HB 234

(FILE 1)

ALASKA STATE LEGISLATURE

Session:
State Capitol, Room 432
Juneau, AK 99801

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REPRESENTATIVE LIZ VAZQUEZ
District 22 – Jewel Lake, Sand Lake, Kincaid & Dimond

House Bill 234

Sponsor Statement

"An Act related to insurance coverage for mental health benefits provided through telemedicine."

This bill seeks to require health care insurers that offer, issue, or renew insurance plans in Alaska to reimburse mental health professionals for medically necessary services delivered using telemedicine via secure phone or intemet video applications. This legislation would not require an initial face to face visit but requires providers be licensed in Alaska.

There is no law in Alaska requiring private insurance companies that provide mental health benefits to reimburse for services provided though telemedicine. There are thousands of Alaskans across the state that have private health insurance but have little or no access or choice of professional mental health providers because some private insurers do not reimburse for telephonic or video mental health counseling. Currently, mental health providers and individuals must demonstrate to some insurance companies that the individual has a severe mobility issue and cannot obtain counseling where they live, or that an emergency exists. In many cases individuals are still often refused reimbursement for mental health services furnished through telemedicine.

Alaska's Medicaid program funds most mental health services for individuals with severe or chronic mental illness. Medicaid regulations clearly allows payment for telemedicine delivery, and do not require face-to-face visits. Thus, there is currently a double standard in Alaska between public and private health care reimbursement for services furnished through telemedicine. The national trend is to allow for reimbursement for mental health services provided through telemedicine. According to the Center for Connected Health Policy, State Telehealth Laws and Medicaid Programs Policies, 32 states and the District of Columbia currently have telehealth parity

laws, some of which will go into effect by 2016 and 2017. An interactive map from the Center for Connected Health Policy can be retrieved online at http://cchpca.org/state-laws-and-reimbursement-policies.

Historically, there was a reluctance to reimburse for services delivered through telemedicine because there was no established code of ethics regarding electronic counseling and no secure video or telephonic resources. However, today the mental health counseling profession has to comply with the national Telemedicine Codes of Ethics addressing internet services. In addition, there are free encrypted, HIPAA compliant telephone and video conferencing applications that work with low broadband internet. Thus, with the current available technology and code of ethics regulating the professional use of this technology, there are numerous advantages to both patients and Alaskan mental health providers.

Advantages of Telemedicine:

- Provides for better access/privacy in rural and remote as well as urban areas of Alaska
- Early intervention is key to prevention, which saves money
- Often individuals will seek counseling earlier in distress if they aren't seen entering an office
- Alaskans with mild to moderate needs may seek help that is more convenient/accessible
- It saves time and money for many patients if they do not have to leave home or office
- Greater access for referrals to providers who specialize in treating specific issues
- Better access means a potential reduction in suicides, domestic violence and more serious crises
- Costs are expected to be the same to insurance companies as face to face counseling
- Zero impact on state budget

In summary, this proposed legislation is very limited in scope. First, it does not require insurers to provide or cover mental health benefits. It only requires insurers that presently offer mental health benefits to reimburse for these benefits delivered through telemedicine. In addition, this bill requires that the mental health service be provided "by a health care provider licensed in this state".

In conformance with the mental health profession, this bill uses the term "mental health" versus "behavioral health". Research has shown that both terms are used interchangeably by those in the mental health profession and that the term "behavioral health" is not defined within Alaska Statute or regulation.

7 AAC 12.449. Definitions. "Telemedicine" means the practice of health care delivery, evaluation, diagnosis, consultation, or treatment, using the transfer of medical data, audio, visual, or data communications that are performed over two or more locations between providers who are physically separated from the recipient or from each other.

Fiscal Note Number:
() Publish Date:

Identifier: HB234-DCCED-DOI-03-11-16
Title: INSURANCE COVERAGE FOR TELEMEDICINE
Sponsor: VAZQUEZ
Requester: Health and Social Services, Labor and Commerce

Department: Department of Commerce, Community and Economic Development
Appropriation: Insurance Operations
Allocation: Insurance Operations
OMB Component Number: 354

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2017**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Fund Source (Operating Only)

None							
Total	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Positions

Full-time							
Part-time							
Temporary							

Change in Revenues							

Estimated SUPPLEMENTAL (FY2016) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2017) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? No
If yes, by what date are the regulations to be adopted, amended or repealed?

Why this fiscal note differs from previous version:

Not applicable, initial version.

Prepared By: Lori Wing-Heier, Director Phone: (907)465-2560

Analysis

HB234 amends Title 21, the Insurance statutes, to require health care insurers to provide coverage for mental health benefits provided through telemedicine without a previous in person visit. This requirement would only apply to individual health insurance plans, not to group market or self-funded plans.

The Division of Insurance does not anticipate fiscal impact from this legislation.

Trust
Alaska Mental Health
Trust Authority

907-269-7960
www.mhtrust.org

March 16, 2016

Representative Vazquez
Alaska Legislature

RE: HB234 - Telemedicine and mental health benefits.

Dear Representative Vazquez,

The Alaska Mental Health Trust Authority serves as a catalyst for change and improvement in Alaska's mental health and home and community-based service systems. HB234, the bill regarding telemedicine and mental health benefits compliments the work and efforts made by the State and the Trust to enhance access to mental health services across the Alaska.

Our charge at the Trust is to help provide mental health services for beneficiaries who do not have access to treatment services through other resources. There are many Alaskans living in remote or urban areas with insurance who need greater access, specialization of services and flexibility than provided now under current insurance practices. The ripple effect of tele-counseling will result in more people living healthier lives which will benefit all Alaskans.

Contemporary technology is available to work in remote villages that may only have access to phone or internet service. As an example, Vsee, https://vsee.com/ is free encrypted software that allows for video conferencing using low bandwidth.

All of the Alaska licensed mental health professionals have statutes and regulations that mandate codes of ethics and continuing education. The codes of ethics now cover appropriate use of technology for psychotherapy.

If the technology is available, Alaskans have insurance, and the practice of using technology is seen as approved by the professions on a national level, then it only makes sense that the State should pass this bill requiring insurance companies that work in Alaska reimburse for counseling services delivered by Alaska licensed professionals via telemedicine.

Respectfully submitted,

Jeff Jessee, Chief Executive Officer
Alaska Mental Health Trust Authority

Advancing psychology as a science, a profession, and a means of promoting health and welfare

March 6, 2016

Representative Liz Vazquez
Alaska House of Representatives
Alaska State Capitol Building
Juneau, AK 99801-1120

RE: HB 234 – "Insurance Coverage for Telemedicine"

Dear Representative Vazquez:

The Alaska Psychological Association (AK-PA) was formed in 1963 as a member-based entity to advance psychology as science, profession and as a means for promoting human welfare in Alaska. We have been actively involved in the healthcare reform efforts that are currently underway in Alaska, and are especially encouraged by the introduction of HB 234.

The delivery of healthcare services through properly regulated technology such as telemedicine is critical for a state such as ours to provide access to needed services. This has certainly been true in psychology and more generally in behavioral health. Requiring healthcare insurers to reimburse for medically necessary telemedicine services that are already covered in existing benefits addresses an obstacle to service provision for many Alaskans and takes us another step forward in healthcare reform that will achieve the goals of quality, comprehensive services that are cost-effective.

Thank you for your dedication to developing the highest quality of healthcare for Alaskans. We applaud your efforts and look forward to working with you moving forward. Please consider us a resource.

Respectfully submitted,

Michael Sobocinski, PhD
President, Alaska Psychological Association

cc: Members of House Health & Social Services Committee
Valerie Davidson, Commissioner, DHSS
Randall Burns, Division of Behavior Health, DHSS
Tom Chard, Alaska Behavioral Health Association
Jeff Jessee, Mental Health Trust

January 18, 2016

Representative Liz Vasquez
State Capitol Room 428
Juneau, Alaska 99801-1182

SUBJ: HB234 – An Act relating to insurance coverage for mental health benefits provided through telemedicine

Dear Rep. Vasquez:

Thank you for sponsoring this important bill that would provide telemedicine mental health access to many Alaskans living in rural communities. HB 234 would eliminate an existing barrier to providing telemedicine mental health services in our state. It does so by removing the requirement that prior in-person contact occur between the healthcare provider and patient before payment is made for covered services.

I represent Juneau Alliance for Mental Health, Inc. (JAMHI), the Community Behavioral Health Center in Juneau and a provider of telebehavioral health services in Southeast Alaska. In a state as large and rural as Alaska, it is no surprise that many rural residents experience great hardship when trying to access needed medical or behavioral health services. Travel to larger communities is very expensive and at times, weather can pose unsurmountable challenges. Rural residents may postpone preventative care, medication refills, or early intervention with mental health problems until they become serious or urgent, driving up costs, increasing the likelihood of hospitalization, and reducing the likelihood of successful treatment outcomes.

As a provider of telebehavioral health services, we strongly support passage of this bill that would increase access to needed services for residents of Rural Alaska, including veterans. If you have any questions about our services, need any information I might be able to provide, please don't hesitate to contact me. Again, thank you for sponsoring HB 234.

Sincerely,

Pamela L. Watts
Executive Director

Juneau, Alaska, 99801

March 15, 2016

Representative Liz Vazquez
State Capitol Room 432
Juneau, Alaska 99801

Re: HB 234 – Telemedicine and Mental Health Benefits

Representative Vazquez,

The Alaska Mental Health Board and the Advisory Board on Alcoholism and Drug Abuse thank you for your efforts to address the need for increased access to behavioral health services across Alaska. Like you, the Boards recognize that telehealth is a key strategy in the improvement of health outcomes and containment of health care costs. We appreciate that HB 234 extends the conversation about tele-behavioral health beyond the Medicaid and tribal health systems to private insurers.

The Boards have long supported the use of telehealth to deliver integrated mental health and substance use disorder treatment and prevention services. Many community behavioral health centers currently provide clinical behavioral health services through telehealth systems. Our hope is that HB 234 will augment the existing services by increasing access to substance use and mental health disorder treatment for Alaskans with private health insurance.

As written, HB 234 only requires private insurers to cover telehealth services for "mental health services," defined in AS 21.54.500(22) as whatever "mental health services" are under the terms of the health care insurance plan. This definition explicitly excludes "benefits for treatment of substance abuse or chemical dependency." The Boards recommend that the language of HB 234 explicitly include substance use disorder treatment, given the high incidence of co-occurring substance use disorders with mental illness (*see* the attached *Policy Statement: Co-Occurring Mental Health and Substance Use Disorders*).

The Boards understand that HB 234 was drafted to limit the ability of private insurers to restrict delivery of telehealth services. We recommend balancing that goal and health care providers' need to adhere to accepted standards of care that may require in-person assessment or other treatment encounter prior to delivery of telemedicine/telehealth services. Expressly including that intent in the legislative record would be an effective way to balance those interests.

Thank you again for your work on behalf of Alaskans experiencing behavioral health disorders.

J. Kate Burkhart

Co-Occurring Mental Health and Substance Use Disorders

The Alaska Mental Health Board and Advisory Board on Alcoholism and Drug Abuse were created by statute to provide advice and counsel related to mental health and substance abuse to the legislature, executive agencies, and other entities. Pursuant to that statutory responsibility, the Boards restate and expand upon their commitment to the public policy of an integrated behavioral health system that serves the entire person, not merely the diagnosis. The Boards' policy statement is aligned with similar policy statements and initiatives issued by the State of Alaska Department of Health and Social Services, Division of Behavioral Health, Substance Abuse and Mental Health Services Administration (2011), the American Society for Addiction Medicine (2000), the National Associations of State Mental Health Program Directors and Alcohol/Drug Abuse Directors (1999), and the President's New Freedom Commission on Mental Health (2003).

BACKGROUND

Since 1998, the Alaska Mental Health Board (AMHB) and Advisory Board on Alcoholism and Drug Abuse (ABADA) have participated in efforts by the State of Alaska and the providers of mental health and substance abuse prevention, treatment, and recovery services to create an integrated behavioral health system in Alaska. The Boards have, through efforts to operate as collaboratively as possible, strengthened their understanding of the nature of co-occurring mental health and substance use disorders and the most effective ways to prevent, treat, and support recovery from them.

Research and evidence shows that a high proportion of substance use disorders occur along with other substance use disorders and/or mental health disorders. Treatment services that address co-occurring disorders and that include measures to prevent the development of co-occurring disorders are most effective. Similarly, recovery supports that address the individual as a whole and support recovery from diverse behavioral health disorders are most likely to result in improved outcomes.

AMHB and ABADA are committed to Alaska's public behavioral health systems efforts to address the complex needs of individuals and families experiencing co-occurring mental health and substance use disorders, in all levels of care, across all agencies, and throughout the entire process of recovery.

Prevalence

In the United States, an estimated 23.2% of adults with serious mental illness also experience a substance use disorder (three times the prevalence of addiction among individuals without a serious mental illness). Among adults experiencing a substance use disorder, 20.4% are estimated to also experience serious mental illness.[1] The National Co-morbidity Study (2007) reports a lifetime prevalence rate for any behavioral health disorder of 57.4%, and a past-12

month prevalence rate of 32.4%. The National Co-morbidity Study also reports that 41-65% of individuals with a lifetime substance use disorder also have a lifetime history of at least one mental health disorder.[2] More than half of individuals with one or more lifetime mental health disorders also have a lifetime history of at least one substance use disorder.[3]

Youth experiencing major depression are twice as likely to abuse inhalants[4] and nearly three times as likely to abuse stimulants.[5] Research also shows a strong relationship between adverse childhood experiences (which include trauma and problem drinking) and illicit drug use, prescription drug use, and addiction in adulthood.[6]

Individuals with co-occurring disorders are more likely to experience a chronic course of illness and are more likely to seek services than those with only a mental health disorder or only a substance use disorder. The extent of the prevalence of co-occurring substance use and mental health disorders is seen in the nearly 25% growth of Alaskans receiving co-occurring disorders treatment (from publicly funded providers) since 2009.[7]

In addition to the co-occurrence of mental health and substance use disorders, individuals often experience dependence upon or abuse of more than one drug. The National Survey of Drug Use and Health reports that 6% of people age 12 and older who reported drinking alcohol in the past month also reported using an illicit drug at the same time or within a few hours of drinking alcohol.[8] Concurrent illicit drug use was reported by 13.9% of binge drinkers age 12 and older.[9] The prevalence of multiple substance use disorders is important, as this has been associated with increased risk of mental health disorders developing.[10]

While there is little recent research that indicates the prevalence of behavioral health disorders among Alaska Native peoples, there is research that indicates that substance use disorders and mental health disorders are often both present among Alaska Native and American Indian peoples seeking mental health services.[11] Research conducted over the past three decades show that substance use disorders and mental health disorders are often co-occurring among Alaska Native and American Indian populations.[12] Co-occurring disorders may be implicated in suicide data reported by the Alaska Violent Death Registry. During the period 2003-2008, alcohol intoxication was associated with 41.3% of all suicides, and active use of marijuana, amphetamines, antidepressants, cocaine, opiates, and other drugs was documented in 25-35% of cases.[13] The National Survey of Drug Use and Health also reports that Alaska Native and American Indian individuals over age 12 are more likely than people of other ethnicities to report concurrent use of alcohol and illicit drugs.[14]

Prevention

The Institute of Medicine has identified effective strategies that prevent mental, emotional and behavioral disorders from developing among adolescents and adults.[15] Strengthening families by addressing violence and parental substance abuse (both of which are adverse childhood experiences that can contribute to co-occurring disorders later in life) enhances the well-being of children. Early screening and identification of risk factors and early behavioral and emotional issues, when followed by access to services, reduces later onset of behavioral health disorders.[16] Promoting strong parenting skills and supports, social-emotional learning, resilience, and

protective factors in families, schools, and communities also reduces the likelihood of mental illness or addiction.

Coordination of prevention efforts to address the common underlying factors related to mental illness, suicide, and addiction promotes the overall well-being of individuals, families, and communities. It also promotes better use of resources and shared accountability for outcomes.

Treatment

Research and practice both support combined treatment of co-occurring disorders.[17] Integrated treatment is associated with lower costs and better outcomes. These forms of integrated treatment result in reduced substance use, improved psychiatric symptoms and functioning, decreased hospitalization, improved housing stability, fewer criminal justice contacts, and improved overall quality of life.

Substance abuse treatment that is designed to address co-occurring disorders can be effective for clients experiencing general mental health disorders and serious mental illness. It has also been shown to be effective for individuals experiencing co-occurring disorders who are homeless, incarcerated, or victims of trauma.

The "No Wrong Door" approach to treating co-occurring disorders begins with an integrated screening and assessment. When mental health and substance use disorders coexist, each disorder should be considered as a primary diagnosis, and integrated services should include treatment matched to each diagnosis.[18] Ideally, public behavioral health providers can provide both mental health and substance use disorder treatment. If co-occurring treatment is not available, thoughtful and supported linkages to qualified services can be just as effective.

Treatment of co-occurring disorders occurs beyond the clinic setting, often delivered through a range of social services and provider networks. This requires that treatment models be flexible and responsive to the specific clients, providers, and programs.[19] Evidence-based practices shown to be effective for co-occurring disorders include behavioral interventions, motivational interventions, Assertive Community treatment, and certain therapeutic community programs.[20]

Recovery

"Serious psychiatric and substance use disorders are chronic, relapsing illnesses that can be conceptualized by using a disease and recovery model, with parallel phases of treatment or recovery."[21] Understanding the nature of co-occurring disorders, and how they can develop together or separately, is integral to maintaining and enhancing recovery.

In the President's New Freedom Commission on Mental Health Report (2003), services that increase the ability to cope with life's challenges, promote recovery, and build resilience were identified as key to recovery.[22] Recovery and peer support programs that provide meaningful relapse prevention strategies to people experiencing mental health disorders are most effective.

RECOMMENDATIONS

- ✓ The commitment to an integrated public behavioral health care system — evidenced by Alaska's "No Wrong Door Policy," Alaska Screening Tool, trauma-informed care initiative and Co-Occurring Disorders Institute, and other efforts — should continue to be recognized and supported by national, state, and community partners.

- ✓ Funding of public programs should support entirely the mission and objectives of Alaska's behavioral health system and the implementation of integrated care principles.

- ✓ Co-occurring disorders are to be expected in all behavioral health settings. System planning should address the need to serve people experiencing co-occurring disorders and their families in all policies, regulations, funding mechanisms, and programming.

- ✓ Recognizing the need for specialty services such as inpatient psychiatric treatment and detoxification, expanding access to behavioral health services that address multiple substance use disorders and co-occurring disorders should remain a high priority.

- ✓ The values and core practices of both the mental health and addiction fields should inform the integrated behavioral health system.

- ✓ Services should be welcoming, person-centered, and planned and delivered in a way that considers the entire person and all of his or her identified mental health and substance use disorders.

- ✓ Philosophies of treatment should support timely and culturally appropriate treatment of co-occurring disorders. Family members and other sources of natural support should be included in the treatment and recovery process.

- ✓ Evidence-based practices should be implemented whenever possible and appropriate, with emphasis on developing emerging and promising practices into evidence-based practices.

- ✓ Statewide and community prevention efforts should be designed and coordinated in order to address the root causes of mental health and substance use disorders (as well as suicide, violence, and other public health concerns).

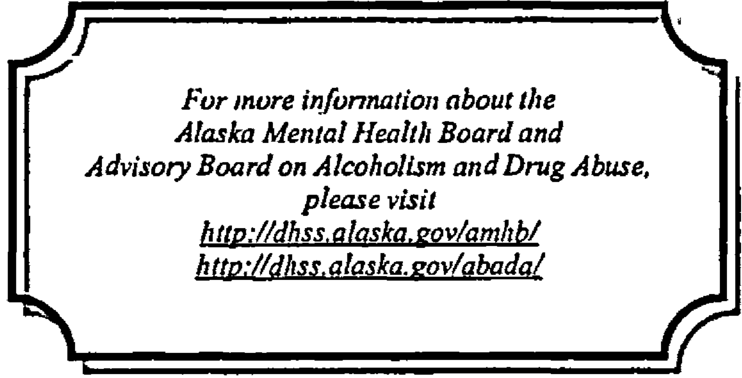
- ✓ Stigma associated with all behavioral health disorders, as well as stigma related exclusively to serious mental illness or to addiction, should be addressed to mitigate fear and misunderstanding and promote acceptance and inclusion of individuals experiencing disabilities.

- ✓ The financial and human investment in developing co-occurring disorder capacity should be recognized and continued, so that every publicly funded behavioral health care provider can effectively serve Alaskans experiencing co-occurring disorders.

- ✓ Recovery and peer support services should be responsive to the needs of individuals experiencing and at risk of experiencing co-occurring disorders, as well as their families.

- ✓ The integration of mental health and substance use disorder prevention, treatment, and recovery services should continue to evolve to include services to address the physical health care needs of clients, with a focus on the overall health and wellness of the entire person.

- ✓ Research on the nature of co-occurring disorders and their prevention and treatment should be supported, with a focus on bringing research to practice in a timely manner.



Endnotes

[1] Substance Abuse and Mental Health Administration Treatment Improvement Protocol #42, citing data from the 2002 National Survey on Drug Use and Health.

[2] *Mental Health: A Report of the Surgeon General*, 1999 at 167.

[3] *Mental Health: A Report of the Surgeon General*, 1999 at 167 (*citing* Kessler, R. C. et al.(1996). The epidemiology of co-occurring addictive and mental disorders: Implications for prevention and service utilization. *American Journal of Orthopsychiatry. 66*, 17-31).

[4] The NSDUH Report: Inhalant Use and Major depressive Episode ad Youths Ages 12-17: 2004 to 2006, August 21, 2009. In most (71.6%) of cases reported, initiation of inhalant abuse occurred at the time of or after the first major depressive episode.

[5] The NSDUH Report: Nonmedical Stimulant Use, Other Drug Use, Delinquent Behaviors, and Depression Among Adolescents, February 28, 2008. *See* Figure 3.

[6] A bibliography of peer-reviewed research on the connection between ACEs and substance abuse is available from the Centers for Disease Prevention and Control at http://www.cdc.gov/ace/outcomes.htm.

[7] Alaska Department of Health and Social Services FY14 Budget Overview at 120.

[8] The illicit drug most often reported by alcohol drinkers was marijuana. The NSDUH Report: Concurrent Illicit Drug and Alcohol Use, March 19, 2009.

[9] The NSDUH Report: Concurrent Illicit Drug and Alcohol Use, March 19, 2009. *See* Figure 4.

[10] Substance Abuse and Mental Health Administration Treatment Improvement Protocol #42 (*citing* Flynn P.M., et al. (1996) Comorbidity of antisocial personality and mood disorders among psychoactive substance-dependent treatment clients. *Journal of Personality Disorders*. 10(1):56–67).

[11] *Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General*, 2001.

[12] E.g. Westermeyer, J. & Peake, E.; A ten year follow-up of alcoholic Native Americans in Minnesota. (1983) *American Journal of Psychiatry*, 140, 189–194 at 194. *See also Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General* Chapter 4 Mental Health Care for American Indians and Alaska Natives.

[13] Alaska Violent Death Reporting System, 2003-2008 – August 2011 at 14.

[14] The NSDUH Report: Concurrent Illicit Drug and Alcohol Use, March 19, 2009. *See* Figure 3.

[15] *Preventing Mental, Emotional and Behavioral Disorders Among Young People: Progress and Possibilities*, 2009. Institute of Medicine.

[16] Early screening for childhood mental health and behavioral concerns was also identified as a strategy for preventing onset of co-occurring disorders by the President's New Freedom Commission in Mental Health. The President's New Freedom Commission on Mental Health Report (2003) at 17.

[17] *Mental Health: A Report of the Surgeon General*, 1999 at 18.

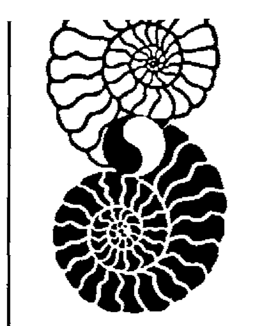
[18] Minkoff, K. Best Practices: Developing Standards of Care for Individuals with Co-occurring Psychiatric and Substance Use Disorders. (2001) *Psychiatric Services*, 52:5 at 598-599. *See also Overarching Principles to Address the Needs of Persons With Co-Occurring Disorders*, SAMHSA Center for Co-Occurring Excellence, 2006 at 4.

[19] *Overarching Principles to Address the Needs of Persons With Co-Occurring Disorders*, SAMHSA Center for Co-Occurring Excellence, 2006 at 3.

[20] *Understanding Evidence-Based Practices for Co-Occurring Disorders*, SAMHSA Center for Co-Occurring Excellence, 2007 at 3-4.

[21] Minkoff, K. Best Practices: Developing Standards of Care for Individuals with Co-occurring Psychiatric and Substance Use Disorders. (2001) *Psychiatric Services*, 52:5 at 598.

[22] The President's New Freedom Commission on Mental Health Report (2003) at 7.



ANNE L. HENRY, LPC
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January 19, 2016

Dear Representative Vazquez,

I strongly urge the passage of your bill, HB234.

I am a Licensed Professional Counselor. I have practiced in Alaska since 1992, first in Juneau for 15 years and now in Anchorage. In the past I have worked as a counselor flying out to Kake to do substance abuse evaluations and counseling. I also worked for the State of Alaska, the Division of Behavioral Health for several years where I became acutely aware of the shortages of counselors across the state, and particularly in rural areas.

In my current private practice in Anchorage it has become very clear that access is not just a rural issue. I have clients who struggle with physical and medical conditions that make it difficult, uncomfortable and exhausting for them to come to my office for counseling. They along with many other people would benefit from HB234. I tried calling for permission from an insurer to serve an insured client and service was denied even though this individual suffers extreme physical problems. HB234 would allow that client and many others to continue to receive counseling services without having to leave their homes or beds.

Additionally, over my career as a counselor, I have had hundreds of people who have had to cancel appointments because a child was sick, or they had a last minute meeting run late at work. HB234 would allow those Alaskans to stay wherever they are and still have the benefit of uninterrupted counseling.

There are thousands of people who for dozens of reasons will benefit from the passage of HB234. If people are insured and their counseling fees are reimbursed by insurance if they are in my office why should insurance companies be able to deny those services delivered by telemedicine? It makes no sense.

Respectfully, Anne L. Henry, LPC

From: Rep. Liz Vazquez
Sent: Saturday, January 16, 2016 10:22 PM
To: Anita Halterman
Subject: Fwd: HB 234

Follow Up Flag: Flag for follow up
Flag Status: Flagged

Sent from my iPhone

Begin forwarded message:

> **From:** John DeRuyter <JDeRuyter@hopecounselingcenter.org>
> **Date:** January 14, 2016 at 9:29:01 AM AKST
> **To:** "'Representative.Liz.Vazquez@akleg.gov'" <Representative.Liz.Vazquez@akleg.gov>
> **Subject: HB 234**
>
> Dear Representative Vazquez,
>
> I write this letter as practicing Psychologist, a Training Director for the Alaska Psychology Internship Consortium, a former member of the Alaska Board of Psychologist and Psychological Associate Examiners, and the Executive Director of Hope Counseling Center in Fairbanks. As a psychologist, I am a current provider of mental health services delivered via telehealth technologies.
>
> Recently I was made aware of the HB 234, a bill which you are sponsoring. I completely support the premise that insurance companies doing business in the State of Alaska be required to reimburse for mental health services delivered via telehealth technologies. However I am very concerned that the bill's language specifically prohibits a requirement that face to face evaluation occur prior to telehealth services being reimbursed. This prohibition is a SIGNIFICANT end run around Best Practices and the safe delivery of mental health services using telehealth technologies.
>
> For the safety of those who would receive mental health services I STRONGLY recommend that the prohibition to require face to face contact prior to being reimbursed by insurance for those services be removed. Obviously there are cases when face to face contact is simply not possible (i.e. emergencies, or extremely limited transportation access). However those should be the extreme exception. Perhaps language could be included that stipulates prior authorization by the

Representative Vazquez, this is truly a Protection of the Public issue. There are many other safety considerations I've not mentioned. However, for the purposes of this bill's language and what it would allow if passed, I make my concerns known.

Respectfully,

John DeRuyter Psy.D

Executive Director

Hope Counseling Center Inc.

907-451-8208

From: Pamela Lund <PLund@ForakerGroup.org>
Sent: Monday, February 01, 2016 9:45 AM
To: Rep. Liz Vazquez
Subject: Support for HB234

Dear Representative Vazquez,

I am writing you today to support HB234. I am an insured Alaskan who travels around the state for my work. I am often in remote areas. I understand that HB24 would allow me a, and others like me, to continue regular counseling appointments regardless of where I travel.

This sounds like an idea whose time has come. I know the technology is available as is the need. Everyone I have talked to about it thinks it is a good idea. I know it will help a lot of people in this state.

I understand you are sponsoring this bill, so I want to thank you for recognizing the potential for good legislation that will help your constituents — and many others.

Sincerely,

Pam Lund

Pamela Lund
Pre-Development Project Manager
The Foraker Group
907.250.7669 cell
907.743.1200

From: Rep. Liz Vazquez
Sent: Tuesday, March 08, 2016 4:45 PM
To: Anita Halterman
Subject: FW: letter to Representative Vazquez

Thanks,
Tom

From: Rep. Liz Vazquez
Sent: Tuesday, January 26, 2016 4:14 PM
To: Anita Halterman <Anita.Halterman@akleg.gov>
Subject: Fwd: letter to Representative Vazquez

Sent from my iPhone

Begin forwarded message:

> **From:** Maureen Lawlor <maureen.lawlor55@gmail.com>
> **Date:** January 26, 2016 at 1:19:55 PM AKST
> **To:** <Representative.Liz.Vazquez@akleg.gov>
> **Subject: letter to Representative Vazquez**
>
> Dear Representative Vazquez,
>
> I have recently learned about HB234 and want to let you know that I support the change in access to services this bill will make not only to myself but to many Alaskans. I was born and raised in Alaska and have recently had the experience of moving from one town to another. While living rurally I had an excellent relationship with a counselor and it was difficult to no longer see her. Now that I live in a different place I would love to be able to continue working with her again. HB234 will allow that to happen.
>
> Thank you and best of luck,
>
> Maureen Lawlor

Sent: Monday, March 14, 2016 3:58 PM
To: Rep. Paul Seaton <Rep.Paul.Seaton@akleg.gov>
Subject:

3-14-2016

My name is Lise Klein Kirsis. I'm a Licensed Professional Counselor. I have worked for community mental health centers in Alaska for the duration of my career. I am writing today to state my strong support for telecounseling. I am asking you to support the telecounseling bill that is being discussed in the House HESS committee. My reasons are simple. Providing psychotherapy by phone is primarily a safer option than traveling great distances to get mental health services. My clients have to fly, boat or drive long distances depending on where they live to see me and to see their psychiatrist. In the winter, this is asking our clients accept the additional (what I think is unreasonable) risk of flying or boating in inclement weather for a service that is achievable over the phone, or through a system such as SKYPE. I believe that allowing telecounseling as a insurance payable service will save the state money in travel fees, and reduce travel-hazard risks that are a reality in this state.

Sincerely,

Lise Klein Kirsis, MA, MS, LPC

From: Rep. Liz Vazquez
Sent: Tuesday, March 08, 2016 4:44 PM
To: Anita Halterman
Subject: FW: HB234

Thanks,
Tom

From: Rep. Liz Vazquez
Sent: Saturday, January 23, 2016 11:37 AM
To: Anita Halterman <Anita.Halterman@akleg.gov>
Subject: Fwd: HB234

Sent from my iPhone

Begin forwarded message:

> **From:** Bobbi <bobbi917@yahoo.com>
> **Date:** January 19, 2016 at 6:00:47 PM AKST
> **To:** <Representative.Liz.Vazquez@akleg.gov>
> **Subject: HB234**
>
> Hello Representative Vazquez,
> Thank you for the opportunity to briefly speak to this bill. As a licensed professional counselor interested in working with more remote populations, this bill is imperative to the health of ALL Alaskans. It says a lot about our state's geography that Anchor Point is in fact "the most westerly highway point in North America" (there sure is a lot of land mass west of the south part of the Sterling Hwy!) Geography aside, there are certainly individuals who find their mental illness so debilitating that they are paralyzed from venturing out. Please consider this variable as well as this superbly beneficial bill is explored during your legislative session.
> With Respect,
> Bobbi

From: Lynn Edwards <laedwards117@gmail.com>
Sent: Friday, January 22, 2016 12:41 AM
To: Rep. Liz Vazquez
Subject: HB234

I am writing in support of teletherapy. I believe that it would provide people in rural areas a much needed service. Living in a small community myself, I understand the need for privacy which this would provide to individuals that choose to seek distance teletherapy. It would allow for individuals to find licensed counselors that specialize in their area of need. The ability to find a therapist that fits would also be a benefit. In small communities anonymity is almost unheard of, this form of therapy would allow someone their privacy. The access to therapists in communities that do not have counselors would have insurmountable benefits.

From: Rep. Liz Vazquez
Sent: Saturday, January 16, 2016 4:29 PM
To: Anita Halterman
Subject: Fwd: Telehealth

Follow Up Flag: Flag for follow up
Flag Status: Flagged

Sent from my iPhone

Begin forwarded message:

> **From:** Joel Wieman <joelwieman@gci.net>
> **Date:** January 14, 2016 at 11:51:03 AM AKST
> **To:** <Representative.Liz.Vazquez@akleg.gov>
> **Subject: Telehealth**
>
> Hi Liz,
>
> Just wanted to let you know I am thankful for your support with tele-health in Alaska. As you know I am on the licensing board and we are working to modernize service delivery.
> As a psychologist I have two concerns with tele-health and have a couple of additions to the bill. First, that it should stipulate that services need to be provided by a licensed provider of mental health services, licensed here
> in the state in which the client resides. Telehealth is an issue that our national organization of psychology licensing boards is wrestling with, and this is one of our main concerns.
> This allows for state laws regulating mental health services to be effective and enforceable, and will protect the public from unscrupulous or undertrained providers. When we can't regulate service across state lines, we should not allow those services to be provided, or the least trained, least regulated (read unregulated) individuals will be providing the service. Our national organization will be meeting in Anchorage in April and you are welcome to sit in if this issue come up.
> (Next time I see you at Rotary I will give you an earful if you want the full scoop!)
>
> I would also like to see language that requires periodic face to face visits between providers and clients. So much is lost via phone or Skype, and the client is the looser in this case.
> Granted tele-health is far better than nothing, but we should strive for best practices and see clients face to face at least once early on in the treatment process if at all possible.
>
> On another topic, the licensing board, along with Kathy Geisel, continues to pursue SB 41 to require background checks for renewing psychologists and new licensees. There has been some pushback from a few people and their comments seem to misrepresent the issue.
> I will send you a separate letter with regard to that.

Oh yes, about the budget, After you have trimmed the fat, I want to pay my own way. Please kill the dividend check, tax my income, and I'm even willing to deal with a sales tax. It will hurt but it's time for us to grow up and be like the rest of the country.

Thanks, Joel

From: cinderbdt@gmail.com on behalf of Bryan D. Thomas <bryan.d.thomas@acm.org>
Sent: Monday, February 01, 2016 7:25 PM
To: Rep. Liz Vazquez
Cc: Sen. Donny Olson; Rep. Benjamin Nageak
Subject: HB 234 letter of support

Dear Rep Vazquez:

I want to thank you for introducing HB 234 (amending AS 21.54). I am writing to express my support.
My family and I live in a part of Alaska that is not on the road system. It routinely costs hundreds of dollars for a one way airplane ticket to an Alaska population center like Fairbanks or Anchorage.
One of our highest cost is travel, and one of our highest travel drivers is medical care.
If HB 234 could help reduce travel, it would be good for our state and our climate.
Insured people in rural and urban locations could seek services from hundreds of different providers across the state.
We could get help from a wider range of providers, so we could preserve our choice and find the right fit for us.
As parents of three small children, we often have trouble getting coverage, but if our kids are sick we could sick still make appointments from home.
Thank you for suggesting this change.
Allowing insurance coverage even before the first in-person appointment will help us find the right provider.

Regards,
Bryan Thomas

From: J Gallagher <nngc5@hotmail com>
Sent: Wednesday, January 27, 2016 7:30 PM
To: Rep. Liz Vazquez
Subject: HB 234

Dear Representative Vazquez,

Thank you very much for sponsoring HB 234. I believe this bill is important and will ensure that people who live in remote communities have access to counseling without having to travel long distances. I appreciate your attention to this important issue. Sincerely,

Sheila Gallagher
Soldotna, Alaska

From: Rep. Liz Vazquez
Sent: Tuesday, March 08, 2016 4:44 PM
To: Anita Halterman
Subject: FW: HB234

Thanks,
Tom

From: Rep. Liz Vazquez
Sent: Saturday, January 23, 2016 11:43 AM
To: Anita Halterman <Anita.Halterman@akleg.gov>
Subject: Fwd: HB234

Sent from my iPhone

Begin forwarded message:

> **From:** Flash Light <beautysmistress@gmail.com>
> **Date:** January 19, 2016 at 11:51:53 AM AKST
> **To:** <representative.liz.vazquez@akleg.gov>
> **Subject: HB234**
>
> Dear Ms Vazquez,
> Thank you for sponsoring this bill. I think it is important for folks everywhere in Alaska be able to receive good mental health as well as medical help regardless of location.
> All the best
> Lita White

From: Amy Barker <alb5869@yahoo.com>
Sent: Friday, February 26, 2016 8:40 AM
To: Rep. Paul Seaton
Subject: HB234

ALL Alaskans should have access to mental health services!!! Insurance companies doing business in Alaska need to cover telehealth!!!

Thank you for your advocacy on this matter!

Amy L. Smith, LCSW LLC
Anchorage, Alaska

Sent from my iPhone

From: Rep. Paul Seaton
Sent: Friday, February 12, 2016 1:21 PM
To: Taneeka Hansen
Subject: FW: HB234

Categories: committee

Taneeka Hansen
Legislative Aide
Representative Paul Seaton
Committee Aide, Health and Social Services
(907) 465-3923

-----Original Message-----
From: Chantal Cohen [mailto:chantal.therapy@icloud.com]
Sent: Friday, February 12, 2016 1:09 PM
To: Rep. Paul Seaton <Rep.Paul.Seaton@akleg.gov>
Subject: HB234

Representative Seaton

I am a licensed MFT in Alaska. I also am an approved supervisor for LMFT and LPC therapists. They are in the bush and the only to get their supervision is by using video conferencing. There also Alaskan children and adults who need services but are unable to receive them because their Heath provider will not pay for tele mental health. Please help our future clinicians and Alaskans. Thanks

Chantal Cohen, LMFT
Sent from my iPhone

On Jan 18, 2016, at 1:09 PM, annebnorton <annebnorton@gmail.com> wrote:

Greetings Representative Vazquez,
Im so grateful you are willing to support this bill to increase access to quality mental health services by requiring insurance plans to allow for telemedicine delivery and to reimburse therapists/ clinicians, psychologists.

I have been providing telemedicine in Alaskans for a several years, as well as in New Mexico and Washington state. (I am licensed in all states) and have had great difficulty with insurance plans reimbursing me, and in some cases have not been successful in gaining approval.
I work with teachers in the bush, who cannot possibly travel out to see me weekly, or even monthly as that is cost prohibitive, yet they require mental health support. I also have a very unique speciality, (working with deaf clients using sign language) and those clients need someone with my skills, as there are only a couple others with the ability to provide direct therapy using fluent sign language. I cannot possibly travel to all deaf clients, and neither can they travel in. Thus, I provide web services.
Many more Alaskan clinicians would likely provide telemedicine services if this bill is approved, offering all their unique and wonderful services that are now only available in Anchorage, to the entire state!

Imagine the potential increase in mental health, and the potential decrease in suicides in this wonderful state with the passage of this bill.
Alaska is simply too big, with too few providers in outlying areas, to not pass this bill. It will cost the state nothing, but the benefit is significant.

If you have any questions feel free to contact me.
Thank you,
Anne B Norton PLLC Psy.S., LPC LMHCA
Providing distance psychotherapy and Coaching to teens and adults
annebnorton@gmail.com
907 315 3985

Date: March 15, 2016 at 12:38:18 AM AKDT
To: Representative.Liz.Vazquez@akleg.gov
Subject: HB 284

Dear Representative Vazquez, I am writing to strongly support HB 284 and to tell you what this would mean to me personally. I have dealt with severe depression since I was a small child. Fortunately, at various times in my life when I needed it, I was able to get mental health support that has included both medical treatment and counseling. I was able to graduate from college and later receive a graduate certificate in public health. Fortunately I had health insurance.

Eventually I became the Director of the Anchorage Department of Health and Human Services, where I served under Mayors Begich, Claman, and Sullivan. Unfortunately after 24 years I had to medically retire in 2012 for other medical issues. Leaving a career that I loved was and continues to be difficult for me and being able to continue counseling services has been beneficial to facing with the most difficult period of my life. As my health continues to deteriorate it is more difficult to leave my house and because of balance and instability I am not driving at this time and my husband has to drive me whenever I am able to leave my house for appointments. While I prefer an in-person visit with my counselor, if I had the flexibility to speak to her by phone it would be most helpful especially since it is those days when I am not able to leave the house that I could benefit from counseling the most.

As a legislator I know that you understand the great reward that comes from making a difference and the hard and demanding work that is involved. I suspect that you know that much of that reward is the internal satisfaction when you are able to assist your constituents and indeed all Alaskans.

Mental health is such an important issue in our state and I am a firm believer that anything we can do to bring services to people where they are will ultimately be helpful.

Thank you and your staff for working so diligently on this bill.

