

Idaho Telehealth Strategic Planning

Background Review of Policies, Enablers, and Barriers to Telehealth for Idaho

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Prepared by:
ICF Incorporated, LLC



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BACKGROUND REVIEW OF POLICIES, ENABLERS, AND BARRIERS TO TELEHEALTH FOR IDAHO

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Idaho Telehealth Task Force Executive Committee

- Lynda Bennett, MA
- Stacey Carson
- Marc Chasin, MD
- Robert Cuoio, MBA
- Rick Goodwin, MS, MBAH
- William Hazle, MD
- Nancy Kerr, RN, MEd
- Casey Meza
- Michael Meza, MD
- David Morledge, PhD, CCC-A, DABNM, FASNMM
- John Rusche, M.D., FAAP Minority Leader, Idaho House of Representatives
- Tiffany Whitmore Seibert, MPA

Idaho Department of Health and Welfare

- Deputy Director Denise Chuckovich, MS

ICF International

- Marnie House, EdD
- Teri Johnson, MBA
- Lara Malakoff, MURP
- Danielle Nielsen, MPH
- Michelle Revels, PhD
- Dara Schlueter, MPH

INTRODUCTION

As we develop a plan to help expand the use of telehealth services in Idaho, it is important to understand the issues and factors that could serve as enablers or barriers to promoting and supporting its use. The following is a review of information gathered on several issues that are known to affect the use of telehealth services to provide medical care and monitoring, especially in rural areas. The issues addressed in this review include:

- licensing
- reimbursement and payment
- technology and network infrastructure
- privacy and security

For each topic, the review presents a brief overview of any related Federal policies; specific information about Idaho; a brief overview of related policies from other states, including examples of similar programs and legislation; and a discussion of potential enablers and barriers to the use of telehealth.

METHODS

Initial information about the range of issues that affect and are affected by telehealth adoption in Idaho was obtained from one-on-one discussions with telehealth stakeholders in the state. In-depth, but not exhaustive, Internet-based research was performed to obtain information about these specific issues at the Federal level; in states that are similar in geography, population, and political climate to Idaho; and in Idaho. Each topic presented in the Findings section is organized to provide an overview of the issue, national policy implications, information about select states, and details specifically related to the State of Idaho, where available. Detailed reports that present more in-depth information and overviews of the topics are referenced or included as appendices to this review.

FINDINGS

Licensure

Defining what constitutes telehealth is the key to determining whether a health care provider is licensed to provide telehealth services. The best source for the definition of telehealth is the state licensing authority in the jurisdiction in which the provider is based, according to John D. Blum, professor, Loyola University Chicago School of Law's Beazley Institute for Health Law and Policy and member of the board of the Center for Telehealth and E-Health Law (CTeL).¹

The Federation of State Medical Boards (FSMB) also has influenced licensing, and it recently revised its definition of telemedicine and its position on medical licensure for telehealth service delivery.² FSMB's new telehealth policy guidelines are an update to the previous guidelines, which were nearly a decade old. According to the new policy guidelines, released by FSMB on April 26, 2014, telemedicine is care that "typically involves the application of secure

¹ <http://www.luc.edu/media/lucedu/law/centers/healthlaw/pdfs/advancedirective/pdfs/issue1/clifton.pdf>

² <http://www.luc.edu/media/lucedu/law/centers/healthlaw/pdfs/advancedirective/pdfs/issue1/clifton.pdf>

videoconferencing ... to provide or support health care delivery by replicating the interaction of a traditional encounter in person between provider and a patient.” It is not, according to the federation, “an audio-only, telephone conversation, e-mail/instant messaging conversation or fax.”³ FSMB’s policy statement also recommends that physicians:

- obtain a license in the state where the patient is located,
- verify the identity and location of the patient they are treating,
- disclose their credentials,
- acquire consent form from the patient for the care they are delivering,
- not write patient prescriptions that were based only on an online questionnaire.⁴

The revised guidelines further enable telehealth, because they endorse the initiation of a patient-physician relationship, via telehealth, regardless of whether there has been an initial in-person encounter between patient and physician, and provided the standard of care is met.⁵ The full FSMB policy document can be found in Appendix A.

As currently recommended by the FSMB, a common legislative approach for states regarding licensing for telehealth is to require practitioners to obtain a license in each state in which they practice in-person or via telehealth, with some exceptions (e.g., physician-to-physician consultations, military service, medical emergencies, education, and interns/residents). As a result, a doctor who practices in-person in one state and telehealth in another has to obtain and maintain licenses in both states. This can be a significant logistical and cost barrier for physicians. The cost to doctors of obtaining multiple licenses is estimated at \$300 million a year, according to Gary Capistrant, public policy director at the American Telemedicine Association.⁶

Alternative Licensing Approaches

To reduce the barriers caused by requiring licenses in multiple states to deliver telehealth services, several alternative licensing models had been promoted, and in some states, adopted. These include mutual recognition, interstate medical licensure compact/reciprocity, licensure by endorsement, special purpose or limited licenses, and consulting exceptions. A brief description of each approach is provided below.

- **Mutual recognition:**⁷ A state licensing authority legally accepts the licensure of a licensee’s home state. Proponents of this model argue that doctors take standardized national exams, and most requirements are set at the Federal level by agencies, such as the U.S. Department of Health and Human Services. The Nurse Licensure Compact (NLC) Model, first implemented by the National Council of State Boards of Nursing (NCSBN) in Maryland, Texas, Utah, and Washington in 2000, is an example of this model. Idaho joined the compact in 2001, and currently 24 states are part of the compact. A potential barrier to wider implementation of the mutual recognition model for physicians is that some state medical boards want to protect their doctors from out-of-

³ http://www.fsmb.org/pdf/FSMB_Telemedicine_Policy.pdf

⁴ http://www.fsmb.org/pdf/FSMB_Telemedicine_Policy.pdf

⁵ <http://vsee.com/blog/category/vc-opinion/>

⁶ <http://www.usatoday.com/story/news/nation/2014/03/07/stateline-telemedicine-expansion/6159775/>

⁷ <http://www.telehealthresourcecenter.org/toolbox-module/licensure-and-scope-practice#12>

state competition and preserve state revenue from the licensing fees paid by out-of-state doctors.⁸

- **Interstate medical licensure compact/reciprocity:**⁹ Agreements are between two or more states in which each state gives the subjects of the other certain privileges, under the condition that those privileges are granted in return. Authorities of each state must negotiate and enter into agreements to recognize other states' licenses without review of individual credentials. Doctors and patients are legally protected in any state that is part of the compact. Data on investigations of licensed doctors can be shared across states within the compact, giving patients greater protection.
- **Licensure by endorsement:** State licensing boards grant licenses to health care professionals in other states with equivalent standards. A potential drawback to this model is that it can be very time-consuming for physicians to comply with multiple sets of state requirements and standards.¹⁰
- **Special purpose or limited licenses:**¹¹ Health professionals maintain a limited license for the delivery of specific health services under particular circumstances besides holding a full license in the state where they primarily practice. Ten states (Alabama, Louisiana, Montana, Nevada, New Mexico, Ohio, Oklahoma, Oregon, Tennessee, and Texas) have adopted a version of this model. However, data from the information technology supplement to the American Hospital Association 2012 Annual Survey of Hospitals indicated that states that require out-of-state providers to have special licenses for delivering telehealth services are less likely to offer these services.¹²
- **Consulting exceptions:** An out-of-state licensed physician can practice medicine in another state without a license in that state at the request of, and in consultation with, a referring physician in the state. Physicians practicing under this model are generally not allowed to open an office or receive calls directly in the state. This approach was not designed to include telehealth, and it does not always apply to the provision of ongoing, regular telehealth care.¹³

Select State Licensing Approaches

Below is a brief overview of licensing approaches for select states that exhibit some geographic, population, or political similarities to the state of Idaho. These state approaches are organized based on the licensing types discussed above; however, each state approach has a nuanced set of guidelines and restrictions. These examples can inform an approach that may work for Idaho, when it comes to licensing for telehealth. For information about additional states, see Appendix B.

