' offices and EDs) relative to the change in telehealth visits. A decrease in non-telehealth visits of similar magnitude to the increase in telehealth visits would indicate substitution. No change in non-telehealth visits would indicate new utilization. The change in non-telehealth visits was estimated by comparing trends in those visits between the users and the nonusers.

Our utilization measure was therefore the average number of annual acute respiratory infection visits per 100 people, among those continuously enrolled for the year. More details on our analytic approach appear in the Appendix.

**STATISTICAL ANALYSES** To estimate differences in per episode spending, we summed total episode spending on acute respiratory infection visits in all three sites of care for each person and year for both telehealth users and nonusers. Spending consisted of out-of-pocket and insurance spending. We used the allowed amount included in the claims data.

To estimate the changes in utilization and spending associated with direct-to-consumer telehealth visits, we compared the levels of utilization and spending between the year before the first telehealth visit (the pre period) and the final year of data (the post period) for both sets of enrollees. We used multiple linear regression models with one observation for each combination of year, city, and set of enrollees (direct-to-consumer telehealth user or nonuser). To address possible selection bias remaining after propensity score matching, we used difference-in-differences models. Our independent var-
The fact that telehealth visits are less expensive per episode suggests that they have the potential to decrease spending.

Variables were an indicator for the telehealth user cohort, an indicator for the year, and an indicator for the interaction of user cohort and year. We compared changes in our outcomes from the pre to the post period for our two sets of enrollees. The differential change for the telehealth user cohort, relative to the cohort of matched controls—captured by indicator for the interaction—served as an estimate of the change in non-telehealth visits.

To estimate what fraction of telehealth visits represented substitution as opposed to new utilization, we compared the decrease in non-telehealth visits to the increase in telehealth visits.

We used SAS, version 9.3, for all analyses.

**Sensitivity Analyses** To assess possible changes in spending from a societal perspective, we conducted a sensitivity analysis in which we also incorporated potential savings from the reduction in time spent on acute respiratory infection care. There is no published literature on the relative time spent on direct-to-consumer telehealth visits compared to visits to other sites. To estimate the change in time spent on acute respiratory infection care for direct-to-consumer telehealth users, we applied estimates of time spent on ambulatory care at physicians’ offices. These estimates included travel time, total time at the physician’s office (including waiting time), and time with a physician. The average total time spent on a visit was estimated to be 121 minutes. The dollar value of those 121 minutes—in terms of lost time that could have been spent on other activities, such as employment—was $43, on average. Travel time was estimated to be 37 minutes, on average ($13), and time with a physician was estimated to be 20 minutes ($7).

Since we did not have time estimates directly related to telehealth, we assumed that the time spent on a telehealth visit was the same as the clinic time for the average office visit, so that the only time saved was travel time. This yielded a 31 percent reduction in the time needed for a visit. This analysis allowed us to provide some insights into the possible impacts of direct-to-consumer telehealth usage on patient time.

To address the concern that any change in utilization seen among direct-to-consumer telehealth users was driven by an increased propensity to seek care for any condition, we conducted a falsification test. We examined trends in musculoskeletal strains among those in the cohort of telehealth users versus those in the cohort of nonusers (for a more detailed description of this analysis, see the Appendix). Musculoskeletal strains are common low-acuity conditions that are addressed in visits to physician offices and EDs, but not in direct-to-consumer telehealth visits. We would therefore not expect visit rates for such conditions to be affected by the introduction of direct-to-consumer telehealth services.

We performed an additional sensitivity analysis in which we limited the sample to people who did not have a claim for a visit to any health care provider in 2011, a population that likely included people who did not have a regular source of care. We were not able to directly test the impact of direct-to-consumer telehealth on access to care, but this analysis gave us some insights into how people who were nonusers—or at least infrequent users—of health care responded to the introduction of direct-to-consumer telehealth. The results of this analysis are presented in Appendix Exhibit A2 and briefly discussed below.