Diane Ingle
Home: 907-243-4159
Cell: 907-227-8369

Institute of Social and Economic Research

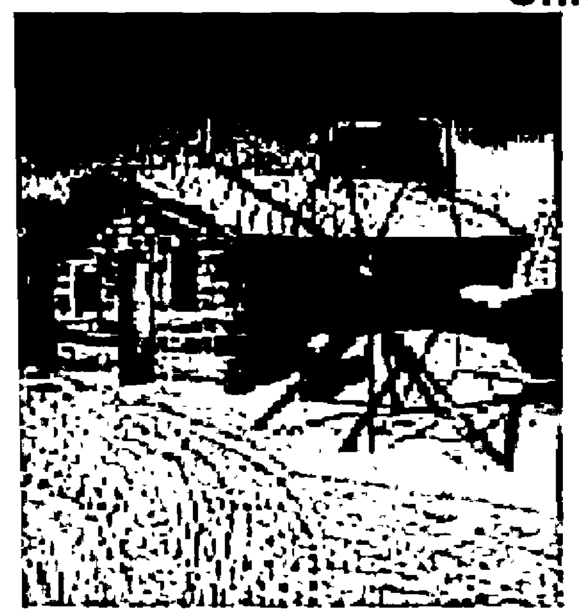
UNIVERSITY of ALASKA ANCHORAGE

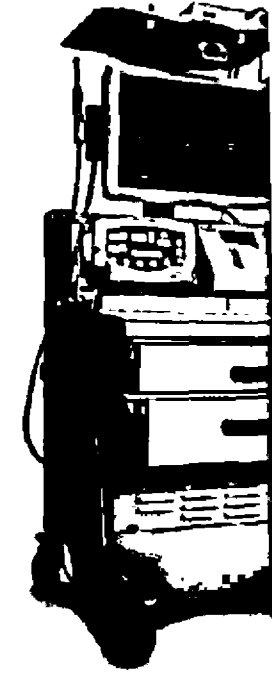
Rural Telemedicine and Telehealth: The Alaskan Experience

Professor Heather E. Hudson

Director, Institute of Social and Economic Research (ISER)

University of Alaska Anchorage

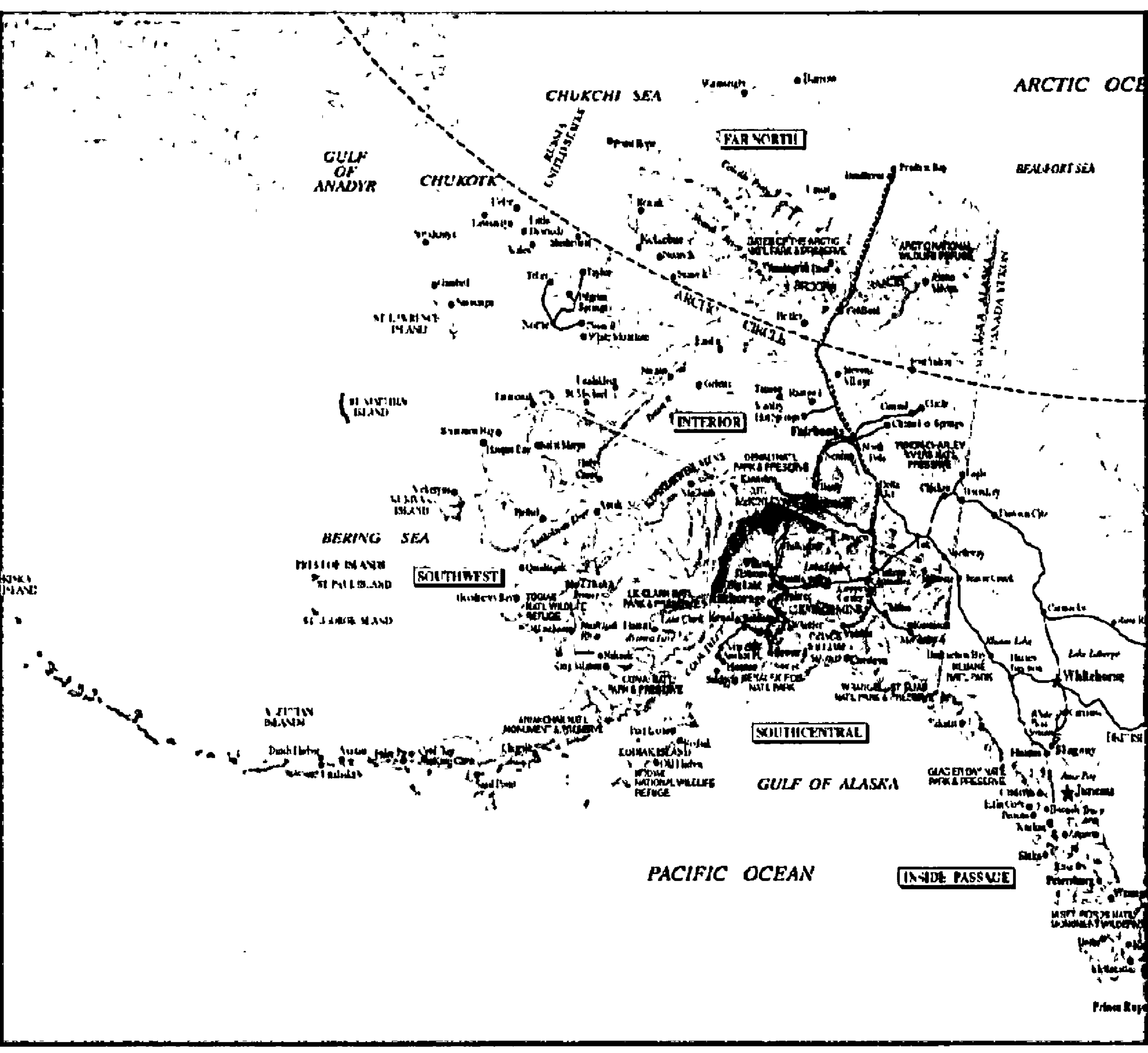


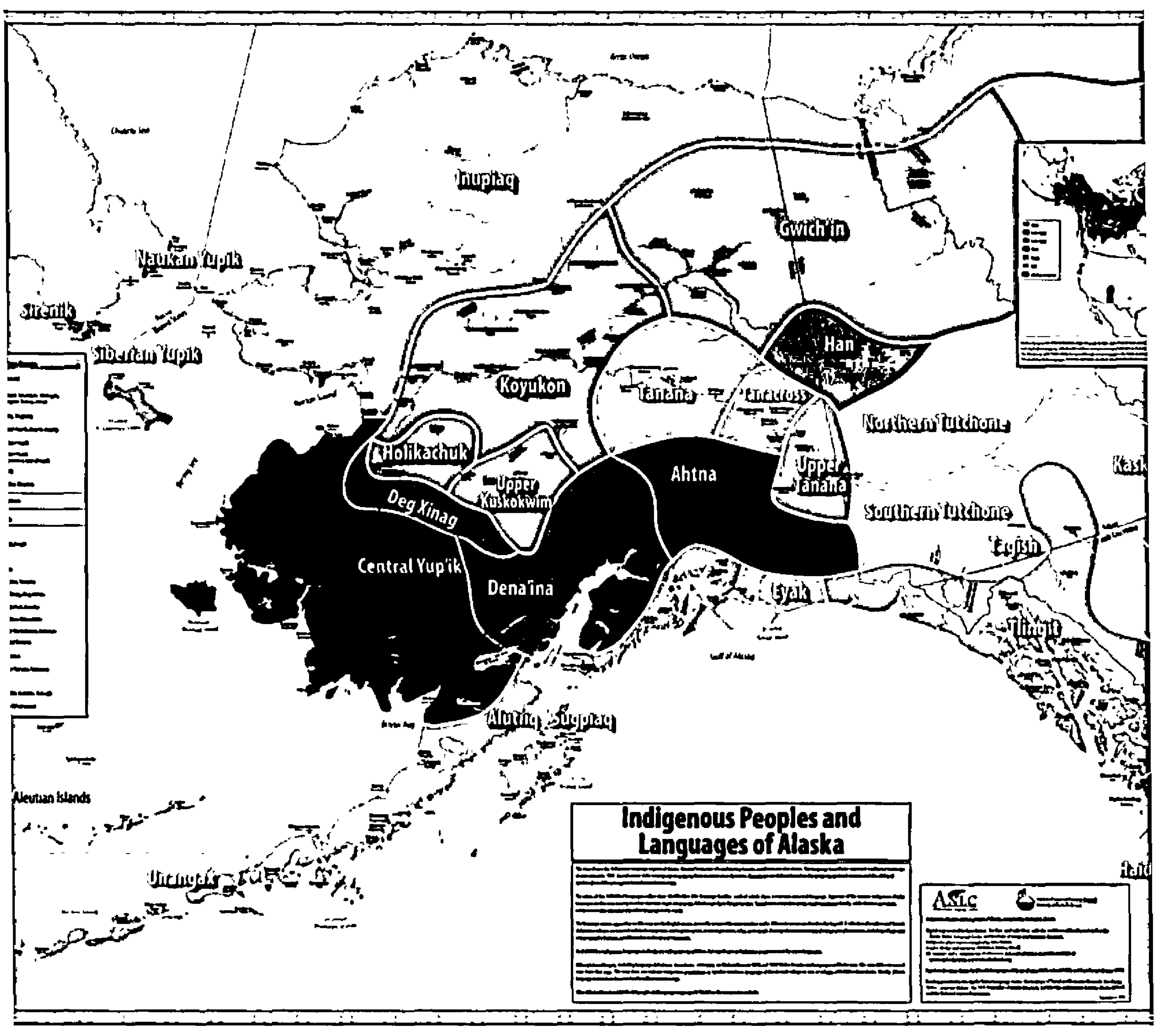


ılaska: Context

- ırgest state: 1,481,346 sq. km.
- opulation: >710,000
- ɔwest population density:
  - < .5 persons per sq. km.
- alf population in Anchorage

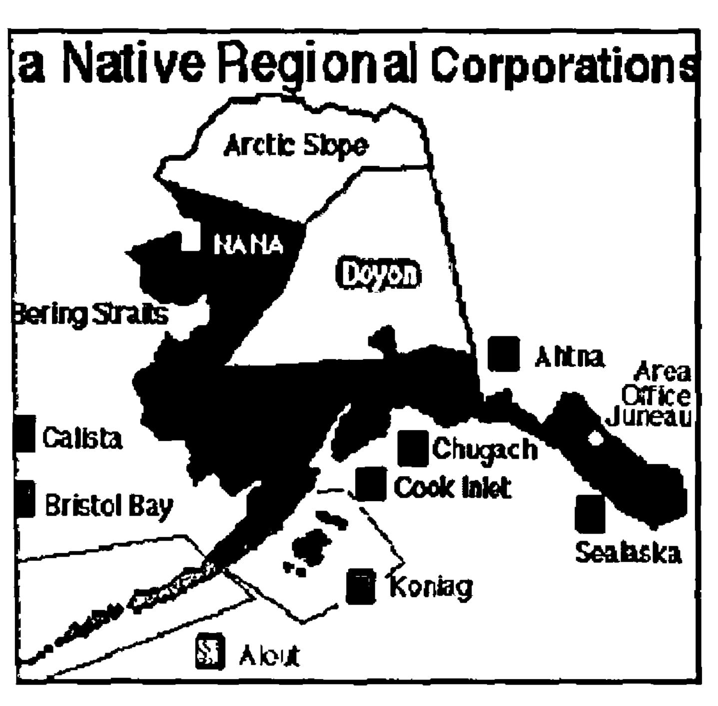
- laska natives: 14.8% of population
- major linguistic/cultural groups, 226 ibes
- '3 live in more than 200 villages
- ɜry limited road system
- lany villages accessible only by boat · bush plane


ARCTIC OCE
CHUKCHI SEA
FAR NORTH
BEAUFORT SEA
GULF OF ANADYR
CHUKOTK
ARCTIC CIRCLE
BERING SEA
SOUTHWEST
INTERIOR
SOUTHCENTRAL
GULF OF ALASKA
PACIFIC OCEAN
INSIDE PASSAGE
Fairbanks
Anchorage
Whitehorse
Juneau



Indigenous Peoples and Languages of Alaska
Inupiaq
Gwich'in
Naukan Yupik
Sirenik
Siberian Yupik
Koyukon
Han
Tanana
Tanacross
Northern Tutchone
Holikachuk
Upper Kuskokwim
Ahtna
Upper Tanana
Deg Xinag
Southern Tutchone
Tagish
Central Yup'ik
Dena'ina
Eyak
Tlingit
Alutiiq Sugpiaq
Aleutian Islands
Unangax
ANLC

Alaska Native Claims Settlement Act (ANCSA)



- No treaties or reservations
- ANCSA became law in 1971
- Settled land claims before construction of oil pipeline
- Received 44 million acres and $962.5 million
- 13 Native Corporations
  - Nonprofit affiliates administ health services
- Also more than 200 village corporations

Alaska: Challenges in Rural Education and Health Care Delivery

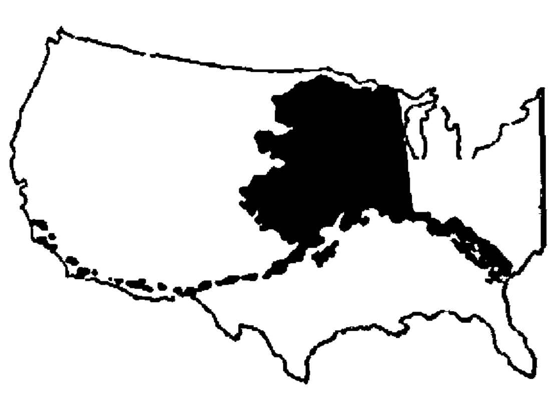
Shortage of professionals
- teachers, physicians

Distance from specialized expertise
- medical specialists
- teachers of specialized and advanced subjects

Problems exacerbated by poverty and isolation

Lowest population density in U.S.
- Only 4 communities over 10,000
- Isolated villages and small towns
  - More than 200 villages
  - Many villages accessible only by boat or bush plane
  - Most of village population is native American

\LASKA's PHYSICIANS



hortage of physicians

'istance from specialized expertise

– medical specialists

roblems exacerbated by poverty and isolation

19% of all physicians in Alaska are primary :are physicians

- U.S. average is 28%

\laska is 48th of states in "doctors to 'esidents" ratio

- 65% are located in Anchorage
- Shortages in many specialties

i9% of the state's residents are in medically ınderserved areas.

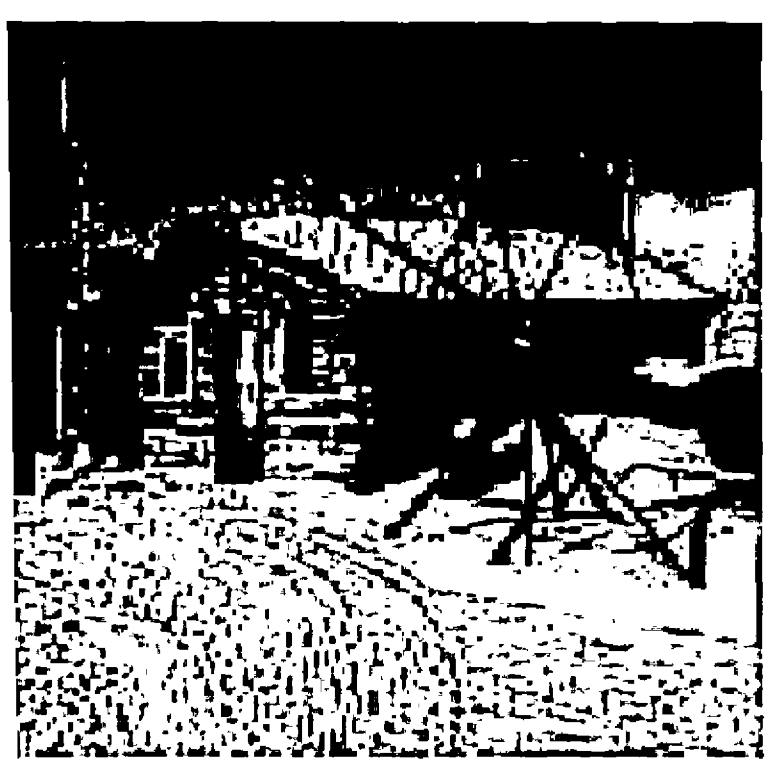
Historically, Alaskan h(care has incorporatec public health mission primary care focus, aı less reliant on special acute care than other parts of the country.

Early Telemedicine...

"We went from house to house taking care of the sick... Our tools consisted of a thermometer, a stethoscope, and a blood pressure cuff.... We had no phones... but used the school's [HF] radio to report [on] our patients. There was no nonsense about confidentiality."

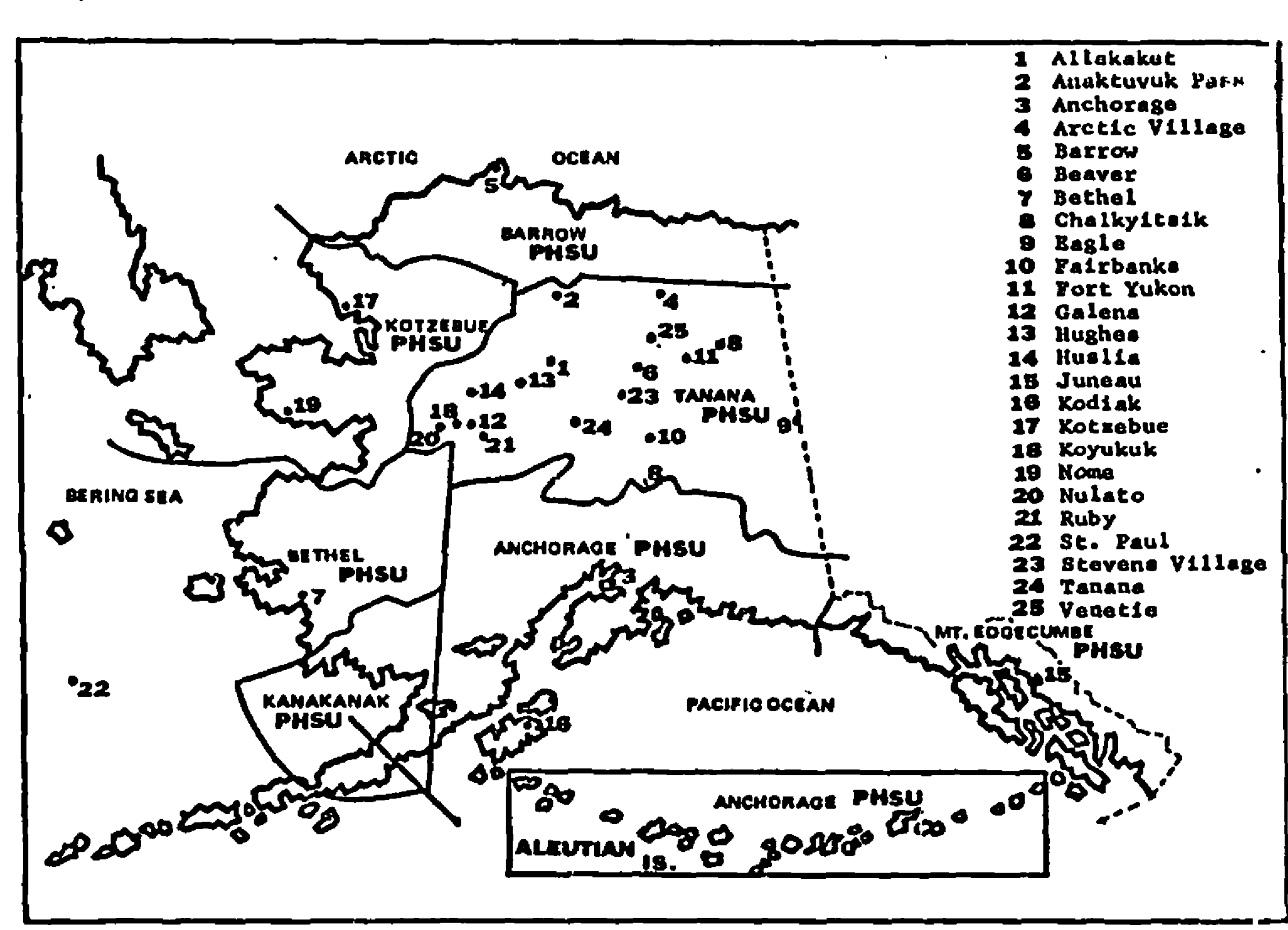
-- Health aide Paula Ayunerak

arly Experiments: NASA ATS-1 Satelli Single Channel Voice Network



1971-1976: led to satellite communications for all rural clini and reliable communications for all villages

ALASKA LOCATIONS WITH ATS-1 GROUND STATIONS



PHSU = Public Health Service Unit

Days of Communication for Village Clinics

	Before Satellite 1970-71	After Satellite 1971-72	After Satellite 1972-73
ellite Villages	51.7 (14%)*	270.2 (74%)	310 (85.0%
Radio Villages	44.0 (12%)	24.3 (7%)	N/

possible contact days

Number of Episodes Treated with Doctor's Advice

	Before Satellite 1970-71	After Satellite 1971-72
Satellite Villages	47.1	184.6
HF Radio Villages	24.7	15.0

From "Bush Telegraph" to Broadband

Early days: communication by HF radio

Since 1980s, all permanent communities of at least 25 peopl
have telephone service

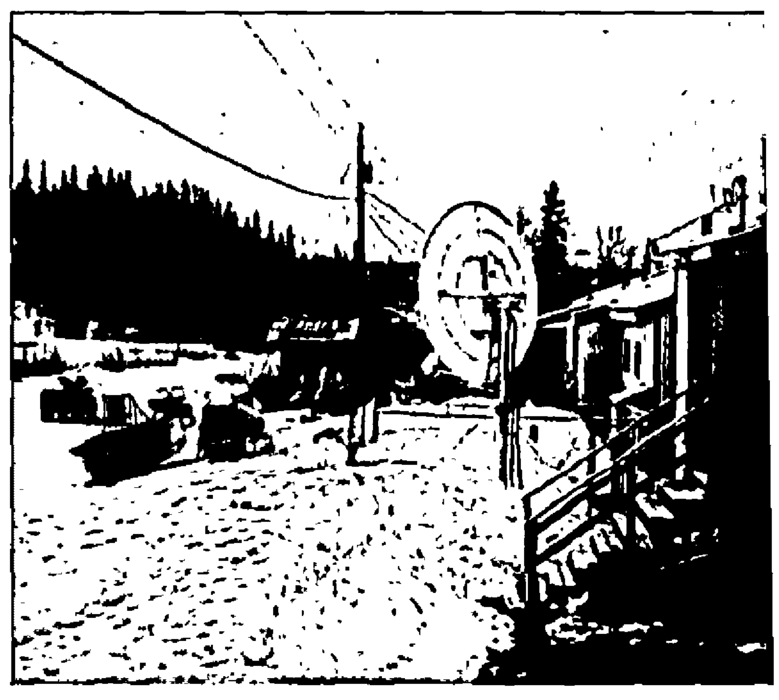
>95% of households have telephones

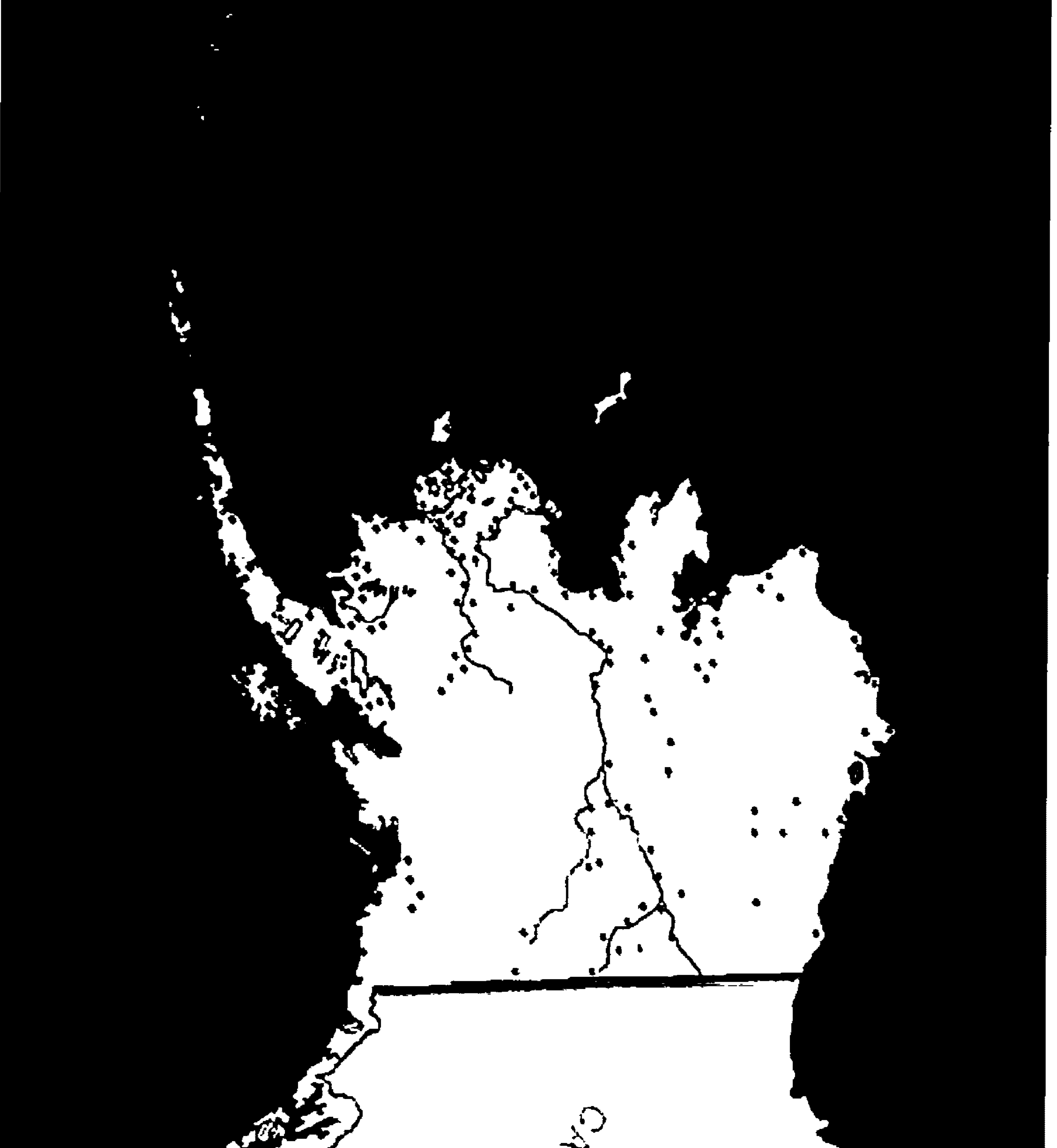
Broadband in Anchorage
and large towns

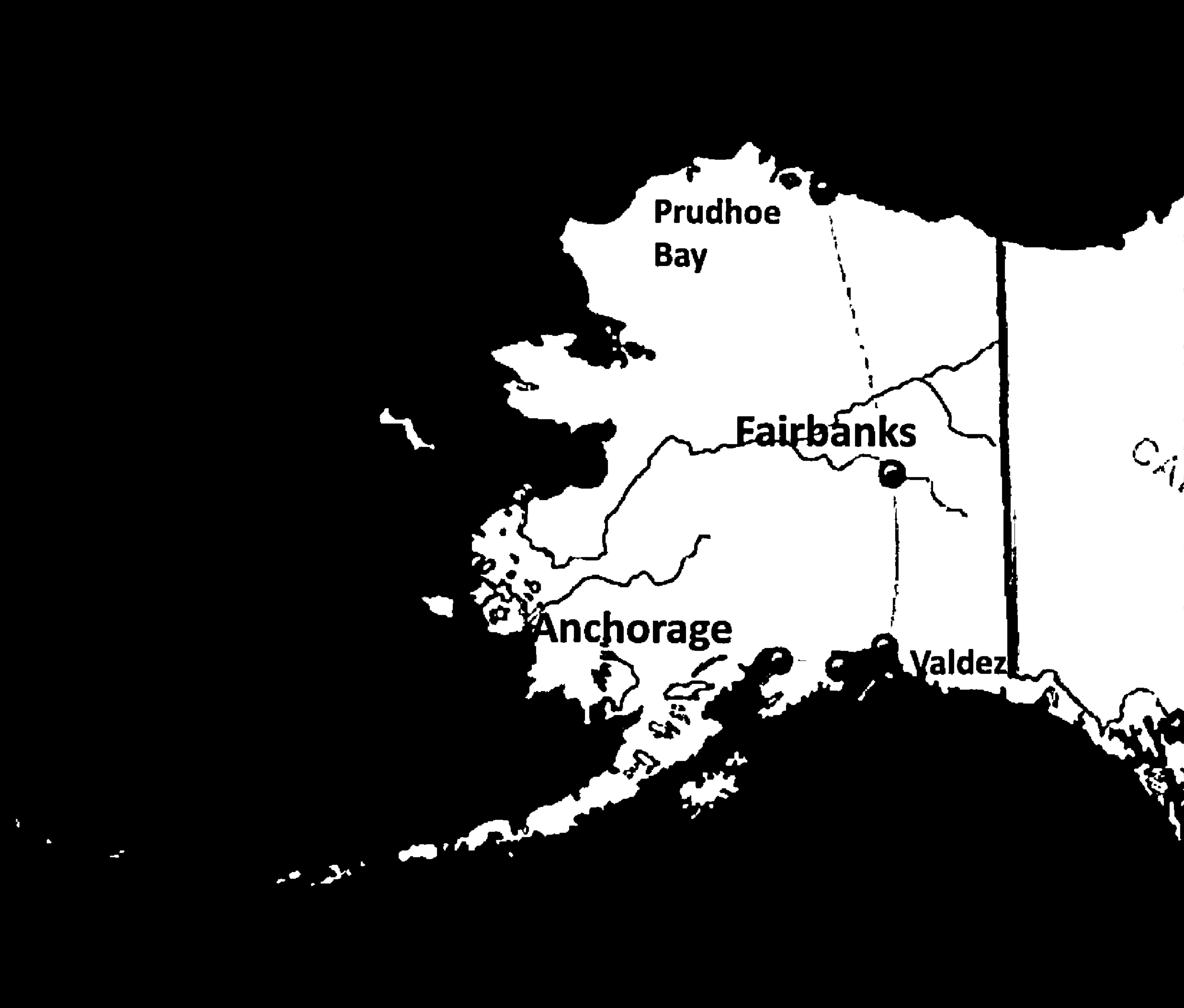
Rural/remote service
typically 768 kbps

Remote service by satellite:

- Generally reliable, but latency, high cost

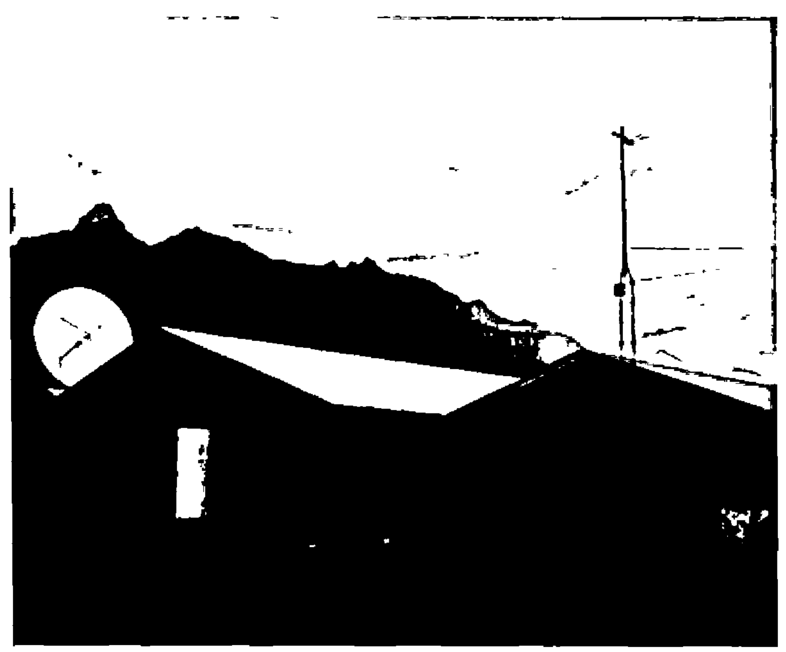




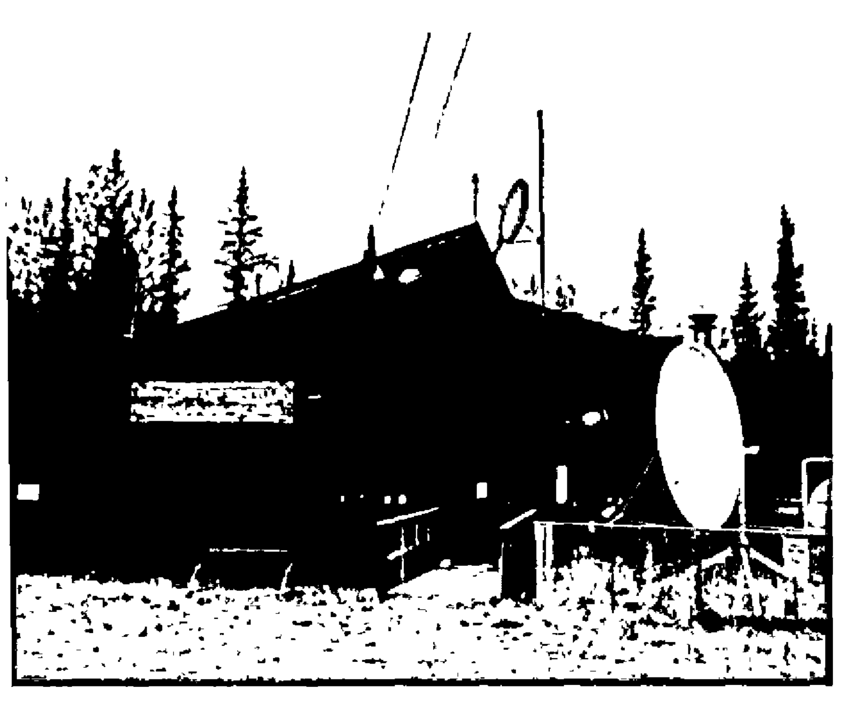

Prudhoe
Bay
Fairbanks
Anchorage
Valdez

Community Access in Rural Alaska:

At the post office, at the store, or under a tree...



Internet Access in Rural Alaska Schools



Village schools must offer K-12 if at l
students

Lack of specialized teachers

Use of Internet for homework, cours
content, online classes

Schools with E-rate as anchor tenant

Telemedicine in Alaska Today: The AFHCAN Network

ICAN Telehealth System:

253 sites; 70 member organizations

- Village clinics: Native health aides
- Public Health clinics
- Regional hospitals
- Military installations, Coast Guard, Veterans Administration

Covers more than 212,000 beneficiaries

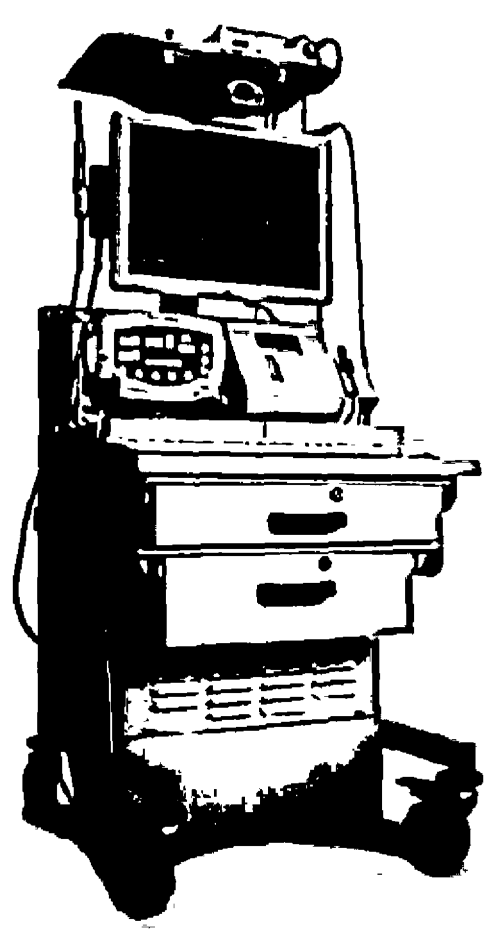
- About 40% of Alaska population
- Majority are in Alaska native villages

ıpported by USF Rural Health Care Program

Alaska receives the largest amount of

ıny State: $29m in 2009

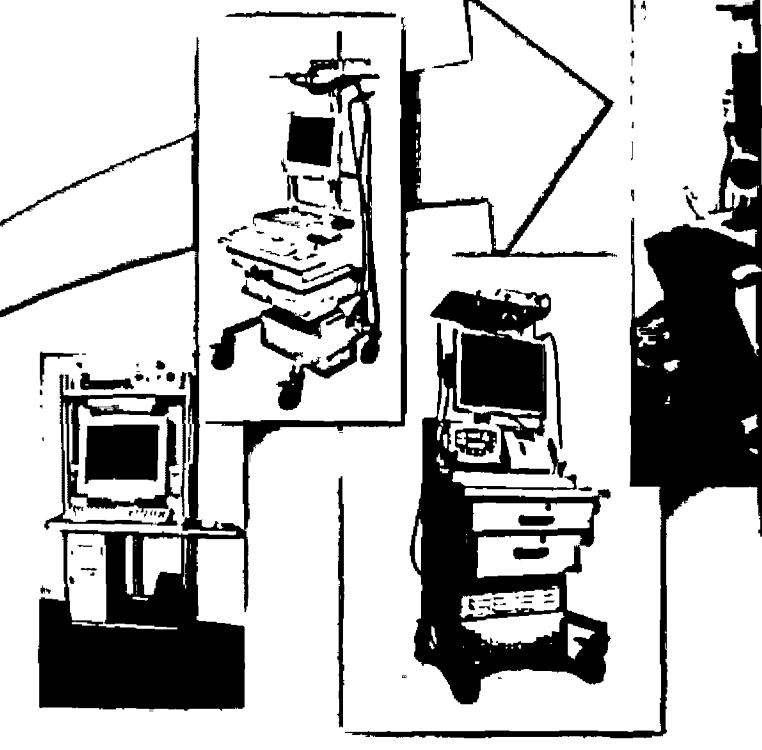
See www.afhcan.org



)esign Evolution

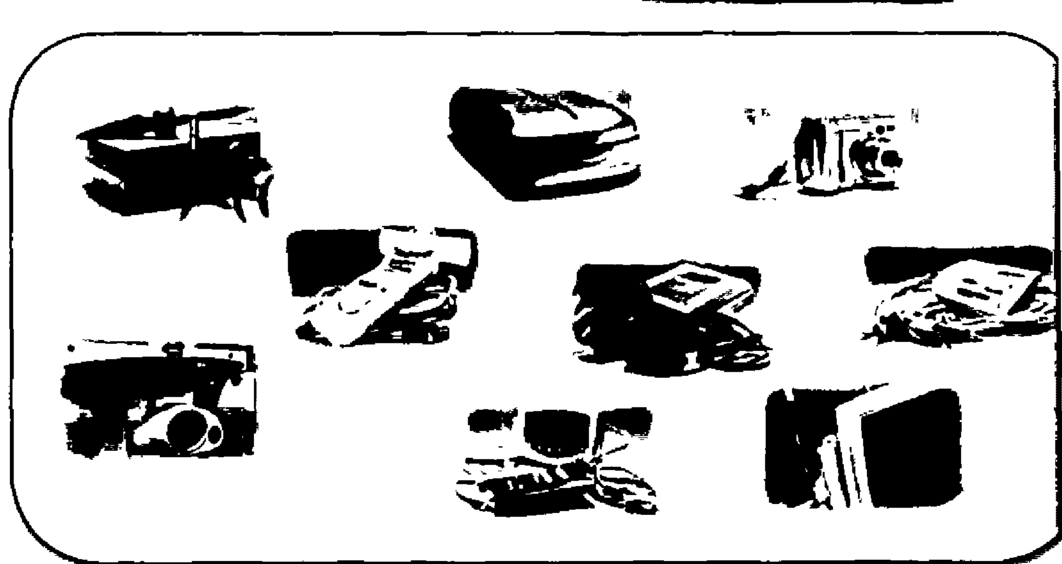
Base Cart include:

- Metal Frame
- Isolated Power System
- CPU and LCD Touchscreen
- Expansion Ports for USB, RS232, Video In/Out, External Display



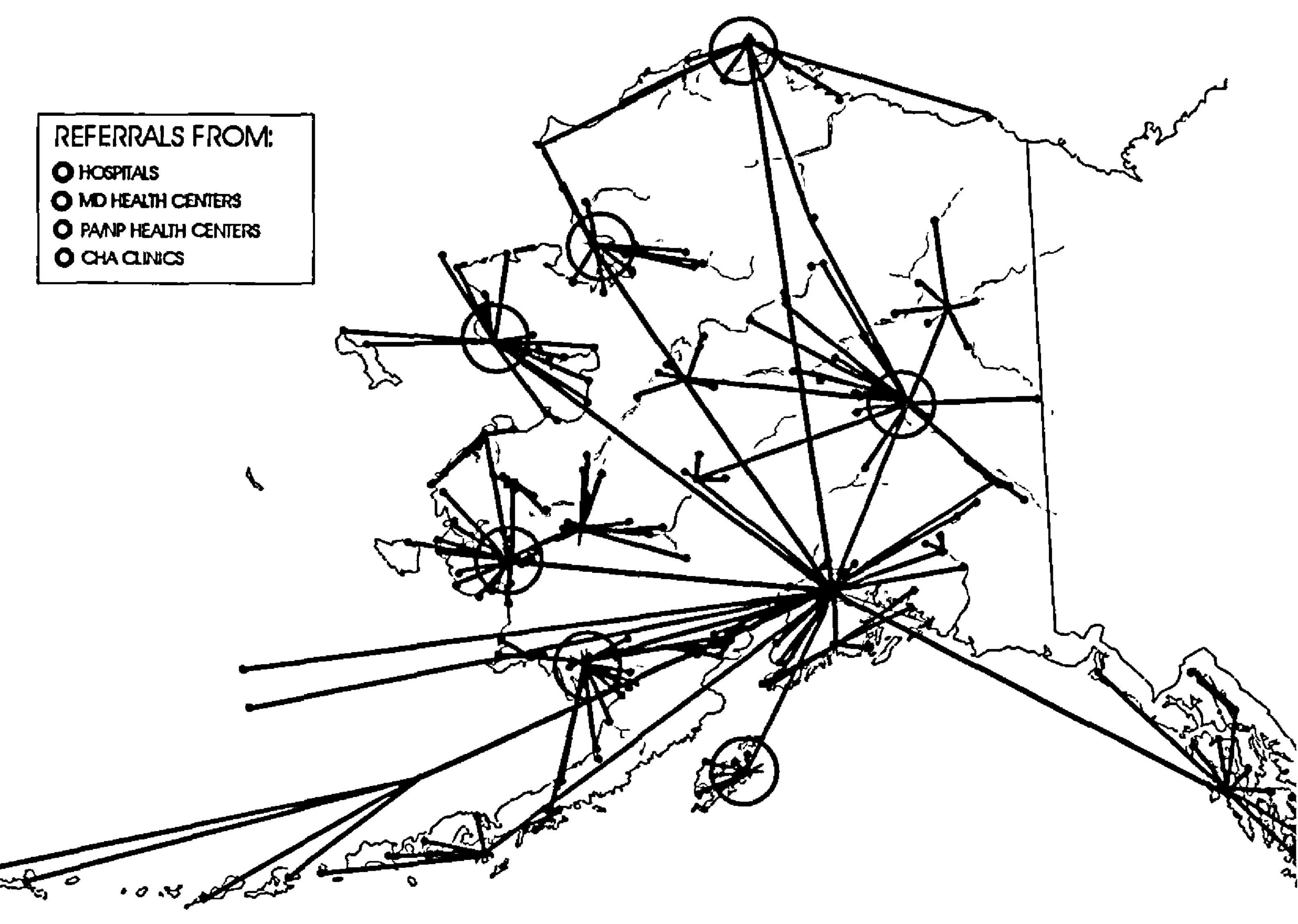
Currently Supported Peripherals include:

- Video Otoscope
- Digital Camera
- Scanner
- Video Conferencing
- ECG
- Spirometer
- Tympanometer
- Audiometer
- Dental Camera
- Vital Signs Monitor
- Stethoscope