Full License Required

- **Alaska:** An out-of-state physician must be licensed by the Alaska State Medical Board to provide patient care. This includes reading and interpreting medical records and radiology films, and providing second opinions, if a fee is charged.

⁸ <http://www.usatoday.com/story/news/nation/2014/03/07/stateline-telemedicine-expansion/6159775/>

⁹ <http://www.telehealthresourcecenter.org/toolbox-module/licensure-and-scope-practice#13>

¹⁰ <http://www.hrsa.gov/ruralhealth/about/telehealth/licenserpt10.pdf>

¹¹ <http://www.telehealthresourcecenter.org/toolbox-module/licensure-and-scope-practice#13>

¹² <http://www.fiercehealthit.com/story/state-policy-big-factor-whether-hospitals-offer-telehealth-services/2014-02-03>

¹³ <http://www.hrsa.gov/ruralhealth/about/telehealth/licenserpt10.pdf>

- **Texas:** A physician licensed in another state, but treating a patient through telehealth in Texas, is subject to the appropriate regulation by the board, which is able to issue a telehealth license.¹⁴ Texas provides guidance on telehealth standards in its Administrative Code. The code defines telehealth and its proper and improper use. It states that treatment given in an online setting is held to the same standards as treatment given in in-person settings. Providers also must inform patients of the risks and benefits of treatment via telehealth, including how to receive follow-up care if an adverse reaction is experienced, or there is a technological failure.
- **Wyoming:** Any medical diagnosis or treatment rendered by a physician requires the physician to have a state medical license, regardless of the physician's location. For radiology services, a full, unrestricted Wyoming medical license is required if the reading is obtained directly from a patient. This regulation does not apply if an out-of-state consultation is provided by telephone or electronic means if the attending physician is exempt as a consultant called in by a physician licensed to practice in the state for a maximum of seven days in a 52-week period.

Mutual Recognition

- Nine Midwest states (Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, South Dakota, and Wisconsin) are part of a pilot program that aims to standardize the medical licensing requirements across the nine states to better enable physicians to practice in more than one of the states.¹⁵

Interstate Medical Licensure Compact/Reciprocity

- **North Dakota:** The North Dakota Medical Board may, at its discretion based on an applicant's qualifications, engage in reciprocal licensing agreements with out-of-state licensing agencies, but is not required to do so.¹⁶

Special Purpose or Limited Licenses

- **Nevada:** Nevada issues special-purpose licenses to out-of-state physicians for telehealth services. Physicians must hold a full, unrestricted license in another state; not have any disciplinary or other action taken by any state or jurisdiction; and be certified by the American Board of Medical Specialties.¹⁷
- **Utah:** An out-of-state physician may practice without a Utah license if: the physician is licensed in another state, with no licensing action pending and at least 10 years of professional experience; the services are rendered as a public service and for a noncommercial purpose; no fee or other consideration of value is charged, expected or contemplated, beyond an amount necessary to cover the proportionate cost of malpractice insurance; the physician does not otherwise engage in unlawful or unprofessional conduct.¹⁸ A mental health therapist licensed in another state can provide short-term transitional mental health therapy or transitional substance use disorder counseling remotely if: the mental health therapist is present in the state where he/she is licensed; the

¹⁴ <http://www.statutes.legis.state.tx.us/Docs/OC/htm/OC.151.htm>

¹⁵ <http://www.amednews.com/article/20120917/profession/309179950/2/>

¹⁶ <http://www.legis.nd.gov/cencode/t43c17.pdf?20130219173624>

¹⁷ <http://www.leg.state.nv.us/NRS/NRS-630.html#NRS630Sec261>

¹⁸ http://le.utah.gov/code/TITLE58/htm/58_67_030500.htm

client relocates to Utah, and was a client immediately before the relocation; the therapy or counseling is provided for a maximum of 45 days after the client relocates; within 10 days of the client's relocation, the mental health therapist provides a written notice to the Division of Occupational and Professional Licensing of their intent to provide therapy/counseling remotely; and the mental health therapist does not engage in unlawful or unprofessional conduct.¹⁹

- **Montana:** Montana issues telehealth licenses to out-of-state physicians that only allow the physician to practice telehealth in the specialty in which the physician is board-certified or meets the current requirements to take the examination to become board-certified. This license does not authorize the physician to practice medicine while physically present within the state.²⁰ Radiologists are exempt for reading x-rays to provide a diagnosis.

Consulting Exceptions

- **Arizona:** An out-of-state doctor may engage in a single or infrequent consultation with an Arizona physician.²¹

For further information on the licensing requirements in all 50 states, please see State Telehealth Laws and Reimbursement Policies: A Comprehensive Scan of the 50 States and the District of Columbia, available here:

<http://cchpca.org/sites/default/files/50%20State%20Medicaid%20Update%20Nov.%202013%20-%20Rev.%2012-20.pdf>

Idaho Licensing

The State of Idaho requires a full, unrestricted medical license for physicians to provide telehealth services in the state. For example, an out-of-state physician who regularly reads radiologic or imaging studies that were (1) conducted in Idaho, (2) by Idaho physicians, and (3) on patients in Idaho is required to hold a medical license in Idaho. In addition to the cost of obtaining the second license, the amount of time the process takes can be challenging. Idaho is one of several states (with Iowa, Michigan, Nevada, New Mexico, North Carolina, Oregon, and Rhode Island) that has an expedited licensure process, which allows physicians in good standing in their own state, have no significant malpractice or disciplinary history, and submit to a criminal background check, to complete the licensing process in Idaho in two to three weeks, instead of the normal 45 days.²² This expedited process has been in place for approximately five years.

In Idaho, the licensing laws for other health care professionals differ. For example, Idaho is part of the NLC, along with Delaware, Kentucky, Maine, Maryland, New Hampshire, North Carolina, South Carolina, Virginia, Tennessee, Mississippi, Arkansas, Missouri, Iowa, Wisconsin, North Dakota, South Dakota, Nebraska, Colorado, New Mexico, Texas, Arizona, and Utah. Nurses must only obtain one multi-state license in their primary state of residence to provide services via telehealth in other participating states.

¹⁹ http://le.utah.gov/code/TITLE58/htm/58_61_030700.htm

²⁰ <http://codes.lp.findlaw.com/mtcode/37/3/3/37-3-343>

²¹ <http://www.azleg.state.az.us/FormatDocument.asp?inDoc=/ars/32/01421.htm&Title=32&DocType=ARS>

²² <http://www.hrsa.gov/ruralhealth/about/telehealth/licenserpt10.pdf>

Providers of telepsychology licensed in another state may practice in Idaho for up to 30 days within a calendar year if they hold an interjurisdictional practice certificate (IPC).²³ This Idaho statute also authorizes the psychology licensing board to develop standards and requirements addressing the use of communication technology in the practice of psychology, including supervision.

Idaho state legislatures recently passed House Concurrent Resolution No. 46 to set state standards for the provision of telemedicine, which will help ensure that health care professionals can be confident that the care they provide remotely complies with state licensing regulations.

Reimbursement and Payment

Payers

Three primary sources of reimbursement/payment for telehealth services—Medicare, Medicaid, and private payers—are outlined in further detail below.