**Limitations** Our study had several limitations. First, we assessed only spending related to one direct-to-consumer telehealth company in a population of patients in California. Our study focused on patients with generous commercial insurance, and it should be noted that utilization patterns among the uninsured, people with government insurance, or those with high-deductible health plans might differ.

Second, we focused on utilization patterns among a limited population who used direct-to-consumer telehealth and a similar matched cohort. There was low uptake of telehealth in this population, so it is difficult to predict what would happen if and when telehealth became more popular. The fraction of telehealth visits that represented new utilization versus substitution could change in the future as more people embrace this innovation in health care delivery.

Third, despite our efforts to address selection bias through propensity score matching and a difference-in-differences modeling approach, it is possible that we did not account for changing
unobserved characteristics among telehealth users that influenced the patterns we observed.

Finally, we focused on the most common set of conditions treated via direct-to-consumer telehealth. It is possible that some aspects of our results, such as the breakdown of spending by episode, would change if we looked at different conditions.

**Study Results**

In the period April 2012–November 2013, 981 enrollees had a telehealth visit for acute respiratory infection. We matched these to 1,962 enrollees who had a first visit to a different care setting for acute respiratory infection during the same time period. Before matching, there were a few differences between direct-to-consumer telehealth users and nonusers. The main differences were health status and previous utilization, with users more likely to have no comorbid conditions and more likely to have had no visits in the previous year, compared to nonusers (Exhibit 1). After matching, these cohorts of users and nonusers were similar on our all matching criteria, including health status and number of previous visits.

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**Exhibit 1**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Telehealth users (n = 981)</th>
<th>Telehealth nonusers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Before matching (n = 43,959)</td>
<td>Standardized difference*</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>61.3%</td>
<td>0.01</td>
</tr>
<tr>
<td>Male</td>
<td>38.7</td>
<td>38.4</td>
</tr>
<tr>
<td>Age range (years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18–30</td>
<td>142</td>
<td>16.2</td>
</tr>
<tr>
<td>31–50</td>
<td>57.7</td>
<td>44.6</td>
</tr>
<tr>
<td>51–64</td>
<td>28.1</td>
<td>39.3</td>
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<tr>
<td>ZIP code median household income ($)</td>
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<td></td>
</tr>
<tr>
<td>Less than 45,000</td>
<td>8.5</td>
<td>9.0</td>
</tr>
<tr>
<td>45,000–65,000</td>
<td>43.3</td>
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</tr>
<tr>
<td>More than 65,000</td>
<td>45.2</td>
<td>46.7</td>
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<tr>
<td>Missing data</td>
<td>3.1</td>
<td>2.6</td>
</tr>
<tr>
<td>Comorbidities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>38.94</td>
<td>35.02</td>
</tr>
<tr>
<td>1</td>
<td>25.69</td>
<td>22.94</td>
</tr>
<tr>
<td>More than 1</td>
<td>35.37</td>
<td>42.03</td>
</tr>
<tr>
<td>Visits for acute respiratory infection per year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>65.14</td>
<td>40.82</td>
</tr>
<tr>
<td>At least 1</td>
<td>34.86</td>
<td>59.18</td>
</tr>
</tbody>
</table>

**Source:** Authors’ analysis of claims and enrollment data from the California Public Employees’ Retirement System for the period 2011–13. **Notes:** The matched enrollees had a first visit for acute respiratory infection in the same time period, but to a different care setting. *Variables with standardized differences between values for direct-to-consumer telehealth users and nonusers of -0.2 to 0.2 were considered balanced. *Not applicable.
nition no telehealth visits, and non-telehealth visits per 100 enrollees increased from sixty to eighty-seven. Based on what was observed in the matched control group, the expected change for telehealth users was an increase of twenty-seven non-telehealth visits, but the observed change was an increase of seventeen. This represented a decrease of ten non-telehealth visits, which we interpreted as the magnitude of direct-to-consumer telehealth substitution for in-person visits. We note that this decrease was not significant.