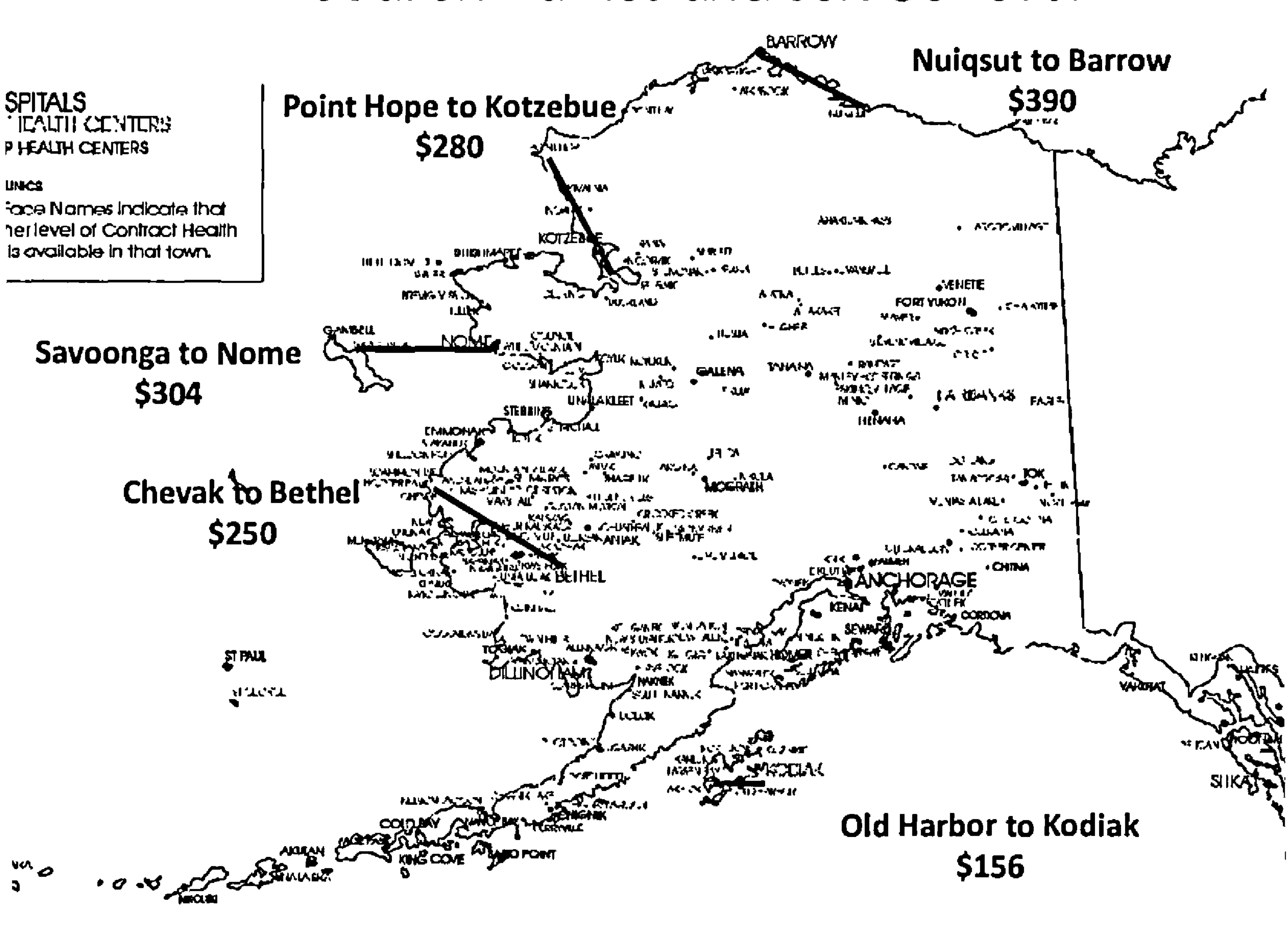
THE ALASKA NATIVE HEALTH CARE SYSTEM

Typical Referral Patterns



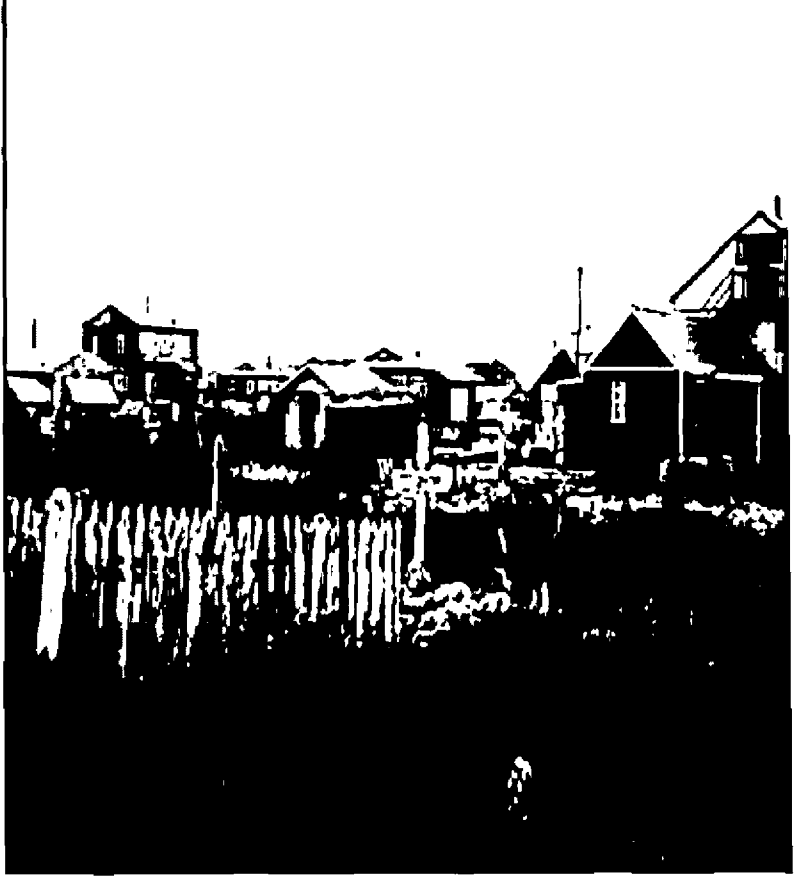
THE ALASKA NATIVE HEALTH CARE SYSTE

Location Names and Service Level

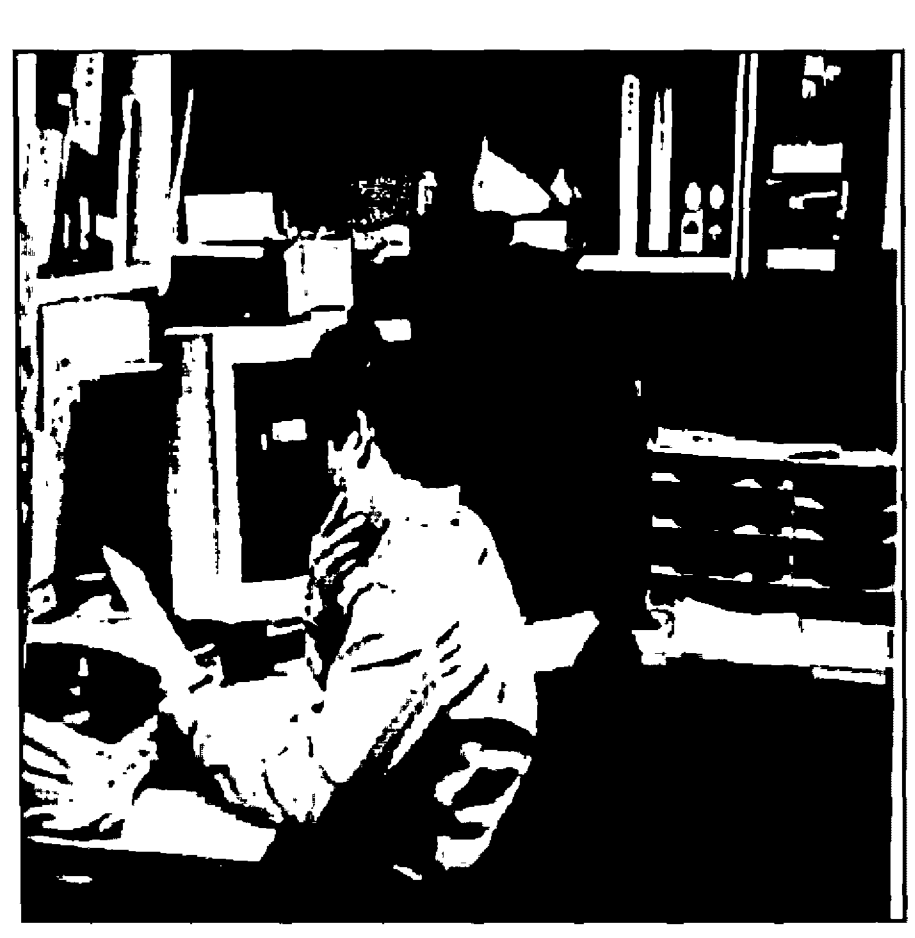


Kotzebue, Alaska:
Inupiat community on the Bering Sea…

- Has regional hospital
- Serves Inupiat villages in NW Ala



Telemedicine facilities for consultation betwe Alaskan regional hospital in Kotzebue and village clinics...

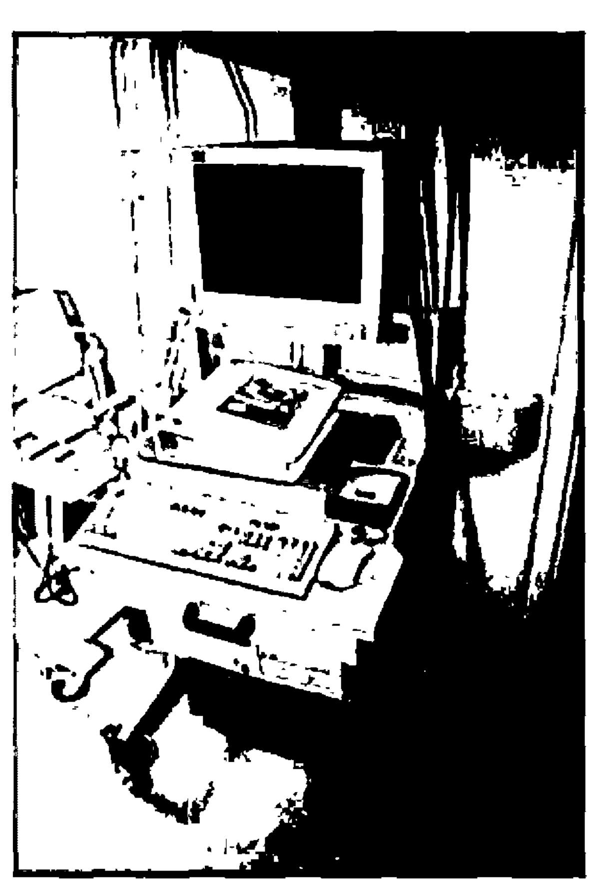


Telehealth: Emergency Delivery

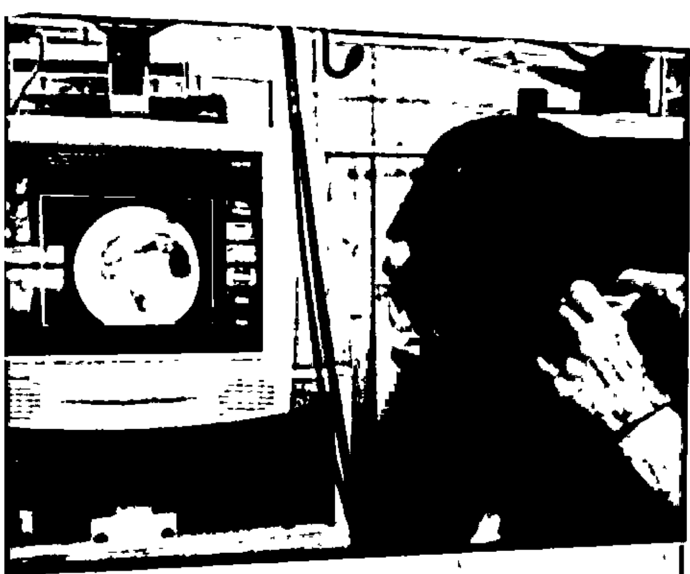
A woman in Alaska's Northwest Arctic Borough goes into labor, hundreds of miles away from the nearest doctor

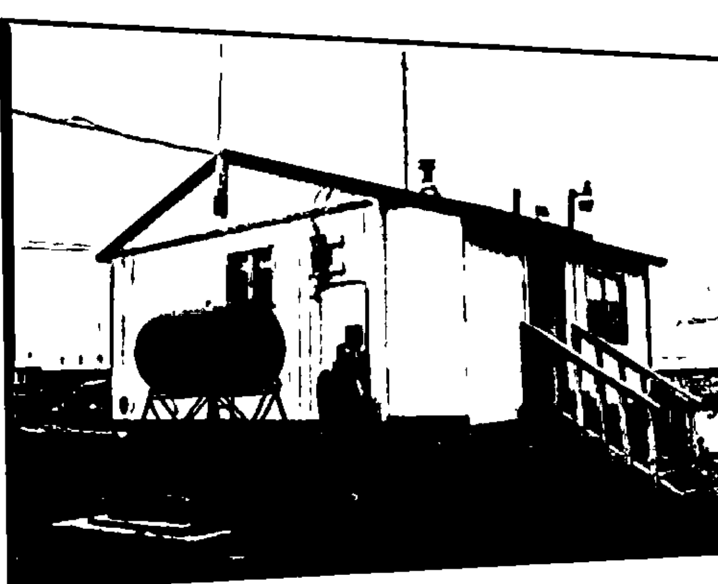
Doctors 200 miles away, in the town of Kotzebue, guided the village's health practitioner through the delivery using live, two-way video and voice technologies

Now more than half of doctors' contact with patients is through telemedicine and thousands of "tele-consultations" occur in the region each year

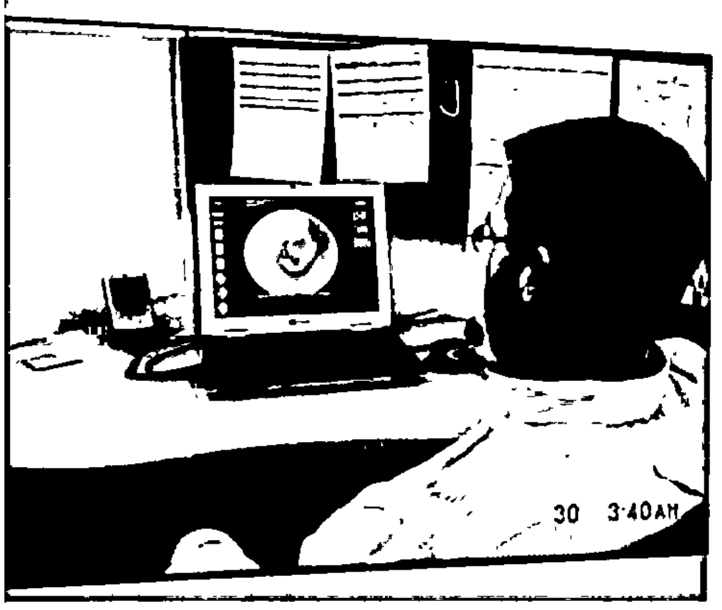


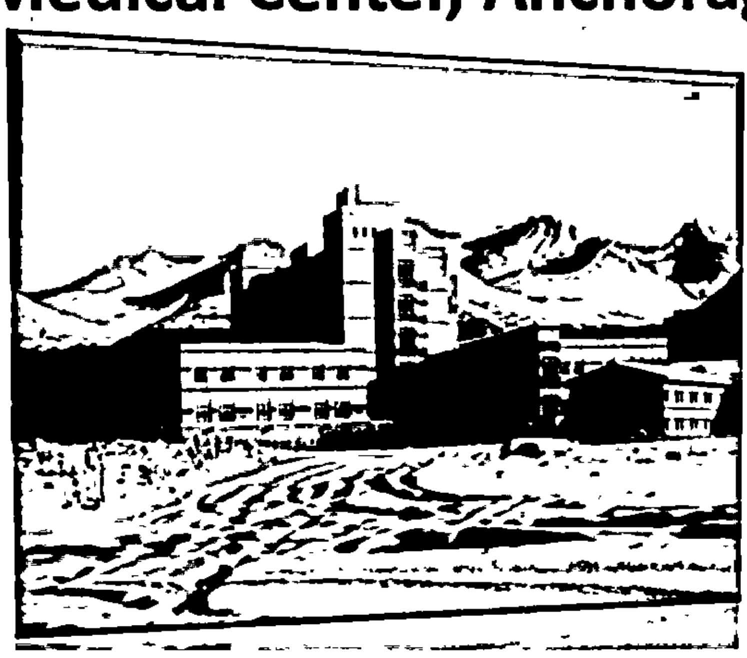
Case originated...





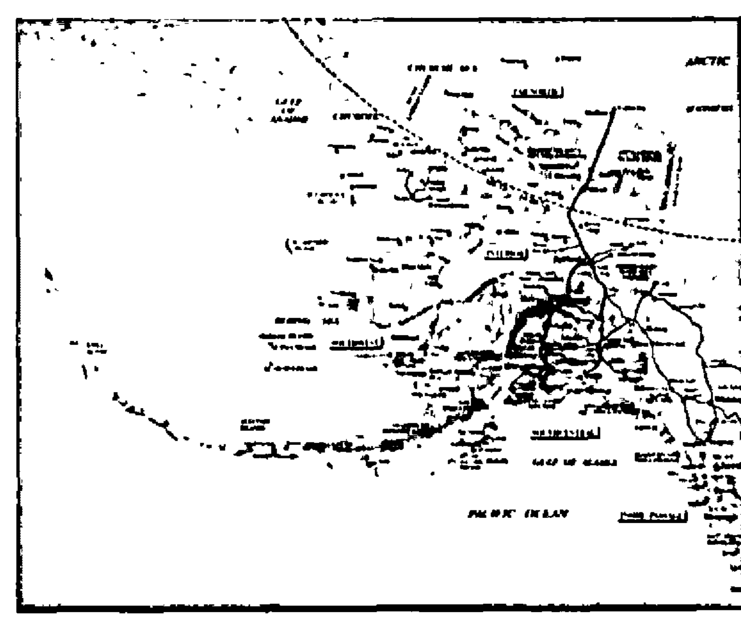
se received...Alaska Native Medical Center, Anchorag



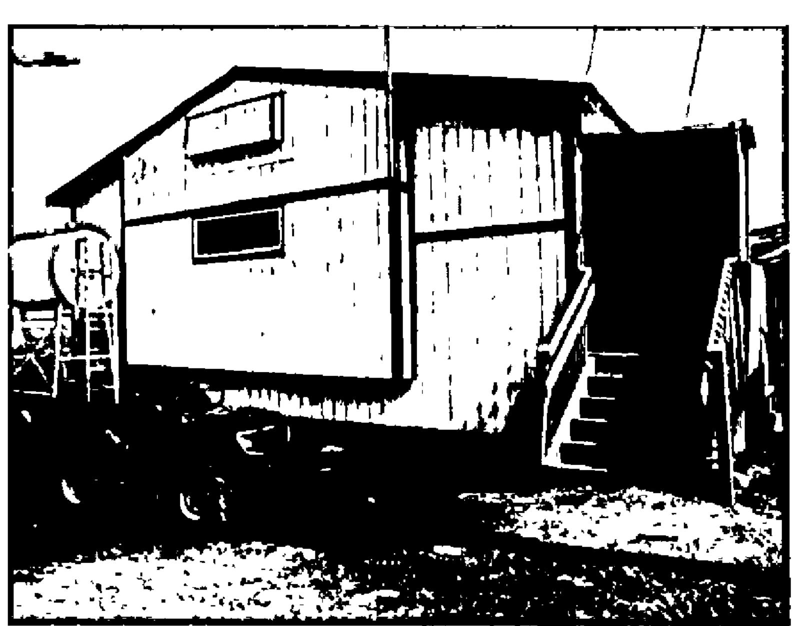


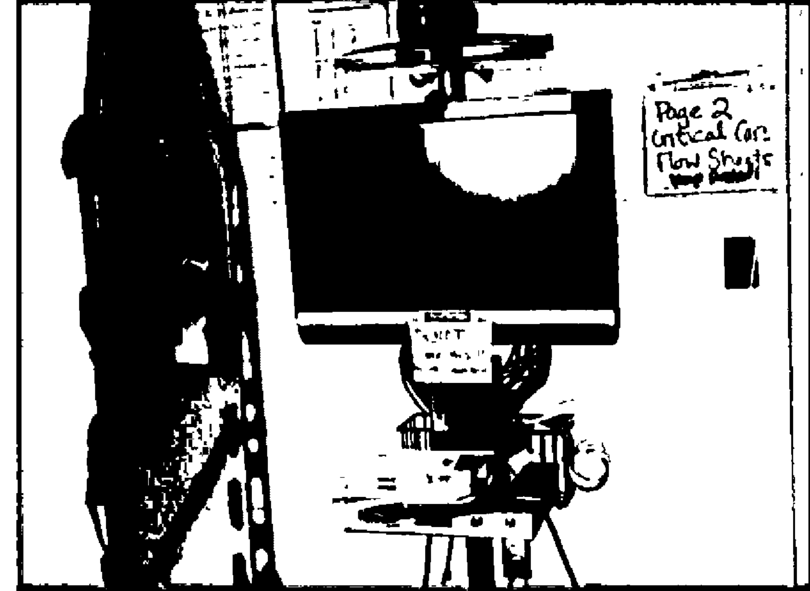
Telemedicine in Wales: Inupiat Village on the Bering Sea

- Closest mainland settlement to Siberia
- Part of Norton Sound Health District (Bering Straits Native Corporation)
- Regional Hospital in Nome



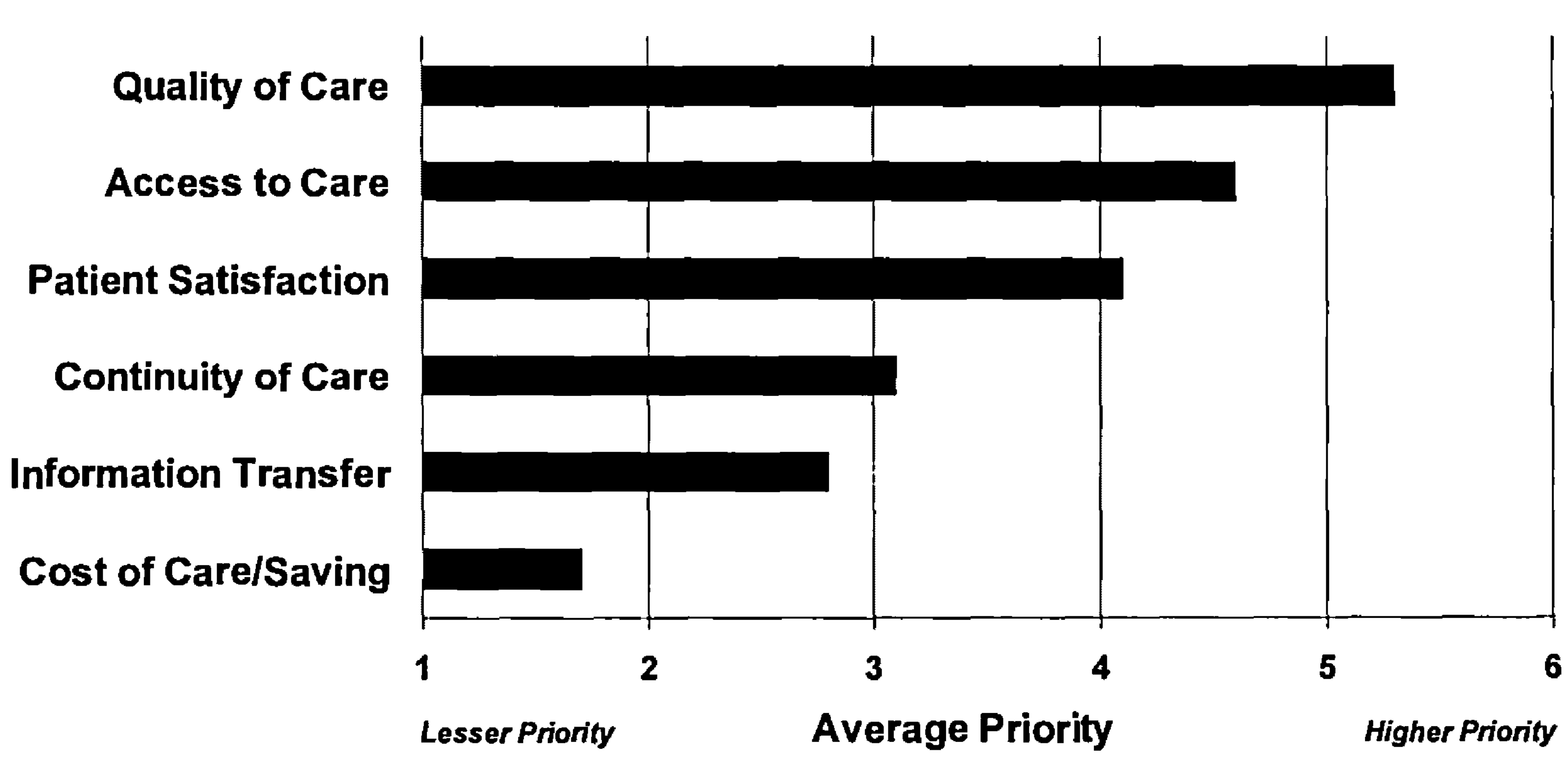
les: Clinic and Telemedicine Facilities





Village Health Aides using Telemedicine Facilities

What are your key organizational goals for telehealth applications?



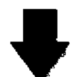
Store & Forward vs Real-Time Telehealth

Store & Forward | Real-Time

- Asynchronous Interaction
- Documents & Images
- Electronic Medical Records
- Patient Education

Remote consultation

- Face-to-Face Interaction
- Immediate Feedback



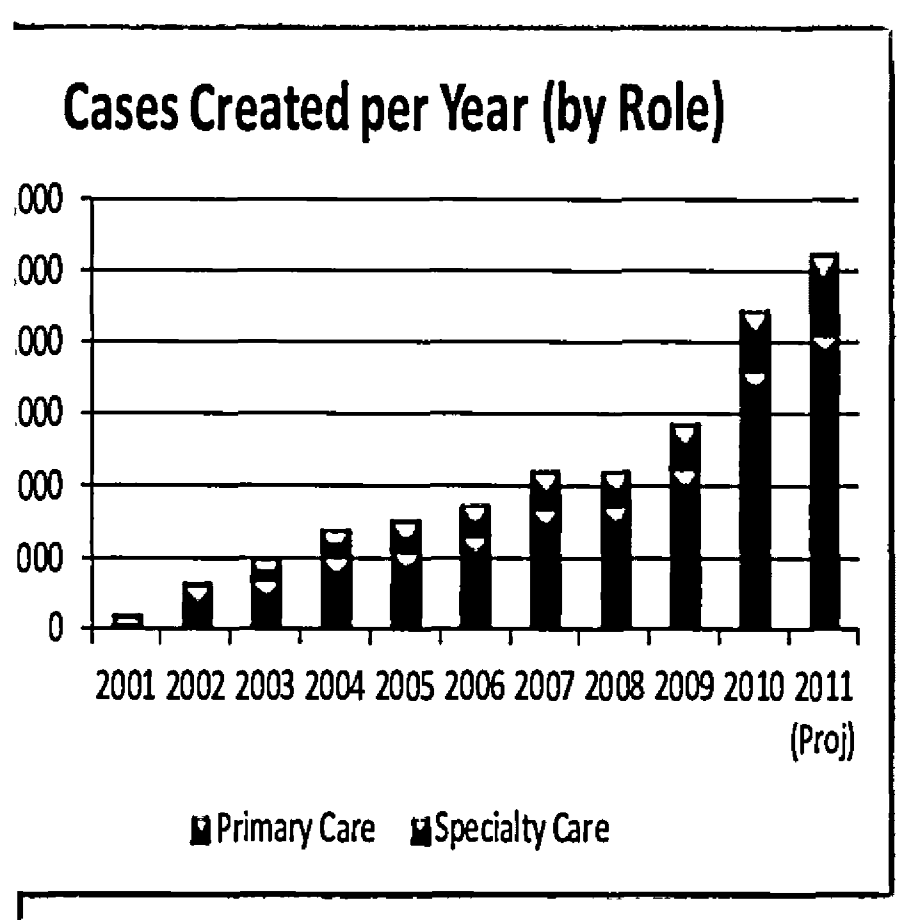
al
alties for
edicine

- Radiology
- Dermatology
- Pathology
- Oncology
- Ophthalmology
- Dental

- Cardiology
- ENT
- GI
- Pulmonary
- Rheumatology

- Psychology/ Psych
- Neurology
- Speech therapy
- Physical therapy

AFHCAN Telehealth

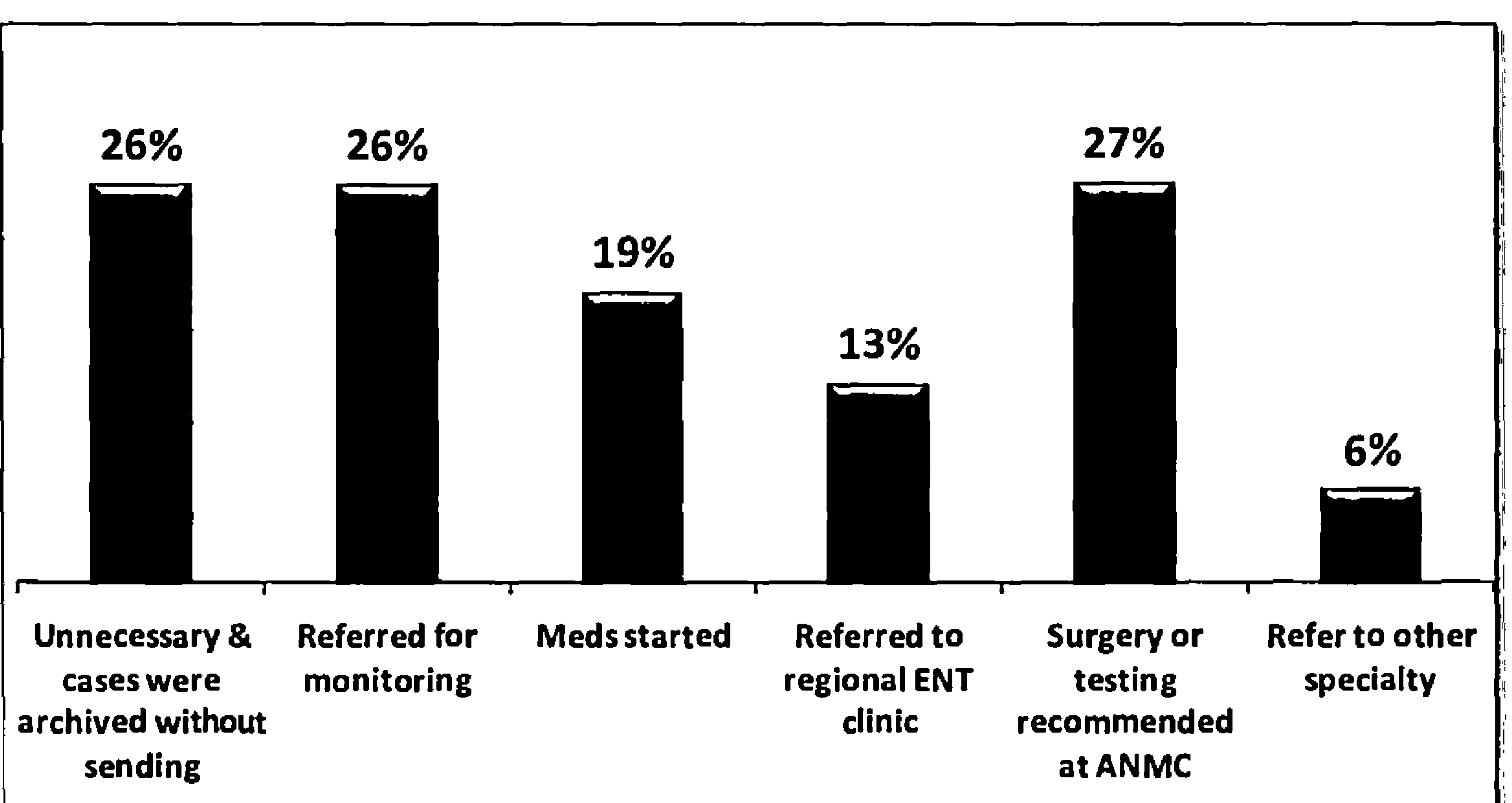


- 10 year Operational Hist
  - 22,000 cases in 2010
- Whole Telehealth Soluti
  - Design → Manufacturing → Deploy Installation → Training → Support · Marketing

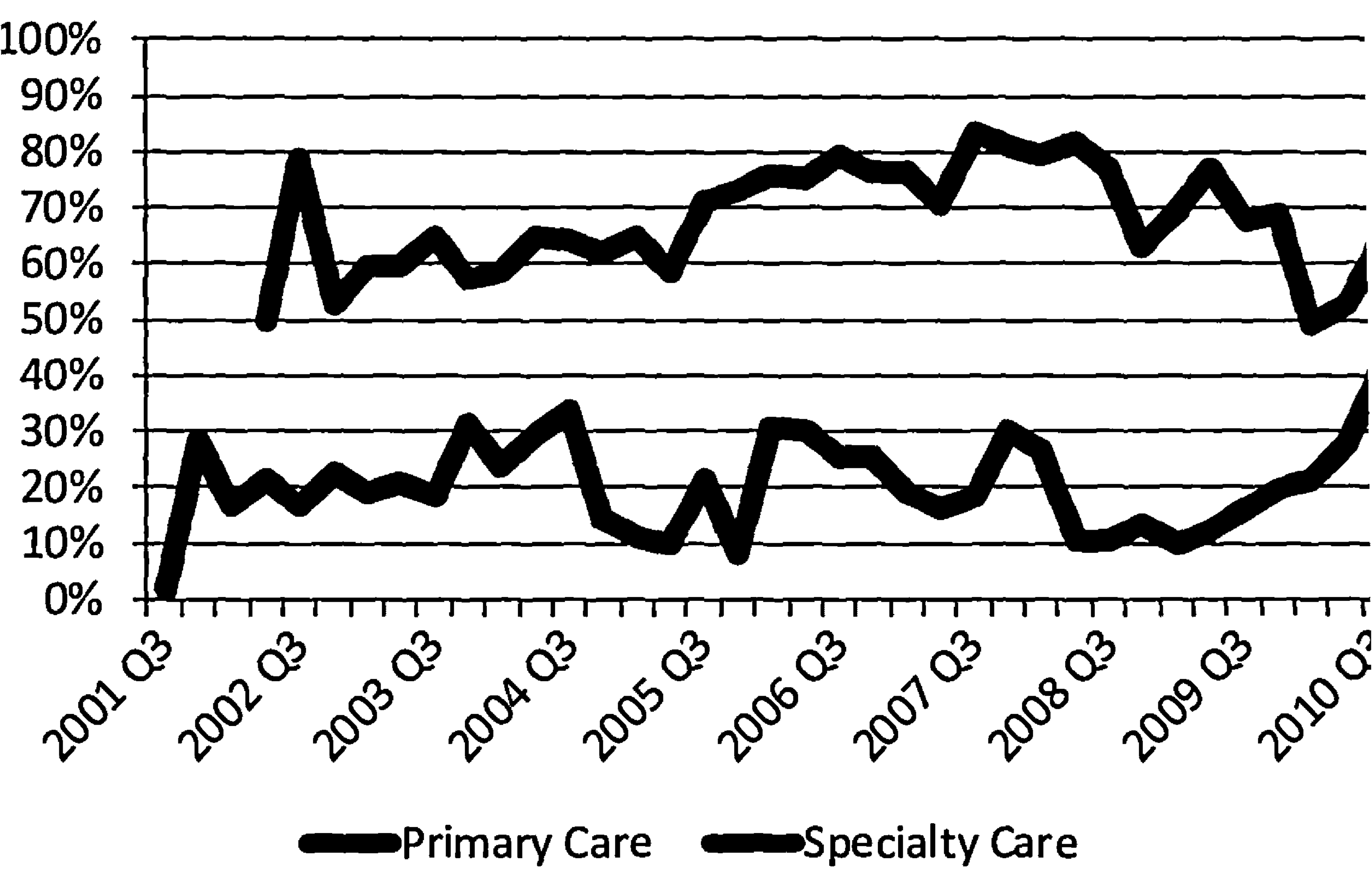
Data from AFHCAN,
Director Stewart Ferguson, Ph.D.

Note1: 1,987 patients
Note2: Percentages may not add to 100% due to multiple outcomes pe

Outcomes

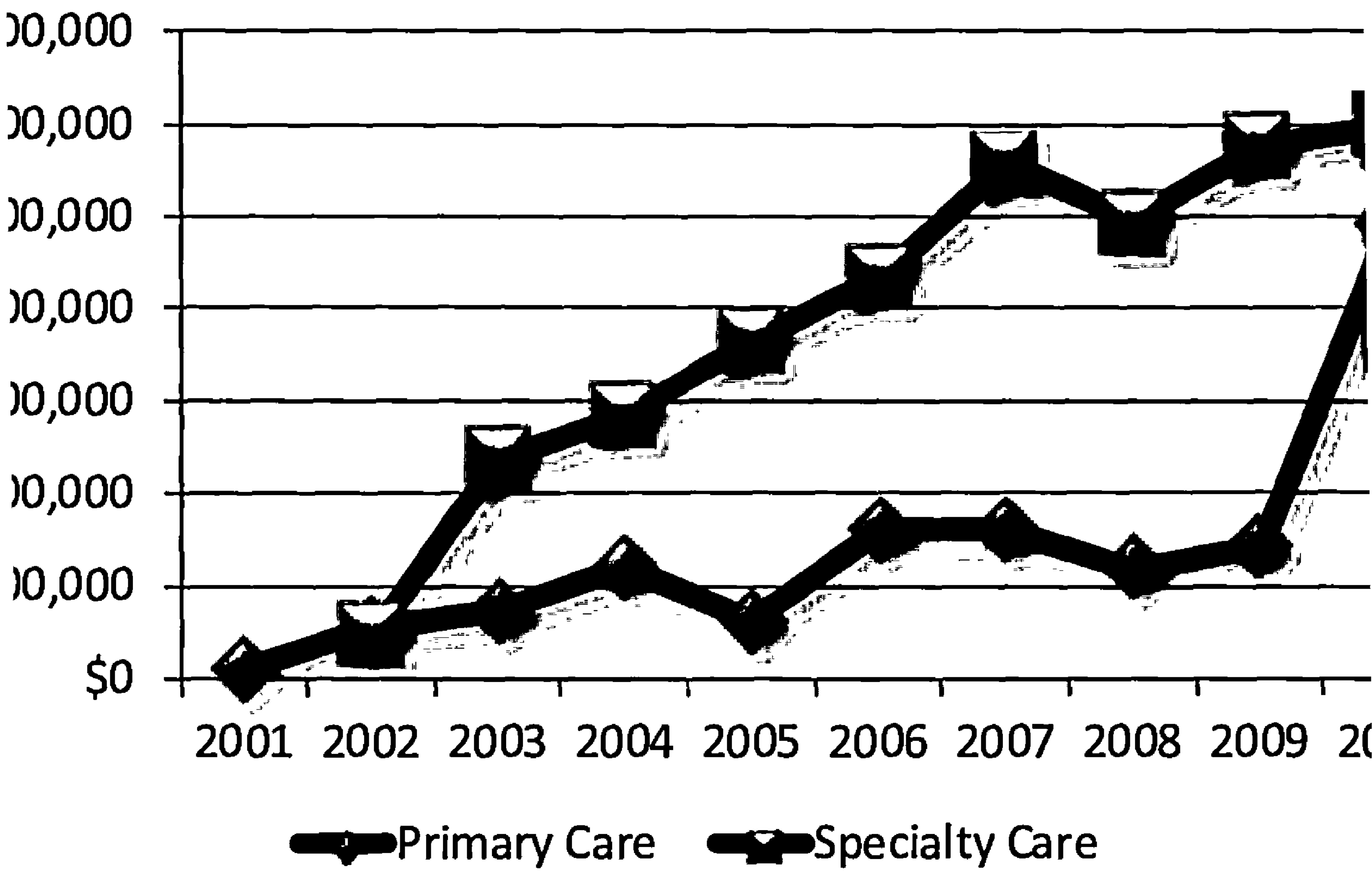


About 72% of the patients seen needed something done (meds, surgery, ongoing monitoring) and 26% needed to be screened out.



a Tribal Health System) (1/1/2001 to 12/31/2010)

Annual Travel Savings (by Case Role)



a Tribal Health System) (1/1/2001 to 12/31/2010)

Medicaid Study: 2003-2009

Decreased Travel = Cost Savings

	Quantity	Cost
Claims Paid by Medicaid	4,482	($269,89
Telemedicine Prevented Travel	3,662	$3,116,0

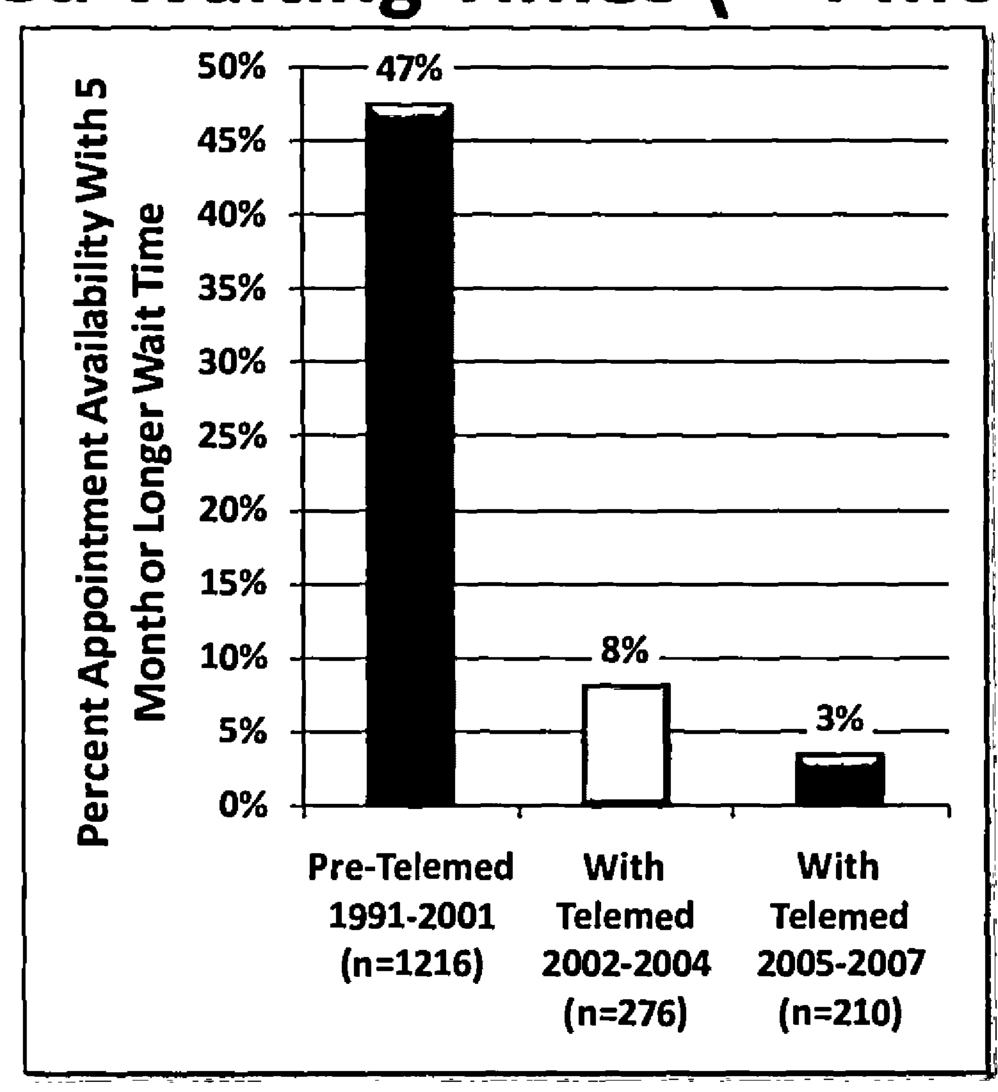
Notes:

- **Travel is saved for 75% of all patients.**
- **Assume all patients under 18 need an escort**
- **Travel costs based on 1 week advance fares**

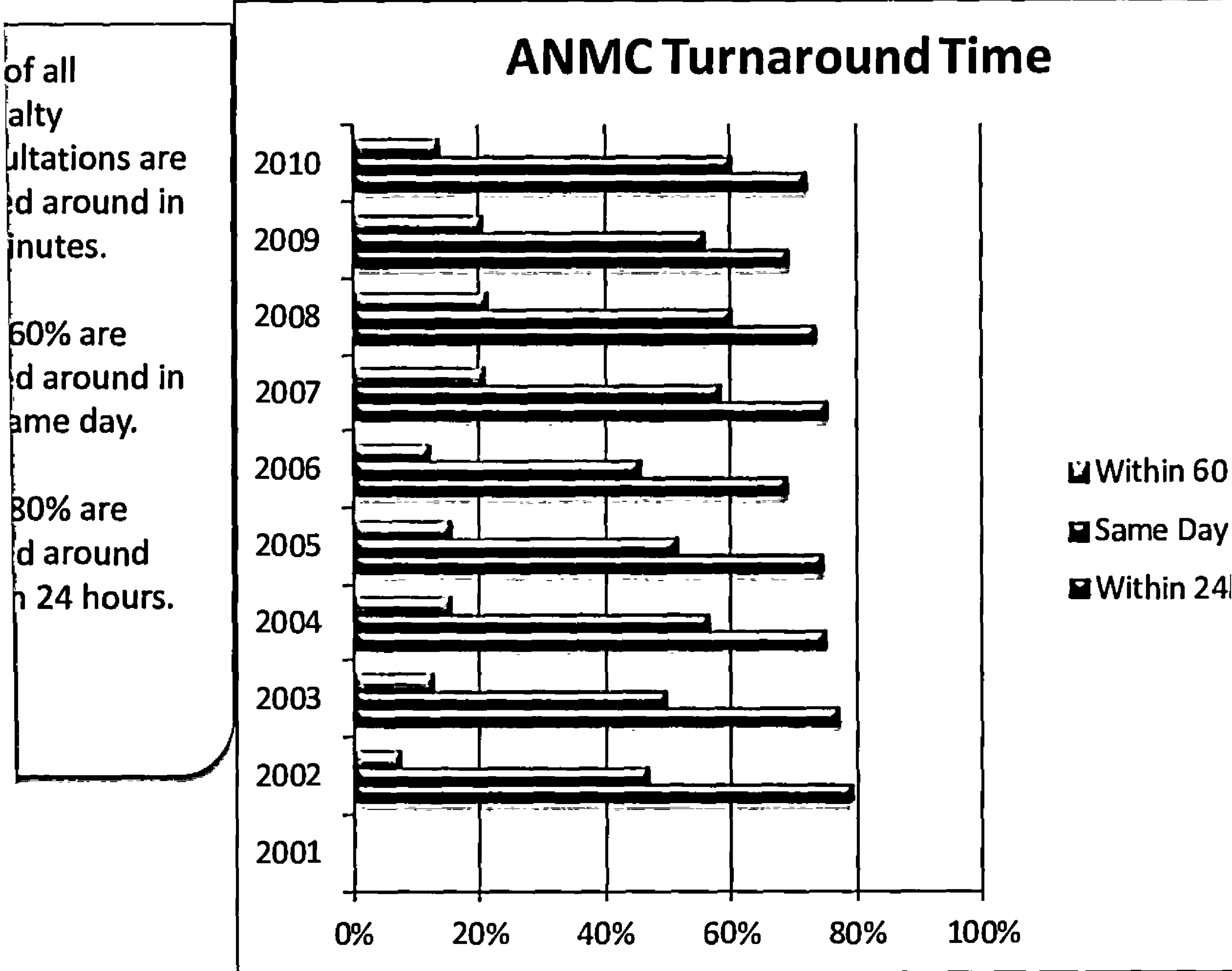
Net Savings Realized by Medicaid		$2,846,1

Note: For every $1 spent by Medicaid on reimbursement, $10.54 is saved on travel costs.