Private Payers

Only 21 states require private plans to cover telemedicine. States also vary on parity laws for private insurance coverage of telehealth (i.e., parity in coverage between telehealth and in-person medical services).²⁴

Public Payers

- **Medicare:** Medicare provides limited reimbursement for certain telehealth services, including, but not limited to, initial consultations, follow-up inpatient consultations, kidney disease education services, diabetes self-management training services, individual psychotherapy, pharmacologic management. A full list of telehealth services covered by Medicare can be found here: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/telehealthsrvcfsctst.pdf>. Patients are generally only able to be reimbursed for these services if they meet a narrow definition of residing in a rural area. Previously, rural areas were defined by the Center for Medicare and Medicaid Services (CMS) as areas not located within a metropolitan statistical area, as defined by the U.S. Census. However, in Medicare's 2014 physician fee schedule, the definition of rural was expanded to include the fringes of all metropolitan statistical areas, resulting in an expansion of coverage.²⁵
- **Medicaid:** Medicaid pays for telehealth services for the poor in most states (except for Iowa, Massachusetts, New Hampshire, New Jersey, and Rhode Island). States determine whether to cover telehealth under Medicaid; what types of services to cover; where, within the state, the covered services can be delivered; what types of practitioners may be reimbursed; and how much to reimburse.²⁶

²³ <http://www.apapracticecentral.org/advocacy/state/telehealth-slides.pdf>

²⁴ <http://www.americantelemed.org/docs/default-source/policy/ata-map-telemedicine-parity-2014-3-7.pdf?sfvrsn=0>

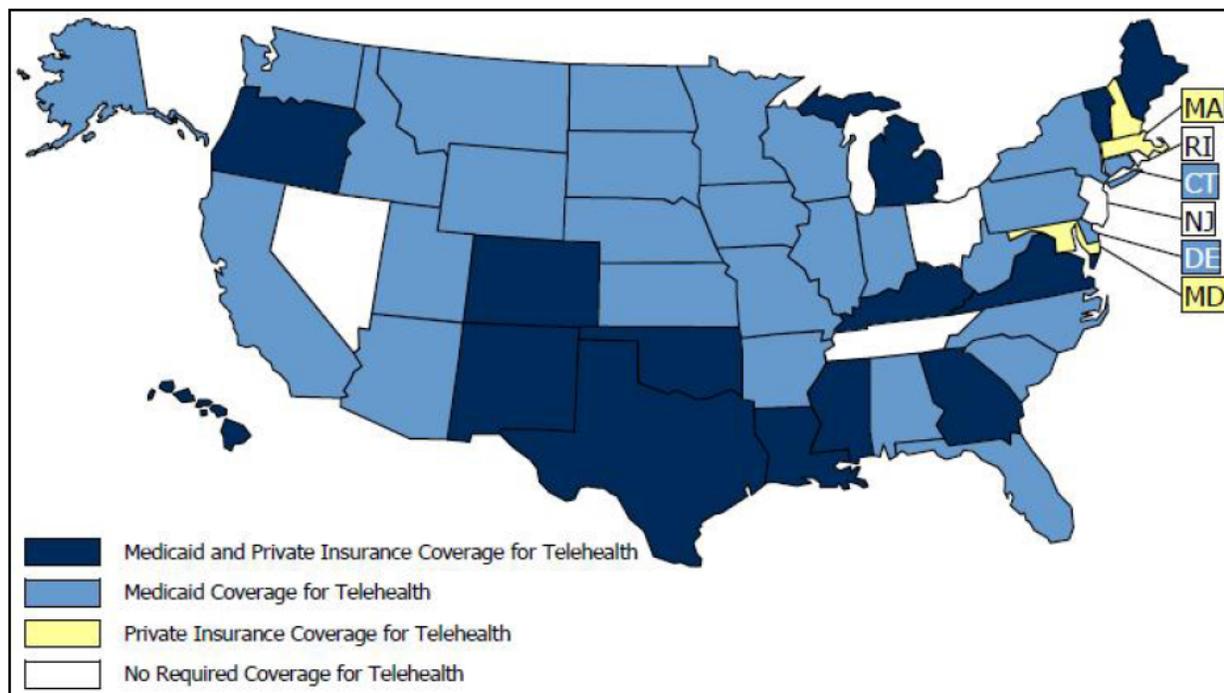
²⁵ <http://www.healthcarepayernews.com/content/cms-expands-medicare-telehealth-coverage>

²⁶ <http://www.nachc.com/client/Telemedicine%20%20SPR48.pdf>

Payment for Telehealth Services Across the States

The map provides an overview of reimbursement under Medicaid and private insurance in states across the country.

Coverage for Telehealth Services by State²⁷



Below is a brief overview of reimbursement for select states that exhibit some geographic, population, or political similarities to Idaho. The examples are grouped by whether telehealth is covered by public payers or both public and private payers. None of the examples from states similar to Idaho offer coverage only from private payers.²⁸ These examples can inform an approach that may work for Idaho, when it comes to reimbursement/payment for telehealth.

Medicaid and Private Insurance Coverage

- **New Mexico:** New Mexico requires telehealth coverage under Medicaid and private insurers. State policy notes that the use of telehealth improves access to quality health care and benefits citizens, health insurers, HMOs, managed-care organizations, and third-party payers. New Mexico's medical assistance program receives State and Federal funding. It provides medical services to low-income residents, encourages the inclusion of telehealth within its policy.

Medicaid Coverage

- **Alaska:** Medical care provided through telehealth as an alternative to traditional in-person care is covered for Medicaid recipients. The state does not require private insurance to reimburse for telehealth.

²⁷ <http://www.nachc.com/client/Telemedicine%20%20SPR48.pdf>

²⁸ <http://www.ncsl.org/research/health/state-coverage-for-telehealth-services.aspx>

- **Arizona:** The Arizona Health Care Cost Containment System (AHCCCS) covers services provided via telehealth if they are medically necessary. As of January 1, 2015, the state will require all private insurance contracts issued, delivered, or renewed by this date, provide coverage for health care services provided via telehealth.
- **Montana:** Montana requires coverage for telemedicine services under Medicaid, as well as through private payers.
- **North Dakota:** North Dakota covers some telehealth services under Medicaid, but it does not require coverage by private payers.
- **South Dakota:** South Dakota limits Medicaid coverage for telehealth to certain services, including follow-up visits to established patients and pharmacological management services. The state does not require coverage by private payers.
- **Wyoming:** In Wyoming, each site can bill for its own services, as long as it is enrolled as a Medicaid provider, including out-of-state Medicaid providers. The state does not require coverage by private payers.

A state-by-state list of coverage—under Medicaid and for private payers—is available through the National Conference of State Legislatures at: <http://www.ncsl.org/research/health/state-coverage-for-telehealth-services.aspx>.

For further information on reimbursement in 50 states, consult State Telehealth Laws and Reimbursement Policies: A Comprehensive Scan of the 50 States and the District of Columbia, available here:

<http://cchpca.org/sites/default/files/50%20State%20Medicaid%20Update%20Nov.%202013%20-%20Rev.%2012-20.pdf>

Parity in Reimbursement

The Information Technology Supplement to the American Hospital Association’s 2012 Annual Survey of Hospitals, which provides data on more than 6,500 hospitals across the country, found that state policies that require reimbursement for telehealth at the same rate as face-to-face services make hospitals more likely to adopt telehealth.²⁹ To promote the use of telehealth, the study recommends states consider focusing on a broad reimbursement policy that supports payment for telehealth in general, rather than payment for individual telehealth services.