Of the eighty-five telehealth visits, the ten visits that substituted for visits to other providers represented only 11.8 percent of the total. We therefore estimated that 88.2 percent of the telehealth visits represented new utilization.

**SPENDING ANALYSES** We found that the cost savings from substitution were outweighed by the increase in spending from new utilization. We estimated that there was a net $45 per person (95% CI: $10, $79) increase in acute respiratory infection spending among the direct-to-consumer telehealth user cohort (data not shown).

**SENSITIVITY ANALYSES** We found that the time costs for the telehealth user cohort actually increased by $21 (95% CI: $15, $27) (data not shown). There were savings in time costs of having telehealth visits instead of physician’s office or ED visits for the 11.8 percent of telehealth visits that represented substitution. However, because most telehealth visits appeared to be new visits, the net effect was an increase in time spent.

In a falsification test, we observed no difference between the two cohorts’ utilization trends for musculoskeletal strains (for results, see the Appendix).

When we repeated our analysis focusing only on infrequent users of health care (enrollees with no visits during the previous year), we found that a smaller proportion of visits (82 percent) represented new utilization (for results, see the Appendix).  

**Discussion**

One of the attractions of direct-to-consumer telehealth is its potential to save money. However, as alluded to above, we wondered about two concerns: First, despite virtual visits’ being less costly than in-person visits, the per episode costs of a telehealth visit could be greater than those of an in-person visit. Second, the convenience of direct-to-consumer telehealth could drive increased utilization and spending.

Our findings do not support the first concern. Per episode, telehealth visits were about 50 percent of the cost of a physician office visit and less than 5 percent of the cost of an ED visit. However, the vast majority of telehealth visits for acute respiratory infections were new utilization rath-

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**EXHIBIT 2**

<table>
<thead>
<tr>
<th>Site of care</th>
<th>E&amp;M day of visit</th>
<th>E&amp;M follow-up</th>
<th>Pharmacy</th>
<th>Imaging</th>
<th>Testing</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telehealth</td>
<td>5,41</td>
<td>9</td>
<td>253</td>
<td>3</td>
<td>7</td>
<td>4</td>
<td>79</td>
</tr>
<tr>
<td>Physician office</td>
<td>84</td>
<td>6</td>
<td>35</td>
<td>12</td>
<td>76</td>
<td>11</td>
<td>146</td>
</tr>
<tr>
<td>ED</td>
<td>674</td>
<td>53</td>
<td>41</td>
<td>12</td>
<td>4</td>
<td>950</td>
<td>1,734</td>
</tr>
</tbody>
</table>

*Source: Authors’ analysis of claims and enrollment data from the California Public Employees’ Retirement System for the period 2011–13. Note: An expanded version of this exhibit, including 95% confidence intervals, appears in Appendix Exhibit A3 (see Note 9 in text). Authors performed t-tests comparing spending for telehealth episodes and each other site of care. Average total allowed amount on claim line items from the same date and site of care with evaluation and management (E&M) procedure codes or revenue codes (for emergency department [ED] visits). Average total allowed amount on all claim line items from the following two days, regardless of site of care, with E&M procedure codes or revenue codes (for ED visits). Average total allowed amount on all claim line items from this category from the same date or the following two days. *P < 0.10 **P < 0.05

**EXHIBIT B**

Changes over time in numbers of acute respiratory infection visits by telehealth users and nonusers, by site of care, 2011–13

<table>
<thead>
<tr>
<th>Site of care</th>
<th>Pre period</th>
<th>Post period</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TELEHEALTH</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Users</td>
<td>0</td>
<td>85</td>
<td>85</td>
</tr>
<tr>
<td>Nonusers</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>PHYSICIAN’S OFFICE OR EMERGENCY DEPARTMENT</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Users</td>
<td>61</td>
<td>78</td>
<td>17**</td>
</tr>
<tr>
<td>Nonusers</td>
<td>60</td>
<td>87</td>
<td>27**</td>
</tr>
</tbody>
</table>