Telehealth Impact
on Extended Waiting Times (> 4 months)

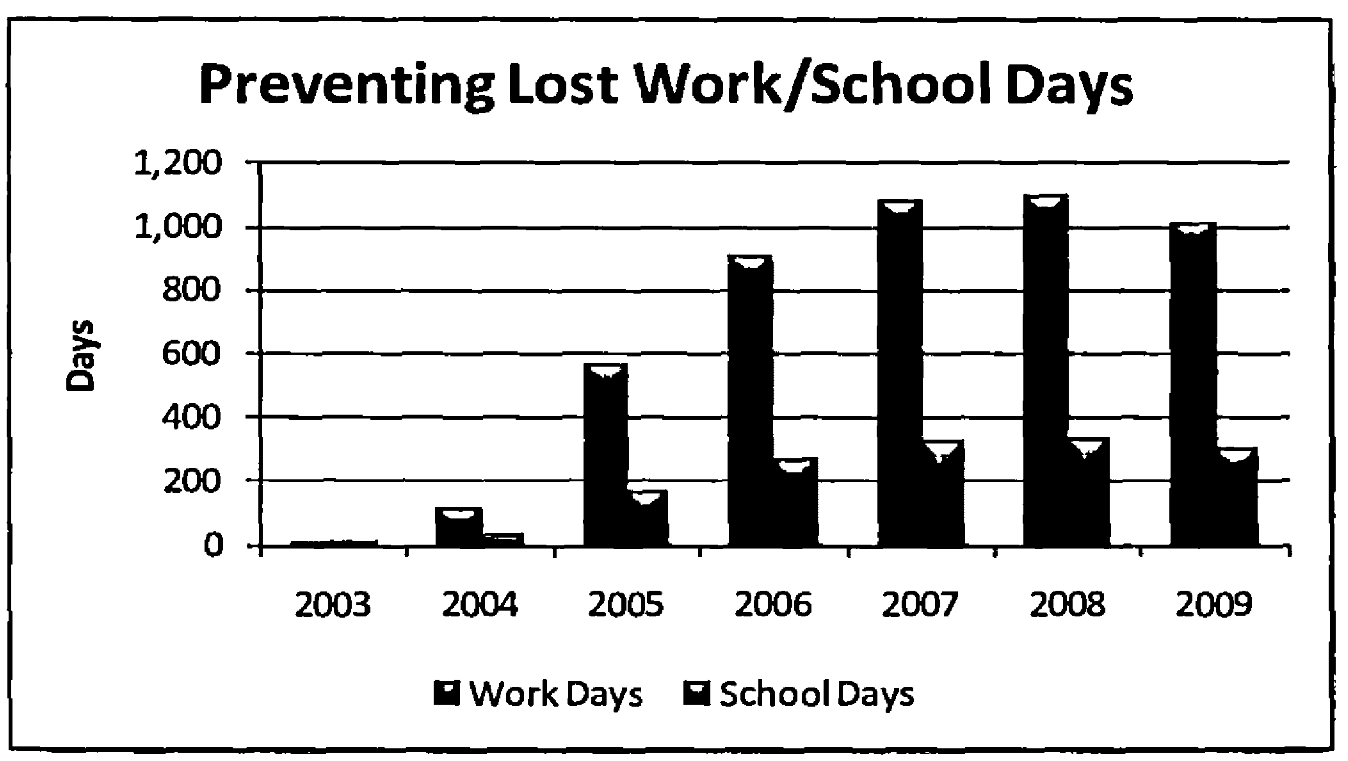


Data courtesy of Phil Hofstetter



a Tribal Health System) (1/1/2001 to 12/31/2010)

Lost Work Days and School Days



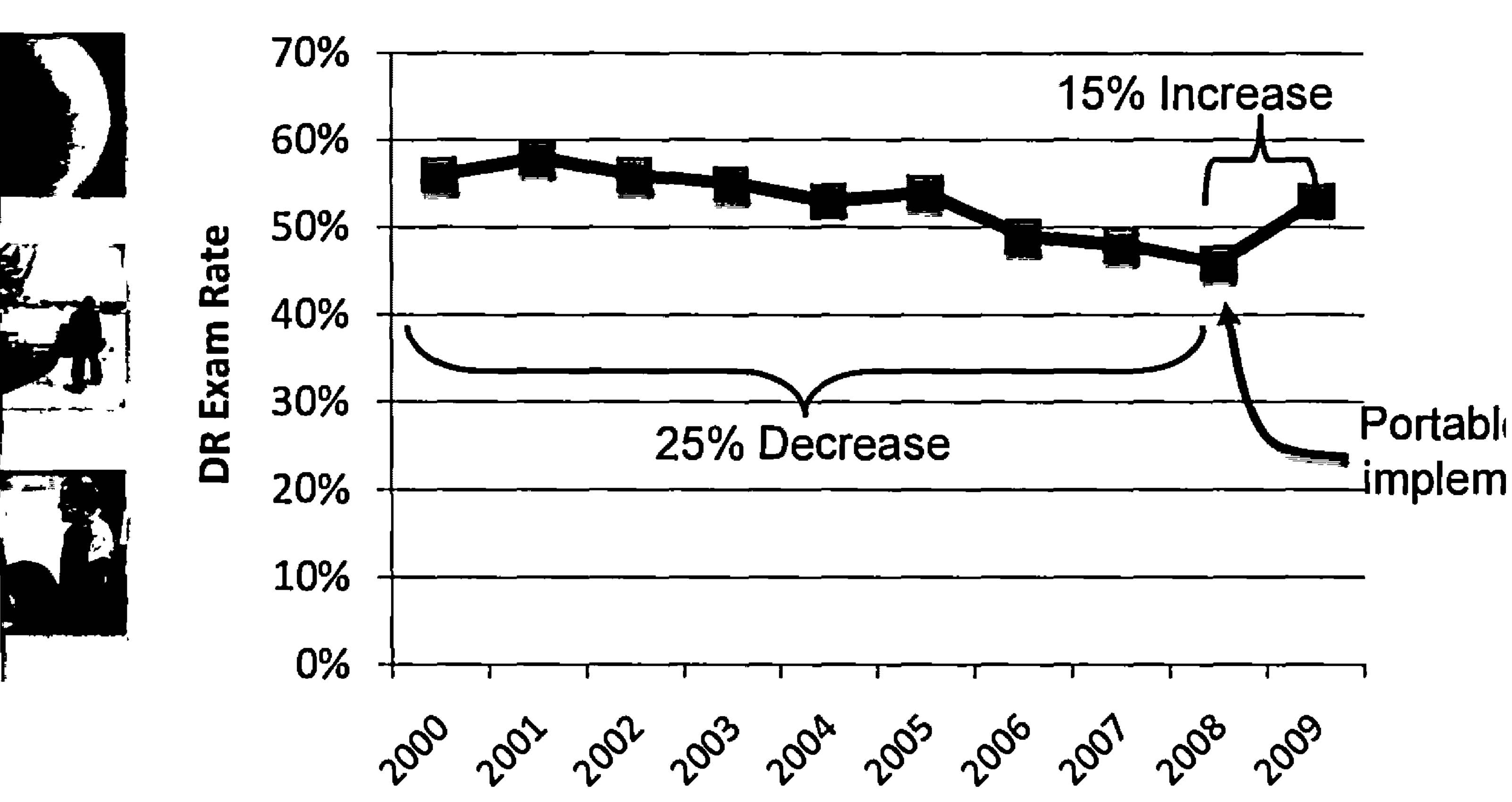
Since 2003, telehealth prevented an estimated 4,777 lost d at work, and a total of 1,444 lost days at school for the patients in this study.

Diabetic Retinopathy

- **Diabetic Retinopathy is the leading cause of new blindn among adults**
- **Blindness due to diabetes ca be eliminated by timely diagnosis and treatment**
- **~ 4% of AI/AN's with DM nee laser treatment to prevent vision loss**

Joslin Vision Network (JVN)
Portable JVN Pilot

Deployment of the IHS-JVN in Alaska using a portabl platform reversed a seven year decline in exam rate



›chlear Implants...

low implants can be done Alaska with follow-up eech therapy using ehealth facilities in mmunities

reviously, patient and nily had to relocate to attle for a year for child to t necessary speech erapy

Lessons from AFHCAN

)esign for Success:

KNOW THE NEEDS of your users (those who will use the system) and customers (those who will pay for the system).

Plan for turnover → "Keep it Simple"

Expect dynamic requirements → "Make it Scalable"

-- Stewart Ferguson, Director, AFHCAN

Lessons from Alaska Telemedicine

Reliable communication between health aides and physicians can improve timeliness and accuracy of patient diagnosis and treatment

Telemedicine consults can reduce the need for transferring patients from their communities, although some serious conditions that might have been overlooked may require patient transfer

Patients may be able to return to their communities soone if they can be monitored by a health aide with consultation when required

Telemedicine must address priority health problems to be cost/effective

Communication with patients in hospital is important for family members in villages

Administrative communication is also valuable for rural health care delivery

Lessons Learned...

Conference circuit (shared audio channel) is valuable for continuing education

Structured continuing medical education and patient education require commitment of time, plus resources for organization and content

Computerized patient records can improve efficiency and accura(of patient-tracking, especially where patients appear at multiple locations

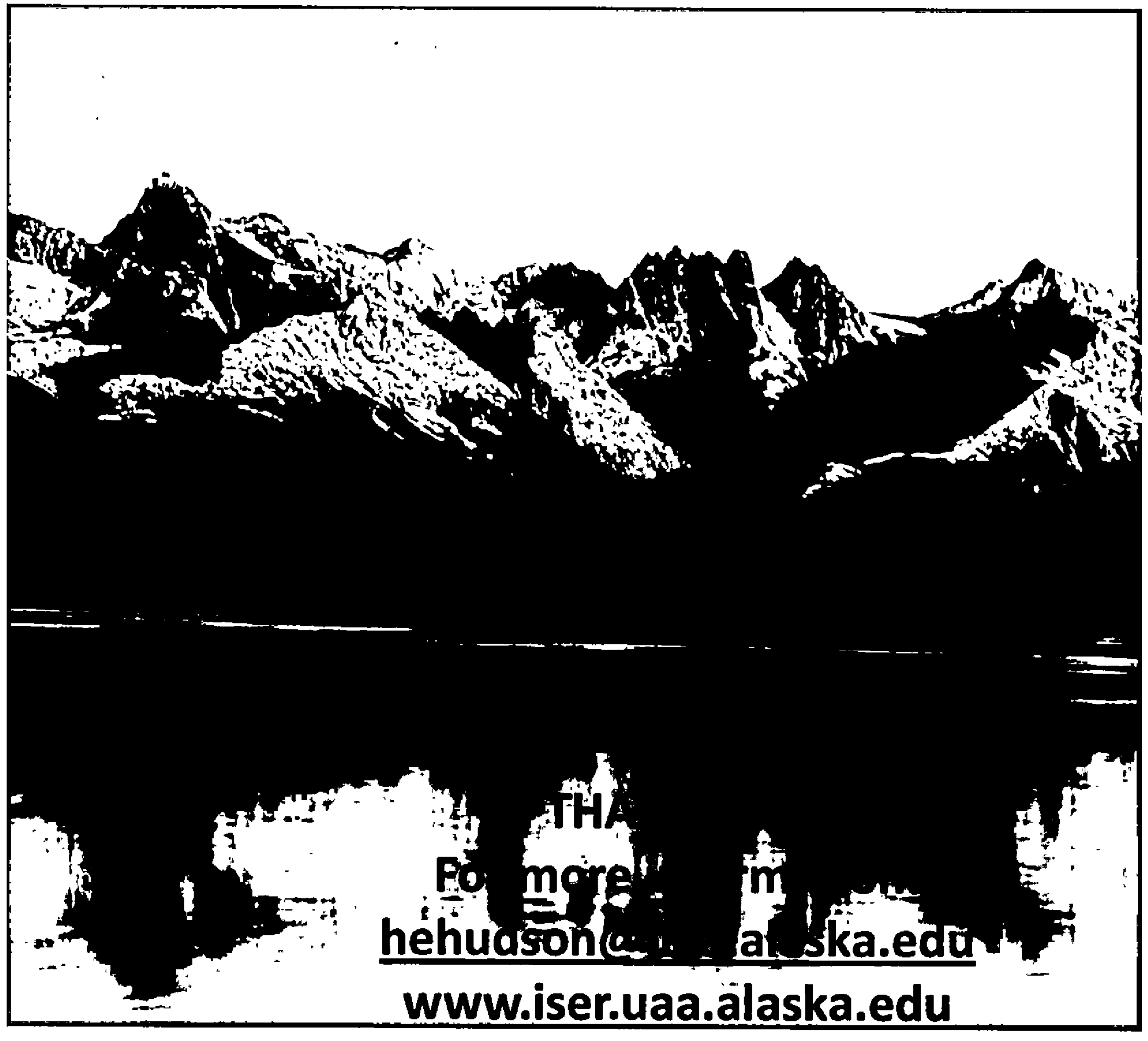
Operational system planning needs to reflect user needs

(e.g. on-demand access, shared audio channel, high reliability)

Planning for sustainability post experimental phase is critical

Health care system can be "anchor tenant" for village communications

Creative approaches to network design, operations, and maintenance can significantly reduce costs of rural communications for telemedicine and other services


www.iser.uaa.alaska.edu

Trial by Tundra

Best Practices in Telehealth

Stewart Ferguson, I
Chief Information Officer (
Alaska Native Tribal Health Conso

AFHCAN MISSION

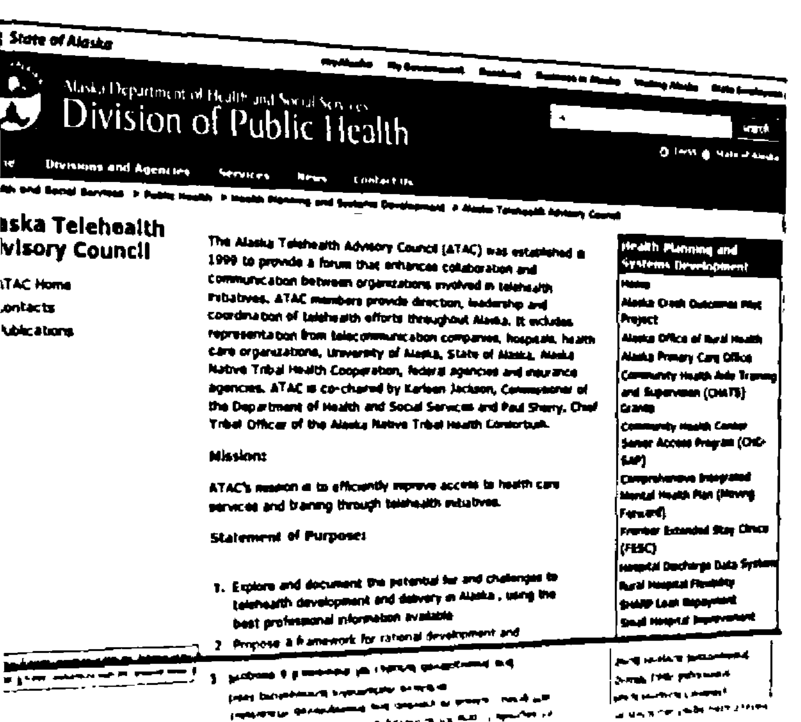
To improve access to health care for federal beneficiaries in Alaska through sustainable telehealth systems

***A**laska*
***F**ederal*
***H**ealth*
***C**are*
***A**ccess*
***N**etwork*

A formal, voluntary, inter-agency relationship between the DoD, DoT, IHS and VA working together by the sharing of each other's resources, talents, and experience to improve patient care throughout the state of Alaska

Alaska Federal Health Care Partnership

- Veterans Affairs
- DoD (Army & Air Force)
- DoT - (USCG)
- Indian Health Service (IHS):
  - Alaska Native Tribal Healthcare Consortium (ANTHC)



The Alaska Telehealth Advisory Council (ATAC was established in 1999 to provide a forum that enhances collaboration and communication between organizations involved in telehealth initiatives.

ATAC members provide direction, leadership and coordination of telehealth efforts throughout Alaska

http://www.hss.state.ak.us/dph/Healthplanning/telehealth/atac/default.htm

Alaska Tribal Health System

Medical Care Service Levels

- Alaska Native Medical Center tertiary care
  - Referrals to private medical providers and other states for complex care
- 6 regional hospitals
- 4 multi-physician health centers
- 25 subregional mid-level care centers
- 180 small community primary care centers

Village-Based Medical Services

\verage Alaska village
→ 350 Residents

- 180 Small Village Health Centers
  - 550 Community Hea Aides/Practitioners
  - 125 Behavioral Healt Aides
  - 20 Dental Health Aid 12 Therapists
  - 100 Home health/personal care attendants

AFHCAN - by the numbers ...

nce 2001		2013
99,562	Cases created	36,22
	Patients served	
	Providers involved	
2,335	Providers creating	914

Alaska Native Tribal Health Consortium

WHY DO IT?

Alaska Native Tribal Health Consortium

Why do you do Telemedicine?

Best for patient care
Helps me communicate with a doctor
Saves my organization money
Most convenient to the patient
Improves patient satisfaction
Makes me more efficient
ne confidence in doing the right thing for the patient
Increase access to care

0% 10% 20% 30% 40% 50%

Best for patient care

Increased access for care

INCREASE ACCESS TO CARE
BEST FOR PATIENT CARE

Alaska Native Tribal Health Consortium

Access

700
600
500
400
300
200
100
0

Referrals to Specialty Clinic

1999 2000 2001 2002 2003 2004 2005 2006

Year

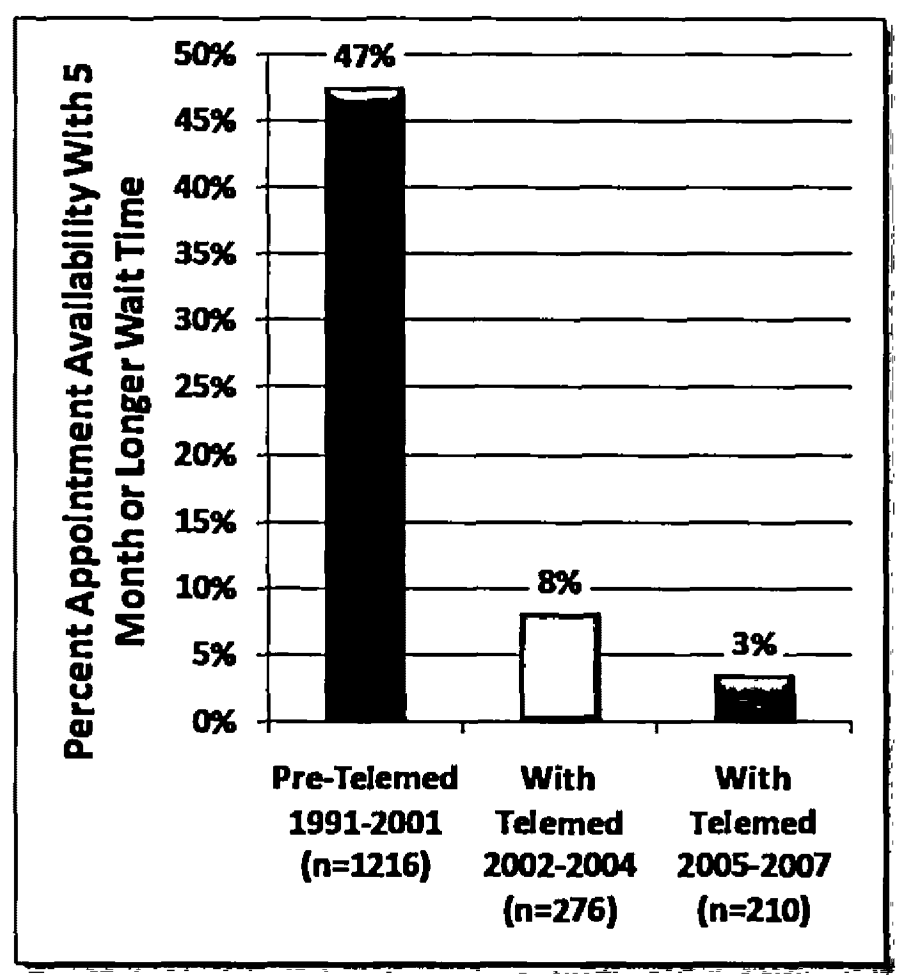
$200,000
$180,000
$160,000
$140,000
$120,000
$100,000
$80,000
$60,000
$40,000
$20,000
$0

Cost Savings

Referrals to Specialty Clinic
Telemed Consults
NSHC cost Savings
Travel Savings

Alaska Native Tribal Health Consortium *Data courtesy of Phil Hofstetter*

Telehealth Impact on Extended Waiting Times (> 4 months)



Data courtes
Ho

ANMC Turnaround Time (Specialty Consults)

1 Day, Same Day, 4 Hour, 2 Hour, 1 Hour

% Cases

100%
80%
60%
40%
20%
0%

FY10 Q2, FY10 Q3, FY10 Q4, FY11 Q1, FY11 Q2, FY11 Q3, FY11 Q4, FY12 Q1, FY12 Q2, FY12 Q3, FY12 Q4, FY13 Q1, FY13 Q2, FY13 Q3, FY13 Q4

n = 11,540

43% of highly experienced users (that create telehealth cases) rated “Speed of Response” as “Extremely Important

30%
25%
20%
15%
10%
5%
0%

% Cases

2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013

Primary Care
Specialty Care

REDUCING COSTS

Alaska Native Tribal Health Consortium

Estimated Travel Savings from Telehealth for **ALL** Patients

$9,000,000
$8,000,000
$7,000,000
$6,000,000
$5,000,000
$4,000,000
$3,000,000
$2,000,000
$1,000,000
$0

2003 2004 2005 2006 2007 2008 2009 2010 2011 2012

Specialty Care
Primary Care

Estimated annual savings from telehealth for all patients amounts to about $8.3m with a total savings of $37.8m since 2003.

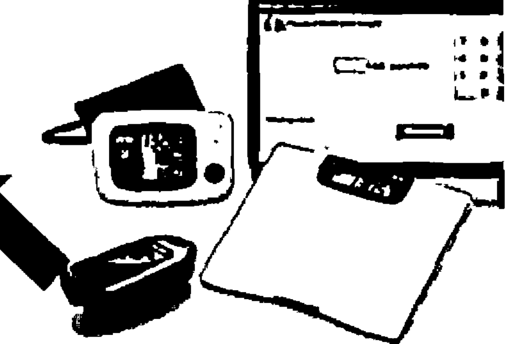
elehomecare Overview

linician Health Coaching:
eaching the Patient how to self-manage & meet their goals

Efficient MRP Engagem
Clinician provides regular upd consults as required

Patient Empowerment:
At home; Sets Personal Goals; Submits vitals/ health responses

mote Patient Monitoring:
Weekday feeds & Alerts



Simple Technology in Ho
Tablet, BP Cuff, Scale & Pulse oxi

How do we know it works?

2007 Phase One Pilot Program

- 8 Family Health Teams (urban and rural)
- 813 patients with COPD and CHF
- Patients were enrolled for four months on average
- Focus on patient self-management: "what matters to you?"
- External third party evaluation (Price Waterhouse*)

Program Outcomes

- 64 – 66 % decrease in hospital admissions
- 72 – 74% reduction in emergency department visits
- 33% decrease in number of primary care physician visits
- 95 – 97% reduction in walk-in clinic visits
- High levels of patient and provider satisfaction
- Best practices were developed

A summary of the evidence from other jurisdictions

QUANTIFIED
benefits

- Reduces first hospitalizations and hospital re-admissions
- Saves $20,000/patient diverted from hospital
- Reduces emergency department visits
- Saves $1,557 (CHF, COPD) - $8,660 (CHF) per patient/year
- Saves $940 (diabetes) per patient/year
- Reduces health care resource utilization across 6 conditions

DESCRIBED
benefits

- High patient satisfaction
- More effective and confident self-care
- Improves quality of life for carers
- Less travel and disruption for routine check-ups
- Retains patient's dignity
- Increases degree of independent living

CAVEATS

- Not all evidence has been compelling; success depends on selecting the <u>right</u> chronic disease patients and <u>right</u> intervention
- Not yet proven that all the evaluation outcomes are fully generalizable beyond the short-term projects

's: Canada Health Infoway 2013I Pare G et al. Home telemonitoring for chronic disease management: an economic assessment (2012) | Commonwealt Scaling telehealth programs: lessons from early adopters (2013) | Darkins A et al. Care coordination home telehealth (2008) | OTN Phase Dne Pilot I 2009 I http://3millionlives.co.uk/about-telehealth-and-telecare#ccg_potential_savings_featured_at_nhs_innovations_expo | http://beat.ottawaheart.ca/2011/02/18/innovative-home-monitoring-initiative-reaches-1000-patient-milestone/#sthash.twsSMYkS.dpuf | http://www.cdnhomecare.ca/media.php?mid=1683

Proportion of CCCP enrollees with one or more Hospitalization

—◆—Proportion of enrollees with 1+ HF hospitalization
—■—Proportion of enrollees with 1 all-caus hospitalization

100.0%

58.1%

39.8%

13.3%

year prior to CCCP enrollment (point estimate and 95% C.I.) One year following CCCP disenrollment (point estimate and 95%

ata Includes 332 CCCP enrollments among 301 unique patients discharged fro: ie CCCP program prior to July 1, 2009. Results are similar within more recen iorts of enrollees discharged from the program prior October 1, 2009 and prior January 1, 2010.

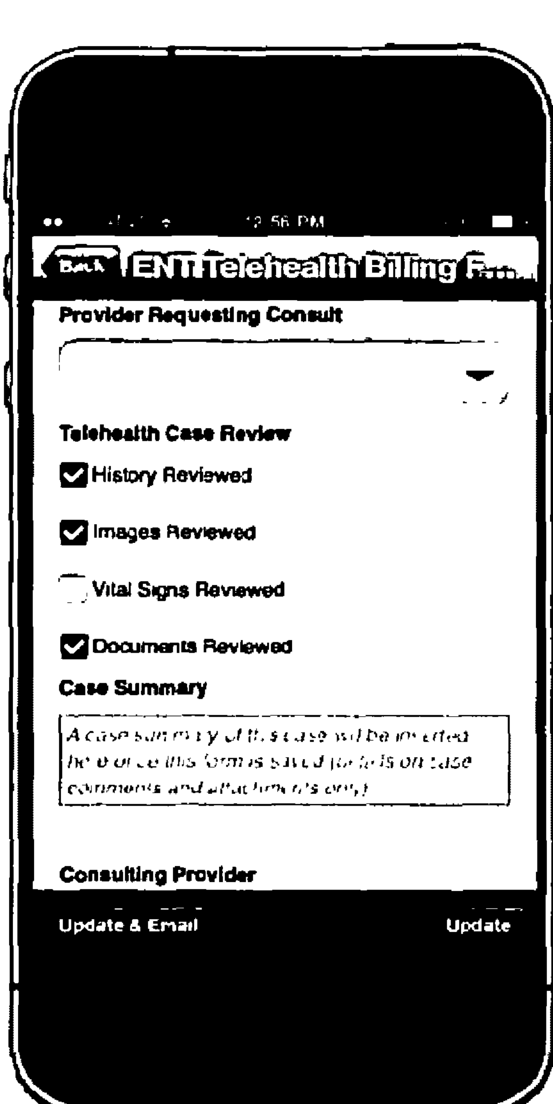
*Telemedicine is one **STRATEGY** to*

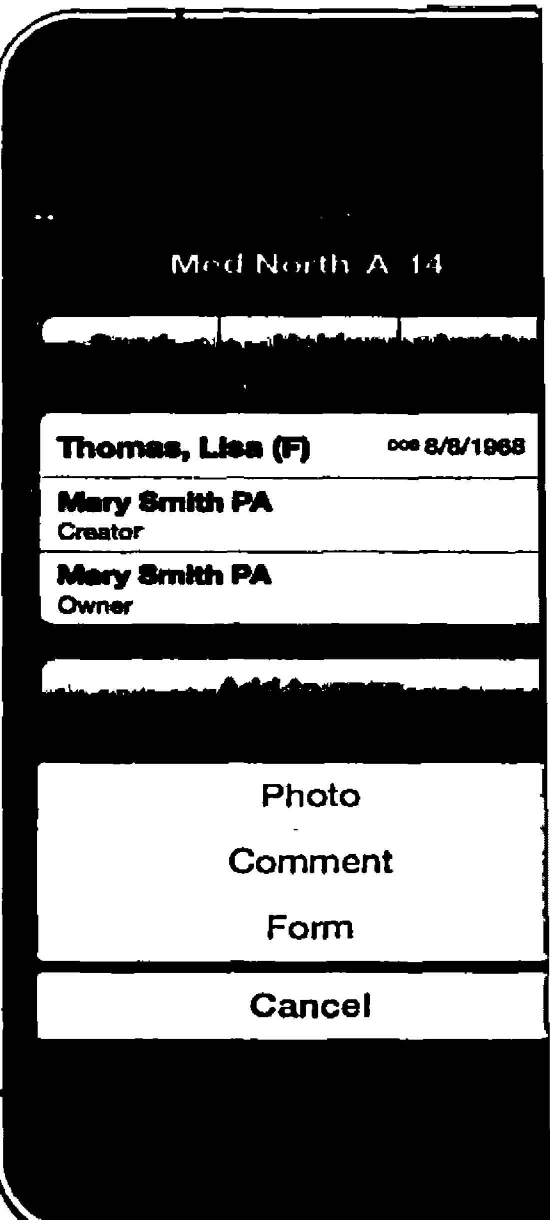
improve access, quality & performance

and to manage

costs & risk

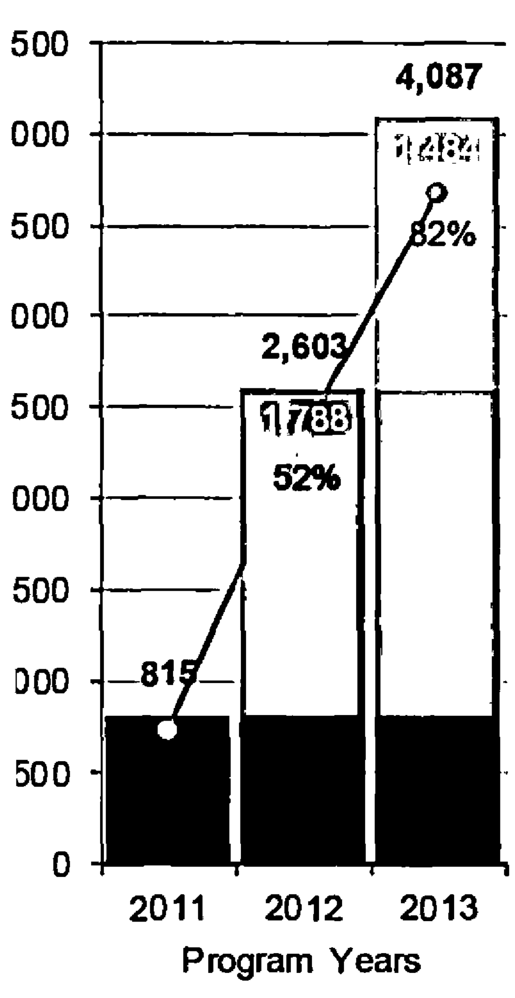
WHERE ARE WE HEADED?





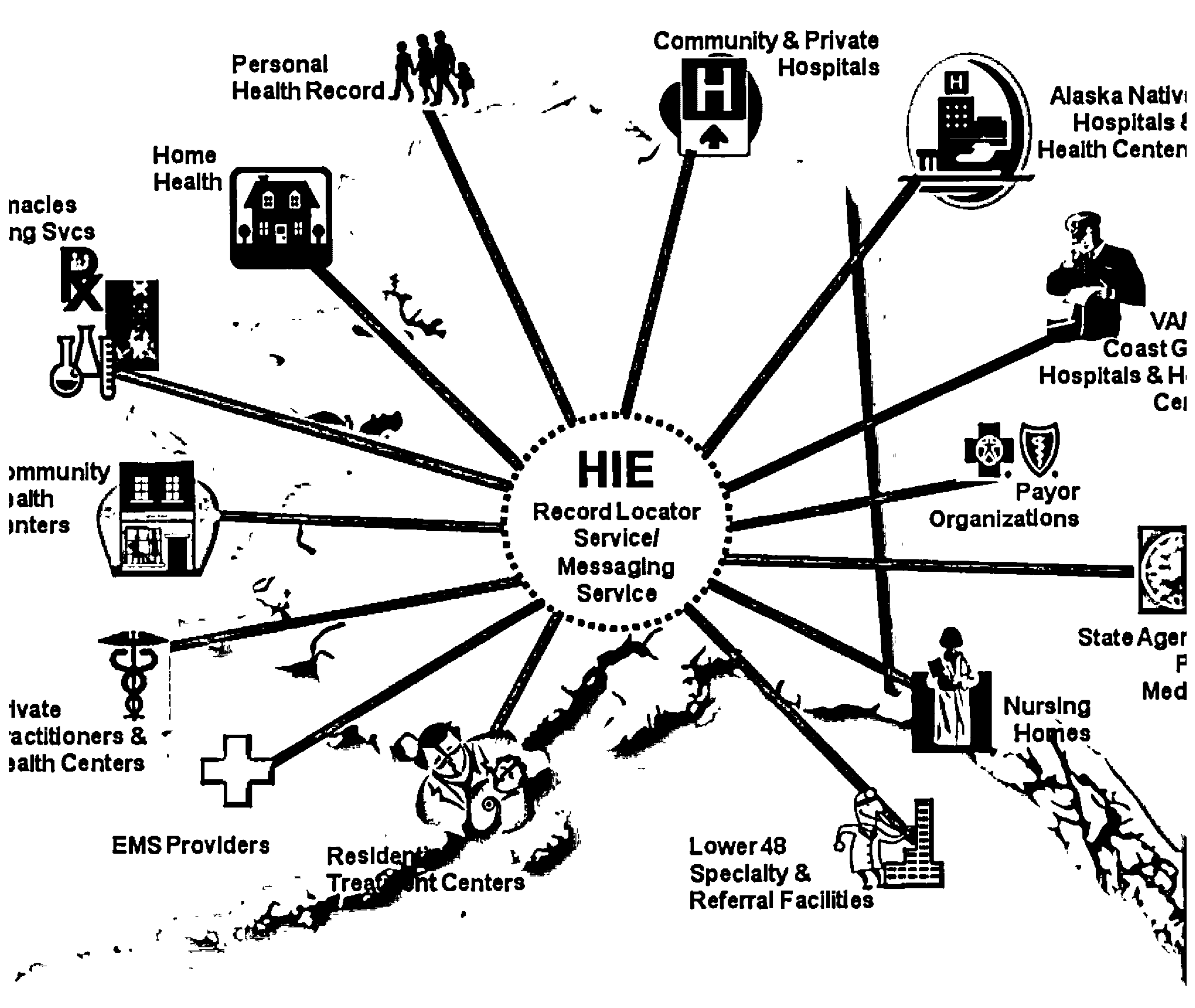
24/7 "On the Go" Telehealth

Meaningful Use Technology



Patient Portals

eVisits



Personal Health Record
Community & Private Hospitals
Home Health
HIE
Record Locator Service/ Messaging Service
Payor Organizations
Nursing Homes
EMS Providers
Lower 48 Specialty & Referral Facilities

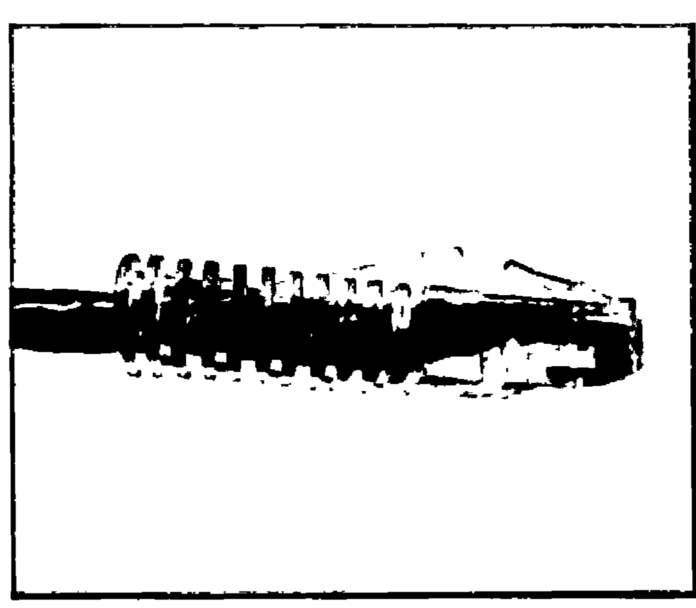
Patients Served by Telemedicine in North America

10,000,000
7,500,000
5,000,000
2,500,000
0
1987 1988 1989 1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 201

Alaska Native Tribal Health Consortium

Courtesy of Jon Link

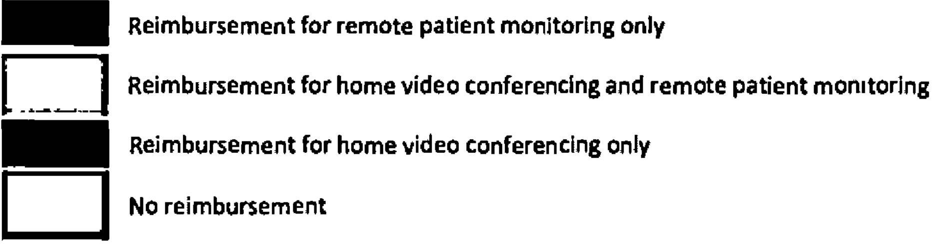
The Clinician's Perspective
… the New Limiting Step



Medicaid - State Telemedicine Reimbursement for Physician Services (2014)

Medicaid - State Telemedicine Reimbursement for Telemental Services (201

Medicaid - State Telemedicine Reimbursement for Home Telehealth (2014)



tate Ratings for Telemedicine Policies Related to Relationships and Visit (201

1.New Hampshire
2.Vermont
3.Massachusetts
4.Rhode Island
5.Connecticut
6.New Jersey
7.Delaware
8.Maryland
9.Washington, DC

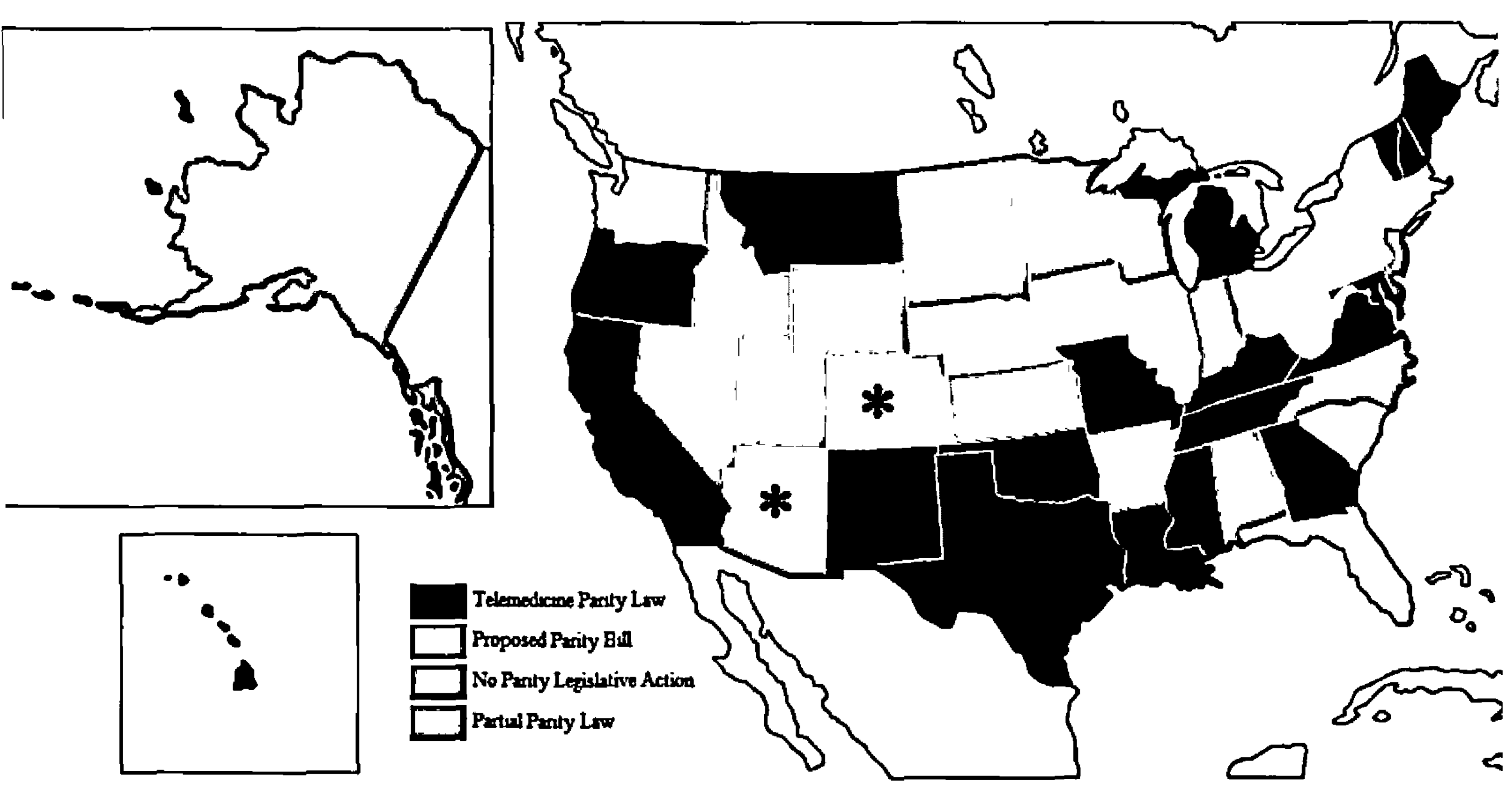
A – No unique requirements for telehealth

B – Allows telehealth in-lieu of in-person exam or to establish physician-patient relationship

C – Requires – at least pre-existing relationship established in-person or in-person exam

★ 2014 State Medical Board Decisions: Alabama, Arkansas, Florida, Georgia, Oklahoma, Tennessee, Washington

;tates with Parity Laws for Private Insurance Coverage of Telemedicine (201.



vith the year of enactment: Arizona (2013)*, California (1996), Colorado (2001)*, Georgia (2006), Hawaii (1999), Kentucky (2000), Louisiana (1995), Maine (2009), Marylan
ın (2012), Mississippi (2013), Missouri (2013), Montana (2013), New Hampshire (2009), New Mexico (2013), Oklahoma (1997), Oregon (2009), Tennessee (2014), Texas (199
ıt (2012), Virginia (2010) and the District of Columbia (2013)

vith proposed/pending legislation: In 2014, Connecticut, Florida, Illinois, Iowa, Massachusetts, Nebraska, New York, Ohio, Pennsylvania, Rhode Island, South Carolina. Ten
ED), Washington, and West Virginia

te-wide coverage. Applies to certain health services and/or rural areas only.