²⁹ <http://www.fiercehealthit.com/story/state-policy-big-factor-whether-hospitals-offer-telehealth-services/2014-02-03>

Medicaid and Medicare

Aside from those covered by one of the commercial payers, an additional 15% of Idaho's population is enrolled in Idaho's Medicaid program, another 15% are Medicare beneficiaries, and 18% do not have coverage. For those without coverage, health services are provided by Idaho's seven local public health districts and 13 non-profit federally qualified health centers (FQHCs).³⁴

In Idaho, telehealth services are covered for participants under Medicaid and Medicare who live in a rural health professional shortage area (HPSA) or in a county outside a metropolitan statistical area (MSA) where there is a shortage of qualified providers. In Idaho, there are 332 HPSAs, and at least one HPSA is located within each of Idaho's 44 counties. Reimbursement is not available to anyone who receives care or corresponds with a physician, via a telephone conversation, e-mail, or fax.³⁵

Butte County, Idaho is one of the 97 counties nationwide whose population is at risk for losing coverage for telehealth services under Medicare. As a result of changes to standard metropolitan statistical areas, Medicare beneficiaries who were once categorized as rural are now categorized as living in metropolitan areas and are currently at risk of losing telehealth benefits. Medicare does not cover telehealth services for beneficiaries living in metropolitan areas.³⁶

Reimbursement for Mental Health Services

According to the Idaho Administrative Procedures Act (IDAPA), Idaho reimburses, via public health insurance programs, for a minority of telehealth services deemed equal in quality to services provided in-person. Applicable services include:

- Psychotherapy with evaluation and management
- Psychiatry diagnostic interview
- Pharmacological management
- Developmental disability (DD) therapeutic consultation
- Developmental disability (DD) crisis intervention

Idaho falls in a Federally-designated shortage area for mental health care, indicating that access to this kind of care in Idaho is a significant barrier to successful health outcomes.³⁷ Optum Health administers behavioral health services to eligible Medicaid members in Idaho.

Idaho Medicaid pays for the following specific behavioral health services provided by a physician and delivered using telehealth technology: psychiatry services for diagnostic assessment, pharmacological management, or psychotherapy with evaluation and management services 20-30 minutes in duration.³⁸

³⁴ Idaho Statewide Healthcare Innovation Plan (December 20, 2013)

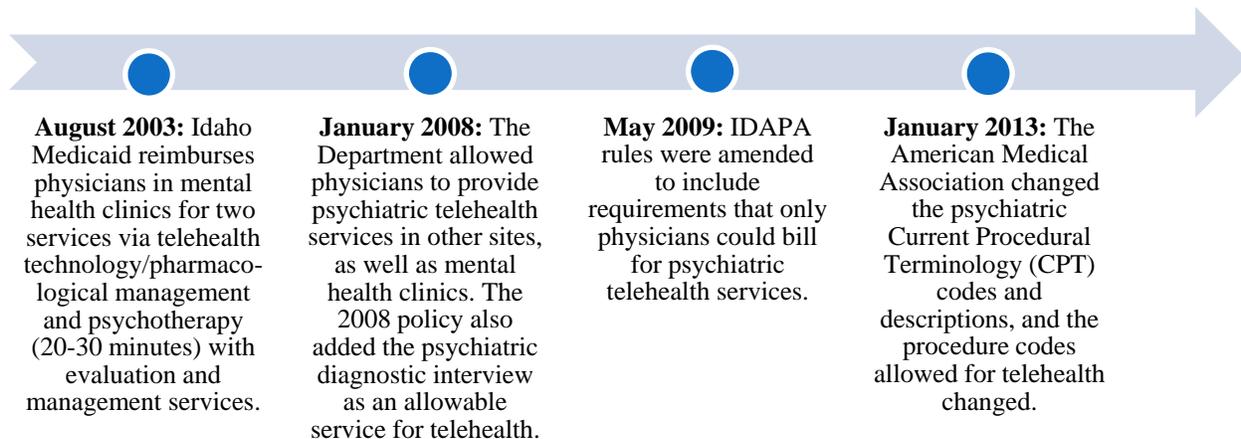
³⁵ Research provided by Stacey Carson, Vice President, Operations and Registry Services, Idaho Hospital Association

³⁶ <http://www.prweb.com/releases/2013/3/prweb10573921.htm>

³⁷ Idaho Statewide Health Innovation Plan (December 20, 2013)

³⁸ Idaho Statewide Health Innovation Plan (December 20, 2013)

The following is a brief overview of reimbursement for mental health services offered, via telehealth technology, in Idaho since 2003.



Reimbursement Opportunities and Challenges

Reimbursement policies that increase access to telehealth services can be used to address specific health or health care issues or challenges. Below are examples from several states where reimbursement policies have been used to address a particular health care challenge.

The states—where the projects highlighted below are located—are not typically identified as states that resemble Idaho in its geography, population, or politics. Yet, they anecdotally provide examples of how policies that support reimbursement of telehealth services can be used to address health care challenges in states that appear dissimilar in many respects. For example, in Mississippi, telehealth is used to address the unusually high rate of diabetes among its residents. In Florida and Indiana, telehealth is used to reduce hospital readmission penalties imposed by the Affordable Care Act. As these potential penalties apply nationwide, these strategies may be useful to many other states.

Mississippi Diabetes Telemedicine Project

Mississippi ranks second in the country in the number of residents suffering from diabetes. The annual cost to the state for caring for patients with the disease is \$2.7 billion, and this represents nearly 3% of the state's gross state product. In January 2014, Mississippi Governor Phil Bryant, along with the University of Mississippi Medical Center and three private technology partners, announced a plan to help low-income residents in the state manage their diabetes through the use of telehealth. To enable this commitment to managing the diabetes epidemic through telehealth, a state law enacted in March 2014 requires private insurers, Medicaid, and state employee health plans to reimburse medical providers for services, dispensed via computer screens and telecommunications, at the same rate they would pay for in-person medical care. Mississippi is the first state to require parity from all insurers for all types of telehealth services. Tennessee followed, by passing a similar law. Project partners hope that this law will result in successful use of telehealth to combat diabetes and also will enable similar telehealth projects to provide similar care for other chronic diseases, both in Mississippi and in other states.³⁹

³⁹ <http://www.usatoday.com/story/news/nation/2014/04/18/stateline-diabetes/7864369/>

Reducing Hospital Readmission

Providing services via telehealth is a way for health care providers to avoid penalties resulting from the Affordable Care Act's program to reduce hospital readmissions.⁴⁰ According to the Center for Medicare and Medicaid Services (CMS), the number of hospital readmissions is an indicator of quality of care, but about 20% of Medicare patients are readmitted to a hospital within one month of discharge.⁴¹ As of October 1, 2012, Medicare payment penalties of up to 1% are applied to hospitals deemed to have "excessive readmissions."⁴²

- **Lee Memorial Health System (Florida):** To prepare for readmission rate penalties, Lee Memorial Health System in Florida sought to reduce readmissions, by 1–2% per year, through remote patient monitoring. The health system used Honeywell's LifeStream Solutions to remotely monitor and track patient outcomes upon their hospital discharges and detect changes in patient conditions early on and apply medical interventions. The program's success can be attributed, in part, to a strategic plan and approach to continual improvement through data collection, data trends analysis, monthly readmission rate calculations, and analyzing clinical outcome data along with financial data to validate system cost savings. Staff also documented interventions that prevented patient readmission, for example, notifying a physician that a patient's vital signs had fallen out of established parameters, and implemented immediate interventions. The system has grown to monitor more than 6,700 patients in its first three years, avoided 950 hospital readmissions, and saved more than \$5.3 million in costs for readmissions.⁴³
- **Central Indiana Beacon Community (Indiana):** Fourteen hospitals in Indiana participated in a pilot remote video conference program between nurses and discharged hospital patients cut hospital readmissions by 75%; 300 patients who were discharged with diagnoses of congestive heart failure and obstructive pulmonary disease participated. One such patient, who had 13 admissions within a year and cost \$156,000, had no admissions in the following 11 months while she was remotely monitored.⁴⁴