*Source: Authors’ analysis of claims and enrollment data from the California Public Employees’ Retirement System for the period 2011–13. Note: An expanded version of this exhibit, including 95% confidence intervals, appears in Appendix Exhibit A4 (see Note 9 in text). For both cohorts, the pre period was the year before telehealth was offered, and the post period was the final year of data. Visits are per 100 people per year. Between-group differences were 85 for telehealth (P < 0.05), –10 for physician office or emergency department (ED), and 74 for all sites (P < 0.05). **P < 0.05.
er than substitution. The savings from substitution were outweighed by the increase in spending for the new utilization, and per enrollee spending on acute respiratory infection treatment was higher among telehealth users, compared to nonusers. This pattern of greater spending for telehealth users remained even after we accounted for time costs to patients for traveling to and completing health care visits.

Consistent with our findings, companies such as Teladoc and American Well argue that direct-to-consumer telehealth visits are less expensive on a per episode basis. However, they argue that roughly 10 percent of telehealth visits represent new utilization, while we estimated that roughly 90 percent represented new utilization. Why are our results on the impact on spending so different from those reported by direct-to-consumer telehealth companies?

The estimates from the companies come from surveys in which users reported that they would have done nothing if direct-to-consumer telehealth had not been available to them (that is, they would have waited to get better or self-medicated at home without seeking care). Retrospectively surveying direct-to-consumer telehealth users is likely influenced by several cognitive biases, including recall bias, hypothetical bias, social desirability bias, and the consistency principle. Respondents are being asked to discuss their decision-making process for a decision they never actually faced. Psychology and behavioral economics suggest that people who ultimately took an action (in this case, elected to use direct-to-consumer telehealth) are likely to report that they would have taken another action (in this case, gone to another care setting) instead of not acting at all. Our study, in contrast, is based on the actual observed utilization of direct-to-consumer telehealth users.

Our findings on direct-to-consumer telehealth are consistent with the impact of other innovations in health care delivery that focus on increasing convenience, such as retail clinics—where approximately 60 percent of visits represent new utilization. Because using direct-to-consumer telehealth is more convenient than traveling to a retail clinic, it may not be surprising that an even greater share of telehealth services represent new utilization. There may be a dose response with respect to convenience and utilization: the more convenient the location, the lower the threshold for seeking care and the greater the utilization may be.

Policy Implications
When facing the decision of whether to cover direct-to-consumer telehealth services, employers and health plans should consider several issues. First, although our findings suggest that direct-to-consumer telehealth is not reducing overall spending, the fact that telehealth visits are less expensive per episode suggests that they have the potential to decrease spending. Telehealth services could save money if greater shares of visits represented substitution for visits to other settings. This could be accomplished by increasing patient cost sharing for telehealth visits, which could be justified by the savings in travel time. Another strategy would be to focus on outreach. For example, a health plan could direct patients who are high users of ED care to direct-to-consumer telehealth.

Second, costs are only one consideration in deciding whether to offer telehealth to a population. Even if direct-to-consumer telehealth services do not save money, telehealth is clearly a service of value to customers and may yield benefits in other metrics, such as employee satisfaction. Furthermore, as direct-to-consumer telehealth services grow in popularity and become a standard offering, employers may come to expect the services to be part of their benefits package. If this becomes the case, the strategy of cost-conscious employers and health plans should be to offer the services while simultaneously attempting to limit oversuse.

Third, the benefits of direct-to-consumer telehealth depend on the conditions treated and the population affected. In this article we focused on acute respiratory infections, which are the most common type of condition treated by direct-to-consumer telehealth providers. Acute respiratory infections are typically self-limiting conditions, and therefore, receiving care does not improve health in many cases. In contrast, an increase in utilization for patients with diabetes or mental illness might be perceived as a net positive. These are conditions that are often undertreated and for which there is clearer evidence that receiving treatment improves health.

Telehealth services could save money if greater shares of visits represented substitution for visits to other settings.
Also, an increase in utilization might be viewed as beneficial if it was observed in an underserved patient population with little access to primary care.