2014 TELEMEDICINE LEGISLATIVE ACTIVITY

Enacted Telemedicine Bills

Proposed Telemedicine Bills

No Legislative Action

* Enacted Telemedicine Bills 2013

Ways in which a LT Governor can impact the use of telemedicine …

- Work with state health departments to expand coverage of telemedicine in state Medicaid programs.
  - ATA has sets of best practices for Medicaid programs.
  - Consider changes to make sure Medicaid managed care programs can provide telemedicine services without any geographic or other restrictions.

Ways in which a LT Governor can impact the use of telemedicine …

- Raise consumer awareness in states that have a mandate for private insurance coverage of telemedicine - about this coverage and what telemedicine can do for consumers.
  - E.g. Launch an "Ask your doctor about telemedicine" program.

- Work with the legislature and state medical board to set up interstate medical license reciprocity laws.
  - This will allow voters in the state to access their own primary care physician when they travel out of state as well as allow them to receive care from specialists located (and fully licensed) in other states.

Ways in which a LT Governor can impact the use of telemedicine …

- Help set up a statewide stroke network involving all of the state's large medical centers with a goal that every emergency room in the state has 24/7/365 access to a neurologist to help diagnose and treat a stroke patient during the first 60 minutes.

- Help change the health insurance coverage for state employees to allow them to access telemedicine services including access to services at the workplace. This helps improve productivity and reduce absenteeism.

Growth Opportunities & Challenges

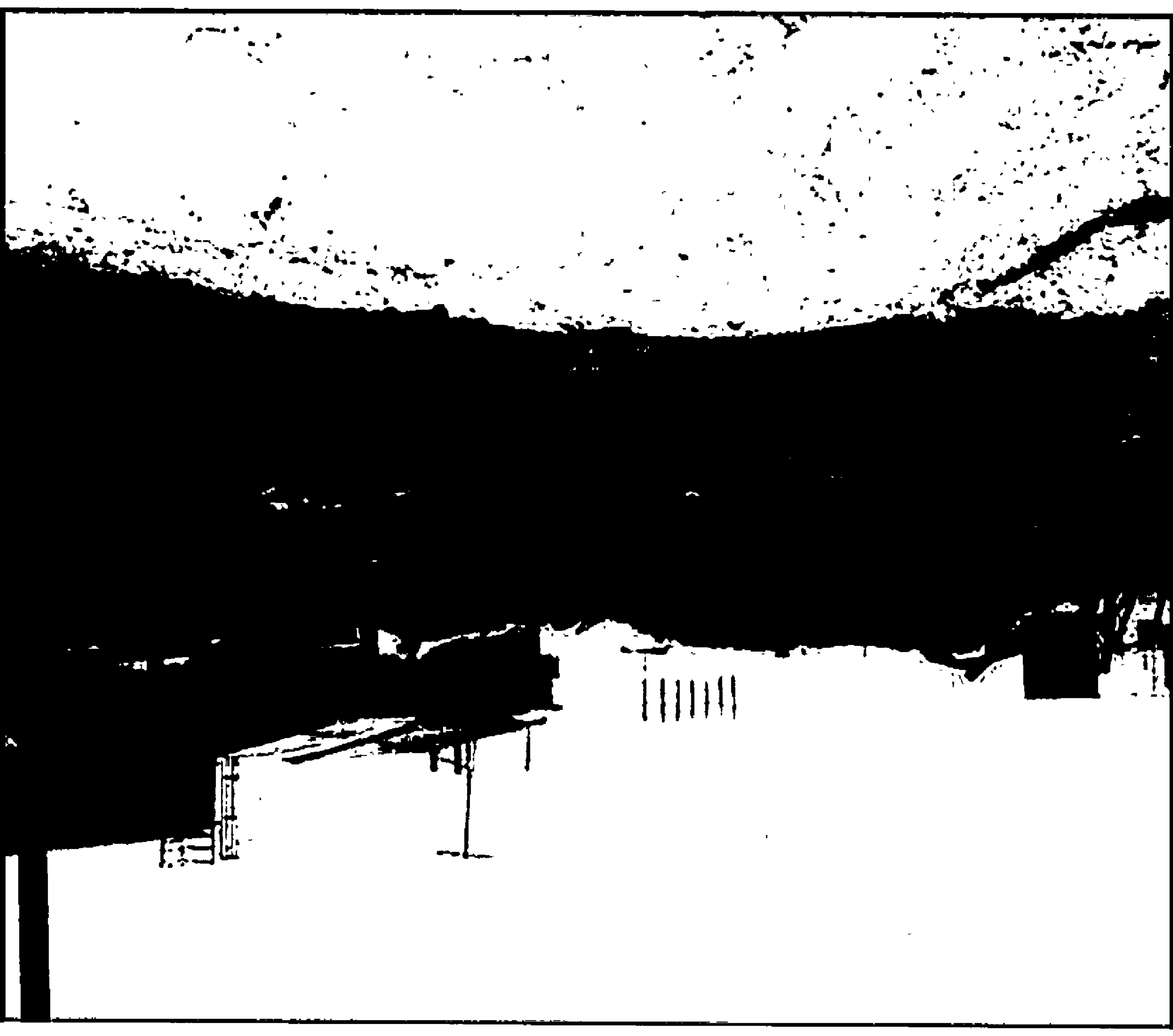
- The ability of health systems, specialists and primary care doctors to provide care wherever their patient is located.
  - Currently restricted by licensure laws.

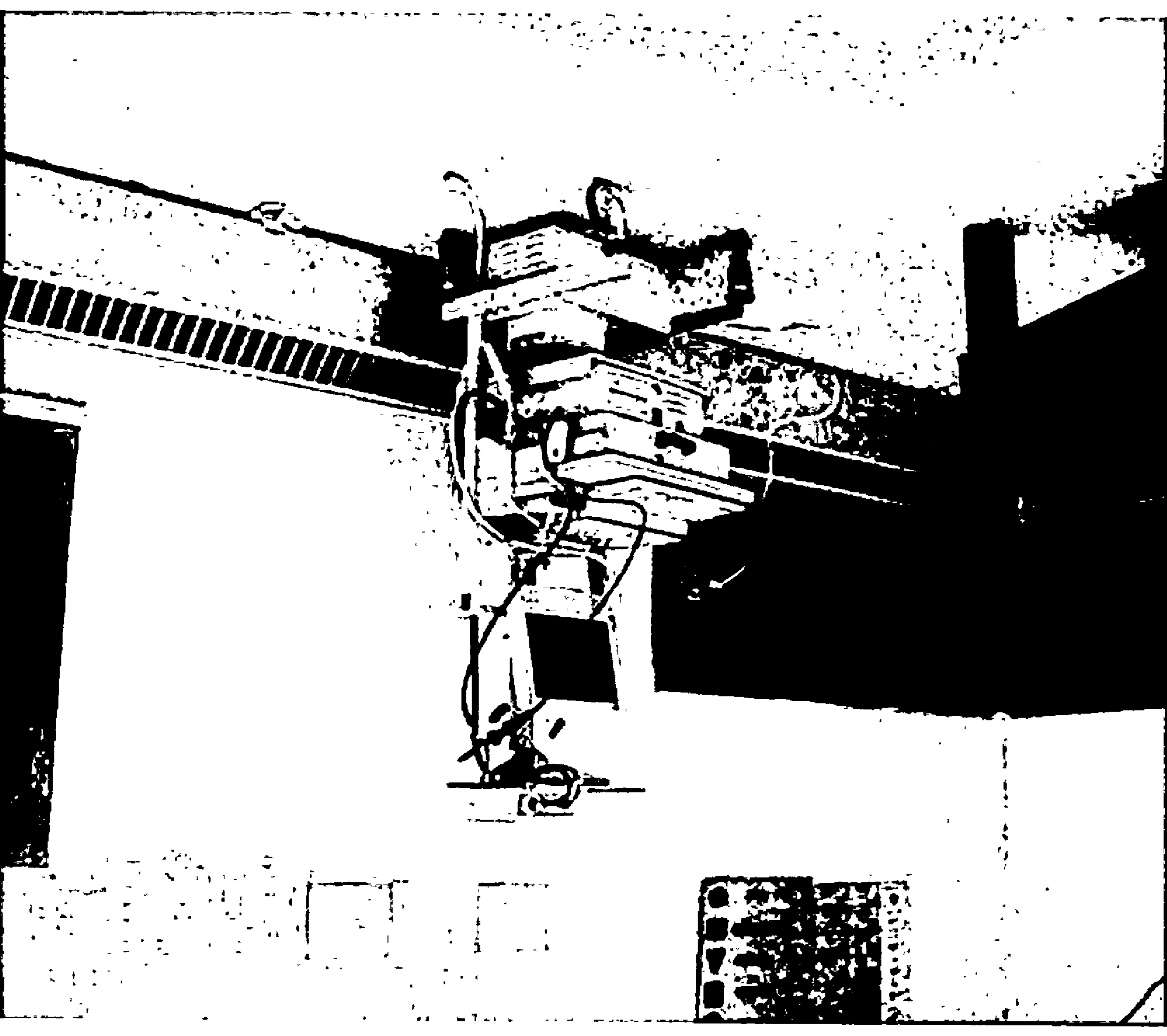
- The growing use of internet-based services and remote medical devices by consumers to track their health and seek professional help.
  - How does this interconnect with their primary care doctor and the state's efforts to set up a health information network.

- Integrating telemedicine services into the day-to-day work flows of the state's health providers (e.g. EHR-based)

- Using telemedicine to help keep down the costs of healthcare – especially for chronic care patients.

- Using telemedicine to overcome growing shortages of physicians and other health providers, especially specialists.





Stewart Ferguson, PhD

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My Statesman from Austin American-Statesman

Murphy: Texas lags behind the country in telemedicine

Opinion

By Kate E. Murphy - Special to the American-Statesman

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Posted: 1:21 p.m. Monday, Feb. 29, 2016

At a recent House Public Health hearing at the State Capitol, an official with the Texas Health and Human Services Commission testified that more Texans on Medicaid are using telemedicine services for mental health than anything else. The top billing codes all relate to telepsychiatry. These include pharmacological management, psychiatric diagnostic interview and examination, psychotherapy with evaluation and management, and psychiatric diagnostic evaluation.

That's because the Texas Medical Board has not restricted access to behavioral health services through telemedicine the same way they've restricted other services.

It's simply, really. Because people can call a psychiatrist or counselor without establishing a relationship in person or interfacing with some other provider, more people are able to take advantage of this service. It removes a barrier to access for people without transportation are or those who have to travel hundreds of miles to a site where someone can help them make the call to the provider — a call they would otherwise be perfectly capable of making on their own.

Unfortunately, the Texas Board of Examiners of Professional Counselors recently proposed a rule which would require licensed counselors who want to provide telehealth services to reside in Texas and perform an initial face-to-face intake session before telehealth counseling, raising the same barrier to behavioral health services that the medical board has raised for general telemedicine services.

Texas is dead last in the nation in access to health care and in expanding the use of innovative technology, like telemedicine, to meet that need. It's a shame the Lone Star State would hamper access to behavioral health services just like it has with other telemedicine services. Texas and Arkansas are the only states that require an in-person or face-to-face video conference visit with a

physician prior to using telemedicine. Texas is also one of the only states that requires an in-office follow-up visit after using telemedicine.

The Texas Medical Board's regulations, if allowed to stand, will prevent the rapid expansion of telemedicine now underway in the state's private health sector. But you know who has been benefitting from telemedicine in Texas for decades? Prisoners. The University of Texas-Medical Branch has been providing telemedicine to state prisons improving health outcomes and saving taxpayers about $780 million.

UTMB also provides telemedicine to large companies and community health centers in rural communities. Their research shows telemedicine cuts non-emergent ER visits in half — saving even more money — and patients love it.

As this type of research mounts, most states are working to loosen their telemedicine regulations. Most recently, Alahama lifted its similarly restrictive telemedicine regulations. In Alaska, telemedicine providers don't just have to be licensed in Alaska; they also have to be physically present in Alaska to provide services. Lawmakers there are trying to remove the physical location requirements for remote medical practice and Internet prescribing. The legislation would also remove barriers to telehealth services provided hy licensed providers. Mississippi legislators have introduced 80 hills to expand telemedicine. Michigan and South Dakota have also improved their physician practice standards and licensure requirements. Likewise, Florida, New Mexico, and Missouri are making positive changes.

Texas is doing the opposite. The medical board argues that their new regulations, approved in April of last year, were passed to keep people safe. But if that's true, why have 48 other states decided these types of regulations are overkill? And why do the Texas regulations exclude people who are most in need of affordable, immediate and remote care? The truth is, these protectionist policies undermine Texas' efforts to increase access to medical care through telemedicine at a time when Texas desperately needs it.

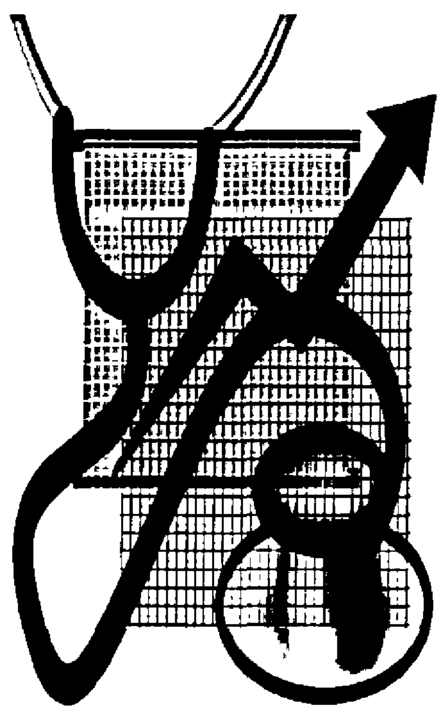
The Texas Medical Board, which is facing a federal lawsuit for its draconian telemedicine regulations, is just one example of the potential harm these boards can cause. Overbearing licensing boards are a national problem. Last year in a North Carolina case — the State Board of Dental Examiners v. F.T.C. — the Supreme Court heard case in which a state licensing board was cracking down on teeth-whitening kiosks for engaging in the unauthorized practice of dentistry. Justice Kennedy's majority opinion noted that when you put market participants in charge of regulating their own market, they often work to squeeze out competition rather than promote public good, sometimes without even realizing they're doing it. The Supreme Court ruled against the state board, which is now subject to heightened scrutiny under federal antitrust law.

Telemedicine and telepsychiatry could be a huge help to many Texans — if the medical board would just get out of the way.

Murphy is a mental health policy fellow contributing to the Center for Health Care Policy at the Texas Public Policy Foundation.

Teleconsultation: A Health Care System for the 21st Century

Charles Townley and Rachel Yalowich



This issue brief is intended to serve as a resource for state policymakers and other stakeholders as they build new or expand existing telehealth and teleconsultation programs. It offers strategies to address various regulatory and legal structures that present barriers to the diffusion of telehealth. It also offers strategies that may result in increased telehealth adoption and shares examples from five leading telehealth and teleconsultation programs in Alaska, Massachusetts, Mississippi, New Mexico, and Washington.

Introduction

Individuals with medical and behavioral health comorbidities often receive fragmented care, resulting in higher costs and poorer outcomes.[1] States, the federal government, and providers have all made significant investments to build and expand evidence-based integration models, such as the collaborative care model,[2] to reduce fragmentation and improve care. However, workforce shortages and limited resources may hinder the feasibility of these models, particularly in rural areas. Emerging evidence demonstrates that telehealth services and provider teleconsultation may be viable alternatives for individuals that are willing to participate and can deliver equal or better care when compared to traditional in-person care for individuals with behavioral health needs.[3,4,5] While telehealth is often framed as a way to improve access in rural settings, patients in urban settings may also benefit.[6]

While some individuals may prefer to continue to receive traditional in-person care, telehealth and teleconsultation offer opportunities for states to increase patient choice and expand the scope of services individuals can receive at their usual care site—including primary care clinics, mental health centers, and correctional facilities. These programs may also build the primary care systems' capacity to treat mild-to-moderate behavioral health conditions. More research is necessary to understand the full effect on service utilization and healthcare costs, but early findings demonstrate that telehealth and teleconsultation programs for behavioral health services may reduce state spending or produce overall cost savings:

- Wyoming Medicaid found a 1.82:1 return-on-investment, and a 42 percent reduction in the number of children aged five or younger using psychotropic medications after implementing a psychiatric teleconsultation program to support primary care physicians serving children with behavioral health needs in the state.[7]

Using technology to connect patients and providers is often referred to by many names, including, but not limited to: telehealth, telemedicine, telebehavioral health, and telemental health. For the purposes of this issue brief, we use the following definitions:

- Telehealth or Telemedicine: A system in which patients receive services from providers in a different location.
- Telebehavioral health or Telepsychiatry: A subset of telemedicine that remotely connects patients with behavioral health providers.
- Teleconsultation: A system in which providers remotely consult with other providers in a different location.

Depending on the policies of individual states, these programs may or may not require a local provider's presence or referral for an individual to receive remote services. It is also important to note that there are various modes of telehealth, including real-time communication, asynchronous store-and-forward, remote patient monitoring, and mobile health.[10] Unless otherwise noted, the scope of this paper is limited to real-time communication.

telehealth to serve individuals in correctional facilities. The state reported savings of $500 per telehealth encounter ($9 million in fiscal year 2011), largely due to reduced transportation and staffing costs.[8]

- A study of 106 nursing homes residents in New York and Vermont found that a combined 278 telepsychiatry encounters resulted in estimated savings ranging from $33,739-$67,477 in reduced personnel costs and $84,347-$253,040 in avoided physician travel.[9]

Improving Patient Access Through Telehealth

When referrals to in-person services are not feasible, remotely connecting patients and providers through telehealth can be an effective way to increase the scope of services delivered at an individual's usual care site. Alaska and Mississippi are two leaders in this area, having built statewide telehealth programs that have expanded patient access to services and reduced costs (See Table 1).

Implementation

While many of the leading telehealth programs across the country are payer- or provider-driven initiatives, each state's unique policy environment has shaped how payers in the state treat telehealth services and provider adoption rates.[11] There are many important roles for states to play in supporting the development of new or enhancement of existing telehealth programs. As a purchaser, for example, the state can implement policies to provide reimbursement for telehealth services on behalf of the state employees or Medicaid and Children's Health Insurance Program (CHIP) enrollees. As of April 2015, 48 state Medicaid programs reimbursed for some level of telemedicine and telebehavioral health services.[12]

Beyond purchasing power, states can leverage their roles as lawmakers, regulators, and conveners to advance telehealth programs while also protecting consumers and payers. State officials may find the following strategies useful when determining how to leverage remote services to increase patient access to care:

1. Amend regulatory restrictions limiting reimbursement;
2. Foster or mandate multi-payer support;
3. Provide education and guidance on pertinent legal considerations; and
4. Leverage federal funds to develop broadband infrastructure in rural areas.

Table 1. Telebehavioral Health Services in Alaska and Mississippi

	Alaska Psychiatric Institute's Telebehavioral Health Center	Center for Telehealth at the University of Mississippi Medical Center
Program Description	In 2003, Alaska began a telebehavioral health pilot. Today, the Frontline Remote Access Clinic, housed within the Alaska Psychiatric Institute (API), provides telebehavioral health services to individuals in approximately 26 towns and villages across the state—only four of which are connected to the state's road system.[13]	In 2003, the University of Mississippi Medical Center (UMMC) began their telehealth program for emergency medicine services in rural hospitals.[14] In 2008, telepsychiatry services were added to the program to serve mental health clinics and are available on an acute or scheduled basis. Today, UMMC's Center for Telehealth includes more than 30 different specialties and serves patients at more than 194 locations across the state (including primary care clinics, mental health clinics, local health departments, schools, and prisons), and is expanding telepsychiatry services to nursing homes in 2015.
Funding	As the state's psychiatric hospital, API is funded through legislative appropriations. The Frontline Remote Access Clinic within API bills remote sites at an hourly rate for their services. Grant funding also supports API's telebehavioral health work.	The Center has developed a sustainable business model with revenue from contracts and insurance reimbursement for telemedicine services. Mississippi law requires private and public payers, including Medicaid, to reimburse for telehealth services. Approximately 100,000 telehealth visits occur annually.
Outcomes	API's telebehavioral health services generated over $1 million in avoided hospitalization costs in state fiscal year (SFY) 2015, building on the $600,000 in avoided hospital costs in SFY2014. An additional $70,000 in patient travel costs was avoided over those years.[15]	Telepsychiatry is one of UMMC's most demanded services and is being delivered to mental health clinics, group homes, emergency departments, primary care clinics and to students in schools and colleges. Although outcomes data specific to telepsychiatry are not available, the model has generated positive outcomes for other services. For example, the Center's TelEmergency program reduced rural ED staffing costs by 25 percent and reduced unnecessary transfers to urban hospitals by 20 percent; patient outcomes in rural hospitals are equal to those at the academic medical center.[16]

Nearly all Medicaid programs reimburse for telemedicine and telebehavioral health services. The federal Medicaid statute does not define telemedicine as a distinct service,[17] and the Centers for Medicare & Medicaid Services (CMS) encourages states to "use the flexibility inherent in federal law to create innovative payment methodologies for services that incorporate telemedicine technology."[18] As a result, states' reimbursement policies vary widely as to which services are reimbursable, which providers can bill, and what types of technology can be used.[19]

Common state regulations and reimbursement policies include provider eligibility requirements, licensure requirements for providers across state lines, and in-person evaluation requirements for remote services. While these policies may limit the development of telehealth programs, they have often been put in place by states to address potential quality and patient safety concerns. If states choose to amend their policies to advance telehealth, it will be important to incorporate consumer protections into these policies.

Eligible practice settings and technologies

Challenges: Many states place restrictions on where patients can be seen in order for providers to bill for remote services, such as limiting the types of providers who may provide remote services, limiting the setting in which remote services are billable, or establishing minimum mileage requirements between the patient and remote provider as a condition of payment.[20]

Strategies: Many states have telehealth laws that allow reimbursement in non-traditional care settings; for example, 16 states allow for remote services at schools or school-based health centers, and 25 states allow patients to receive telehealth services at home.[21] Furthermore, while most states have removed mileage requirements for reimbursement—Colorado expanded their law earlier this year[22]—exceptions may still apply.[23] In maintained a minimum required distance of 20 miles when reimbursing other eligible providers.[24] Similarly some states place limitations on which technologies can be used for provider-to-patient communication (e.g., live communication, asynchronous communication); approximately half of states limit reimbursement to real-time communication.[25]

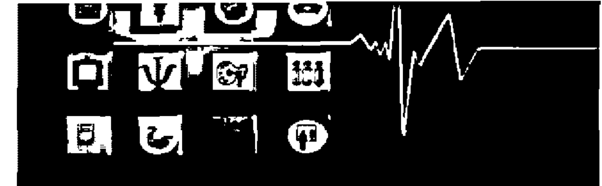
As of April 2015, 48 state Medicaid programs reimbursed for some level of telemedicine and telebehaviorial health services.

Latoya Thomas and Gary Capistrant, State Telemedicine Gaps Analysis: Coverage & Reimbursement (Washington, D.C.: American Telemedicine Association, May 2015) http://www.americantelemed.org/docs/default-source/policy/50-state-telemedicine-gaps-analysis—coverage-and-reimbursement.pdf.

Practicing telehealth across state lines

Challenges: When telehealth services are provided across state lines, cross-state licensure issues arise. The majority of state medical boards require physicians to hold active licenses in each state where patients receiving telehealth services legally reside,[26] although some states have exceptions to their licensure laws that allow physicians to provide infrequent services either directly to patients or in consultation with another physician without procuring a license from each state.[27]

Strategies: In September 2014, the Federation of State Medical Boards introduced model legislation for states interested in adopting the Interstate Medical Licensure Compact to reduce administrative burden of physicians applying for licenses in additional states.[28] Under the Compact, each state retains its authority to regulate the practice of medicine, and out-of-state physicians are subject to the laws and rules set forth by the legislatures and medical boards in the state where the patient is located. Within a span of a year, 11 states have enacted the Compact through legislation;[29] although some state medical boards have expressed concerns.[30] The Consortium of Telehealth Resource Centers has suggested other potential models to mitigate licensure barriers, including endorsement



In-person requirements for remote services

Challenges: Some state laws and regulations require an in-person visit before an individual can receive services remotely. For example, the Arkansas Medical Board requires an in-person evaluation prior to most remote services,[32] and the Texas Board of Medicine requires that patients receive an in-person evaluation annually after remote consultations.[33] These medical practice standards are particularly important for providers using telemedicine to remotely prescribe medication, as those are subject to various state and federal laws intended to ensure proper prescribing and use. This is an important consideration given the U.S. Government Accountability Office's findings that children in Medicaid are already prescribed psychotropic and antipsychotic medications at higher rates than privately insured children.[34] Although federal law provides some exemptions for prescribing controlled substances via telemedicine, the interpretation of these exemptions have been left to local Drug Enforcement Agency (DEA) branches, which has established procedures that require face-to-face office visits before providers can prescribe controlled substances in some telemedicine programs.[35]

Strategies: Some state legislatures agencies have passed legislation or released administrative guidance clarifying what is and is not acceptable when providing remote services under state law. For example, Alaska recently passed legislation stipulating a physician can prescribe, dispense, or administer prescriptions for controlled substances without a physical examination as long as: 1) the physician is licensed and physically located in the state and 2) the patient has access to follow-up care and agrees to have all medical records from remote encounters sent to his or her primary care provider. In addition to these requirements, a physician must either have a previously established relationship with the patient or have another appropriate licensed provider physically present with the patient to aid the prescribing physician with an examination and diagnosis.[36] Alaska's policy serves as a reminder that state officials should carefully consider when it is appropriate to require that a local provider be involved in the provision of remote services.

2. Foster or Mandate Multi-Payer Support

In addition to deciding which telehealth services are reimbursable, payers also need to decide how much to pay for those services. When determining sustainable payment rates, state policymakers may also find that multi-payer participation is an important component of long-term support and sustainability for telehealth programs.

Challenges: Limited access to behavioral health services and workforce shortages affect the entire health care system, not just Medicaid. Some commercial health plans may set restrictive telehealth policies, limiting providers' ability to meet the needs of commercial populations.

Strategies: As more payers reimburse for telehealth services, the proportion of a practice's panel eligible to receive telehealth services increases. This not only increases patients' access to remote services, but it also may reduce the administrative burden on providers. This may also help promote

employee health plans, and private insurers to provide coverage for telehealth services to the same extent that the services would be covered if they were provided in-person.[37] The legislation received broad support, including, most notably, support from Governor Phil Bryant.

The University of Mississippi Medical Center's Center for Telehealth cites multi-payer telehealth payments as a critical aspect of the enduring success of its program; furthermore, payment parity has allowed the telehealth program to be sustainable outside of grant funding.[38] Mississippi Medicaid has also worked to ensure that its payment policies encourage the use of telehealth, including new originating site facility fees effective July 1, 2015.[39] As of July 2015, 28 other states and the District of Columbia have passed parity laws for private insurers.[40] Medicare has also covered telehealth services since the Balanced Budget Act of 1997, although federal law limits reimbursement to individuals seen in specific rural care settings.[41]

3. Provide Education and Guidance on Pertinent Legal Considerations

When providers practice medicine remotely, they must meet the same legal standards that apply when serving patients in their offices. State agencies have an important role in helping providers understand how to meet these legal obligations by providing education and policy guidance as necessary and appropriate. One important area in which states can provide guidance is on privacy laws and data sharing.

Challenges: Federal privacy laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), set national privacy and security standards for holding and sharing protected health information. 42 CFR Part 2 extends further privacy and security standards to patients' behavioral health data for most drug and alcohol treatment providers.[42] Some states have passed more stringent laws regulating protected health

importance of secure data exchange to providing comprehensive care through telehealth. Telehealth services can be more effective when the remote provider can access and review patients' medical records. Regional and state health information exchanges can be an important tool to facilitate behavioral health information exchange across treating providers.[43] In the absence of a robust health information exchange, providers have entered into contractual arrangements to facilitate data exchange. For example, when providers in Alaska contract with the Frontline Remote Access Clinic housed within the Alaska Psychiatric Institute (API) for telebehavioral health services, API enters into a business associate agreement and memorandum of understanding that allows API's psychiatrists to access the other systems' electronic health records.[44,45]

4. Leverage Federal Funds to Develop Broadband Infratrsucture in Rural Areas

Access to secure, high-speed Internet service is critical to implementing telehealth programs. Providers in communities without access to affordable broadband service or computer equipment can leverage federal programs designed to promote the use of telemedicine.

Challenges: Despite significant investment over the past five years,[46] some rural and frontier providers still lack adequate access to high-speed Internet—and those that have access mav find it

- The Federal Communication Commission's (FCC's) Rural Health Care Program (RHC Program) includes two programs that provide up to $400 million in funding annually:
  - o Eligible providers participating in the Healthcare Connect Fund receive a 65 percent discount on all eligible expenses, including broadband service and equipment.
  - o The Telecommunications Program subsidizes rural providers service costs, allowing rural providers to pay the same rates as urban providers.[48]
- The United States Department of Agriculture and Rural Development (USDA) administers various pertinent grant and loan guarantee programs:
  - o The Distance Learning and Telemedicine Grant Program provides competitive grants between $50,000 and $500,000 with a 15 percent match. The funds can be used to acquire necessary equipment and infrastructure as well as technical assistance to train staff in using the equipment.[49]
  - o The Community Connect Grant Program provides competitive grants between $100,000 and $3,000,000 with a 15 percent match. The funds can be used to build infrastructure in areas where broadband service is not available, as well as provide broadband service free-of-cost to critical community facilities (including hospitals and health care providers) for two years.[50]
  - o The Telecommunications Infrastructure and Farm Bill Broadband Loans & Loan Guarantee Program provide funding to construct, improve, or acquire facilities and equipment required to bring broadband service to eligible rural areas.[51,52]

Due in part to implementation delays, the FCC only disbursed a total of $327 million in the RCH Program's first 12 years, a combined total less than the program's $400 million annual cap.[53] Funding requests have risen sharply in recent years (an average of nearly $235 million annually across fiscal years 2013 and 2014), but as of September 30, 2015, less than $100 million has been requested for fiscal year 2015.[54] States and local government agencies are eligible applicants for all of the USDA grant and loan programs identified above; states may also be in a position to assist providers in participating in these programs if they can cover a portion of the required matching funds or help secure foundation or private payer support.

Increasing Provider Capacity Through Teleconsultation

Remotely connecting patients to specialty providers can alleviate access issues, but access to specialty providers is only half of the equation. By providing distance learning opportunities and supports, the primary care system becomes better equipped at managing individuals' behavioral health needs and referring out to specialty services as necessary. Two models in particular, the Massachusetts Child Psychiatry Access Project (MCPAP) and the University of New Mexico's Project ECHO, have gained national momentum over the past few years (See Table 2).[55]

Implementation

Comparatively, teleconsultation programs can be much easier to implement than telehealth programs. Many of the legal and regulatory issues discussed in the previous section are not applicable provided that the program does not create a new physician-patient relationship under state law (a legal standard that varies by state). Furthermore, only four states (Michigan, North Dakota, Pennsylvania, and South Dakota) do not have a law providing some exclusions to state licensure require-

	The Massachusetts Child Psychiatry Access Project	University of New Mexico's Project ECHO
Program Description	First piloted in 2003, the Massachusetts Child Psychiatry Access Project (MCPAP) telephonically connects pediatricians across the state with one of six regional behavioral health teams. The teams consist of a child psychiatrist, a social worker, and a care coordinator; all of whom assist pediatricians to diagnose, treat, and manage children with behavioral health needs. The program can provide one-time face-to-face consultations with patients and facilitates referrals to in-person services as necessary and appropriate.	Launched in 2003, Project ECHO is a hub-and-spoke model that uses web-based video to connect primary care providers with specialist mentors. Providers have applied the model to nearly 40 health conditions, including an Integrated Addiction and Psychiatry (IAP) TeleECHO Clinic. Participating primary care teams take part in case-based learning that includes a mix of didactic presentations and reviewing actual cases using de-identified information.
Funding	MCPAP is funded through a Massachusetts Department of Mental Health line item ($3.1 million in FY2015) and, beginning in FY2015, commercial health plans pay a surcharge for their share of program costs. Budget shortfalls required the program to scale back in recent years, but it is currently being expanded through the state's State Innovation Model Test Award.	Funded through a mix of federal, state, and philanthropic dollars, including consultative service payments to providers by New Mexico's Medicaid managed care plans. In July 2015, the GE Foundation awarded a $14 million grant to Project ECHO and the Institute for Healthcare Improvement to extend the model to additional community health centers across the country.[57]
Outcomes	In 2012, 92 percent of practices in the state with more than 2,000 children used the service. After using the service, prescriber-level psychiatric care remained with the primary care provider 67 percent of the time. A survey of participating providers found that 64 percent either agreed or strongly agreed that they could "meet the needs of children with behavioral health problems," compared to 8 percent before enrollment.[58]	Although outcomes data specific to the IAP TeleECHO Clinic are not available, the model has generated positive outcomes for other conditions. Participating primary care providers were able to manage Hepatitis C treatment as effectively as an academic medical center with fewer reported serious adverse events.[59] When the IAP network was used to recruit participants for buprenorphine training, more New Mexico physicians from traditionally underserved areas chose to be trained, compared with physicians nationwide.[60]
Spread	Similar programs are underway in various stages of implementation in 30 states and the District of Columbia.[61]	Hubs currently operate in 22 states; some serve multiple states.

on providers' willingness to participate. Provider outreach and engagement activities that make the case for participation to both specialty and primary care providers may have the greatest impact.

Challenges: Specialists may be resistant to sharing their expertise, particularly if it means fewer referrals. Primary care providers may also be hesitant to work with behavioral health providers with whom they do not have an established working relationship.

Strategies: Teleconsultation programs have benefitted from identifying and engaging specialty physicians who will champion the model.[62] Messaging can be critical, and it is important to remind stakeholders that the purpose of these types of programs is not to supplant specialty care, but rather ensure that patients receive appropriate care in the appropriate setting. Facilitating face-to-face introductions between the primary care providers and consulting physicians may increase the comfort levels of both participanting providers and risk managers, even if it's a one-time meeting.[63]

2. Sustainability

The physical infrastructure required for teleconsultation programs can cost significantly less compared to telehealth programs. For example, MCPAP requires nothing more than a telephone line and telephone. Sustaining teleconsultation programs may require significant funding commitments depending on the staffing model and whether participating providers are compensated for their time, but larger providers hosting or administering teleconsultation programs may be in a financial position to bear some of the associated costs.

Challenges: Grant funding and/or annual legislative appropriations is sometimes used to provide seed funding to launch or maintain teleconsultation appropriations creates uncertainty as to whether the program will be sustainable. Traditional fee-for-service billing may not be appropriate for programs that do not provide direct medical services to patients. Even if a direct billing mechanism is created, it does not necessarily mean the program will be sustainable. In other child psychiatry access programs, fee-for-service was not a sustainable payment methodology due to variable billing volume and cumbersome billing processes, as well as increased legal risk due to the fact that the payment created new physician-patient relationships.[64]

Strategies: Teleconsultation programs may be more sustainable when paid for using alternative, value-based payment models that promote team-based care and allow flexibility to cover services that may be non-billable, including physician consultation and care coordination. Furthermore, like other payment and delivery system reforms, sustainability may rest in multi-payer participation. This was a particularly important issue in Massachusetts, where more than half of the MCPAP encounters in FY2014 (58 percent) were for children covered by commercial insurance.[65] With legislative authority granted in the state's FY2015 budget, the Massachusetts Department of Public Health promulgated new regulations ensuring commercial plans would proportionally share in their cost to the program.[66]

Blending Telehealth and Teleconsultation

In addition to the telehealth and telepsychiatry services described earlier, the programs in Mississippi and Alaska also offer educational services that build provider capacity similar to Project ECHO. For example, the University of Mississippi Medical Center's Distance Learning Educational Series for Behavioral Health is available to all of the sites for which it provides telemedicine and telepsychiatry services.[67]

Medical Center's Center for Telehealth and Project ECHO discussed potential benefits of blending their programs.[68,69]

One Medicaid managed care plan in Washington found that telepsychiatry was most effective in a stepped-care model where primary care providers worked with a behavioral health coordinator and consulting psychiatrist before connecting patients with the psychiatrist through telepsychiatry (see Table 3); practices using telepsychiatry alone have had a harder time integrating remote services into their workflows.[70] As new initiatives are launched, program leaders may wish to explore how telehealth and teleconsultation services can be combined to achieve program goals.

Table 3. Washington State's Mental Health Integration Program

	Washington State Mental Health Integration Program (MHIP)
Program Description	Launched in 2008, Community Health Plan of Washington (CHPW), one of the state's Medicaid managed care plans, administers the Washington State Mental Health Integration Program (MHIP). Building on the Collaborative Care Model,[71] behavioral health coordinators embedded in over 100 community health centers across the state work closely with primary care teams and meet weekly with a remote consulting psychiatrist at the University of Washington Medical Center.[72] Primary care physicians can also consult directly with the psychiatrist as needed. Since launch, CHPW has introduced telepsychiatry services into MHIP, allowing patients to remotely meet with the consulting physician.
Funding	First supported through legislative appropriations, CHPW provides two payments: one to community health centers to hire the behavioral health coordinator; and a second to University of Washington Medical Center to pay for a portion the consulting psychiatrists' time. A unit-based caseload rate provides the necessary flexibility to cover the coordinators' time spent consulting with the primary care providers and psychiatrist, as well as entering data into a registry. It also provides flexibility for the psychiatrists, who allocate their time between working in the registry and consulting with the coordinator, primary care team, and patients. A 2015 law requires Washington's Medicaid managed care, state employee, and commercial health plans to begin reimbursing for telemedicine services no later than January 1, 2017.[73] CHPW is actively exploring how the new law impacts their payment model for direct telepsychiatry services, but the law does not provide reimbursement for remote consultation.
Outcomes	MHIP has decreased specialty referrals and increased primary care providers' ability to meet the behavioral health needs of their patients.[74] In the first 14 months, the program reports that it saved more than $11 million in avoided hospital costs; the program also created positive social outcomes, including fewer arrests and smaller increases in homelessness.[75]

technologies that remotely connect patients with providers and their peers are shaping the future of the health care system. For example:

- Payers and providers across the country are beginning to partner with Big White Wall, an "anonymous clinically facilitated peer community" that connects individuals with credentialed therapists and peer supports online.[76]

- In June 2015, former executives from Facebook, Google, and other leading technology companies launched Lyra Health, a startup that plans to use web-based screening tools and data analytics to identify individuals with unmet behavioral health needs and connect them with providers that match their preferences.[77]

It remains to be seen how or if states will adopt these or similar initiatives in their public insurance programs. When deciding which new technologies to implement, states will need to weigh the costs of implementation with their fiscal climate and the potential for the technology to create a return on investment. Once a technology is selected for implementation, states will need to examine whether any state-level legal or regulatory barriers will make implementation challenging or restrict its effectiveness. Flexibility can be important when designing new state laws and regulations affecting telehealth policy because it is likely that technological innovations will outpace the laws and regulations.