Technology and Network Infrastructure

Telehealth relies more on broadband bandwidth and latency than many other uses of broadband. Timing and being able to interact with patients in real time with no delay, or latency, could have significant effects on doctors' ability to provide effective care via telehealth. For example, if a doctor is watching a heartbeat, via videoconference, latency could cause a key indicator of a problem to be missed.⁴⁵ Additional crucial technical infrastructure requirements for telehealth

⁴⁰ <http://www.informationweek.com/mobile/telehealth-to-grow-six-fold-by-2017/d/d-id/1108328>

⁴¹ <https://www.acep.org/Legislation-and-Advocacy/Practice-Management-Issues/Physician-Payment-Reform/Medicare-s-Hospital-Readmission-Reduction-Program-FAQ/>

⁴² <https://www.acep.org/Legislation-and-Advocacy/Practice-Management-Issues/Physician-Payment-Reform/Medicare-s-Hospital-Readmission-Reduction-Program-FAQ/>

⁴³ https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=5&cad=rja&uact=8&ved=0CEgQFjAE&url=https%3A%2F%2Fwww.hommed.com%2Fwp-content%2Fuploads%2F2013%2F08%2FReadmissions-News-Role-of-Telehealth-in-Reducing-Readmissions.pdf&ei=pSdQU47NBIAhyASM34CgDg&usg=AFQjCNEIHFX13Eboh1FPlkqG0G9rE4oZ2w&sig=2=j0Itw1jK_-Pz5BIe6EW1Tw&bvm=bv.64764171,d.b2U

⁴⁴ <http://www.fiercehealthcare.com/story/remote-monitoring-cut-readmissions-75/2012-11-27>

⁴⁵ <http://newsok.com/oklahoma-corporation-commission-hears-from-telemedicine-providers-on-broadband-needs/article/3874065>

include high rates of data transmission, advanced imaging technology, high-resolution display monitors, and medical devices such as stethoscopes equipped with integrated video technology.⁴⁶

More than 14 million U.S. households are unserved or underserved by terrestrial broadband, because they are rural, remote, or exurban. Especially in more rural areas, there are two major technology-related barriers to the use of telehealth:

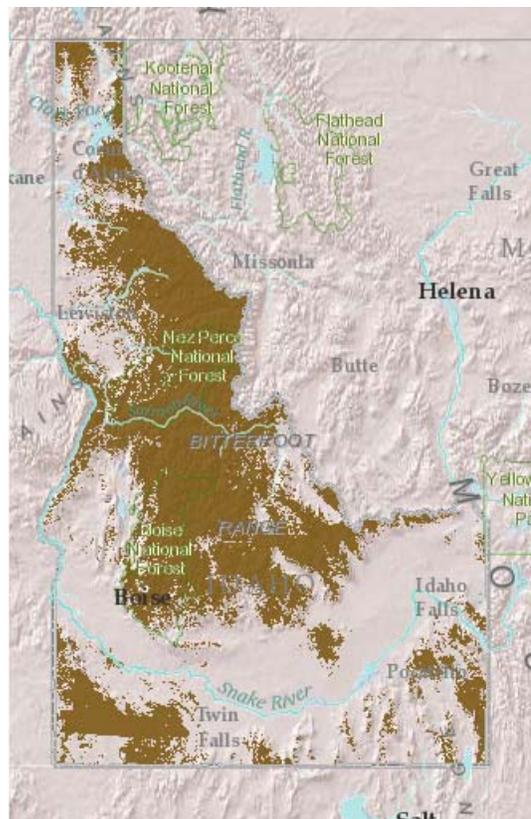
- Rural areas often cannot provide the density and economy of scale to encourage the development of reliable, high-speed broadband infrastructure, significantly limiting the access to the technology upon which telehealth relies.
- A lack of understanding exists among broadband consumers and potential consumers—individual householders and organizations, such as hospitals and local governments—about available broadband connectivity options, including options that extend beyond the most common—cable, DSL, and fiber.⁴⁷ This lack of understanding poses a barrier to the adoption of telehealth, which relies on reliable broadband connectivity.

Failures in technology performance and unreliability of connections also pose significant barriers to the adoption of telehealth by health care providers, because of concerns that failed connections could interrupt service delivery or lead to patients receiving misinformation. Combatting potential barriers associated with technology performance and reliability relies on stable Internet connections, strong scheduling platforms, infrastructure to address possible issues, and training for hospital staff.⁴⁸

Idaho's Technology and Network Infrastructure

Since being funded in 2009 under the American Recovery and Reinvestment Act (ARRA), LinkIDAHO implements projects for broadband mapping and planning, infrastructure development, public computer centers, and sustainable adoption programs. Through this project, LinkIDAHO has developed a state broadband map that depicts where broadband currently exists in the state and where there are gaps.

The Idaho state broadband map shows the wide swaths of area that are reportedly not covered by any broadband service (see right; areas shaded in dark brown are reportedly not covered by broadband service). There remains a lack of coverage in the most rural areas, precisely where telehealth is most needed to fill in gaps in in-person health care.



⁴⁶ <http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Telehealth/whatarethetechnical.html>

⁴⁷ <http://www.govhealthit.com/blog/telehealth-and-broadband-problem>

⁴⁸ <http://www.beckershospitalreview.com/healthcare-information-technology/overcoming-4-challenges-in-implementing-telemedicine-healthcares-next-frontier.html>

This information informed the development of the Idaho Broadband Framework by the LinkIDAHO Broadband Advisory Team, the Idaho Rural Partnership, the State of Idaho Office of the CIO, and the state’s Regional Planning Teams. The framework provides an overview of the current broadband context in Idaho and provides recommendations for how to expand broadband infrastructure in the state. Two of the most relevant broadband technology needs that informed the development of the framework were:

- Data collected in 2012 from broadband providers in the state showed that Idaho is ranked 44th among States, with respect to providing download speeds at 10mbps. As stated in the Framework, 10mbps is the minimum download speed required to engage in complex telemedicine, education services, complex telecommuting, and high-quality telepresence.
- Idaho is ranked 38th when it comes to download speeds of 25mbps, considered “advanced Internet.” This level of service is generally found only in the state’s more urban and densely populated areas.

The recommendations for improving broadband technology included:

- expand broadband east of Coeur d’Alene and in Shoshone County (Region 1)
- expand broadband infrastructure between Grangeville and Riggins (Region 2)
- deploy Ethernet in Latah County (Region 2)
- increase broadband availability in the rural and low-income areas, especially in Region 3
- improve redundancy (or fiber route diversity) in for critical services, like health care in Regions 4 and 5
- address geographic barriers preventing high-speed fiber infrastructure in Region 6

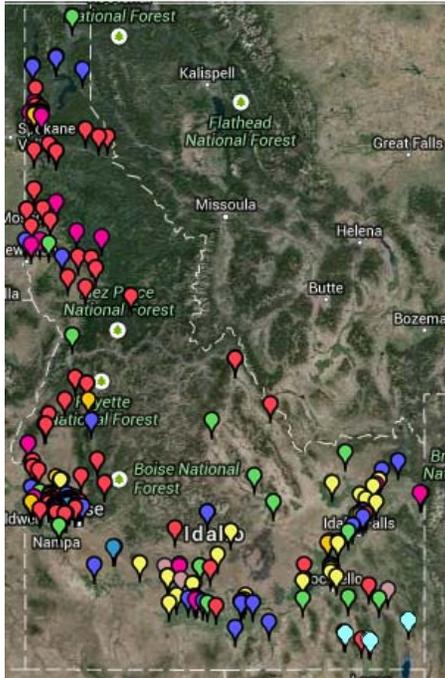
Projects to advance the availability of broadband service in the state include the Idaho Education Network (IEN) and the Idaho Regional Optical Network (IRON). IEN connects public schools to broadband and online educational resources. IRON is a cooperation between universities in the region, the State of Idaho, the Idaho Hospital Association, and the Idaho National Laboratory to enable research, education, and health care through the use of broadband technology. Other entities, such as the Nez Perce Tribe and the Idaho Commission for Libraries, have received grants to advance broadband in the state through programs like the Broadband Technologies Opportunity Program (BTOP).