**Conclusion**

Telehealth has been promoted by direct-to-consumer telehealth companies and by health plans as a way to decrease health care spending. While we found that per episode spending was lower if the patient had a direct-to-consumer telehealth visit, compared to an in-person visit, the convenience of telehealth led to greater use of care and therefore increased health care spending. Creative strategies such as increasing patient cost sharing, targeted patient outreach, and the integration of telehealth into overall care may make it possible to use this emerging and popular service as a way to increase the value of care. ■

The research reported here was supported by a grant from the California Health Care Foundation. Atteev Mehrotra was also supported by an unrestricted gift to Harvard Medical School by Melvin Hall and CHS Inc. Corporation. The funders had no role in the design or conduct of the study; no role in the collection, management, analysis, or interpretation of the data; no role in the preparation, review, or approval of the manuscript; and no role in the decision to submit the manuscript for publication.

**NOTES**


7. Usher-Pines L, Mehrotra A. Analysis of Teladoc use seems to indicate expanded access to care for patients without prior connection to a provider. Health Aff (Millwood). 2014;33(2):258-64.


9. To access the Appendix, click on the Appendix link in the box to the right of the article online.


The Tipping Point Has Arrived, says Rock Health’s Digital Health Consumer Adoption Report

March 1, 2017

For several years, insiders in digital health have been promising that the digital revolution is coming, when wearables, telemedicine and other technological advances would allow for cost-saving efficiencies and improved, personalized care delivery. Rock Health’s newest report on consumer adoption of these technologies in 2016 suggests those promises are coming to fruition (http://hitconsultant.net/2017/03/01/37655/).
“Last year was the tipping point,” said Ashlee Adams, vice president of strategy and partnerships at Rock Health (https://rockhealth.com/). “Not only because of the record rate at which consumers adopted digital health technologies, but also because they are actively utilizing numerous tools.”

[The report] surveyed more than 4,000 respondents across the U.S. [and] indicated that 46 percent of consumers are now considered active digital health adopters, having used three or more tools in categories such as telemedicine and wearables over the course of 12 months.

These numbers on consumer adoption of digital health technology show an impressive increase over 2015’s numbers. The report suggests provider adoption may be responsible for the increase in consumer adoption.

Adams indicated that the report’s findings showed provider recommendations were an important driver in getting consumers to use digital technologies. Similarly, increased provider adoption of technology in care delivery could also be partly responsible for the uptick in consumer use. For example, in October of last year, Kaiser Permanente announced (http://fortune.com/2016/10/06/kaiser-permanente-virtual-doctor-visits/) that more than half of its patient visits were virtual. Other providers are following suit, which was reflected in the jump in telemedicine adoption from 7 percent in 2015 to 22 percent in 2016.

The report examined not only the raw numbers on adoption trends but also consumer attitudes about their increasing adoption, specifically delineating four main shifts in attitude.

First, the Will to Pay for digital health technology increased, and the incentive is particularly strong for those with poor health.

Consumer willingness to pay saw a dramatic threefold increase from 2015, with 39 percent of consumers strongly agreeing that they are willing to pay for health expenses out of pocket. Naturally, the changing insurance landscape (with the advent of high deductible health plans, for example) is driving this attitude since more of the cost burden is placed on patients.
"Despite the common narrative that digital health is for the well, our study found that those who are unhealthy and feel accountable for their healthcare—as judged by personal responsibility, self-management, and willingness to pay out-of-pocket—were the most likely to adopt several categories of digital health technologies," said Adams, "...suggesting that a positive attitude and responsibility for one's health may be a stronger indicator of likeliness to adopt digital health than health status."

Second, the Will to Share health information is fairly high, at least with recipients deemed trustworthy, and again, that willingness was markedly higher among consumers who were chronically ill or in some way consider themselves unwell.

For example, 62 percent said they would freely share their health data to contribute to medical research, far more than the 42 percent who said they would do so in exchange for money.

When it comes to who Americans trust with their medical data, physicians and families were at the top while government and tech companies were documented as the least trusted. Similarly, when asked which health entities were most aligned with consumers’ health interests, physicians ranked at the top.