Ultimately, it is in states' best interest to have a process in place to ensure that new technologies are cost-effective and safe. States' Medicaid advisory committees and similar oversight and evaluation committees are important partners for policymakers when determining which technologies to adopt and how to implement and pay for these technologies to ensure appropriate consumer protections, limit inappropriate utilization, and manage costs.

Conclusion

As the programs discussed in this issue brief show, telehealth and teleconsultation programs have the potential to improve access, increase provider and system capacity, and promote a health care system in which appropriate services are provided in the appropriate setting. Mild-to-moderate behavioral health conditions are prevalent in primary care, and primary care providers play an important role in addressing these conditions while simultaneously managing physical health comorbidities.[78] As primary care providers' capacity to treat mild-to-moderate conditions increases, specialty providers have more time to spend with complex, high-need individuals.

Additional Resources

State officials and other stakeholders interested in learning more are encouraged to visit the following organizations' websites:

- American Telemedicine Association: State Policy Resource Center
- Center for Connected Health Policy: Telehealth Medicaid & State Policy
- National Conference of State Legislatures: State Coverage for Telehealth Services
- Health Resources and Services Administration: Telehealth
- SAMSHA-HRSA Center for Integrated Health Solutions: Telebehavioral Health

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BOARDS

Model Policy for the Appropriate Use of Telemedicine Technologies

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

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).*

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.[3] 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.[4]

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.[5]

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

[4] *Id.*

- 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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[6] *American 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.*

[7] [illegible]

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.

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[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.*

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).[9] 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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[9] *45 C.F.R. § 160, 164 (2000).*

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.

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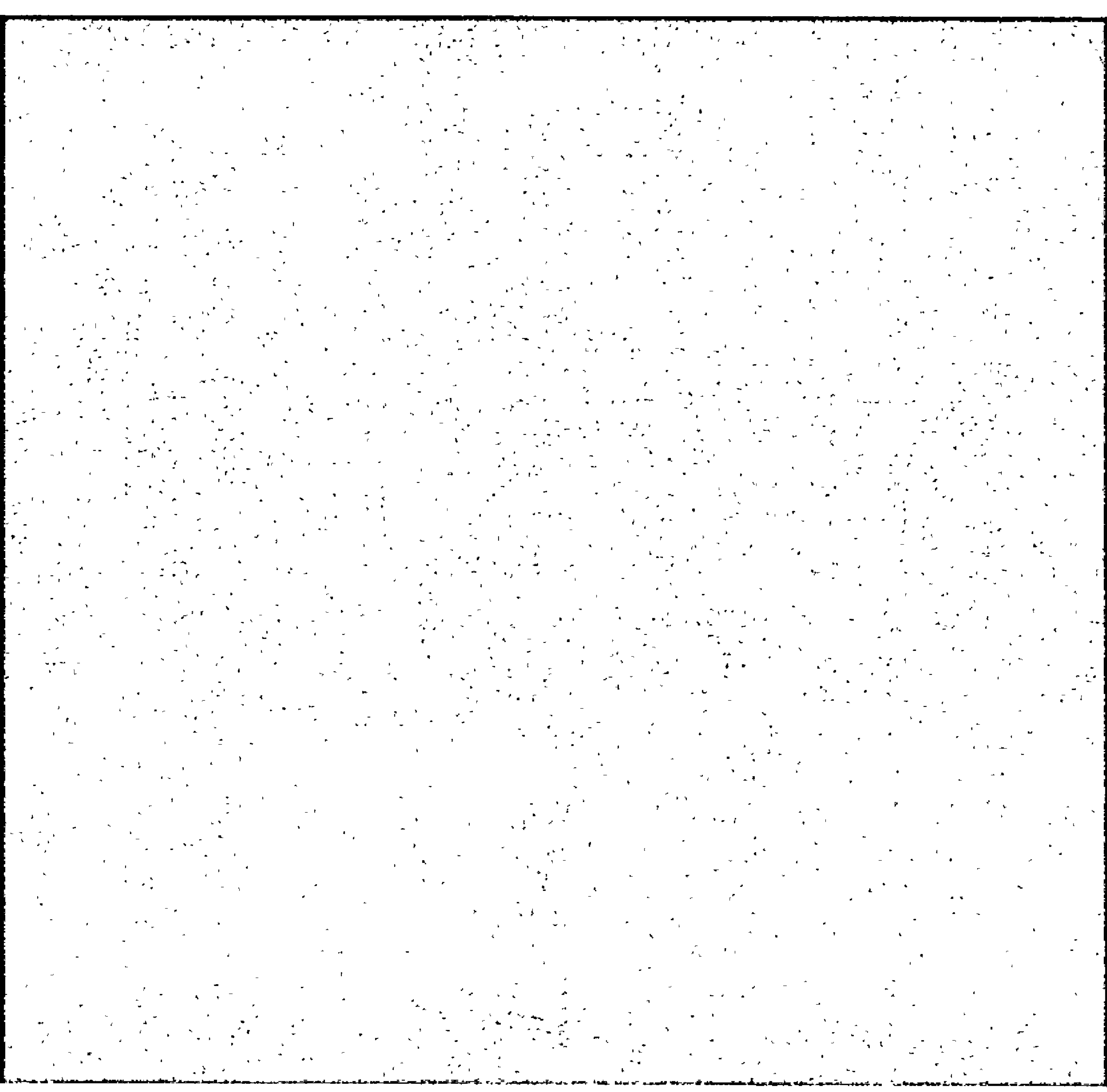

State Telemedicine Gaps Analysis

Physician Practice Standards & Licensure

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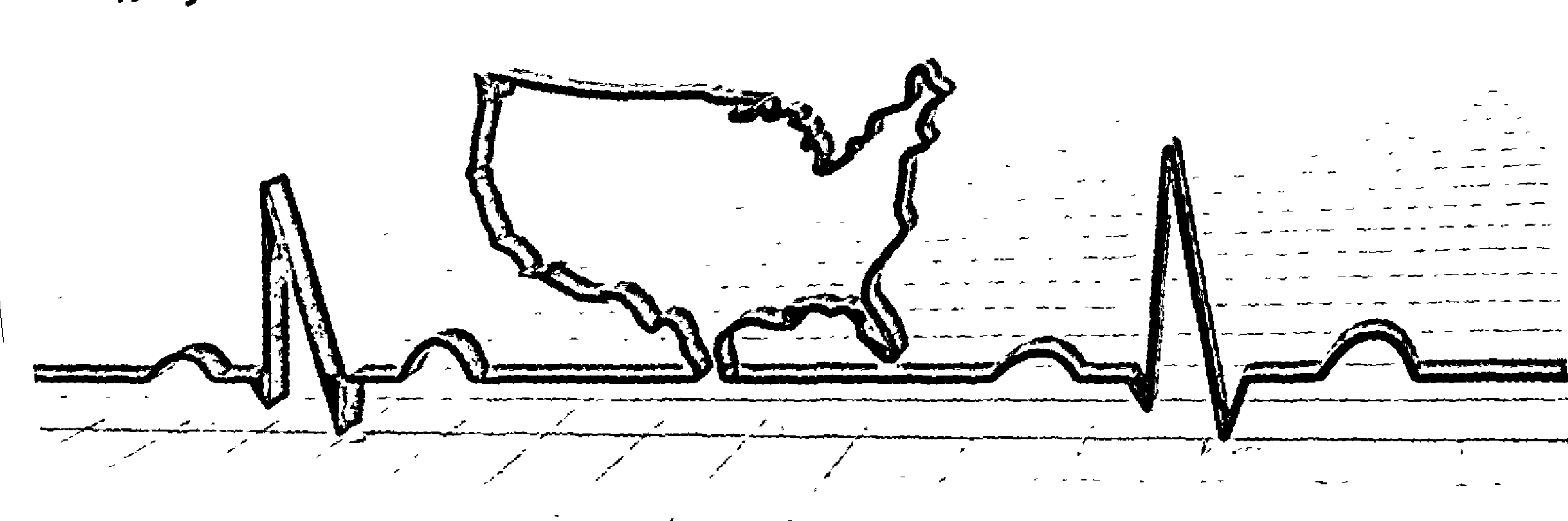
May 2015



50 State Telemedicine Gaps Analysis

Physician Practice Standards & Licensure

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May 2015

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NOTE: Execerpt only- Full text on Basis under HB 234

Table of Contents

Executive Summary 1
Purpose 4
Overview 4
Assessment Methods 5
Scoring 5
Limitations 5
Indicators 6
Physician Practice Standards 6
Physician-patient Encounter 6
Telepresenter 7
Informed Consent 8
Licensure 9
Licensure and Out-of-State Practice 9
Internet Prescribing 9
State Report Card 10
Alabama 11
Alaska 12
Arizona 13
Arkansas 14
California 15
Colorado 16
Connecticut 17
Delaware 18
District of Columbia 19
Florida 20
Georgia 21
Hawaii 22
Idaho 23
Illinois 24
Indiana 25

Iowa ... 26
Kansas ... 27
Kentucky ... 28
Louisiana ... 29
Maine ... 30
Maryland ... 31
Massachusetts ... 32
Michigan ... 33
Minnesota ... 34
Mississippi ... 35
Missouri ... 36
Montana ... 37
Nebraska ... 38
Nevada ... 39
New Hampshire ... 40
New Jersey ... 41
New Mexico ... 42
New York ... 43
North Carolina ... 44
North Dakota ... 45
Ohio ... 46
Oklahoma ... 47
Oregon ... 48
Pennsylvania ... 49
Rhode Island ... 50
South Carolina ... 51
South Dakota ... 52
Tennessee ... 53
Texas ... 54
Utah ... 55
Vermont ... 56

Virginia 57
Washington 58
West Virginia 59
Wisconsin 60
Wyoming 61
Appendix 62
State Ratings – Map: Physician-Patient Encounter via Telemedicine 63
State Ratings – Map: Telepresenter Requirements 64
State Ratings – Map: Informed Consent Requirements 65
State Ratings – Map: Licensure and Out-of-State Practice 66
Matrix: Physician Practice Standards 67
Matrix: Physician-to-Physician Consultations 72
Matrix: Licensure 80
Matrix: Internet Prescribing 81
References 83

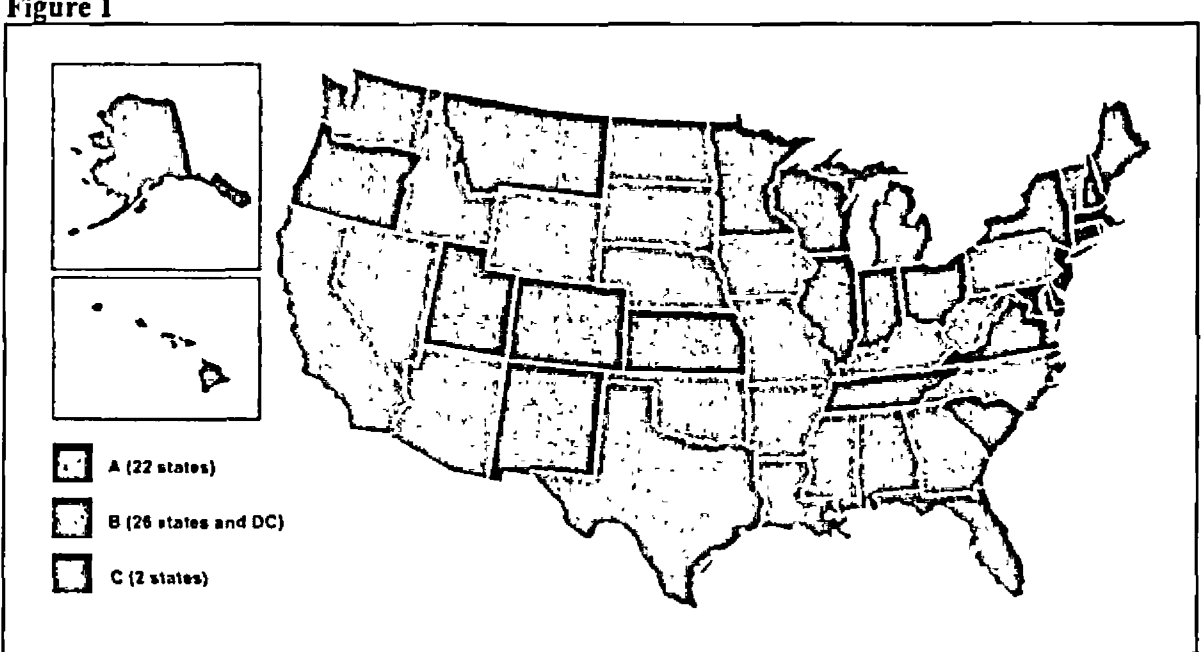
NOTE: Execerpt only- Full text on Basis under HB 234

Professional licensure portability and practice standards for providers using telemedicine are some of the biggest challenges for health care providers considering telemedicine adoption. Providers often encounter a patchwork of conflicting and disparate requirements for insurance claims and practice standards that prohibit them from fully taking advantage of telemedicine.

The American Telemedicine Association (ATA) has captured the complex policy landscape of 50 states with 50 different telemedicine policies, and translated this information into an easy to use format. This report extracts and compares physician practice standards for telemedicine for every state in the U.S. ultimately assigning a grade which indicates existing policy barriers that inhibit the use of telemedicine that would enable patient and provider choice to quality health care services.

Our analysis indicates that decades of evidence-based research highlighting positive patient compliance, clinical outcomes and increasing telemedicine utilization have been met with a mix of strides and stagnation in state-based policy. Since the initial release of our September 2014 report, there has not been much variance in the composite grades given to the states. When comparing the numerous state laws and differing medical board standards regarding telemedicine, twenty-two states averaged the highest "composite grade" suggesting a supportive policy landscape that accommodates telemedicine adoption and usage. Twenty-six states and D.C. fall in the middle with room for improvement. Two states averaged the lowest composite score suggesting many barriers for telemedicine advancement (Figure 1 and Table 1).

Figure 1



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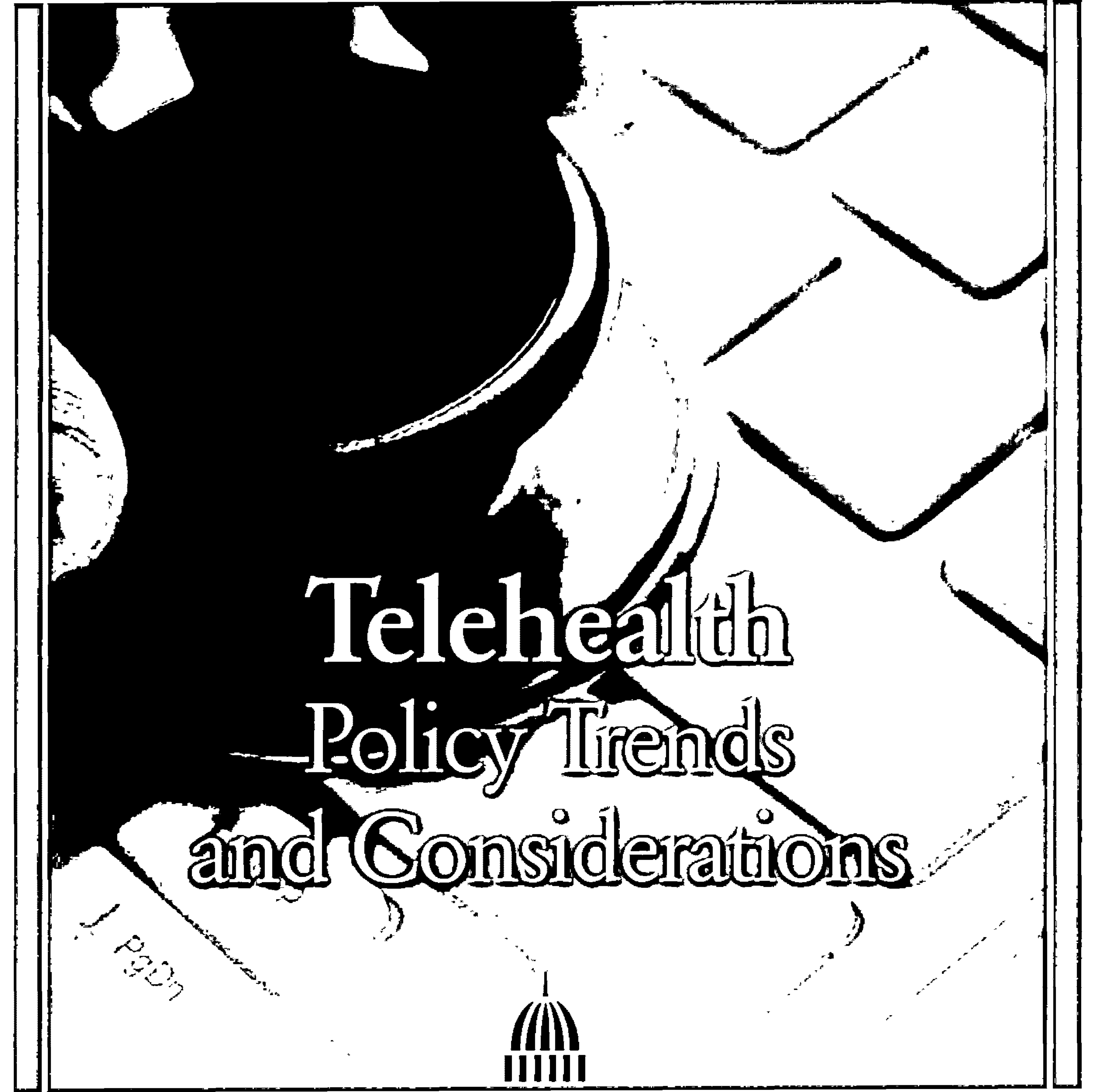

Telehealth Policy Trends and Considerations

NCSL Partnership Project on Telehealth

In December 2014, NCSL brought together state legislators, legislative staff and private industry representatives to discuss telehealth adoption and barriers. The group met for one year and focused its attention on three policy areas: reimbursement of telehealth encounters, licensure for telehealth providers, and patient privacy, safety and security. This white paper represents the outcome of those discussions and provides options for state policymakers in those three areas.

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Overview 6
Effectiveness and value 7
Policy issues 10
Coverage and reimbursement 10
Medicare 11
Medicaid 11
Private payers and state employees 14
Coverage and reimbursement policy checklist 15
Licensure 16
Licensing options 16
Federal efforts 18
Related issues 18
Licensure policy checklist 19
Safety and security 20
Patient-provider relationships and prescribing 20
Informed consent 21
Related issues 22
Safety and security policy checklist 23
Conclusion 23
Notes 26

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care, improved health outcomes and lower costs. It is widely acknowledged for its potential to ameliorate health care workforce issues by creating efficiencies and extending the reach of existing providers. With the potential to overcome access barriers, telehealth is also viewed as a means to reduce health disparities for aging and underserved populations, as well as reduce costs and burdens for patients.

Telehealth is a tool that capitalizes on technology to remotely provide health services. The federal Health Resources and Services Administration (HRSA) defines telehealth as "the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health, and health administration." It encompasses health-related services, including patient education, provider consultation and training, and remote care and home monitoring.

The adoption and expansion of telehealth across the nation poses various challenges, some of which present policy questions for state leaders. This report focuses on the following three primary policy issues related to telehealth.

- **Coverage and Reimbursement:** Differences in payment and coverage for telehealth services in the public and private sector, as well as different policies across states, remain a barrier for widespread telehealth use. States have enacted various policies related to Medicaid, and in many cases, private payers. State policy typically determines what constitutes telehealth; the types of technologies, services and providers that are eligible for reimbursement; where telehealth is covered and how; and other guidelines.

- **Licensure:** With technology's ability to span state borders, provider licensure portability is a key issue that states are examining to expand access and improve efficiency in the existing workforce. Poli-

state lines through various mechanisms, including reciprocity with other states and interstate compacts.

- **Safety and Security:** Ensuring safe telehealth encounters for patients, as well as privacy and data security, has become an increasingly important issue as telehealth has grown. Some states are ensuring patient safety by defining which services are appropriate to be delivered remotely, creating guidelines for establishing a patient-provider relationship and mandating certain informed consent requirements.

Policymakers are working to craft frameworks that capitalize on the benefits of telehealth, while maintaining an appropriate level of oversight to safeguard state investments and ensure effective health care delivery and health outcomes.

Legislators can ask questions to learn more about benefits, opportunities and challenges related to telehealth in their states. Leaders can guide policy discussions that center on telehealth as a way to extend existing health care services.

In considering telehealth policies, legislators may want to convene a variety of stakeholders from all sectors and perspectives. Policymakers modifying or creating policies may consider the level of oversight needed to ensure that services are effective in terms of costs and outcomes, and balance those needs with potential unintended consequences or future hurdles as telehealth continues to develop. Reimbursement, licensure and patient safety—along with new challenges and opportunities—will continue to

- [ ] **Examine existing policies** related to telehealth reimbursement and coverage in your state. Ask questions such as: Which providers can be reimbursed? For which services and telehealth modalities? Where must a provider or patient be located to ensure payment or coverage? What other policies affect coverage and reimbursement?

- [ ] **Consider existing definitions** of telehealth, and to what extent they may enable or constrain telehealth. Explore other states' definitions; weigh benefits and obstacles to promoting consistent language across states to help standardize telehealth.

- [ ] **Look at Medicaid and state employee reimbursement policies** and, if appropriate, consider expanding covered services.

- [ ] **Evaluate the benefits of telehealth expansion** within the context of other state needs. Consult with stakeholders and/or consider studying the potential initial costs associated with increased service utilization versus other state budget needs and the potential to save money in the future.

- [ ] **Work with private carriers** to determine if private payer requirements would help promote telehealth in your state. If so, consider the level and requirements of parity.

- [ ] **Consider the role for legislation** related to licensure and workforce issues in telehealth. Consult with stakeholders, including provider boards, providers, payers (who are responsible for creating adequate networks) and consumers. Consider language in legislation to help provide appropriate guidance to boards.

- [ ] **Look at current workforce or access gaps** and consider ways to facilitate coverage through telehealth. Assess opportunities for allowing providers to practice across state lines, including reciprocity or joining interstate compacts.

- [ ] **Assess the role of licensure** in existing or new payment and delivery reforms. If applicable to your state, examine ways to streamline licensure.

- [ ] **When creating legislation, consider language** that includes or can apply to all provider types, including those who may provide telehealth services in the future.

- [ ] **Study existing statutes** to see whether and where clarity might be needed to help guide safe telehealth policies and practices. For example, look at definitions of patient-provider relationships or examinations, and consult with stakeholders about changes or considerations.

- [ ] **In looking at existing or new legislation, balance the constraints** being placed on telehealth with the need to safeguard patient safety and security.

- [ ] **Examine how data are collected** on health care services delivered by telehealth. Data collection that includes a telehealth-specific identifier for billing helps in evaluating programs and in monitoring for fraud and abuse.

by nearly all states and even by different entities within the federal government. The federal Health Resources and Services Administration (HRSA) defines telehealth as "the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health, and health administration."[1] Telemedicine typically refers to clinical services, whereas telehealth encompasses health-related services more broadly, including

tation and training, and remote care or home monitoring. However, telehealth and telemedicine are often used interchangeably.

Definitions of telehealth affect the services covered and reimbursed in each state. Some states limit telehealth definitions to certain types of technologies, while others allow more flexibility through broad definitions. In addition, most states exclude—or do not specify inclusion of—email, telephone and fax in their definitions of telehealth.

24-56.4: "'Telemedicine' means the practice, by a duly licensed physician or other health care provider acting within the scope of such provider's practice, of health care delivery, diagnosis, consultation, treatment, or transfer of medical data by means of audio, video, or data communications which are used during a medical visit with a patient or which are used to transfer medical data obtained during a medical visit with a patient. Standard telephone,

OVERVIEW

Telehealth offers one potential strategy to help achieve the triple aim of better health care, improved health outcomes and lower costs. States spend a significant portion of their dollars on health care, and despite a recent slowdown, new projections estimate that health care spending in the United States will increase by an average of 5.8 percent per year from 2014 to 2024.[2] While examining cost drivers, state leaders are looking to leverage resources in a cost effective manner that improves health for the population.

Telehealth is a tool—or means—of delivering care that capitalizes on technology to remotely provide health care and other health services. It brings the services directly to the patient, changing the way patients and their families can interact with providers and the health care system.

With this mechanism for care delivery on the rise, many advocates and experts believe telehealth will continue to grow and gain acceptance to grow from 250,000 patients in 2013 to 3.2 million patients in 2018.[3] This trend is playing out in state legislatures, as more than 200 telehealth-related bills were introduced in 42 states in 2015.[4] State leaders are grappling with how to leverage the potential of telehealth while also ensuring appropriate use, health outcomes and safety. This report describes some of the trends and issues in state telehealth policies, and key considerations for lawmakers.

The roots of telehealth have been linked to innovative ideas from the late 1800s and early 1900s, as evidenced in an 1879 Lancet article that cited using the telephone to reduce unneeded office visits.[5] Over the past few decades, telehealth has been largely viewed as a means to reach rural communities, which typically face additional barriers to accessing care, such as fewer providers and greater travel distances. However, telehealth is increasingly being viewed more broadly as a way to reach multiple populations in different settings and to address various health care issues.

unsecured email, or a combination thereof do not constitute telemedicine services."

- **Minnesota** Statute § 62A.671: "'Telemedicine' means the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between licensed health care providers that consists solely of a telephone conversation, email , or facsimile tute telemedicine consultations or services. A communication between a licensed health care provider and a patient that consists solely of an email or facsimile transmission does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care sessment, diagnosis, consultation, treatment, education, and care management of a patient's health care."

- **Nevada** AB 292 (2015): "'Telehealth' means the delivery of services from a provider of health care to a patient at a different location through the use of information and audio-visual communication technology, not including standard telephone, facsimile or electronic mail."

Sources. Center for Connected Health Policy; NCSL

tential to ameliorate health care workforce shortages and maldistributions. Though it does not increase the size of the provider workforce, it can help better distribute providers by creating efficiencies and extending the reach of existing providers. With its potential to overcome workforce and access barriers, telehealth is also viewed as a means to reduce health disparities for aging and underserved populations, as well as reduce costs and burdens for patients associated with lost work time, transportation and child care.

Telehealth can increase health care access in other ways, including, for example, the ability to access care outside typical provider office hours or in different settings such as homes, long-term care facilities, schools, workplaces or prisons By improving access to lower-cost primary and necessary specialty care, telehealth could provide timely, accessible care in lower-cost environments and help reduce expensive emergency room (ER) visits. For older people, telehealth may assist family caregivers, support aging in place and reduce institutional care. And certain telehealth modalities may be especially helpful in managing chronic conditions at home, thereby reducing ER and hospital readmissions.

The possibility to improve health,[6] along with consumer demand for convenience, is also a driving factor for many health leaders and providers to invest in telehealth programs. For example, 74 percent of consumers reported that they were likely to use online services.[7]

EFFECTIVENESS AND VALUE

Telehealth can help achieve the goals of the triple aim—improving care, bettering health and lowering costs—by improving access to appropriate, lower-cost services, such as timely primary or specialty care, or through lower-cost settings, including clinics, homes or workplaces. For example, it is viewed as a beneficial tool to support patients and family caregivers in home health care for older Americans, who are a growing population and account for about 75 percent of health care costs. The Centers for Medicare and Medicaid Services (CMS) notes

TELEHEALTH APPLICATIONS

Four modes, or modalities, are typically included in the definition of telehealth. The first three are most often seen in states' policies, whereas mobile health is less common in policies, but is a rapidly growing field.

■ **Real-time or Live Video:** Real-time or synchronous audio and video communication between a patient (and/or family member) and provider; e.g., visiting with a specialty care provider in real time over video.

■ **Store and Forward:** Transmission of data, images, sound or video from one care site to another; e.g., teleradiology or teledermatology, where images are sent to specialists for evaluation.

■ **Remote Patient Monitoring:** Services in which a patient's vital signs and other data are collected at home or outside a clinic and transferred to a provider for monitoring and response, if needed; e.g., at-home monitoring of patients with diabetes or blood glucose levels and other vital signs.

■ **mHealth (mobile health):** Health education, information or public health services provided by a mobile device; e.g., health education applications (apps) on cell phones, wearable devices or reminders to take medications. This

Telehealth is often associated with increasing access to primary care services.

However, it includes, but is not limited to, numerous other applications such as:

- Acute care, such as trauma, telestroke and tele-ICU programs
- Chronic care management
- Behavioral health care, such as telepsychiatry
- Long-term services and supports
- Home health care
- Dental care
- Specialty medical services, such as dermatology and radiology

For more information on specific uses of telehealth, please see resources such as the American Telemedicine Association's case studies.

comparable—or no difference in—patient care and outcomes compared to traditional care delivery. The American Telemedicine Association, a telehealth advocacy organization, suggests that much of the research has found care provided through telehealth to be comparable to in-person care without differences in the ability to obtain necessary information, make a diagnosis or develop a treatment plan.[9] A recent review of 93 randomized control trials—the gold standard of research—found similar or better outcomes through telehealth alone or telehealth with usual care, as compared to usual care alone, for patients with a variety of health issues.[10] The findings were primarily related to patients with heart failure and diabetes, but some evidence supports comparable outcomes in areas such as mental health and dermatology.

In terms of clinical outcomes and cost effectiveness, many note that more research is needed. The review of randomized control trials concluded that effectiveness of telehealth may depend on different factors, including patient population (e.g., disease or condition), how telehealth is used (e.g., clinical visit, remote monitoring), and the health care providers or systems involved in delivering telehealth. The review noted that limited data were available on patient and provider satisfaction, as well as costs. Similarly, a stakeholder group convened by the Center for Connected Health Policy concluded that "larger, longer, more rigorously designed controlled studies" were needed to better evaluate telehealth.[11]

Many of the peer-reviewed, rigorous studies of telehealth cost effectiveness are only recently emerging,[12] and there are multiple challenges associated with measuring and making generalized conclusions about cost effectiveness. The studies in this field are each limited to different telehealth modalities, settings, diseases or conditions, or patient groups.[13] This makes it difficult to make a broad statement about cost

Researchers, states and other groups are trying to measure the effects of telehealth on costs. For example, among 12 peer-reviewed studies published since 2007, most of the research found cost savings or no difference in telehealth compared to traditional care delivery (see box on page 10 for examples).[15] In addition, in a report required by legislation, Maryland's Department of Health and Hygiene found that Medicaid expenditures using a "hub and spoke" telemedicine model could increase costs for the state between $500,000 and $700,000 through increased service use. The report also suggested the projected increases were relatively small and would likely be offset by the reductions in ER visits and transportation costs. In a different context, an analysis of various private payer data found cost savings of approximately $126 for each commercial telehealth visit, compared to in-person acute care.[16] It also estimated that Medicare could save around $45 per telehealth visit.

Data on outcomes and cost effectiveness are vital to policymakers seeking to invest state resources wisely and will continue to be important moving forward. State leaders can support collecting and measuring data on telehealth services to help strengthen the evidence base. Relevant data may include service, cost and health information found in claims data, pharmacy records and patient medical records. Even data from remote patient monitoring or wearable electronics (such as activity trackers) may provide valuable information. Data analytics, including a comprehensive strategy for collecting and using data among multiple health care stakeholders, is increasingly important to understand cost drivers and manage the population's health. State reforms, including alternative payment and delivery models, will also likely have implications for the use, outcomes and costs associated with telehealth. Policymakers may wish to consider the roles of telehealth, along with availability and integration of data, when

RESEARCH

Some newer studies related to cost effectiveness in telehealth have found comparable costs or cost savings compared to traditional care delivery.

A study of a private nursing home chain that switched from on-call physicians to telemedicine physician coverage during off-hours looked at hospitalizations and the level to which nursing homes were engaged in telehealth service.[17] Among other things, the researchers found that facilities that used telehealth to a greater extent realized a significant decline in hospitalizations. They found the average savings to Medicare would be $151,000 per nursing home per year for the more engaged facilities. The authors also acknowledge that Medicare better incentivizes reducing hospitalizations, while nursing homes may have a financial disincentive to invest in telehealth to prevent hospitalizations for long-term Medicaid patients. This is because, instead of Medicaid payments, the facility will often receive a higher skilled-nursing benefit from Medicare when patients return post-hospitalization.

An analysis of a Veterans Health Administration chronic disease management program that included care coordination with home telehealth monitoring devices to help veterans age in place and prevent nursing home admissions found positive results.[18] The findings included that the care coordination home telehealth group, in comparison to the usual care group, had significantly lower health care costs and smaller increases in Medicare costs. The group also had a greater increase in pharmacy costs attributed to better medication management and adherence. These findings built on a 2008 study, which found a 25 percent reduction in numbers of "bed days," a 19 percent reduction in hospital admissions, and a cost of $1,600 per patient per year, substantially less than other non-institutional care programs and nursing home care.[19]

An evaluation of the Hospital at Home model to serve aging Medicaid and Medicare patients with chronic diseases also found benefits for the telehealth group.[20] The Hospital at Home group had a telehealth unit in the home and a remote telehealth nurse to monitor conditions, as well as more extensive services such as physician and nurse visits. The study found 19 percent cost savings, similar outcomes and higher patient satisfaction in Hospital at Home, compared to similar inpatients.

present policy questions for state leaders. For example, lack of broadband and cellular connectivity, and availability and affordability of devices for consumers and providers can hinder telehealth. The telehealth field is changing rapidly, and in some cases, technology may be getting ahead of policy. Policymakers are working to craft frameworks that capitalize on the advancements and potential for telehealth, while maintaining an appropriate level of oversight to safeguard state investments and ensure effective health care delivery and their constituents' health outcomes.

This report focuses on the following three primary policy issues related to telehealth often cited by advocates, providers and lawmakers.

- **Coverage and Reimbursement:** Differences in payment and coverage for telehealth services in the public and private sector, as well as different policies across states, remain a barrier for widespread telehealth use.
- **Licensure:** With technology's ability to span state borders, provider licensure portability is a key issue that states are examining to expand access and improve efficiency in the existing workforce
- **Safety and Security:** Ensuring safe telehealth encounters for patients, as well as privacy and data security, has become an increasingly important issue as telehealth has grown.

COVERAGE AND REIMBURSEMENT

Coverage and payment are important pieces for all parties involved in telehealth. Health care professionals may be concerned about adequate payment for providing services remotely, and lack of payment could affect their ability to invest in telehealth technologies.[21] Similarly, differences

bursement policies for Medicaid programs and, in some cases, for private carriers.

Medicare

Medicare, the federal insurance program for people age 65 and older and younger people with disabilities or certain conditions, began covering telehealth on a limited basis in 1997.[22] Though Medicare is a federal program, it affects what states can do for vulnerable populations, including those dually eligible under Medicare and Medicaid. Over time, the program has expanded its scope in terms of telehealth, but many limitations remain in place.

Medicare specifies reimbursement only for certain telehealth modalities, services and locations, including geography. It limits coverage to live-video (real-time audio and video technology) telehealth for office visits, office psychiatry services and provider consultations.[23] Store and forward methods are only covered in Alaska and Hawaii, the two exceptions to the live video policy, and remote patient monitoring is not covered at all.

Reimbursement for telehealth under Medicare is also dependent on the location of the beneficiary, or patient, receiving the services. The site of the patient—also known as the originating site— must be a rural location, which is defined as a Health Professional Shortage Area (HPSA) or in a county that is outside of a Metropolitan Statistical Area (MSA).[24] In addition, while the provider can be remote, the originating site must be a medical facility, which includes certain settings such as hospitals, provider offices, critical access hospitals, rural health clinics, federally qualified health centers, skilled nursing facilities and community mental health centers.[25] This restriction excludes settings such as patients' homes.

States have the ability, through the Affordable Care Act (ACA), to use telehealth in integrat- (CMS) Capitated Financial Alignment Model for Medicare-Medicaid Enrollees.[26] And under CMS approval, Virginia has waived some of the Medicare barriers to telehealth. For example, Virginia allows plans to use and reimburse for telehealth in rural and urban settings, including store and forward and remote patient monitoring services.

At least two pending congressional bills would affect telehealth practices for Medicare. The Medicare Telehealth Parity Act (HR 2948), one of several proposed federal pieces of legislation, would expand telehealth under the Medicare program. Among other things, it would amend the definition of an originating site and direct the Government Accountability Office to study the effectiveness and savings of certain telehealth services. The Telehealth Enhancement Act (HR 2066) also seeks to expand telehealth under Medicare, including by expanding originating sites and authorizing accountable care organizations to include telehealth and remote patient monitoring as supplemental health care benefits, as well as in a national pilot on payment bundling. Both bills were introduced in 2015 and remain under consideration at time of publication.

Many state policymakers and telehealth stakeholders view the Medicare policies as burdensome barriers to telehealth growth. Because of the restrictions, many states are now leading the way with innovative policies for programs that fall under their purview.

Medicaid

States have significant control and flexibility in their Medicaid programs, unlike in Medicare, including the ability to decide Medicaid coverage and reimbursement for telehealth. According to CMS, "states are encouraged to use the flexibility inherent in federal law to create innovative payment methodologies for services that incorporate telemedicine technology."[27] State policy typically determines what constitutes telehealth; the types

vices—which allow users to connect to the Internet at high speeds—are important when considering how patients can access the growing availability of telehealth services. Smartphone use among Americans is at about two-thirds and around 70 percent have broadband access at home. Yet there are disparities. The broadband numbers dip when looking at older adults and those with lower education levels, limited incomes, chronic health conditions or disabilities, or who live in rural areas. And some—around 20 percent in smartphones or broadband does not necessarily guarantee access to services because of speed or data limitations.

Providers, especially rural or smaller clinics or practices, may also face challenges in connectivity. This is particularly important for those who want or need to connect to larger or other health care systems. Nearly all states have enacted legislation to support broadband in some way, including promotion, coordination or funding. The federal government is also involved in expanding broadband. access to broadband services for health care providers, particularly in rural areas, and encourages the formation of state and regional broadband networks. This may be one avenue for states and providers to leverage in order to expand provider connectivity. The Federal Communications Commission created a National Broadband Plan, which also cited the need to expand broadband to enable health-related technologies, including in rural areas.

Sources. Pew Research Center's Internet Project; NCSL

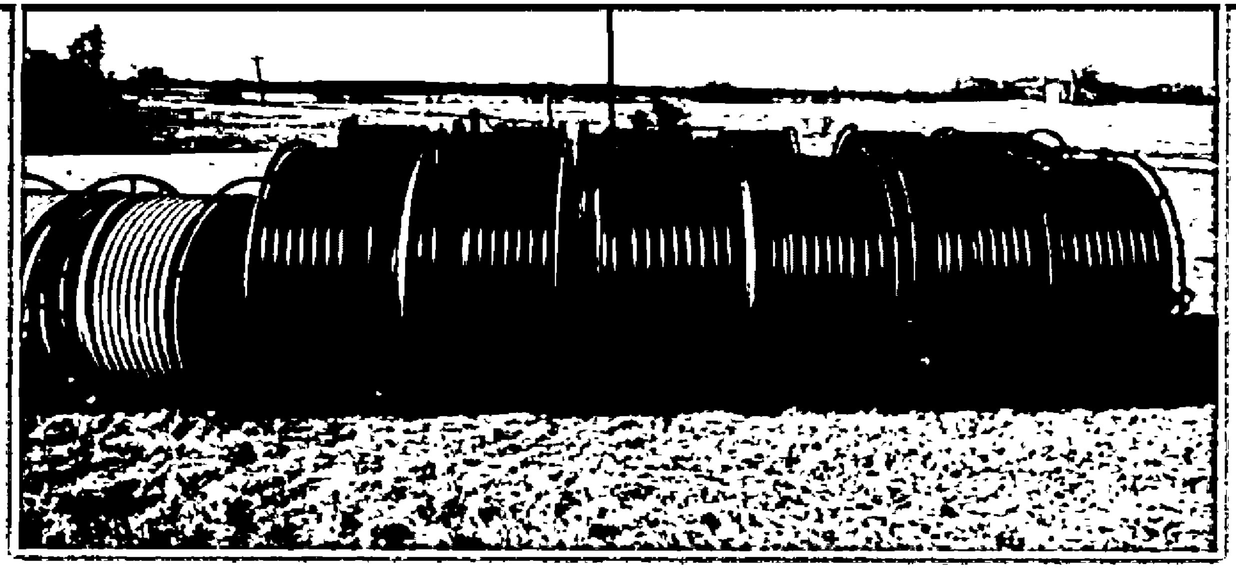
eligible for reimbursement; where telehealth is covered and how; and other guidelines.

Based on analysis from the Center for Connected Health Policy, the American Telemedicine Association and NCSL research, telehealth coverage and reimbursement in state Medicaid programs vary considerably.[28]

- Almost all states (49) and the District of Columbia have some coverage for telehealth.
- Nearly all reimburse for live video telehealth.
- Nine states—Alaska, Arizona, California, Illinois, Minnesota, Mississippi, New Mexico, Oklahoma and Virginia—reimburse for store and forward services.
- At least 17 states have some reimbursement for remote patient monitoring (RPM) in Medicaid: Alabama, Alaska, Colorado, Illinois, Indiana, Kansas, Louisiana, Maine, Massachusetts, Minnesota, Mississippi, New York, South Carolina, Texas, Utah, Vermont and Washington, plus Pennsylvania and South Dakota, who reimburse for
- Most states specifically exclude—or do not specify inclusion of—email, phone and fax in their definitions of telehealth services that can be reimbursed.