The maps highlight where the Idaho Education Network (IEN)⁴⁹ and Idaho Regional Optical Network (IRON)⁵⁰ provide high-speed Internet access in Idaho.

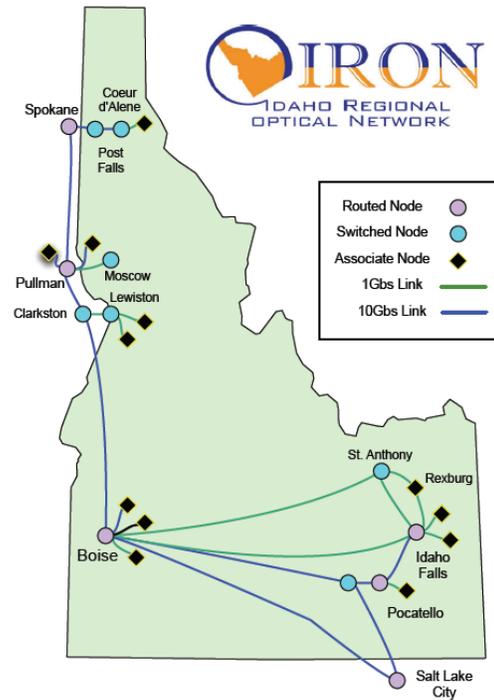
⁴⁹ http://www.iен.idaho.gov/resources/iен_map_all.html

⁵⁰ <http://www.ironforidaho.net/pdf/IRONMediaBulletsFinal20101216.pdf>

Idaho Education Network (IEN)



Idaho Regional Optical Network (IRON)



Privacy and Security

With the use of technology to provide health care, there may be increased opportunities for patient information to be exposed.⁵¹ An increased number of people may be involved in managing the technology and electronic systems associated with providing telemedicine; therefore an increased number of people may be involved in provision of telehealth. Also, transmitting patient data over communication lines could make it accessible to hackers if proper security measures are not taken. However, the Health Insurance Portability and Accountability Act (HIPAA) applies to telemedicine in the same way that it applies to conventional medicine. Telehealth providers are expected to safeguard medical records; keep treatments confidential; and store electronic files, images, and audio/video tapes, etc. with the same precautions as paper documents. In addition, telehealth providers must ensure that patients are informed about all participants involved in a telemedicine consultation and understand that their privacy and confidentiality will be maintained.⁵²

Under Medicaid in Idaho, according to Idaho Administrative Procedures Act policy, the equipment used to provide telehealth services must comply with HIPAA privacy requirements. If teleconferencing equipment must be operated by someone other than an employee of the involved agency, the operator must sign a confidentiality agreement. The form must be filed and made available upon request. If the patient indicates a desire to stop using the technology to

⁵¹ <http://www.fiercehealthit.com/story/providers-dont-overlook-telemedicine-drawbacks/2014-01-14>

⁵² <http://www.telehealthresourcecenter.org/toolbox-module/privacy-confidentiality-and-security>

receive health care, the service is to cease immediately, and an in-person appointment is to be scheduled.⁵³

CONCLUSION

The information presented in this document provides a brief summary of issues that are important to consider as part of the development of Idaho's telehealth plan. Review and discussion of this information by the Idaho Telehealth Task Force and other stakeholders can help inform issues that have implications for expanding telehealth service throughout Idaho.

⁵³ <http://www.healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/TelehealthPolicy.pdf>

1 interaction between a licensee in one location and a patient in another location with or without an
2 intervening healthcare provider.³ However, state medical boards, in fulfilling their duty to
3 protect the public, face complex regulatory challenges and patient safety concerns in adapting
4 regulations and standards historically intended for the in-person provision of medical care to new
5 delivery models involving telemedicine technologies, including but not limited to: 1)
6 determining when a physician-patient relationship is established; 2) assuring privacy of patient
7 data; 3) guaranteeing proper evaluation and treatment of the patient; and 4) limiting the
8 prescribing and dispensing of certain medications.

9 The [Name of Board] recognizes that using telemedicine technologies in the delivery of medical
10 services offers potential benefits in the provision of medical care. The appropriate application of
11 these technologies can enhance medical care by facilitating communication with physicians and
12 their patients or other health care providers, including prescribing medication, obtaining
13 laboratory results, scheduling appointments, monitoring chronic conditions, providing health
14 care information, and clarifying medical advice.⁴

15 These guidelines should not be construed to alter the scope of practice of any health care
16 provider or authorize the delivery of health care services in a setting, or in a manner, not
17 otherwise authorized by law. In fact, these guidelines support a consistent standard of care and
18 scope of practice notwithstanding the delivery tool or business method in enabling Physician-to-
19 Patient communications. For clarity, a physician using telemedicine technologies in the
20 provision of medical services to a patient (whether existing or new) must take appropriate steps
21 to establish the physician-patient relationship and conduct all appropriate evaluations and history
22 of the patient consistent with traditional standards of care for the particular patient presentation.
23 As such, some situations and patient presentations are appropriate for the utilization of
24 telemedicine technologies as a component of, or in lieu of, in-person provision of medical care,
25 while others are not.⁵

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

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

- 32
- 33 • Place the welfare of patients first;
 - 34 • Maintain acceptable and appropriate standards of practice;
 - Adhere to recognized ethical codes governing the medical profession;

³ See Center for Telehealth and eHealth Law (Ctel), <http://ctel.org/> (last visited Dec. 17, 2013).

⁴ *Id.*

⁵ See Cal. Bus. & Prof. Code § 2290.5(d).

- 1 • Properly supervise non-physician clinicians; and
- 2 • Protect patient confidentiality.

3 **Section Two. Establishing the Physician-Patient Relationship**

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

14 The physician-patient relationship is fundamental to the provision of acceptable medical care. It
15 is the expectation of the Board that physicians recognize the obligations, responsibilities, and
16 patient rights associated with establishing and maintaining a physician-patient relationship. A
17 physician is discouraged from rendering medical advice and/or care using telemedicine
18 technologies without (1) fully verifying and authenticating the location and, to the extent
19 possible, identifying the requesting patient; (2) disclosing and validating the provider’s identity
20 and applicable credential(s); and (3) obtaining appropriate consents from requesting patients
21 after disclosures regarding the delivery models and treatment methods or limitations, including
22 any special informed consents regarding the use of telemedicine technologies. An appropriate
23 physician-patient relationship has not been established when the identity of the physician may be
24 unknown to the patient. Where appropriate, a patient must be able to select an identified
25 physician for telemedicine services and not be assigned to a physician at random.

26 **Section Three. Definitions**

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

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

⁶American Medical Association, Council on Ethical and Judicial Affairs, *Fundamental Elements of the Patient-Physician Relationship* (1990), available at <http://www.ama-assn.org/resources/doc/code-medical-ethics/1001a.pdf>

1 healthcare delivery by replicating the interaction of a traditional, encounter in person between a
2 provider and a patient.⁷

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

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

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

11 Licensure:

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

17 Establishment of a Physician-Patient Relationship:

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

22 Evaluation and Treatment of the Patient:

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

31 Informed Consent:

⁷ See Ctel.

