

Telemedicine: Professional Practice Standards (Part Three of a Four-Part Series)

As highlighted in Part Two of this four-part series on telemedicine, the growth in reimbursable telemedicine services has been widely varied across payor types, as well as across the United States. Much of this variance can be attributed to the current state of medical licensure rules for each state. While many state legislatures have debated increasing reimbursement for telemedicine services,¹ state medical boards continue to impose restrictive regulations on telemedicine.² The third installment in this Health Capital Topics' four-part series on telemedicine will examine today's shifting telemedicine licensure environment in light of the legislative trends and professional practice standards impacting healthcare delivery.

The *Federation of State Medical Boards* (FSMB) recently issued a *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine* (Model Policy)³ requiring those practicing telemedicine to be licensed in the state where a patient is located.⁴ The FSMB's conservative position on telemedicine cites overriding concerns for patient welfare.⁵ Many state medical boards and legislatures are debating the extent to which state laws and professional standards will embrace telemedicine.⁶ Only nine states extend some form of conditional or telemedicine licensure to out-of-state providers,⁷ down 10% since July 2014.⁸ Additionally, 19 states and the District of Columbia now require *prior informed consent* (which is largely attributable to state legislatures adopting the Model Policy language).⁹

Although telemedicine solutions such as video diagnosis and remote patient monitoring are bridging spatial divides,¹⁰ professional practice standards have remained relatively rigid.¹¹ Several states have begun exploring legislative solutions for relaxing telemedicine strictures—citing physician shortages and pressure to increase access to care under the ACA.¹² Within the past year, over 25 states have considered various proposals to revise professional standards and licensure requirements for telemedicine.¹³ Every state has a policy in place that hinders the practice of medicine across state lines.¹⁴ Currently, D.C., Maryland, New York, and Virginia, are the only states that would allow licensure reciprocity from neighboring states.¹⁵

Practitioners have cited “*administrative burdens and time required for state licensing and hospital credentialing; reimbursement; and the cost of technology*” as the three greatest barriers to the expansion of telemedicine.¹⁶ Of these barriers, telemedicine practitioners have stated that differing state licensure requirements most inhibit telemedicine expansion.¹⁷ The American Telemedicine Association echoed these concerns noting that professional licensure portability and practice standards pose significant challenges to greater telemedicine implementation.¹⁸

Twelve states have adopted laws giving effect to the FSMB Compact, which expedites licensure, but still “*requires physicians to obtain a separate license for each state.*”¹⁹ Likewise, the Interstate Medical Licensure Compact (enacted in 12 states) creates a pathway to expedite the licensing of qualified physicians who wish to practice in multiple states.²⁰ Twenty-four states have signed onto a somewhat analogous agreement—the *Nurse Licensure Compact* (NLC).²¹ The NLC was launched in 2000, and has effectively allowed for nurses to practice in other NLC states physically, telephonically, and electronically.²² *Mutual recognition* has also piqued recent interest as a potential telemedicine licensure solution.²³ Successful mutual recognition models in medicine exist today in the European Community, Australia, the U.S. Veterans Administration, the U.S. military, and the Public Health Service.²⁴ Health law scholars have cited mutual recognition as a potential “workable solution” whereby states would enter into collaborative agreements to honor one another's physician licenses (much like they do with driver's licenses).²⁵ These models, among others, appear to hold promise for ensuring the quality of patient care while providing licensure for the telemedicine solutions of tomorrow.

Telemedicine proponents argue that today's medical licensure scheme has lost its necessity as all U.S. physicians must pass either the U.S. Medical Licensure Examinations or the Comprehensive Osteopathic Medical Licensing Examination.²⁶ Commentators have further stated that borders are becoming less relevant,²⁷ and many of today's state-by-state licensure requirements prevent patients from receiving critical “*medical services that may be available...just across the*

state line.”²⁸ The American Telemedicine Association (ATA) has advanced the notion that rigid licensure requirements erect “*economic trade barriers, restricting access to medical services and artificially protecting markets from competition.*”²⁹ In addressing this question, health law observers have highlighted the *Federal Trade Commission’s* (FTC’s) recent attention to this issue.³⁰ Yet, a singular game-changing edict from the FTC appears unlikely as the commission recently issued a clarifying statement in response to wider anticompetitive concerns for state medical boards underscoring the fact that its guidance “*does not suggest that states should actively supervise regulatory boards, nor does it recommend a one-size-fits-all approach. Instead, [the FTC] identified certain overarching legal principles governing when and how a state may provide active supervision for a regulatory board.*”³¹ Moreover, critics of twentieth-century state licensure requirements argue that inelastic standards have stymied the growth and innovation of telemedicine.³² Amidst these critiques are concerns that telemedicine will usher in disruptive market forces (e.g., bottomless new norms for patient encounters at unknown intervals with lower payor costs—driving down the value of clinical services).³³

Addressing the relationship between the quality of care and the emerging norms for remote clinical services may define new best practices, shape standards, and alleviate state medical boards’ concerns regarding telemedicine. A recent national survey by the Robert Graham Center evaluated telemedicine developments in light of the *Triple Aim of Health Care’s* (Triple Aim’s)³⁴ goals of: (1) “*improving the patient experience of care (including quality and satisfaction);*” and (2) “*improving the health of populations;*” [emphasis added] while, (3) “*reducing the per capita cost of health care.*”³⁵ The survey noted:

*“A variety of barriers must be overcome before [telemedicine] services can become a routine tool for primary care physicians. Guidelines for the use of [telemedicine] services in clinical practice, definitions of quality, and measurable outcomes must be established.”*³⁶

As health systems seek to meet the expansion of access goals of the *Patient Protection and Affordable Care Act* (ACA), telemedicine solutions appear to hold promise.³⁷ Yet, state boards and the FSMB demand that telemedicine satisfy long-held professional practice standards that:

*“Place the welfare of patients first; Maintain acceptable and appropriate standards of practice; Adhere to recognized ethical codes governing the medical profession; Properly supervise non-physician clinicians; and Protect patient confidentiality.”*³⁸

Licensure regimes such as the FSMB Compact, Mutual Recognition, and the Interstate Medical Licensure

Compact appear to address these standards—and the ACA’s concerns regarding patient welfare, privacy, and standards of care—while allowing for the telemedicine solutions of tomorrow that will advance the Triple Aim. The next article in this four-part series will further advance this analysis by exploring several technology, cost, and competition concerns across the developing telemedicine market.


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