Within these reimbursement structures, there are many nuances among states. For all modalities, states may restrict the types of services and specialties, the types of providers and the location of the patient in order to be eligible for reimbursement.[29] For example, 48 states have some coverage for mental or behavioral health services provided via live video, whereas eight states reimburse for telehealth under their home health services.[30] In addition, 19 states allow fewer than nine provider types to receive reimbursement for telehealth (including four states that allow reimbursement only for physicians), while 15 states and the District of Columbia do not specify the type of provider.[31]

Though some states created geographic limits similar to Medicare, requiring that patients be located in rural settings, the trend increasingly is for states to remove these restrictions: The majority of states do not currently have rural



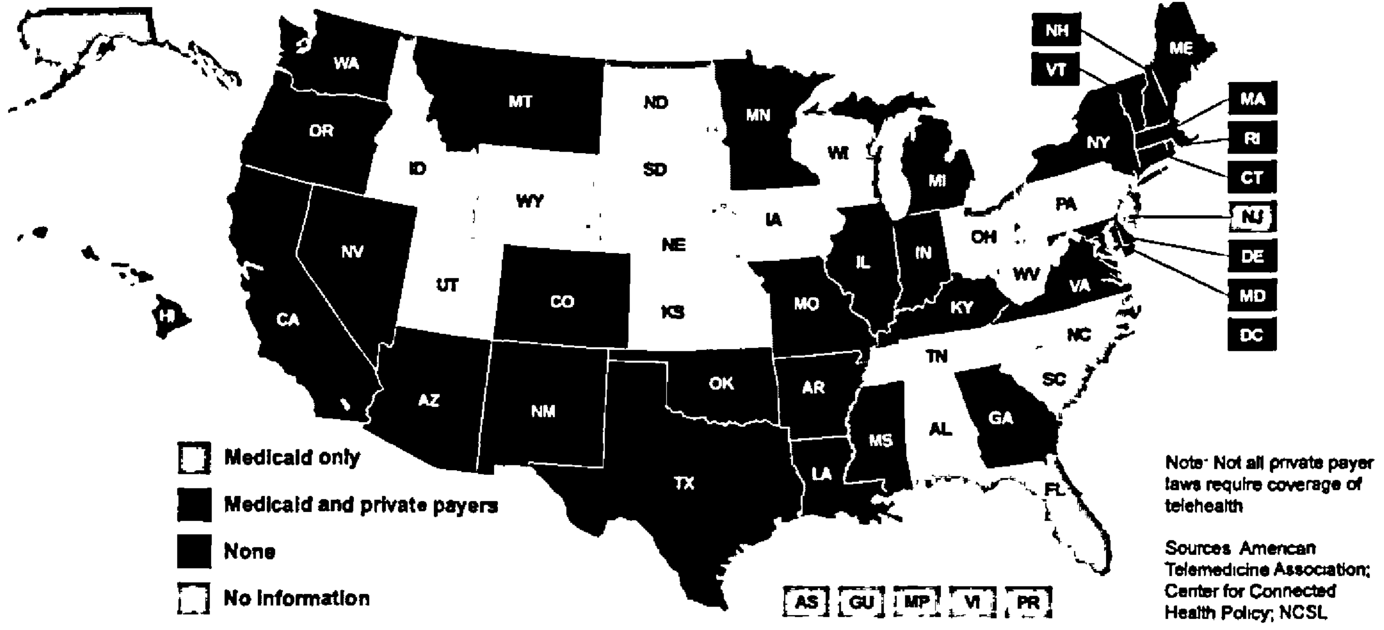
and Missouri removed their geographic restrictions in recent years, and Colorado (HB 1029) removed its requirement during the 2015 legislative session.

States may also require other conditions for Medicaid reimbursement for telehealth. They include, for example, the type of site that can be an originating site (where the patient is located) or distant site (where the provider is located), and whether another provider must be present with the patient as a "telepresenter." Currently, states are relatively split in regard to these requirements. Twenty-four states and the District of Columbia do not specify a patient setting or patient location as a condition of payment.[32] Half of all states allow a patient's home to serve as an originating site, and 16 recognize schools or school-based health centers.[33] And 28 states and D.C. do not require a telepresenter during the telehealth encounter or on the premises during the service.[34]

As states continue to transform the ways they deliver and pay for care, telehealth is one tool that may be deployed within state reforms. For example, 24 states allow telehealth services

spects, alternative models such as Managed Care Organizations (MCOs) and Accountable Care Organizations (ACOs) that typically have capitated payments (e.g., per member, per month) or global payments for patient care have greater ability to cover telehealth. These approaches often emphasize care coordination, and the payment models share risk while providing incentives for positive outcomes and value of care over volume of services. These models may offer more flexibility and incentive to offer services via telehealth. In fact, some argue that the fee-for service model is a barrier to telehealth.[36] The global payment structure in MCOs and ACOs may allow hospitals, clinics and other providers the ability to invest some resources in telehealth, and realize the benefits and cost savings in the future.[37]

States can experiment with some of these alternative approaches through Medicaid state plan amendments, waivers and grants. Alabama, Iowa, Maine, New York, Ohio and West Virginia have used state plan amendments that include telehealth in their health home proposals. Kan-



used waivers to cover remote patient monitoring for long-term care services.[38] In addition, components of Vermont and Oregon's State Innovation Model (SIM) grants from the Center for Medicare and Medicaid Innovation (CMMI) included telehealth pilots. Massachusetts uses SIM funds to support behavioral health integration in primary care, including through telehealth. Hawaii also received support from CMMI for its State Innovation plan, which included expanding telehealth services, and Arkansas similarly included telehealth as a tool to increase availability and access to services. As lawmakers examine telehealth, they may consider it within the context and goals of any of these experiments, or within other state delivery or payment system reforms. Telehealth policies around reimbursement in particular may need to be examined or developed to promote reform goals—aligned with the triple aim—of containing costs and/or better coordinating care to improve health.

Private Payers and State Employees

bursement of telehealth in order to facilitate wider access and adoption. State laws governing private payers vary: Some stipulate certain criteria if payers choose to cover telehealth; some require coverage of telehealth for certain services, certain populations or all beneficiaries; and others require certain payment for telehealth.

In states that mandate reimbursement, some require that reimbursement is "equivalent to" or at the same rate as in-person services. Others—such as Colorado, Missouri and Virginia—require payment "on the same basis," as in-person services, which some argue may better take into account cost differences that could be achieved through telehealth, such as lower facility and administrative fees. Currently, 32 states and the District of Columbia have telehealth parity laws, some of which will go into effect in 2016 or 2017.[39] Full parity—which exists in at least 23 states and the District of Columbia, according to the American Telemedicine Association—is considered when both coverage and reimbursement are comparable to in-person services.[40] Many states with parity laws stipulate that telehealth

The University of Mississippi developed a telehealth program with rural hospitals and clinics in 2003 in order to increase access to health care and specialty services throughout the state, particularly for rural Mississippians. The Center for Telehealth at the University of Mississippi Medical Center uses telehealth video technology to provide remote medical care—including more than 30 different specialties—as well as health education and public health services to 200 clinical sites in three-quarters of Mississippi's counties. The center has served more than 500,000 rural residents. It keeps patients in their home communities and helps improve rural facilities' workforce and bottom line. In addition, projections of savings for Medicaid from the use of UMMC's remote monitoring program for chronic disease management is estimated to be in excess of $189 million per year. Mississippi's program can serve as a model for other states and rural hospitals with specialty care shortages.

Source: The Center for Telehealth at the University of Mississippi Medical Center

Regardless of parity laws, some private insurers choose to cover telehealth services for all or a select segment of their members. For example, through Live Health Online, Anthem offers online live video telehealth visits with providers as a covered benefit for members in most of their commercial markets. These services are also available for a fee to non-members.

All states provide health insurance coverage for their employees. While there is significant variation between individual states, states collectively paid about $25 billion in 2013 to insure their employees.[41] State employee health coverage is a significant portion of state health spending, second only to Medicaid.[42] Twenty-four states allow some type of coverage for telehealth in state employee plans, with 21 extending the coverage through their parity laws.[43]

For states considering health care reforms, including telehealth implementation, employee plans can provide a model for other employers[44] or serve as a demonstration for potential new policies and services. North Dakota, for example, recently enacted legislation (HB 1038) to pilot telehealth in its employee health

Coverage and Reimbursement Policy Checklist

- Examine existing policies related to telehealth reimbursement and coverage in your state. Ask questions such as: Which providers can be reimbursed? For which services and telehealth modalities? Where must a provider or patient be located to ensure payment or coverage? What other policies affect coverage and reimbursement?
- Consider existing definitions of telehealth, and to what extent they may enable or constrain telehealth. Explore other states' definitions; weigh benefits and obstacles to promoting consistent language across states to help standardize telehealth.
- Look at Medicaid and state employee reimbursement policies and, if appropriate, consider expanding covered services.
- Evaluate the benefits of telehealth expansion within the context of other state needs. Consult with stakeholders and/or consider studying the potential initial costs associated with increased service utilization versus other state budget needs and the potential to save money in the future.
- Work with private carriers to determine if coverage requirements would help promote growth of telehealth in your state. If so, consider the level and requirements of parity.

vider networks beyond its borders through telehealth or other means. Licensing policies can also help address existing workforce shortages and the greater provider workloads resulting from more insured patients through the ACA.

Licensure is the responsibility of each state, which determines the qualifications to be licensed providers within its borders and the services and circumstances for health care practice. Through licensing, states have the authority to protect patients located in their borders and hold health care providers accountable to their practice, patient safety and liability laws. Telehealth can be delivered under current state licensure laws. Licensure is based on the location of the patient—providers abide by laws and requirements in the state where the patient receives services—which poses challenges for providers and states seeking to expand access across state lines, particularly through telehealth.

Licensing Options

Most providers are licensed in the state in which they practice health care, and providers wishing to practice in other states can apply for full licenses in those states. Credentialing, which is discussed on page 19, is another issue in telehealth related to licensure.

In order to provide services via telehealth across state lines, some states grant temporary licenses, telehealth-specific licenses or have reciprocity with neighboring states. Wyoming, for example, offers a temporary, expedited license for telehealth for physicians and physician assistants. Nine states—Alabama, Louisiana, New Mexico, Nevada, Ohio, Oklahoma, Oregon, Tennessee and Texas—have special licenses related to telehealth.[45] These allow physicians to provide services remotely across state lines, and typically include certain terms, such as agreeing not to set up a physical office in the state. Other vehicles for out-of-state prac-

state license. Endorsement, as in Connecticut, simply allows an out-of-state physician to obtain an in-state license based on his or her home-state standards.[46]

Interstate compacts are another avenue for cross-state licensing that may promote and expand telehealth. Compacts are formed when a certain number of states enact the same legislation, with specific language that must be adopted. Joining a compact is voluntary on the part of the provider in compact states. States maintain their authority to monitor and discipline providers in their states, and both the home and other compact states have jurisdiction to do so over the health care professionals providing care within their borders. Compacts have the ability to expand provider networks, facilitate expedited help from out-of-state providers in the wake of disasters, and allow states to share information about bad actors. On the other hand, some parties may resist compacts for fear of losing authority, and others are concemed about costs for the state or providers related to implementing compacts.

Licensure compacts have been created for providers such as physicians, nurses and advanced practice registered nurses. The Federation of State Medical Boards' (FSMB) Interstate Medical Licensure Compact for physicians was first introduced in 2015. This compact creates an expedited process for eligible physicians to apply for licensure in compact states. It is intended to allow for a less onerous and time-consuming process for physicians seeking licenses in multiple states. Though the compact enables full licensure not specific to telehealth, one of the goals was to increase access to care through telehealth. Eleven states (Alabama, Idaho, Illinois, Iowa, Minnesota, Montana, Nevada, South Dakota, Utah, West Virginia and Wyoming) passed the medical licensure compact language in 2015, all by large margins in their legislatures—more than the minimum number

Two representatives from each state that approves the compact sit on the Interstate Commission, which will provide the administration and oversight, including developing and enforcing rules.[47] The commission met for the first time in October 2015.

Other providers also have interstate compacts, which allow practice—including telehealth— across state borders. The Nurse Licensure Compact preceded FSMB's physician compact; it has been in existence for about 15 years with 25 states participating. The Nurse Compact creates a multi-state license similar to a driver's license, where the license is recognized in the home state and other compact member states.[48] This is different from the medical licensure compact that has an expedited approval process but still requires physicians to obtain licenses from each state where they practice. The model language for this compact was recently revised, and beginning in 2016, existing states and those wishing to join will need to pass the new language. Many of the modifications to the language were made based on feedback from states. The compact will go into effect after 26 states join or by Dec. 31, 2018, whichever occurs first. Similar to the Nurse Licensure Compact,

PROJECT ECHO

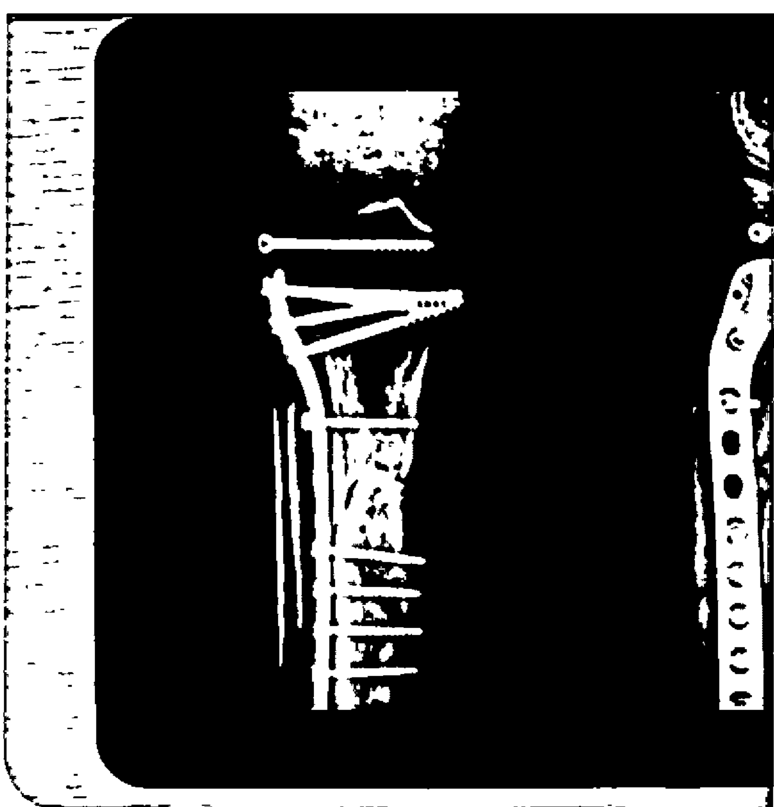
In some cases, providers can consult with each other across state lines without running into licensure issues. Project ECHO (Extension for Community Healthcare Outcomes) is an example of a provider consultation model using telehealth. The project began in New Mexico as a way to build capacity among primary care providers based in rural, underserved areas. Through weekly teleECHO (telemedicine) clinics, primary care clinicians receive support and advice from a specialty care team. In addition to building primary care providers' knowledge and efficacy in certain diseases, the model reduces the isolation of rural providers, increases their satisfaction, expands patient access, and has been shown to achieve care comparable to that delivered in a specialty clinic. There are now 39 ECHO hubs operating in 22 states. For example, during the 2015 legislative session, Missouri appropriated funds to support ECHO clinics.

Source: University of New Mexico School of Medicine, Project ECHO

chologists and physical therapists.

Federal Efforts

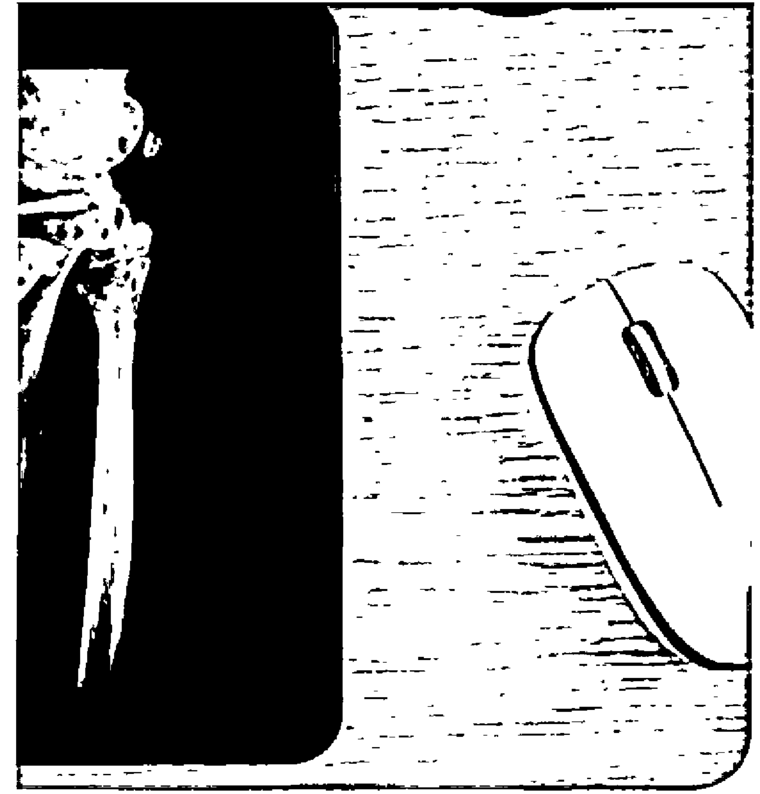
Two pieces of legislation that would affect licensure in Medicare and the Veterans Administration (VA) have also been introduced in Congress. These acts would supersede state requirements around licensure, laws and regulations, and essentially create one license (similar to the driver's license model) in the Medicare and VA programs. The TELE-MED Act (TELEmedicine for MEDicare Act of 2015; SB 1778 and HB 3081) would allow some Medicare providers to offer telehealth services to other Medicare beneficiaries across state lines. The jurisdiction would lie with the licensing or authorizing state. The Veterans E-Health & Telemedicine Support Act of 2015 would allow a health care professional authorized to provide care through the Department of Veterans Affairs and licensed in any state to provide services via telehealth, regardless of where the provider or patient is located.



Related Issues

Outside the licensure realm, several other issues may be of interest to legislators. Some of these issues may be contentious and, according to an Institute of Medicine (IOM) report, "practice standards, scopes of practice and other regulatory issues are increasingly polarizing stakeholders."[49] In many cases, state lawmakers may wish to stay informed about these issues, and in a handful of cases, states are taking action in these areas.

- **Liability:** Most providers may be covered for telehealth under existing liability coverage; however, much of this area is still unsettled and could be a barrier to telehealth. In fact, some of the unresolved issues (described later) involving patient-provider relationships, informed consent and practice standards relate to liability. [...] can have liability implications. State policies on liability also differ and can create issues around interstate practice. Legal issues related to liability also include policy coverage for care via telehealth and for patients in other states; applicable state and federal privacy and security laws; and record retention policies. Lawmakers may want to be aware of existing legal considerations and differences in the application of telehealth, as well as new liability considerations that may arise.
- **Scope of Practice:** Scope of practice describes what a health professional can and cannot do to or for a patient. A professional's scope of practice is often based on the education, training and experience typical for that profession. Scope of practice is defined by state professional regulatory boards, often with guidance from state legislatures, and



censure and workforce issues in telehealth. Consult with stakeholders, including provider boards, providers, payers (who are responsible for creating adequate networks) and consumers. Consider language in legislation to help provide appropriate guidance to boards.

- Look at current workforce or access gaps and consider ways to facilitate coverage through telehealth Assess opportunities for allowing providers to practice across state lines, including reciprocity or joining interstate compacts.
- Assess the role of licensure in existing or new payment and delivery reforms. If applicable to your state, examine ways to streamline licensure.
- When creating legislation, consider language that includes or can apply to all provider types, including those who may provide telehealth services in the future.

of practice; telehealth can be practiced with a state's existing scope of practice for all provider types. Providers may need to be aware of applicable standards of care and laws on supervision and collaboration through telehealth. While separate from licensure, some states may need to look at scope of practice for some disciplines as they address out-of-state providers, workforce shortages (especially behavioral health) and interstate compacts because of differences in state laws.

- **Credentialing and Privileging:** Credentialing and privileging are undertaken by health care facilities to verify providers' proficiency and expertise through data collection.[51] This can be an issue in telehealth when a provider needs credentialing and privileging at each health care facility at which he or she is treating patients via telehealth. Facilities in some cases can allow credentialing and privileging by proxy, relying on the decisions of the other facility This issue is often being handled by facilities themselves, but some states have gotten involved to help facilitate telehealth. Oregon, for example, enacted legislation in 2013 requiring the Oregon Health Authority to adopt uniform documentation requirements for credentialing providers using telehealth.
- **Provider Training and Education:** Many assert that to improve telehealth adoption and use, students and providers in health care professions need to be trained in telehealth modalities. While telehealth training may occur in pockets, some stakeholders argue that it is not keeping up with the pace of telehealth. Incorporating training into education could help more students leave with the knowledge and skills to work effectively with patients remotely. Providers already delivering care may also need support to understand and implement new technologies. State policymakers may want to consider ways to encourage state-sponsored education that includes telehealth or examine mechanisms to support on-

may ensure or improve patient safety by providing high-quality care that is more timely, accessible or appropriate. Remote patient monitoring, for instance, may be especially beneficial for seniors by keeping them safe and healthy in their homes. Live video counseling with a provider, or even an avatar (an image that represents another person), can help some patients with mental health disorders feel more comfortable. New technologies can also improve care, as in new pill bottles, for example, that can help remind patients about taking medication and allow providers to monitor adherence from a distance.

With excitement about the potential for telehealth has also come concerns for ensuring that services provided remotely are as safe and comprehensive as in-person care. Some argue that this concern needs to be addressed without holding telehealth to a stricter standard than traditional health care delivery. Many policymakers are balancing the rapid acceleration of technology and telehealth and its potential benefits with the responsibility to ensure safe, quality care for their constituents.

The standard of care—what another similarly trained and equipped provider would do in a similar situation—applies to health care providers regardless of the means of service delivery. Therefore, the standard of care and best practices for each health care profession should similarly govern safety in telehealth. In other words, because telehealth is simply a modality of delivering care, the standard of care for each type of service still applies. Some assert there is little or no need for other additional safeguards because the standard of care, as well as best practices and malpractice contingencies, will rein in any outliers in telehealth. As it is further employed, the standard of care of telehealth is likely to evolve.

Best practices and practice guidelines are also, according to the IOM, the "key to the future of

Association (ATA) and the Federation of State Medical Boards—have also put forward best practice guidelines for safe use of telehealth. For example, the AMA developed model state legislation, which provides guidance on establishing a provider-patient relationship. The ATA has a set of practice guidelines that cover different health care services in telehealth. FSMB's guidelines provide guidance for state medical boards.

Some states are also getting involved in ensuring patient safety by defining which services are appropriate to be delivered through telehealth (as described in the reimbursement section), creating guidelines establishing a patient-provider relationship, and mandating certain informed consent requirements.

Patient-Provider Relationships and Prescribing

In telehealth, as with other modes of care, patients should trust that providers will offer necessary information for patients to make decisions about care. They should also expect competent care, assurance of privacy and confidentiality, and continuity of care. Providers' ethical responsibilities remain the same with telehealth, but differences in possible patient-provider interactions in telehealth have brought accountability and the patient-provider relationship to the forefront in discussions about telehealth safety. Some states are examining specific guidelines for those relationships. In many cases, these requirements seek to ensure that providers have adequate information about a patient prior to treatment. As an avenue for service delivery, telehealth ideally would be integrated into regular, coordinated care and services. However, there is some concern about fragmented care from different providers or duplication of services. With that is concern that certain providers could deliver care without the proper medical history or information, which could endanger

CALIFORNIA

Kaiser Permanente Northern California implemented new technology and telehealth tools in 2008, including Internet and video communication. Kaiser offered secure email services and phone appointments with providers, both of which ware rated highly by patients—more than 80 percent of members in surveys reported that the communication with providers using these technologies was very good or excellent at meeting their needs. Kaiser also used video visits for some services, including after-hours medical care. Providers could refer patients to in-person emergency care as needed, but largely these visits helped avoid more costly ER visits. Physicians also reported that the online tools helped them provide better care. From 2008 to 2013, the number of virtual visits grew by more than 6 million.

Source: R. Pearl, "Kaiser Permanente Northern California: Current Experiences With Internet, Mobile, And Video Technologies," Health Affairs 33, no. 2 (2014): 251-257.

unease about creating higher standards for telehealth that can inhibit access to care.

At the crux of the patient safety issue are questions about whether and how a patient-provider relationship can be established via telehealth. The majority of states allow a patient-provider relationship to be established via telehealth. Some states have laws requiring an initial "face-to-face" visit or an exam; however statutes are not always clear whether "face-to-face" means in-person or

enacted legislation in 2015 (SB 133) that designates specific requirements for determining a professional relationship, such as conducting a prior in-person exam or "personally [knowing]" the patient.* Alabama, Georgia and Texas also require an in-person follow-up after a telehealth visit.[53] Many stakeholders are wary of requiring in-person visits because of the additional burden placed on the patient to seek in-person care, which could help recreate some of the barriers telehealth seeks to remove.

The patient-provider relationship also comes into play in prescribing medication. Federal law—the Ryan Haight Act—governs controlled substance prescribing via telehealth. State laws also govern a provider's authority to prescribe, including provider board rules and regulations that set the standard of care for prescribing. State pharmacy practice acts also regulate the standard of care for pharmacists. The accepted standard of care is for a provider to conduct a medical exam prior to prescribing a medication.[54] As with telehealth in general, some states allow the exam through telehealth. However, almost all states specifically do not allow an online questionnaire alone to count as an exam, because it relies solely on patients to provide their medical history and other applicable information for a provider, which is not keeping with the standard of care.[55] For example, Idaho's 2015 legislation (HB 189) that defined professional relationships included a clause that treatment based solely on an online questionnaire does not constitute an acceptable standard of care. Most stakeholders agree that if providers can prescribe and dispense medications via traditional means, they should be able to do so via telehealth as well, provided they can establish a relationship and gather the necessary information.

Informed Consent

Informed consent is a process by which a patient is made aware of any benefits and risks

and coordinated with primary care and other providers. On the other hand, as with services like urgent care, there are some concerns about patients accessing services and/or prescriptions online without their primary care providers' knowledge, which could have implications for the patients' usual care. In either instance, questions remain about whether the responsibility to share data among multiple providers rests with the provider or patient.

Connecticut (SB 467) passed legislation in 2015, for example, requiring providers to ask patients to consent to disclose records from the telehealth interactions with their primary care provider, and if consent is granted, to do so in a timely manner. Alternatively, Anthem's Live Health Online offers the patient a record from the visit that he or she can give to his or her primary provider. Other data challenges include creating policies around data storage and retention, ensuring that data are interoperable between platforms and providers, and managing large volumes of data created from modalities like remote patient monitoring and wearable devices.

associated with a particular service or treatment, as well as any alternative courses of action. Many consider this type of knowledge to be good practice regardless of the service delivery mechanism. Informed consent also relates to providers' liability and legal exposure. In the case of telehealth, it may be particularly beneficial for patients to know the potential risks and understand that a condition or treatment may require a provider to defer to in-person services. In terms of informed consent, some states are creating policies specifically related to telehealth.

Currently, 29 states have some type of informed consent policies.[56] This requirement may apply to different arenas—e.g., all providers or just the Medicaid program, or even specific services, depending on the origination (statute, administrative code, Medicaid policy) and intent of the policy.[57] States that require informed consent also vary in whether they require written or verbal consent. Less than 10 states require some type of written consent.[58]

Informed consent also provides patients the option to decline a service or treatment. In Colorado, for example, the law requires providers using telehealth to give patients a written statement of informed consent that includes their right to refuse services delivered by telehealth at any time without losing or withdrawing treatment.

Related Issues

Telehealth considerations often bring related issues such as fraud, abuse, data security and the federal Health Insurance Portability and Accountability Act (HIPAA) to the discussion. Some argue that privacy and security must be addressed to advance telehealth and ensure providers' and patients' trust in telehealth.[59]

Fraud and abuse of services delivered through telehealth can be monitored in the same ways as other health care services. The risk of provider abuse or fraud in telehealth may not necessarily be higher than any other mechanism of care. One provider who bills for a disproportionate amount of telehealth services may warrant an audit, for instance, just as it would be justified for a provider with outlying data in any service provided through traditional care. Including a unique identifier in the data can help stratify telehealth so it can be monitored separately. As telehealth expands, the implications of various federal and state fraud and abuse laws could create more liability concerns for providers.[60]

vacy, confidentiality and data security need to be protected at all stages of a telehealth encounter, as it would be in traditional forms of care delivery. Telehealth services need appropriate protocols and measures to protect patient security and integrity of data at the patient end of the electronic encounter, during transmission, and among all health care professionals and other personnel who may be supporting the technology Audio, video and all other data transmission should be secure through the use of encryption that meets recognized standards Security features such as multi-factor authentication and the ability to remotely disable or erase personal health information are also examples of ways to protect mobile device use.

Some providers and others are paying particular attention to HIPAA compliance in telehealth technologies and electronic health records systems. However, using telehealth does not change existing security guidelines or responsibilities under HIPAA, and entities such as providers and insurers are subject to the same standards as in-person care[61] Business associates, such as technology services that help deliver health information, are also defined under HIPAA and may need to be examined under telehealth protocols and policies. Whether, and the extent to which, state policy is needed is still emerging. However, some stakeholders also believe the federal law—which supersedes state law, except in the cases of more stringent state laws—provides enough guidance.

where clarity might be needed to help guide safe telehealth policies and practices. For example, look at definitions of patient-provider relationships or examinations and consult with stakeholders about changes or considerations.

- In looking at existing or new legislation, balance the constraints being placed on telehealth with the need to safeguard patient privacy, safety and security.
- Examine how data are collected on health care services delivered by telehealth. Data collection that includes a telehealth identifier for billing purposes (as Medicare does) helps in evaluating programs and monitoring for fraud and abuse.

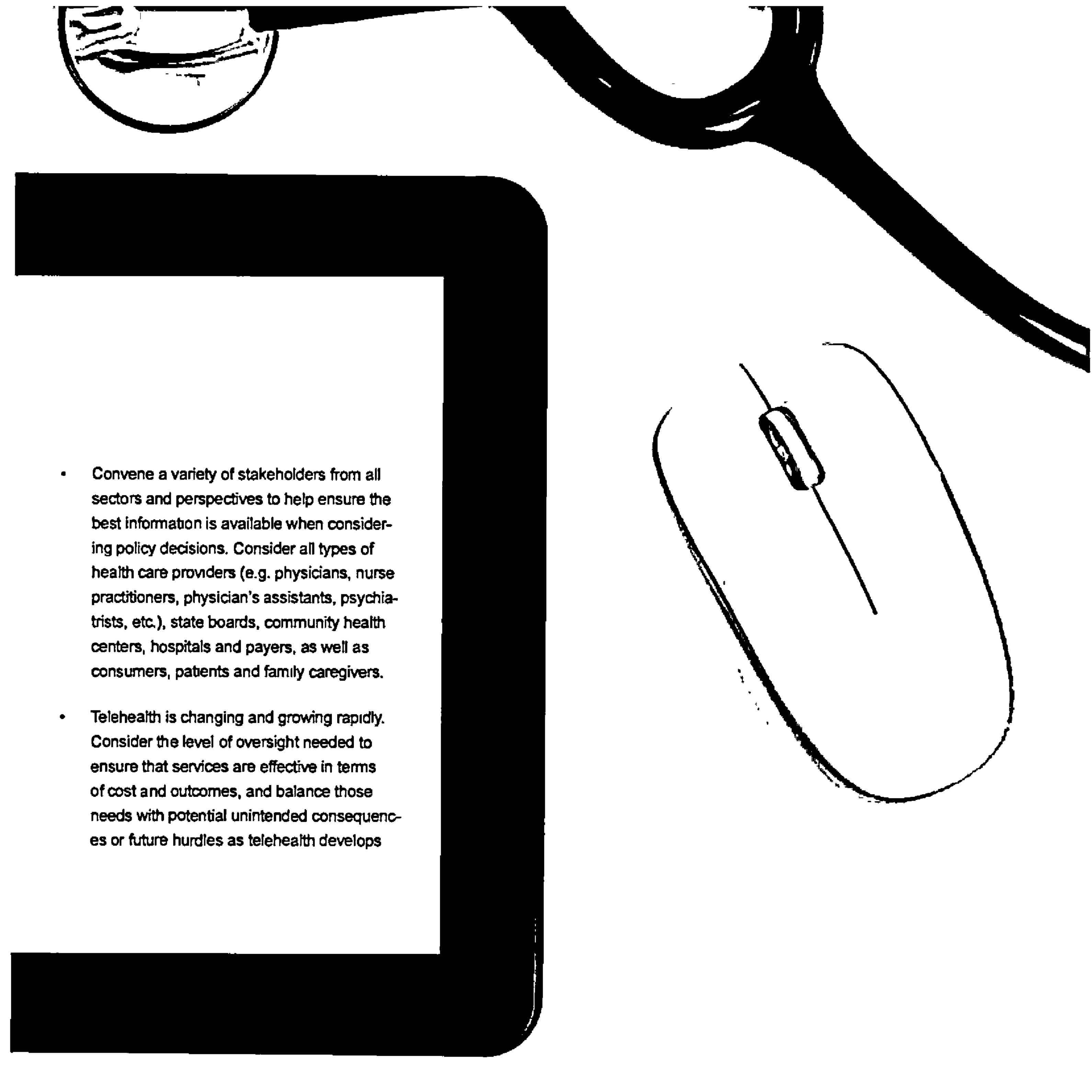
CONCLUSION

Telehealth is a rapidly growing field that has the potential to help states leverage a shrinking and maldistributed provider workforce, increase access to services, improve population health and lower costs. State leaders are grappling with how to capitalize on this potential while safeguarding state investments in telehealth and ensuring patient outcomes and safety. Reimbursement, licensure and patient safety will continue to be issues for state policymakers to consider, along with new challenges and opportunities, as telehealth grows and develops.

OVERALL FRAMEWORK FOR CONSIDERING TELEHEALTH

- Telehealth is a tool for delivering care. Help guide policy discussions that center on telehealth's ability to extend existing health and long-term care services with technology, versus describing telehealth as a new service.

- Conduct a needs assessment to find out where telehealth services are already being used and where investing in telehealth may be most effective. Identify model programs that may be replicable in your state (e.g., university, private hospital systems, etc.). Study existing laws and best practices that may also apply in telehealth (e.g., standard of care).



- Convene a variety of stakeholders from all sectors and perspectives to help ensure the best information is available when considering policy decisions. Consider all types of health care providers (e.g. physicians, nurse practitioners, physician's assistants, psychiatrists, etc.), state boards, community health centers, hospitals and payers, as well as consumers, patients and family caregivers.

- Telehealth is changing and growing rapidly. Consider the level of oversight needed to ensure that services are effective in terms of cost and outcomes, and balance those needs with potential unintended consequences or future hurdles as telehealth develops

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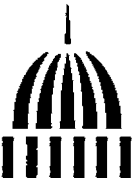

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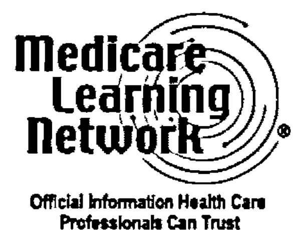

Telehealth Services

RURAL HEALTH FACT SHEET SERIES

Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

This publication provides the following information on calendar year (CY) 2015 Medicare telehealth services:

- Originating sites;
- Distant site practitioners;
- Telehealth services;
- Billing and payment for professional services furnished via telehealth;
- Billing and payment for the originating site facility fee;
- Resources; and
- Lists of helpful websites and Regional Office Rural Health Coordinators.

When "you" is used in this publication, we are referring to physicians or practitioners at the distant site.

Medicare pays for a limited number of Part B services furnished by a physician or practitioner to an eligible beneficiary via a telecommunications system. For eligible telehealth services, the use of a telecommunications system substitutes for an in-person encounter.

ORIGINATING SITES

An originating site is the location of an eligible Medicare beneficiary at the time the service furnished via a telecommunications system occurs. Medicare beneficiaries are eligible for telehealth services only if they are presented from an originating site located in:

- A rural Health Professional Shortage Area (HPSA) located either outside of a Metropolitan Statistical Area (MSA) or in a rural census tract; or
- A county outside of a MSA.

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originating site's eligibility for Medicare telehealth payment at http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth on the Centers for Medicare & Medicaid Services (CMS) website.

Entities that participate in a Federal telemedicine demonstration project approved by (or receiving funding from) the Secretary of the Department of Health and Human Services as of December 31, 2000, qualify as originating sites regardless of geographic location.

Each CY, the geographic eligibility of an originating site is established based on the status of the area as of December 31st of the prior calendar year, and such eligibility continues for the full CY.

The originating sites authorized by law are:

- The offices of physicians or practitioners;
- Hospitals;
- Critical Access Hospitals (CAH);
- Rural Health Clinics;
- Federally Qualified Health Centers;
- Hospital-based or CAH-based Renal Dialysis Centers (including satellites);
- Skilled Nursing Facilities (SNF); and
- Community Mental Health Centers (CMHC).

Note: Independent Renal Dialysis Facilities are not eligible originating sites.

DISTANT SITE PRACTITIONERS

Practitioners at the distant site who may furnish and receive payment for covered telehealth services (subject to State law) are:

- Physicians;
- Nurse practitioners (NP);
- Physician assistants (PA);
- Nurse-midwives;
- Clinical nurse specialists (CNS);
- Certified registered nurse anesthetists;

- Clinical psychologists (CP) and clinical social workers (CSW). CPs and CSWs cannot bill for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services under Medicare. These practitioners may not bill or receive payment for Current Procedural Terminology (CPT) codes 90792, 90833, 90836, and 90838; and
- Registered dietitians or nutrition professionals.

TELEHEALTH SERVICES

As a condition of payment, you must use an interactive audio and video telecommunications system that permits real-time communication between you, at the distant site, and the beneficiary, at the originating site. Asynchronous "store and forward" technology is permitted only in Federal telemedicine demonstration programs conducted in Alaska or Hawaii.

The chart on pages 3 and 4 provides the CY 2015 list of Medicare telehealth services.

Telehealth consultations, emergency department or initial inpatient	HCPCS codes G0425–G0427
Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs	HCPCS codes G0406–G0408
Office or other outpatient visits	CPT codes 99201–99215
Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days	CPT codes 99231–99233
Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days	CPT codes 99307–99310
Individual and group kidney disease education services	HCPCS codes G0420 and G0421
Individual and group diabetes self-management training services, with a minimum of 1 hour of in-person instruction to be furnished in the initial year training period to ensure effective injection training	HCPCS codes G0108 and G0109
Individual and group health and behavior assessment and intervention	CPT codes 96150–96154
Individual psychotherapy	CPT codes 90832–90834 and 90836–90838
Telehealth Pharmacologic Management	HCPCS code G0459
Psychiatric diagnostic interview examination	CPT codes 90791 and 90792
End-Stage Renal Disease (ESRD)-related services included in the monthly capitation payment	CPT codes 90951, 90952, 90954, 90955, 90957, 90958, 90960, and 90961
Individual and group medical nutrition therapy	HCPCS code G0270 and CPT codes 97802–97804
Neurobehavioral status examination	CPT code 96116
Smoking cessation services	HCPCS codes G0436 and G0437 and CPT codes 99406 and 99407
Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services	HCPCS codes G0396 and G0397
Annual alcohol misuse screening, 15 minutes	HCPCS code G0442
Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes	HCPCS code G0443
Annual depression screening, 15 minutes	HCPCS code G0444
High-intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes	HCPCS code G0445
Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes	HCPCS code G0446
Face-to-face behavioral counseling for obesity, 15 minutes	HCPCS code G0447
Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge)	CPT code 99495
Transitional care management services with high medical decision complexity (face-to-face visit within 7 days of discharge)	CPT code 99496
Psychoanalysis (effective for services furnished on and after January 1, 2015)	CPT codes 90845
Family psychotherapy (without the patient present) (effective for services furnished on and after January 1, 2015)	CPT code 90846

Family psychotherapy (conjoint psychotherapy) (with patient present) (effective for services furnished on and after January 1, 2015)	CPT code 90847
Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (effective for services furnished on and after January 1, 2015)	CPT code 99354
Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (effective for services furnished on and after January 1, 2015)	CPT code 99355
Annual Wellness Visit, includes a personalized prevention plan of service (PPPS) first visit (effective for services furnished on and after January 1, 2015)	HCPCS code G0438
Annual Wellness Visit, includes a personalized prevention plan of service (PPPS) subsequent visit (effective for services furnished on and after January 1, 2015)	HCPCS code G0439

For ESRD-related services, a physician, NP, PA, or CNS must furnish at least one "hands on" visit (not telehealth) each month to examine the vascular access site.

BILLING AND PAYMENT FOR PROFESSIONAL SERVICES FURNISHED VIA TELEHEALTH

You should submit claims for telehealth services using the appropriate CPT or HCPCS code for the professional service along with the telehealth modifier GT, "via interactive audio and video telecommunications systems" (for example, 99201 GT). By coding and billing the GT modifier with a covered telehealth procedure code, you are certifying that the beneficiary was present at an eligible originating site when you furnished the telehealth service. By coding and billing the GT modifier with a covered ESRD-related service telehealth code, you are certifying that you furnished one "hands on" visit per month to examine the vascular access site.

For Federal telemedicine demonstration programs conducted in Alaska or Hawaii, you should submit claims using the appropriate CPT or HCPCS code for the professional service along with the telehealth modifier GQ if you performed telehealth services "via an asynchronous telecommunications system" (for example, 99201 GQ). By using the GQ modifier, you are certifying that the asynchronous medical file was collected and transmitted to you at the distant site from a Federal telemedicine demonstration project conducted in Alaska or Hawaii.

You should bill the Medicare Administrative Contractor (MAC) for covered telehealth services. Medicare pays you the appropriate amount under the Medicare Physician Fee Schedule (PFS) for telehealth services. When you are located in a CAH and have reassigned your billing rights to a CAH that has elected the Optional Payment Method, the CAH bills the MAC for telehealth services and the payment amount is 80 percent of the Medicare PFS for telehealth services.

BILLING AND PAYMENT FOR THE ORIGINATING SITE FACILITY FEE

Originating sites are paid an originating site facility fee for telehealth services as described by HCPCS code Q3014. You should bill the MAC for the originating site facility fee, which is a separately billable Part B payment.

Note: When a CMHC serves as an originating site, the originating site facility fee does not count toward the number of services used to determine payment for partial hospitalization services.

For More Information About…	Resource
Telehealth Services	http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth on the CMS website Chapter 15 of the "Medicare Benefit Policy Manual" (Publication 100-02) located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15 pdf on the CMS website Chapter 12 of the "Medicare Claims Processing Manual" (Publication 100-04) located at http://www.cms gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12 pdf on the CMS website
Health Professional Shortage Areas	Medicare Learning Network® (MLN) publication titled "Health Professional Shortage Area (HPSA) Physician Bonus, HPSA Surgical Incentive Payment, and Primary Care Incentive Payment Programs" located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HPSAfctsht.pdf on the CMS website
All Available MLN Products	"MLN Catalog" located at http://www.cms gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf on the CMS website or scan the Quick Response (QR) code on the right
Provider-Specific Medicare Information	MLN publication titled "MLN Guided Pathways: Provider Specific Medicare Resources" located at http://www cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf on the CMS website
Medicare Information for Beneficiaries	http://www medicare.gov on the CMS website

Critical Access Hospitals Center
http://www.cms.gov/Center/Provider-Type/Critical-Access-Hospitals-Center.html

Disproportionate Share Hospital
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html

Federally Qualified Health Centers Center
http://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html

Health Resources and Services Administration
http://www.hrsa.gov

Hospital Center
http://www.cms.gov/Center/Provider-Type/Hospital-Center.html

Medicare Learning Network®
http://go.cms.gov/MLNGenInfo

National Association of Community Health Centers
http://www.nachc.org

National Rural Health Association
http://www.ruralhealthweb.org

Rural Assistance Center
http://www.raconline.org

Rural Health Clinics Center
http://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html

Swing Bed Providers
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/SwingBed.html

Telehealth
http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth

U.S. Census Bureau
http://www.census.gov

REGIONAL OFFICE RURAL HEALTH COORDINATORS

To find contact information for CMS Regional Office Rural Health Coordinators who provide technical, policy, and operational assistance on rural health issues, refer to http://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/Downloads/CMSRuralHealthCoordinators.pdf on the CMS website.

This fact sheet was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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State Telemedicine Gaps Analysis

Physician Practice Standards & Licensure

Latoya Thomas
Gary Capistrant

May 2015

50 State Telemedicine Gaps Analysis

Physician Practice Standards & Licensure

Latoya Thomas and
Gary Capistrant

May 2015

None of the information contained in the Gaps Analysis Series or in this document constitutes legal advice. The information presented is informational and intended to serve as a reference for interested parties, and not to be relied upon as authoritative. Your own legal counsel should be consulted as appropriate.