⁸ Federation of State Medical Boards, *A Model Act to Regulate the Practice of Medicine Across State Lines* (April 1996), available at http://www.fsmb.org/pdf/1996_grpol_telemedicine.pdf.

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

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

16 Continuity of Care:

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

23 Referrals for Emergency Services:

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

28 Medical Records:

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

1 Privacy and Security of Patient Records & Exchange of Information:

2 Physicians should meet or exceed applicable federal and state legal requirements of
3 medical/health information privacy, including compliance with the Health Insurance Portability
4 and Accountability Act (HIPAA) and state privacy, confidentiality, security, and medical
5 retention rules. Physicians are referred to “Standards for Privacy of Individually Identifiable
6 Health Information,” issued by the Department of Health and Human Services (HHS).⁹
7 Guidance documents are available on the HHS Office for Civil Rights Web site at:
8 www.hhs.gov/ocr/hipaa.

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

18 Sufficient privacy and security measures must be in place and documented to assure
19 confidentiality and integrity of patient-identifiable information. Transmissions, including patient
20 e-mail, prescriptions, and laboratory results must be secure within existing technology (i.e.
21 password protected, encrypted electronic prescriptions, or other reliable authentication
22 techniques). All patient-physician e-mail, as well as other patient-related electronic
23 communications, should be stored and filed in the patient’s medical record, consistent with
24 traditional record-keeping policies and procedures.

25 Disclosures and Functionality on Online Services Making Available Telemedicine Technologies:

26 Online services used by physicians providing medical services using telemedicine technologies
27 should clearly disclose:

- 28
- 29 • Specific services provided;
 - 30 • Contact information for physician;
 - 31 • Licensure and qualifications of physician(s) and associated physicians;
 - 32 • Fees for services and how payment is to be made;
 - 33 • Financial interests, other than fees charged, in any information, products, or services
34 provided by a physician;
 - 35 • Appropriate uses and limitations of the site, including emergency health situations;

⁹ 45 C.F.R. § 160, 164 (2000).

- 1 • Uses and response times for e-mails, electronic messages and other communications
2 transmitted via telemedicine technologies;
3 • To whom patient health information may be disclosed and for what purpose;
4 • Rights of patients with respect to patient health information; and
5 • Information collected and any passive tracking mechanisms utilized.

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

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

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

15 Advertising or promotion of goods or products from which the physician receives direct
16 remuneration, benefits, or incentives (other than the fees for the medical care services) is
17 prohibited. Notwithstanding, online services may provide links to general health information
18 sites to enhance patient education; however, the physician should not benefit financially from
19 providing such links or from the services or products marketed by such links. When providing
20 links to other sites, physicians should be aware of the implied endorsement of the information,
21 services or products offered from such sites. The maintenance of preferred relationships with
22 any pharmacy is prohibited. Physicians shall not transmit prescriptions to a specific pharmacy,
23 or recommend a pharmacy, in exchange for any type of consideration or benefit form that
24 pharmacy.

25 Prescribing:

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

34 Prescribing medications, in-person or via telemedicine, is at the professional discretion of the
35 physician. The indication, appropriateness, and safety considerations for each telemedicine visit

1 prescription must be evaluated by the physician in accordance with current standards of practice
2 and consequently carry the same professional accountability as prescriptions delivered during an
3 encounter in person. However, where such measures are upheld, and the appropriate clinical
4 consideration is carried out and documented, physicians may exercise their judgment and
5 prescribe medications as part of telemedicine encounters.

6 **Section Five. Parity of Professional and Ethical Standards**

7 Physicians are encouraged to comply with nationally recognized health online service standards
8 and codes of ethics, such as those promulgated by the American Medical Association, American
9 Osteopathic Association, Health Ethics Initiative 2000, Health on the Net and the American
10 Accreditation HealthCare Commission (URAC).

11 There should be parity of ethical and professional standards applied to all aspects of a
12 physician's practice.

13 A physician's professional discretion as to the diagnoses, scope of care, or treatment should not
14 be limited or influenced by non-clinical considerations of telemedicine technologies, and
15 physician remuneration or treatment recommendations should not be materially based on the
16 delivery of patient-desired outcomes (i.e. a prescription or referral) or the utilization of
17 telemedicine technologies.

18 [END].

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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

Ex-Officios

Jon V. Thomas, MD, MBA
Chair, FSMB

Donald H. Polk, DO
Chair-elect, FSMB

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

Subject Matter Experts

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

Staff Support

Lisa A. Robin, MLA
Chief Advocacy Officer, FSMB

Shiri Ahronovich, JD
State Legislative & Policy Manager, FSMB

APPENDIX B: SELECT STATE LICENSING APPROACHES

Presented below is an overview of select state licensing approaches. It presents licensing information for states for which information was readily available through an Internet-based search.

For further information on licensing in all 50 states, consult *State Telehealth Laws and Reimbursement Policies: A Comprehensive Scan of the 50 States and the District of Columbia*, available here: <http://telehealthpolicy.us/sites/telehealthpolicy.us/files/uploader/50-State%20February%202014%20-%20Correct%20Grant%20Numbers.pdf>.

Select State Licensing Approaches

Alabama	A special purpose license allowing practitioners licensed in other states to practice across state lines may be issued. ⁵⁴
Alaska	An out-of-state physician must be licensed by the Alaska State Medical Board to provide patient care. This includes reading and interpreting medical records and radiology films, and providing second opinions if a fee is charged.
Arizona	An out-of-state doctor may engage in a single or infrequent consultation with an Arizona physician. ⁵⁵
Colorado	Telehealth is required to meet the same standards as in-person care, as stated in a 2001 state statute.
Connecticut	Department of Public Health may establish a process of accepting an applicant's license from another state and may issue that applicant a license to practice medicine in the state without examination, if certain conditions are met.
Hawaii	Hawaii recognized, through telehealth legislation, that the standard of care for telehealth may need to be modified to accommodate the lack of ability for a physician to touch a patient. ⁵⁶ Telehealth meets the same standards of practice as those in other physician-patient settings that do not include a face-to-face visit. But telehealth treatment is required to "include a documented patient evaluation, including history and a discussion of physical symptoms adequate to establish a diagnosis and to identify underlying conditions or contraindications to the treatment recommended or provided." Out-of-state radiologists may provide services in Hawaii. ⁵⁷
Iowa	Telehealth providers are treated the same as specialty providers. They are held to a national standard, as opposed to the "locality rule," which holds physicians liable for malpractice, "only if they contravene the custom that prevails among physicians practicing in their own geographic community or in communities 'similar' to their own." ⁵⁸ This means that physicians are only compared with other physicians within the same community, state, or region. In Iowa, the locality rule is not applied to specialists or telehealth providers, because they generally are not limited by the resources or training available in their locality.