The will to share also seemed dependent upon on health status. For example, the report found that those who considered themselves unhealthy were more willing to share their medical history with all stakeholders than those in good health. Notably, they are 12 percent more likely to share that information with their pharmacy, and 11 percent more likely to share it with their physician.

Third, the Will to Wear commercially available devices that in some way measure or track health or fitness data more than doubled in the past year, suggesting clinically-based wearables may be close behind—with a healthy dose of skepticism evident in the medical community.

Nearly a quarter of Americans own a wearable, up from 12 percent in 2015. Seventy-five percent of wearable owners bought the wearable for themselves, a third did so in the last three months, and two-thirds made the purchase in the last six months.

“We are seeing increased interest in wearables and mobile tracking tools from physicians, who see the value in some of this information—but above all, want it to be easy to access and relevant to patient care,” said Adams.
Still, physicians continue to hesitate when it comes to using data from commercial wearables as the data quality and integration simply isn’t there. “This skepticism is healthy, as it prevents providers and our healthcare system from being swept up in the health tech hype,” said Adams. “Wearable companies, and digital health companies more broadly, are quickly discovering that they must prove their value with clinical evidence and rigor to be seriously considered.”

Fourth and finally, the Battle of Wills means that demographics are still king when it comes to what kind of product someone is willing to try.

Perhaps some of the report’s most interesting findings are the revelations regarding who was reached by what medium. In telemedicine adoption, for example, use of video-based telemedicine tools more than tripled from 7 percent in 2015 to 22 percent in 2016. However, usage of telemedicine (http://hitconsultant.net/category/technology/telehealth-2/) across all mediums is highest of those in the 24-34 age bracket; baby boomers (55+) were the least likely group to use telemedicine.

Those findings call into question if telemedicine practices will be effective when it comes to population health management (PHM) (http://hitconsultant.net/category/technology/population-health-management-technology/) and home services. Still, Adams said it’s important to consider the type of medium when looking at telemedicine adoption. Although only 9 percent of Boomers were active adopters of live video-based tools, 55 percent used email and 56 percent used phone calls to seek medical care or advice.

“Different age groups may have more familiarity with different technologies and have different ways of learning to use new tools, so it’s imperative that healthcare organizations engage and teach patients in a way that aligns with their current behavior,” she added. “We remain enthusiastic about the potential of telemedicine and other remote monitoring technologies to improve home healthcare and enable more people to age well in place.”

And health status as well as socio-economic status are also highly predictive of digital health adoption.

Equally compelling was the variance in digital health adoption across health status. Although participants who consider themselves to be in “poor health” may be more willing to share their medical history, only 8 percent of them purchased a wearable last
year. Additionally, only 3 percent of those in “poor health” decided to use a health app because their insurance company recommended it, compared to the 18 percent of those in good health who did.

“We think there is an incredible opportunity for technology to bridge those gaps and make healthcare more accessible and affordable for all people—not only the young, wealthy, or well. There is indeed still a divide between the needs of underserved populations and the solutions,” said Adams. “But we’re noticing the emergence of more technologies being tailored to address the specific health issues of lower income, poly-chronic or older populations, and this is a space we hope will continue to draw much-needed attention and resources.”

Not surprisingly, with indicators suggesting that consumer behavior has hit the tipping point in adopting digital health technology, investors are following suit, and those investments are no longer limited to companies based in traditional innovation hotbeds.

[There is no question that interest in digital health continues to grow—perhaps most interestingly among investors and those in new regions or other industries. In 2016, a record number of 296 companies received funding, and 237 new investors made their first digital health investment. Companies are being founded and funded in different parts of the country; digital health businesses in 31 states received funding in 2016, while companies in only 20 states received funding a few years back.

“We’re encouraged by the attention digital health is garnering from adjacent industries, like financial services and transportation, and are excited by the opportunities that new stakeholders and a rapidly growing ecosystem will create in the coming year,” concluded Adams.