⁵⁴ <http://alisondb.legislature.state.al.us/acas/codeofalabama/1975/34-24-502.htm>

⁵⁵ <http://www.azleg.state.az.us/FormatDocument.asp?inDoc=/ars/32/01421.htm&Title=32&DocType=ARS>

⁵⁶ http://blogs.law.uiowa.edu/ilr/wp-content/uploads/2014/02/ILR_99-2_Kaspar.pdf

⁵⁷ http://hawaii.gov/dcca/pvl/hrs/hrs_pvl_453.pdf

⁵⁸ http://blogs.law.uiowa.edu/ilr/wp-content/uploads/2014/02/ILR_99-2_Kaspar.pdf

Kentucky	A provider must be licensed in Kentucky except for those who, being nonresidents of Kentucky and lawfully licensed to practice medicine or osteopathy in their states of actual residence, infrequently engage in the practice of medicine or osteopathy within this state, when called to see or attend particular patients in consultation and association with a Kentucky-licensed physician. ⁵⁹
Maryland	Maryland has exceptions to its Maryland-only licensed physicians for physicians practicing in the adjoining states of Delaware, Virginia, West Virginia, and Pennsylvania. ⁶⁰
Minnesota	A physician licensed in another state can provide telehealth services to a patient in Minnesota if his or her license has never been revoked or restricted in any state; they agree to not open an office in Minnesota; and he or she registers with the state's board. ⁶¹
Mississippi	Physicians practicing telehealth must have a Mississippi medical license. However, a valid Mississippi license is not required where the evaluation, treatment and/or medicine given by a physician outside of Mississippi is requested by a physician duly licensed to practice medicine in Mississippi, and the physician who has requested such evaluation, treatment and/or medical opinion has already established a doctor/patient relationship with the patient to be evaluated and/or treated. To practice telehealth, a valid "physician patient relationship" must be established. The elements of this valid relationship are: <ul style="list-style-type: none"> • verify that the person requesting the medical treatment is, in fact, who he or she claims to be • conduct an appropriate examination of the patient that meets the applicable standard of care • establish a diagnosis through the use of accepted medical practices, i.e., a patient history, mental status exam, physical exam and appropriate diagnostic and laboratory testing; • discuss with the patient the diagnosis, risks and benefits of various treatment options to obtain informed consent; • ensure the availability of appropriate follow-up care • maintain a complete medical record available to patient and other treating health care providers.⁶²
Montana	Montana issues telehealth licenses to out-of-state physicians that only allow the physician to practice telehealth in the specialty in which the physician is board-certified or meets the current requirements to take the examination to become board-certified. This license does not authorize the physician to practice medicine while physically present within the state. ⁶³ Radiologists are exempt for reading x-rays to provide a diagnosis.
Nevada	Nevada issues special-purpose licenses to out-of-state physicians for telehealth services. Physicians must: hold a full, unrestricted license in another state; not have any disciplinary or other action taken by any state or jurisdiction; and be certified by the American Board of Medical Specialties. ⁶⁴
New Mexico	New Mexico issues telehealth licenses to providers who hold a full, unrestricted license in another state and have good moral character. ⁶⁵

⁵⁹ <http://www.lrc.ky.gov/KRS/311-00/560.PDF>

⁶⁰ <http://www.lexisnexis.com/hottopics/mdcode/>

⁶¹ <https://www.revisor.mn.gov/statutes/?id=147.032>

⁶² [http://www.msmbml.ms.gov/msbml/web.nsf/webpages/Regulations_Regulations/\\$FILE/02-2013Administrative%20Code.pdf?OpenElement](http://www.msmbml.ms.gov/msbml/web.nsf/webpages/Regulations_Regulations/$FILE/02-2013Administrative%20Code.pdf?OpenElement)

⁶³ <http://codes.lp.findlaw.com/mtcode/37/3/3/37-3-343>

⁶⁴ <http://www.leg.state.nv.us/NRS/NRS-630.html#NRS630Sec261>

⁶⁵ <http://www.nmonesource.com/nmnxtadmin/>

North Dakota	The North Dakota Medical Board may engage in reciprocal licensing agreements with out-of-state licensing agencies, but is not required to do so. ⁶⁶
Ohio	Ohio issues telehealth certificates that allow the holder to engage in the practice of telehealth in the state. Providers with telehealth certificates cannot practice in Ohio without a special activity certificate. ⁶⁷
Oklahoma	Legislation effective November 1, 2013 states The State Board of Osteopathic Examiners has the authority to issue a telehealth license. ⁶⁸
Oregon	Out-of-state physicians may receive a license to practice across state lines in Oregon, as long as they are fully licensed in another state and meet certain requirements. ⁶⁹ Oregon has three separate telehealth-related statuses for physicians: <ul style="list-style-type: none"> • Teleradiology: Physicians are licensed, with an agency letter of verification, to read radiological images transmitted from Oregon to their practice location in another state and communicate their radiological findings back to the ordering physician in Oregon. • Telemonitoring: Physicians are licensed, with a letter from a hospital or surgical center, to perform monitoring of data collected during surgery and transmitted to them in a location outside of Oregon via a telehealth link. • Telemedicine: Physicians outside Oregon are licensed, upon completion of a Practice Across State Lines Practice Description form, to directly treat patients, provide them with a written or documented medical opinion concerning diagnosis or treatment in Oregon.
Pennsylvania	Pennsylvania issues extraterritorial licenses to physicians residing or practicing in an adjoining state, near the Pennsylvania boundary, and whose practice extends into Pennsylvania, to practice in Pennsylvania. Pennsylvania bases the granting of this license on the availability of medical care in the area involved, and whether the adjoining state extends similar privileges to Pennsylvania physicians.
Texas	A physician licensed in another state, but treating a patient through telehealth in Texas, is subject to the appropriate regulation by the board, which is able to issue a telehealth license. ⁷⁰ Texas provides guidance on telehealth standards in its Administrative Code. The code defines telehealth and its proper and improper use. It states that treatment given in an online setting is held to the same standards as treatment given in in-person settings. Providers also must inform patients of the risks and benefits of treatment via telehealth, including how to receive follow-up care when an adverse reaction or technological failure occurs.
Utah	An out-of-state physician may practice without a Utah license if: <ul style="list-style-type: none"> • The physician is licensed in another state, with no licensing action pending and at least 10 years of professional experience; • The services are rendered as a public service and for a noncommercial purpose; no fee or other consideration of value is charged, expected or contemplated, beyond an amount necessary to cover the proportionate cost of malpractice insurance; • The physician does not otherwise engage in unlawful or unprofessional conduct.⁷¹ A mental health therapist licensed in another state can provide short-term transitional mental health therapy or transitional substance use disorder counseling remotely if: <ul style="list-style-type: none"> • the mental health therapist is present in the state where he/she is licensed;

⁶⁶ <http://www.legis.nd.gov/cencode/t43c17.pdf?20130219173624>

⁶⁷ <http://codes.ohio.gov/orc/4731.296>

⁶⁸ http://webserver1.lsb.state.ok.us/2013-14bills/HB/hb1235_enr.rtf

⁶⁹ <http://www.leg.state.or.us/ors/677.html>

⁷⁰ <http://www.statutes.legis.state.tx.us/Docs/OC/htm/OC.151.htm>

⁷¹ http://le.utah.gov/code/TITLE58/htm/58_67_030500.htm

	<ul style="list-style-type: none"> • the client relocates to Utah, and was a client immediately before the relocation; • the therapy or counseling is provided for a maximum of 45 days after the client relocates; • within 10 days of the client's relocation, the mental health therapist provides a written notice to the Division of Occupational and Professional Licensing of their intent to provide therapy/counseling remotely; and • the mental health therapist does not engage in unlawful or unprofessional conduct.⁷²
Washington	Out-of-state, licensed practitioners may deliver telehealth services, as long as they do not open an office or appoint a place of meeting patients or receive calls within the state. ⁷³
Wyoming	Any medical diagnosis or treatment rendered by a physician requires a state medical license, regardless of the physician's location. For radiology services, a full, unrestricted Wyoming medical license is required if the reading is directly from a patient. This regulation does not apply if an out-of-state consultation is provided by telephone or electronic means if the attending physician is exempt, as a consultant, or called in by a physician licensed to practice in the state for a maximum of seven days in a 52-week period.

⁷² http://le.utah.gov/code/TITLE58/htm/58_61_030700.htm

⁷³ <http://www.leg.wa.gov/CodeReviser/RCWArchive/Documents/2012/Vol3.pdf>