NOTE: Execerpt only- Full text

Executive Summary 1
Purpose 4
Overview 4
Assessment Methods 5
  Scoring 5
  Limitations 5
Indicators 6
  Physician Practice Standards 6
    Physician-patient Encounter 6
    Telepresenter 7
    Informed Consent 8
  Licensure 9
    Licensure and Out-of-State Practice 9
  Internet Prescribing 9
State Report Card 10
  Alabama 11
  Alaska 12
  Arizona 13
  Arkansas 14
  California 15
  Colorado 16
  Connecticut 17
  Delaware 18
  District of Columbia 19
  Florida 20
  Georgia 21
  Hawaii 22
  Idaho 23
  Illinois 24
  Indiana 25

Kansas 27
Kentucky 28
Louisiana 29
Maine 30
Maryland 31
Massachusetts 32
Michigan 33
Minnesota 34
Mississippi 35
Missouri 36
Montana 37
Nebraska 38
Nevada 39
New Hampshire 40
New Jersey 41
New Mexico 42
New York 43
North Carolina 44
North Dakota 45
Ohio 46
Oklahoma 47
Oregon 48
Pennsylvania 49
Rhode Island 50
South Carolina 51
South Dakota 52
Tennessee 53
Texas 54
Utah 55
Vermont 56

Washington 58
West Virginia 59
Wisconsin 60
Wyoming 61
Appendix 62
State Ratings – Map: Physician-Patient Encounter via Telemedicine 63
State Ratings – Map: Telepresenter Requirements 64
State Ratings – Map: Informed Consent Requirements 65
State Ratings – Map: Licensure and Out-of-State Practice 66
Matrix: Physician Practice Standards 67
Matrix: Physician-to-Physician Consultations 72
Matrix: Licensure 80
Matrix: Internet Prescribing 81
References 83

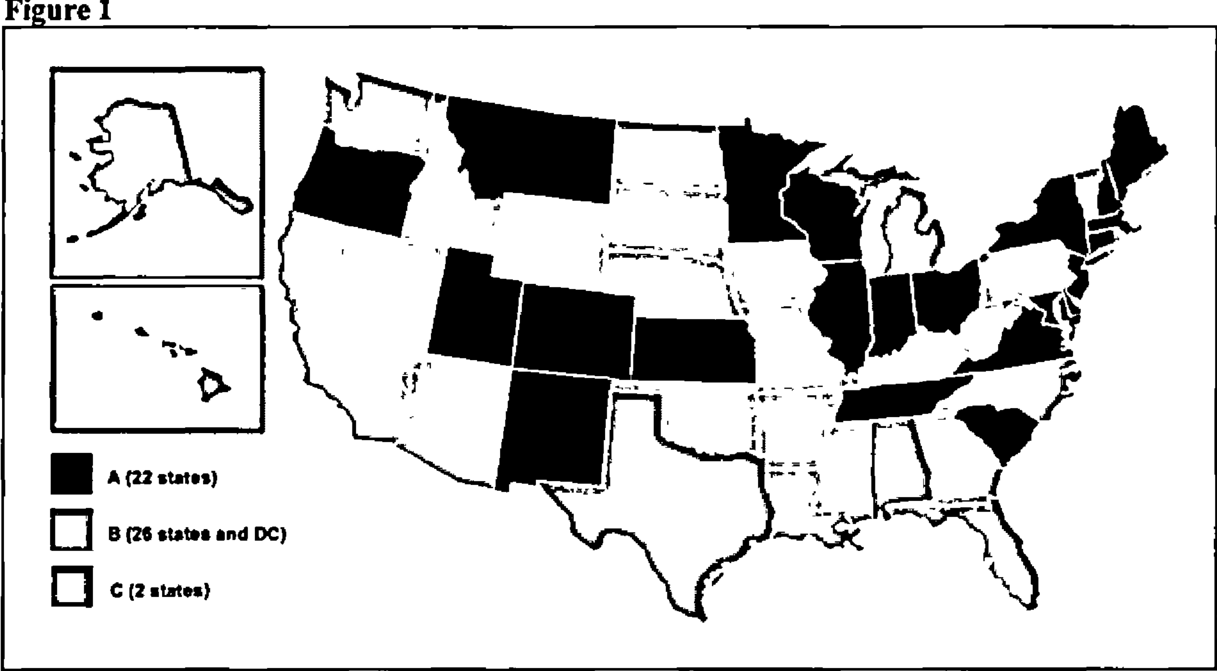
NOTE: Execerpt only- Full text on Basis under HB 234

Professional licensure portability and practice standards for providers using telemedicine are some of the biggest challenges for health care providers considering telemedicine adoption. Providers often encounter a patchwork of conflicting and disparate requirements for insurance claims and practice standards that prohibit them from fully taking advantage of telemedicine.

The American Telemedicine Association (ATA) has captured the complex policy landscape of 50 states with 50 different telemedicine policies, and translated this information into an easy to use format. This report extracts and compares physician practice standards for telemedicine for every state in the U.S. ultimately assigning a grade which indicates existing policy barriers that inhibit the use of telemedicine that would enable patient and provider choice to quality health care services.

Our analysis indicates that decades of evidence-based research highlighting positive patient compliance, clinical outcomes and increasing telemedicine utilization have been met with a mix of strides and stagnation in state-based policy. Since the initial release of our September 2014 report, there has not been much variance in the composite grades given to the states. When comparing the numerous state laws and differing medical board standards regarding telemedicine, twenty-two states averaged the highest "composite grade" suggesting a supportive policy landscape that accommodates telemedicine adoption and usage. Twenty-six states and D.C. fall in the middle with room for improvement. Two states averaged the lowest composite score suggesting many barriers for telemedicine advancement (Figure 1 and Table 1).

Figure 1



NOTE: Execerpt only- Full

Table 1

State	Composite Grades	Physician-patient Encounter	Telepresenter	Informed Consent	Licensure & Out-of-State Practice
AL	C	F	B	F	B
AK	B	B	C	A	C
AZ	B	B	A	B	C
AR	B	F	A	A	C
CA	B	B	A	B	C
CO	A	A	A	A	C
CT	A	A	A	A	C
DC	B	B	A	B	B
DE	A	A	A	A	C
FL	B	B	A	A	C
GA	B	C	A	A	C
HI	B	B	C	A	C
ID	B	B	A	B	C
IL	A	A	A	A	C
IN	A	B	A	F	C
IA	B	B	A	B	C
KS	A	A	A	A	C
KY	B	A	A	B	C
LA	B	B	C	B	B
ME	A	A	A	A	C
MD	A	B	A	A	B
MA	A	A	A	A	C
MI	B	A	A	A	F
MN	A	A	A	A	B
MS	B	B	A	B	C
MO	B	B	A	A	C
MT	A	A	A	A	C
NE	B	B	A	A	C
NV	B	B	A	B	B
NH	A	A	A	A	C
NJ	A	A	A	A	C
NM	A	A	A	A	B
NY	A	B	A	A	B
NC	B	B	A	A	C
ND	B	B	A	A	F

State	Grades	Encounter	Telepresenter	Consent	of-State Practice
OH	A	B	A	A	B
OK	B	B	A	F	C
OR	A	A	A	A	B
PA	B	A	A	A	F
RI	B	B	A	B	C
SC	A	A	A	A	C
SD	B	A	A	A	F
TN	A	A	A	A	B
TX	C	F	B	F	B
UT	A	A	A	A	C
VT	B	B	A	B	C
VA	A	A	A	A	B
WA	B	B	A	F	C
WV	B	B	A	B	C
WI	A	A	A	A	C
WY	B	B	A	A	C

When compared to the September 2014 report and broken down using the four indicators, the state-by-state comparisons still reveal a great disparity.

- Regarding physician-patient encounters, twenty-two states rank the highest, while Alabama, Arkansas, and Texas are ranked the lowest with failing scores mainly because they create the most stringent clinical practice rules for telemedicine providers when compared to in-person practice. (Figure 2).

- Regarding telepresenter requirements, Alaska, Hawaii, and Louisiana are ranked the lowest with failing scores (Figure 3). An overwhelming majority of states do not require the presence of a health professional during a telemedicine encounter. Although most of the country does not require patient informed consent before a telemedicine encounter, sixteen states and D.C. require physicians to obtain patient informed consent (Figure 4). This growing trend is largely due to states adopting language developed by the Federation for State Medical Boards (FSMB) which promotes a regulatory requirement for patient informed consent for telemedicine providers.

According to our scale, no state achieved a top score (A) for their licensure policies. This means that every state imposes a policy that makes practicing medicine across state lines difficult regardless of whether or not telemedicine is used.

A frequently asked question among people interested in telemedicine is "How does my state compare?" To answer that question for two key areas, reimbursement and medical practice rules, ATA has developed an easy-to-use, state-by-state report for each area.

This report on medical practice rules is especially timely with several licensing boards reviewing the emerging and evolving telemedicine practices and telemedicine use within their state.

This report helps answer the basic questions:

- "How does my state's telemedicine policies compare to others?"
- "Which states offer the best policies for physicians using telemedicine?"
- "Which states impose barriers to telemedicine access for patients and providers?"

It is important to note that this report is not a "how-to guide" for becoming a telemedicine provider. This is a reference tool aimed to inform future policy decision making and serve as a reference for interested parties. The results presented in this document are based on information collected from state statutes, regulations, medical board statements, and other federal and state policy resources. However, the report does not assess unwritten medical board policies. It is ATA's best effort to interpret and understand each state's policies. Your own legal counsel should be consulted as appropriate.

Overview

Health care providers have seen a considerable amount of state policy activity to improve coverage and reimbursement of telemedicine-provided services by various payers. However, despite improvements to address the payment challenges, health care providers are encountering conflicting and sometimes confusing policies from their own colleagues.

Within the past year, over 25 states have considered proposals, with varied results, to revise health professional standards and licensure requirements when using telemedicine. Some states are creating new laws that impact access to care via telemedicine, while others are amending existing policies with greater implications.

More notably a few state medical boards are adopting practice standards with higher specifications for telemedicine than in-person care. Specifically, these boards have considered legal guidelines requiring an initial examination be conducted in-person and a physician-patient relationship be established in-person. Boards have also considered other telemedicine barriers including requirements for a telepresenter, in-person follow up exam, and patient informed consent. These decisions leave telemedicine providers no choice but to navigate the medical practice laws in their state or risk punitive action by their board.

Licensure portability, the ability for health care providers to practice out-of-state using one license, is a contentious issue for health care providers whether services are deployed via

patient is located. However, these state-by-state approaches prevent people from receiving critical, often life-saving medical services that may be available to their neighbors living just across the state line. They also create economic trade barriers, restricting access to medical services and artificially protecting markets from competition.

Assessment Methods

Scoring

This report evaluates telemedicine policies in each state based on two categories:

- Physician practice standards
- Licensure.

These categories were measured using 4 indicators. The indicators were chosen based on the most recent and generally accessible information assembled and published by state public entities. Using this information, we took qualitative characteristics based on standards for the physician-patient encounter and licensure requirements and assigned those quantitative values. States were given a certain number of points for each indicator depending on its effectiveness. The points were then used to rank and compare each state by indicator. We used a four-graded system to rank and compare each state. This is based off of the scores given to each state by indicator.

Each indicator was given a maximum number of points ranging from 1 to 9. The aggregate score for each indicator was ranked on a scale of A through F based on the maximum number of points.

The report also includes a category to capture the existence of a state policy or statement on internet prescribing in each state. We have included a matrix with hyperlinks to the policy or board statement language highlighting the position on internet prescribing.

Limitations

Physician licensure and medical practice policies vary in each state. Although groups such as the FSMB offer a uniform application for physician state licensure and guideline recommendations on practice standards, each state medical board has their own unique requirements and process for authorizing and permitting medical practice standards.

We analyzed statutes, regulations, and medical board statements/positions regarding the clinical permissibility of telemedicine. As such, the information in this report is a snapshot of information gathered through April 2015. This report does not assess unwritten medical board policies. The analysis and scores are reflective of the written medical policies regarding telemedicine.

Physician Practice Standards

A. Physician-patient Encounter

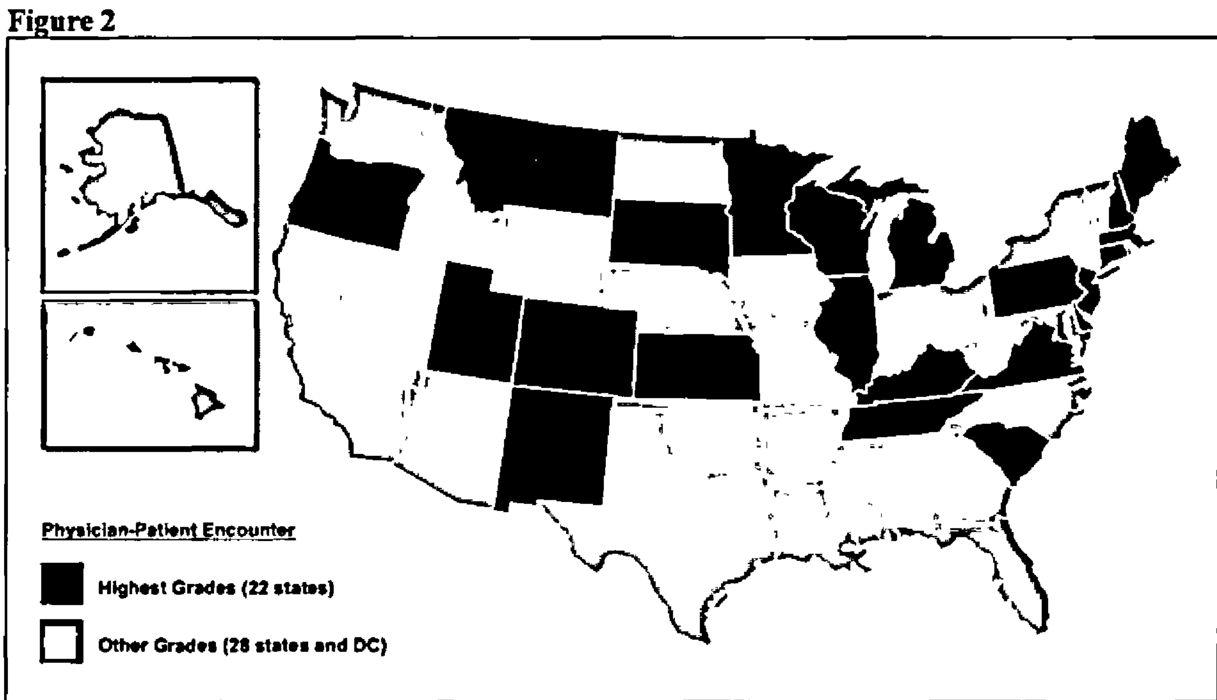
Telemedicine is the use of telecommunications to facilitate health care delivery. As such, telemedicine is seen as a tool to augment, and not replace, the clinical practice, judgment, and expertise of a health care provider.

Each state was assessed based on policies pertaining to the use of telemedicine before, during, and after a patient encounter. Some states institute more stringent standards for physicians when using telemedicine, and may require an in-person visit in addition to any clinical examination performed via telemedicine. Unlike similar policies related to conditions of payment, these policies affect a provider's licensure status and permissibility to practice medicine.

We measured components of state policies that permit or obstruct the professional use of telemedicine before, during, or after the physician-patient encounter.

Scale – Physician-patient Encounter	
A	9 points
B	7-8 points
C	5-6 points
F	≤ 4 point

Figure 2



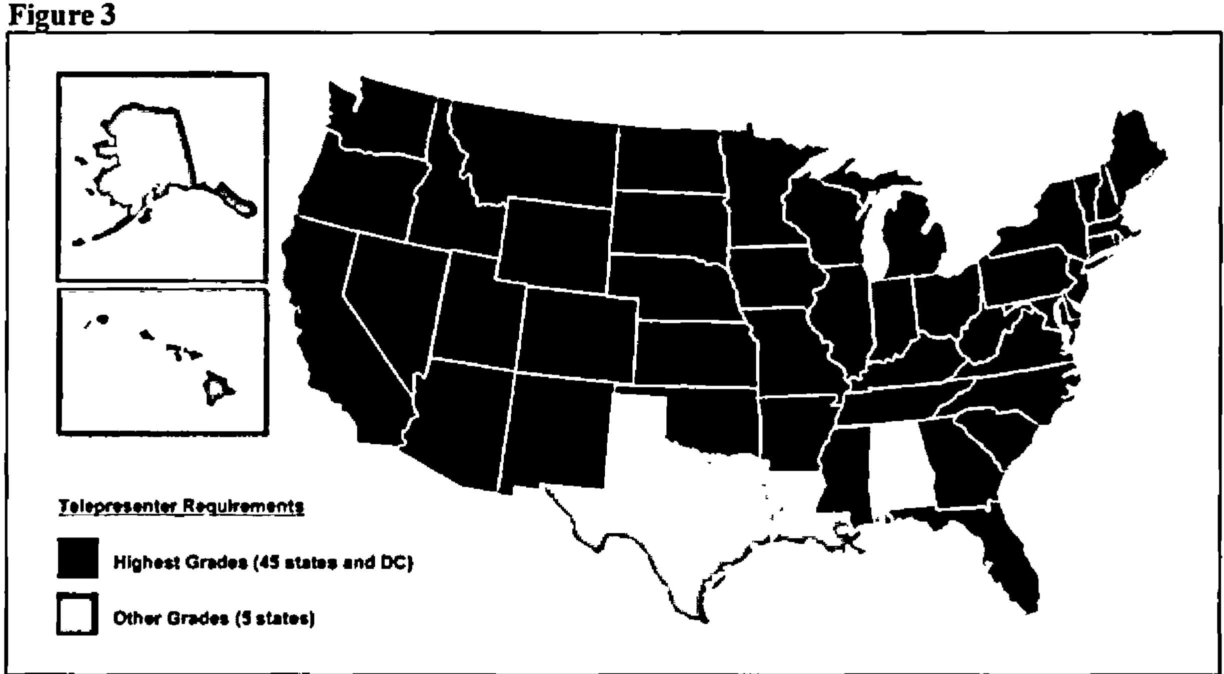
Twenty-two states rank the highest, while Alabama, Arkansas, and Texas are ranked the lowest with failing (F) scores mainly because they create the most stringent clinical practice rules for telemedicine providers when compared to in-person practice (Figure 2). When compared to the September 2014 report, some states are ranking lower because they are developing separate and distinct clinical practice standards for telemedicine when compared to in-person care delivery. Alabama and Texas Medical boards find telemedicine as an acceptable mode of delivering care only when the patient is at an established medical site. Arkansas is the only state that requires an in-person visit before most telemedicine encounters. Alabama, Georgia, and Texas are the only states that require an in-person follow-up after a telemedicine encounter.

B. Telepresenter

For this report, we measured components of state Medical board policies and private insurance parity laws that apply more stringent requirements for telemedicine as opposed to in-person services. States were evaluated based on requirements for a telepresenter or health care provider on the premises during a telemedicine encounter.

Scale – Telepresenter	
A	3 points
B	2 points
C	1 point
F	0 points

Figure 3



Alabama and Texas only require a health care provider to be on the premises and not physically with the patient during a telemedicine encounter. Alaska, Hawaii, and Louisiana are ranked the

initiating provider to obtain a patient's informed consent verbally which no longer requires a telepresenter at the patient site.

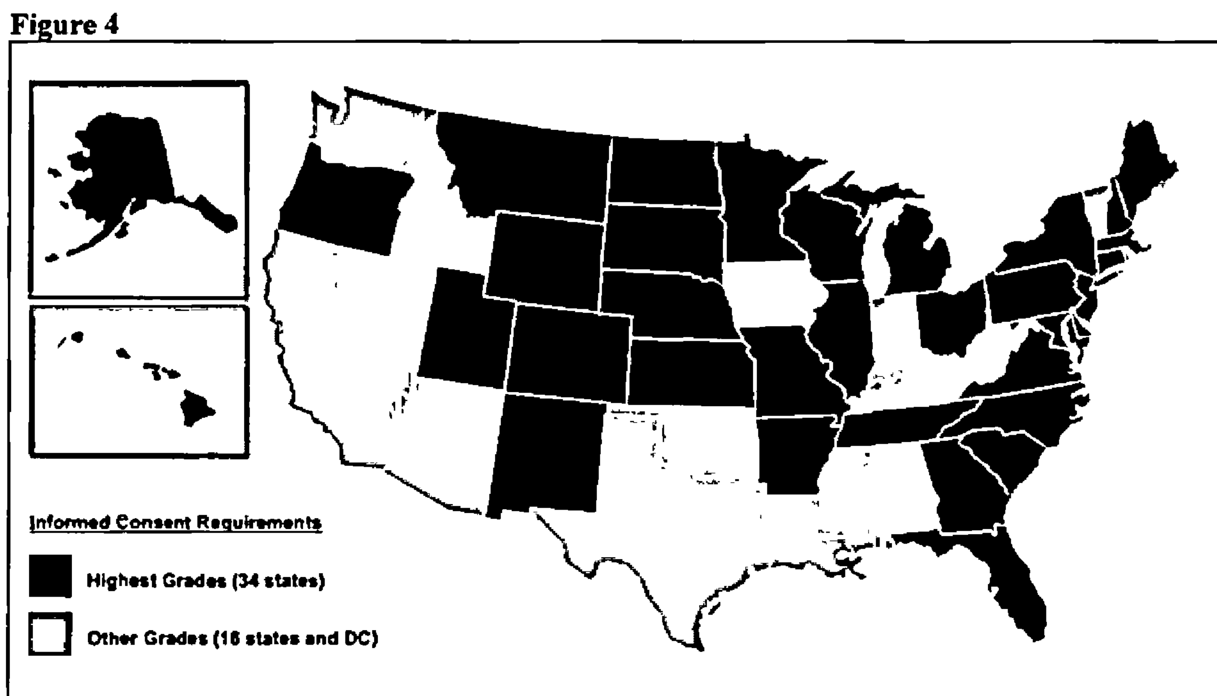
C. *Informed Consent*

We measured components of state Medical board and private insurance parity policies that apply more stringent requirements for telemedicine as opposed to in-person services. States were evaluated based on requirements for written or verbal informed consent, or unspecified methods of informed consent before a telemedicine encounter can be performed.

Scale – Informed Consent	
A	4 points
B	3 points
C	2 points
F	≤ 1 point

Most of the country does not require patient informed consent before a telemedicine encounter (Figure 4). Sixteen states and D.C. have informed consent requirements with Alabama, Indiana, Oklahoma, Texas, and Washington requiring written acknowledgement from the patient. Rhode Island's medical board requires informed consent when using e-mails and text based communications.

Figure 4



D. Licensure and Out-of-State Practice

Licensure portability is an often debated topic. "Where should a health care provider be licensed"? "Which states allow health care providers to consult with one another across state lines"? "Which states inhibit patient choice by limiting the types of providers that can treat them"?

As the use of telecommunication to complement health care service delivery becomes readily available, some states have responded with policies that accommodate patient choice, peer consultation, and health provider shortages. For this report, we measured components of state Medical board licensure requirements for out-of-state telemedicine providers including reciprocity for bordering states, physician-to-physician (P2P) consultation exemptions, and conditional/telemedicine licenses.

Scale – Licensure and Out-of-State Practice	
A	9 points
B	6-8 points
C	3-5 points
F	≤ 2 points

According to our scale, no state achieved a top score (A) for this indicator. This means that every state imposes a policy that makes practicing medicine across state lines difficult regardless of whether or not telemedicine is used. Michigan, North Dakota, Pennsylvania, and South Dakota are the only states that do not allow some type of licensure exemption for physician-to-physician out-of-state consultation. The Massachusetts Board of Registration in Medicine confirms that telemedicine is allowed to facilitate a peer-to-peer out-of-state consultation. Further, D.C., Maryland, New York, and Virginia, are the only states that allow licensure reciprocity from bordering states.

Alabama, Louisiana, Minnesota, Nevada, New Mexico, Ohio, Oregon, Tennessee, and Texas are the only states that extend a conditional or telemedicine license to out-of-state physicians. Montana enacted a law this year to repeal their telemedicine license in favor of a full unrestricted license requirement for out-of-state physicians.

Internet Prescribing

This report also includes a category to capture the existence of a medical and/or pharmacy board policy or statement on internet prescribing in each state. We have included a matrix with hyperlinks to the policy or board statement language highlighting the position on internet prescribing.

State Report Cards

Telemedicine in Alabama

PHYSICIAN PRACTICE STANDARDS & LICENSURE:		
Physician-patient encounter	F	• Last policy revision: January 2014. • Board may exempt requirements to the prescribed if request is submitted in writing. • Separate rules for telemedicine provided at a medical site vs non-medical site. • Allows telemedicine in lieu of an in-person examination and to establish the patient-physician relationship. • Telepresenter on premises required for new conditions with the exception of mental health services. • Written patient informed consent required for telemedicine and use of "interactive electronic text messaging system" to communicate with the patient. • Qualifying out-of-state physician has the option of applying for a full license or a special purpose license to practice in AL. • Allows P2P exemption.
Telepresenter	B	
Informed Consent	F	
Licensure & Out-of-State Practice	B	
MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:	✔	
PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:	✔	

Telemedicine in Alaska

<table>
<tr><td colspan="2">PHYSICIAN PRACTICE STANDARDS & LICENSURE:</td><td></td></tr>
<tr><td>Physician-patient encounter</td><td>B</td><td rowspan="6">

Last policy revision: December 2014.
The Board issued guidance to revise their practice standards for telemedicine providers.
In-person and physician-patient relationships are required. However, telemedicine may be used to satisfy both requirements if a licensed healthcare provider is present with the patient.
A physician is exempt from the telepresenter requirements if they are providing services in a community where no physician, physician assistant, nurse practitioner, nurse, or community health aid is available to conduct an examination.
Radiologists, pathologists, and physicians providing on-call or cross-coverage emergency care are exempt from the previously stated requirements.
Requires full license and allows P2P exemption.
Effective November 2014, physicians physically located in AK may remotely prescribe non-controlled medications without conducting a physical exam in certain cases.

</td></tr>
<tr><td>Telepresenter</td><td>C</td></tr>
<tr><td>Informed Consent</td><td>A</td></tr>
<tr><td>Licensure & Out-of-State Practice</td><td>C</td></tr>
<tr><td>MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:</td><td>✔</td></tr>
<tr><td>PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:</td><td></td></tr>
</table>

Telemedicine in Arizona

<table>
<tr><td colspan="2">PHYSICIAN PRACTICE STANDARDS & LICENSURE:</td><td></td></tr>
<tr><td>Physician-patient encounter</td><td>B</td><td rowspan="7">Last policy revision: April 2014.
Allows telemedicine in lieu of an in-person examination and to establish the patient-physician relationship.
Requires written or verbal patient informed consent with some exceptions.
Requires full license and allows P2P exemption.
2014 law enacted that codifies the allowance of telemedicine to be used in lieu of a physical exam and to establish the patient-physician relationship for the purposes of internet prescribing.[1]</td></tr>
<tr><td>Telepresenter</td><td>A</td></tr>
<tr><td>Informed Consent</td><td>B</td></tr>
<tr><td>Licensure & Out-of-State Practice</td><td>C</td></tr>
<tr><td>MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:</td><td>✔</td></tr>
<tr><td>PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:</td><td>✔</td></tr>
</table>

Telemedicine in Arkansas

PHYSICIAN PRACTICE STANDARDS & LICENSURE:		
Physician-patient encounter	F	• Last policy revision: April 2015. • Act 887 requires a pre-existing physician-patient relationship before a telemedicine encounter. The relationship may be established via an in-person exam, personally knowing the patient and their health status, in consultation with or referral by another health care provider who has a relationship with the patient or through an on-call or cross-coverage arrangement with the patient's regular treating provider.[2] • The patient must be located in a healthcare facility or office, or the home only if they are receiving treatment for end-stage renal disease. • Store-and-forward technology is not considered telemedicine and the law does not restrict the use of store-and-forward. • Requires full license and allows P2P exemption.
Telepresenter	A	
Informed Consent	A	
Licensure & Out-of-State Practice	C	
MEDCIAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:	✔	
PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:	✔	

Telemedicine in California

<table>
<tr><td colspan="2">PHYSICIAN PRACTICE STANDARDS & LICENSURE:</td><td></td></tr>
<tr><td>Physician-patient encounter</td><td>B</td><td rowspan="6">Last policy revision: September 2014.
Allows telemedicine to establish the patient-physician relationship.
Chapter 404 allows physicians the option to obtain written or verbal patient informed consent.[3]
Requires full license and allows P2P exemption.</td></tr>
<tr><td>Telepresenter</td><td>A</td></tr>
<tr><td>Informed Consent</td><td>B</td></tr>
<tr><td>Licensure & Out-of-State Practice</td><td>C</td></tr>
<tr><td>MEDCIAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:</td><td>✔</td></tr>
<tr><td>PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:</td><td>✔</td></tr>
</table>

Telemedicine in Colorado

<table>
<tr><td colspan="2">PHYSICIAN PRACTICE STANDARDS & LICENSURE:</td><td></td></tr>
<tr><td>Physician-patient encounter</td><td>A</td><td rowspan="7">Last policy revision: July 2010
Requirements for telemedicine are on par with requirements for in-person services, not including remote prescribing. No unique practice standard requirements for telemedicine.
Requires full license and allows P2P exemption.</td></tr>
<tr><td>Telepresenter</td><td>A</td></tr>
<tr><td>Informed Consent</td><td>A</td></tr>
<tr><td>Licensure & Out-of-State Practice</td><td>C</td></tr>
<tr><td>MEDCIAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:</td><td>✔</td></tr>
<tr><td>PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:</td><td>✔</td></tr>
</table>

Telemedicine in Connecticut

PHYSICIAN PRACTICE STANDARDS & LICENSURE:		
Physician-patient encounter	A	• Requirements for telemedicine are on par with requirements for in-person services, not including prescribing. No unique practice standard requirements for telemedicine. • Requires full license and allows P2P exemption.
Telepresenter	A	
Informed Consent	A	
Licensure & Out-of-State Practice	C	
MEDCIAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:		
PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:	✔	

Telemedicine in Delaware

PHYSICIAN PRACTICE STANDARDS & LICENSURE:		
Physician-patient encounter	A	• Requirements for telemedicine are on par with requirements for in-person services, not including prescribing. No unique practice standard requirements for telemedicine. • Requires full license and allows P2P exemption.
Telepresenter	A	
Informed Consent	A	
Licensure & Out-of-State Practice	C	
MEDCIAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:	✔	
PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:	✔	

Telemedicine in D.C.

<table>
<tr><td colspan="2">PHYSICIAN PRACTICE STANDARDS & LICENSURE:</td><td></td></tr>
<tr><td>Physician-patient encounter</td><td>B</td><td rowspan="6">

Last policy revision: November 2014
Revised guidelines require a physician to establish a relationship and perform a patient evaluation. The relationship may be established via real-time auditory or real-time visual and auditory communications, or from a patient evaluation performed by another DC licensed physician
Requires the physician to obtain and document patient informed consent except when providing interpretive services
Requires full license, and allows P2P exemption.
Extends licensure reciprocity to bordering states.

</td></tr>
<tr><td>Telepresenter</td><td>A</td></tr>
<tr><td>Informed Consent</td><td>B</td></tr>
<tr><td>Licensure & Out-of-State Practice</td><td>B</td></tr>
<tr><td>MEDCIAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:</td><td>✔</td></tr>
<tr><td>PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:</td><td>✔</td></tr>
</table>

Telemedicine in Florida

<table>
<tr><td colspan="2">PHYSICIAN PRACTICE STANDARDS & LICENSURE:</td><td></td></tr>
<tr><td>Physician-patient encounter</td><td>B</td><td rowspan="7">Last policy revision: June 2014.
Allows telemedicine to establish the patient-physician relationship and conduct examination.
Rules do not apply to emergency medical conditions or emergency medical services provided by emergency physicians, emergency medical technicians, paramedics, and emergency dispatchers.
Phone, e-mail, text messages, and fax do not constitute telemedicine.
Requires full license and allows P2P exemption.</td></tr>
<tr><td>Telepresenter</td><td>A</td></tr>
<tr><td>Informed Consent</td><td>A</td></tr>
<tr><td>Licensure & Out-of-State Practice</td><td>C</td></tr>
<tr><td>MEDCIAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:</td><td>✔</td></tr>
<tr><td>PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:</td><td></td></tr>
</table>

Telemedicine in Georgia

PHYSICIAN PRACTICE STANDARDS & LICENSURE:		
Physician-patient encounter	C	• Last policy revision: April 2014. • Allows telemedicine in lieu of an in-person examination in certain instances. • Requires an in-person follow-up annually. • Medical records must be kept by distant site and referring providers. • Rule does not apply to telephonic consultations in an established physician-patient relationship. • Requires full license and allows P2P exemption.
Telepresenter	A	
Informed Consent	A	
Licensure & Out-of-State Practice	C	
MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:	✔	
PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:		

Telemedicine in Hawaii

PHYSICIAN PRACTICE STANDARDS & LICENSURE:		
Physician-patient encounter	B	• Last policy revision: June 2014. • Allows telemedicine in lieu of an in-person examination and to establish the patient-physician relationship. • Private insurance parity law requires a telepresenter except for cases involving behavioral health services.[4] • Requires full license and allows P2P exemption.
Telepresenter	C	
Informed Consent	A	
Licensure & Out-of-State Practice	C	
MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:	✔	
PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:	✔	

Telemedicine in Idaho

PHYSICIAN PRACTICE STANDARDS & LICENSURE:		
Physician-patient encounter	B	• Latest policy revision: July 2015 • In March 2015, Chapter 121 was enacted to create clinical practice standards for telehealth providers. A provider may use two-way audio-video interaction to establish a provider-patient relationship.[5] • Requires full license and allows P2P exemption.
Telepresenter	A	
Informed Consent	B	
Licensure & Out-of-State Practice	C	
MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:	✔	
PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:	✔	

Telemedicine in Illinois

<table>
<tr><td colspan="2">PHYSICIAN PRACTICE STANDARDS & LICENSURE:</td><td></td></tr>
<tr><td>Physician-patient encounter</td><td>A</td><td rowspan="7">Last policy revision: January 1998.
Requirements for telemedicine are on par with requirements for in-person services, not including prescribing. No unique practice standard requirements for telemedicine.
Requires full license and allows P2P exemption.
Telemedicine rules scheduled to be repealed on December 31, 2015.</td></tr>
<tr><td>Telepresenter</td><td>A</td></tr>
<tr><td>Informed Consent</td><td>A</td></tr>
<tr><td>Licensure & Out-of-State Practice</td><td>C</td></tr>
<tr><td>MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:</td><td></td></tr>
<tr><td>PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:</td><td>✔</td></tr>
</table>

Telemedicine in Indiana

<table>
<tr><td colspan="2">PHYSICIAN PRACTICE STANDARDS & LICENSURE:</td><td></td></tr>
<tr><td>Physician-patient encounter</td><td>B</td><td rowspan="6">Last policy revision: January 2015.
Allows telemedicine in lieu of an in-person examination and to establish physician-patient relationship.
The board is accepting proposals for its Telehealth Services Pilot Program. The pilot will allow IN licensed physicians, who have an established practice in the state, to provide primary, urgent, and nonemergent care via real-time video, secure chat/e-mail, or integrated telephony without establishing an in-person physician-patient relationship.[6]
Requires written patient informed consent for patient-physician e-mail communication.
Requires full license and allows P2P exemption.</td></tr>
<tr><td>Telepresenter</td><td>A</td></tr>
<tr><td>Informed Consent</td><td>F</td></tr>
<tr><td>Licensure & Out-of-State Practice</td><td>C</td></tr>
<tr><td>MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:</td><td>✔</td></tr>
<tr><td>PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:</td><td></td></tr>
</table>

Telemedicine in Iowa

PHYSICIAN PRACTICE STANDARDS & LICENSURE:		
Physician-patient encounter	B	• Latest policy revision: June 2015 • The board voted to approve new regulations concerning the medical practice via telemedicine. The rules will be published April 29th and go into effect June 3rd.[7] • The rules will require a physician to have a valid physician-patient relationship and physical exam that may be satisfied using telemedicine. • Requires unspecified method of obtaining patient's informed consent. • The new regulations also outline special circumstances where the standard of care may not require a licensed provider to examine the patient. • Requires full license and allows P2P exemption.
Telepresenter	A	
Informed Consent	B	
Licensure & Out-of-State Practice	C	
MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:	✔	
PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:	✔	

Telemedicine in Kansas

PHYSICIAN PRACTICE STANDARDS & LICENSURE:		
Physician-patient encounter	A	• Requirements for telemedicine are on par with requirements for in-person services, not including prescribing. No unique practice standard requirements for telemedicine. • Requires full license and allows P2P exemption.
Telepresenter	A	
Informed Consent	A	
Licensure & Out-of-State Practice	C	
MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:	✔	
PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:	✔	

Telemedicine in Kentucky

PHYSICIAN PRACTICE STANDARDS & LICENSURE:		
Physician-patient encounter	A	• Last policy revision: July 2002. • Requirements for telemedicine are on par with requirements for in-person services, not including prescribing. • Requires unspecified method of obtaining patient's informed consent. • Requires full license and allows P2P exemption.
Telepresenter	A	
Informed Consent	B	
Licensure & Out-of-State Practice	C	
MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:	✔	
PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:		

Telemedicine in Louisiana

PHYSICIAN PRACTICE STANDARDS & LICENSURE:	
Physician-patient encounter	B
Telepresenter	C
Informed Consent	B
Licensure & Out-of-State Practice	B
MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:	✔
PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:	✔

- Last policy revision: March 2014.
- Online, electronic or written mail message, or telephonic evaluation does not constitute telemedicine.
- Allows telemedicine in lieu of an in-person examination and to establish the patient-physician relationship.
- Telepresenter required at all times.
- Requires unspecified method of obtaining patient's informed consent.
- No physician may use telemedicine to treat non-cancer related chronic pain/intractable pain, obesity, or prescribe/dispense/administer amphetamines or narcotics unless board certified (with some exceptions).
- Qualifying out-of-state physician has the option of applying for a full license or a telemedicine permit to practice in LA.
- Act No. 442 amends telemedicine practice guidelines for LA licensed health care providers. The board has issued but not finalized their draft regulations.[8]

Telemedicine in Maine

PHYSICIAN PRACTICE STANDARDS & LICENSURE:		
Physician-patient encounter	A	• Last policy revision: December 2008. • Requirements for telemedicine are on par with requirements for in-person services, not including prescribing. No unique practice standard requirements for telemedicine. • Requires full license and allows P2P exemption.
Telepresenter	A	
Informed Consent	A	
Licensure & Out-of-State Practice	C	
MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:	✔	
PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:		

Telemedicine in Maryland

<table>
<tr><td colspan="2">PHYSICIAN PRACTICE STANDARDS & LICENSURE:</td><td></td></tr>
<tr><td>Physician-patient encounter</td><td>B</td><td rowspan="7">Last policy revision: December 2013.
Allows telemedicine in lieu of an in-person examination and to establish the patient-physician relationship.
Requires full license and allows P2P exemption.
Extends licensure reciprocity to bordering states.</td></tr>
<tr><td>Telepresenter</td><td>A</td></tr>
<tr><td>Informed Consent</td><td>A</td></tr>
<tr><td>Licensure & Out-of-State Practice</td><td>B</td></tr>
<tr><td>MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:</td><td>✔</td></tr>
<tr><td>PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:</td><td></td></tr>
</table>

Telemedicine in Massachusetts

PHYSICIAN PRACTICE STANDARDS & LICENSURE:		
Physician-patient encounter	A	• Requirements for telemedicine are on par with requirements for in-person services, not including prescribing. No unique practice standard requirements for telemedicine. • Requires full license and allows P2P exemption.
Telepresenter	A	
Informed Consent	A	
Licensure & Out-of-State Practice	C	
MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:	✔	
PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:		

Telemedicine in Michigan

<table>
<tr><td colspan="2">PHYSICIAN PRACTICE STANDARDS & LICENSURE:</td><td></td></tr>
<tr><td>Physician-patient encounter</td><td>A</td><td rowspan="6">Requirements for telemedicine are on par with requirements for in-person services, not including prescribing. No unique practice standard requirements for telemedicine.
Does not allow licensure exemption for physician-to-physician out-of-state consultation.</td></tr>
<tr><td>Telepresenter</td><td>A</td></tr>
<tr><td>Informed Consent</td><td>A</td></tr>
<tr><td>Licensure & Out-of-State Practice</td><td>F</td></tr>
<tr><td>MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:</td><td>✔</td></tr>
<tr><td>PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:</td><td></td></tr>
</table>

Telemedicine in Minnesota

<table>
<tr><td colspan="2">PHYSICIAN PRACTICE STANDARDS & LICENSURE:</td><td></td></tr>
<tr><td>Physician-patient encounter</td><td>A</td><td rowspan="6">• Requirements for telemedicine are on par with requirements for in-person services, not including prescribing. No unique practice standard requirements for telemedicine.
• Qualifying out-of-state physician has the option of applying for a full license or a telemedicine permit to practice in MN.</td></tr>
<tr><td>Telepresenter</td><td>A</td></tr>
<tr><td>Informed Consent</td><td>A</td></tr>
<tr><td>Licensure & Out-of-State Practice</td><td>B</td></tr>
<tr><td>MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:</td><td>✔</td></tr>
<tr><td>PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:</td><td></td></tr>
</table>

Telemedicine in Mississippi

PHYSICIAN PRACTICE STANDARDS & LICENSURE:		
Physician-patient encounter	B	• Last policy revision: May 2010. • Allows telemedicine in lieu of an in-person examination and to establish the patient-physician relationship. • MS Medical Board requires unspecified method of obtaining patient's informed consent. • Requires full license and allows P2P exemption. • In April 2015, the board issued a hearing notice concerning a draft regulatory proposal to revise physician practice standards.[9]
Telepresenter	A	
Informed Consent	B	
Licensure & Out-of-State Practice	C	
MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:	✔	
PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:		

Telemedicine in Missouri

<table>
<tr><td colspan="2">PHYSICIAN PRACTICE STANDARDS & LICENSURE:</td><td></td></tr>
<tr><td>Physician-patient encounter</td><td>B</td><td rowspan="6">• Last policy revision: August 2013.
• Allows telemedicine in-lieu of an in-person exam and to establish physician-patient relationship.
• Requires full license and allows P2P exemption.</td></tr>
<tr><td>Telepresenter</td><td>A</td></tr>
<tr><td>Informed Consent</td><td>A</td></tr>
<tr><td>Licensure & Out-of-State Practice</td><td>C</td></tr>
<tr><td>MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:</td><td>✔</td></tr>
<tr><td>PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:</td><td></td></tr>
</table>

Telemedicine in Montana

PHYSICIAN PRACTICE STANDARDS & LICENSURE:		
Physician-patient encounter	A	• Requirements for telemedicine are on par with requirements for in-person services, not including prescribing. No unique practice standard requirements for telemedicine. • Requires full license and allows P2P exemption. • Chapter 154 removed the state's telemedicine license.[10]
Telepresenter	A	
Informed Consent	A	
Licensure & Out-of-State Practice	C	
MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:		
PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:		

Telemedicine in Nebraska

<table>
<tr><td colspan="2">PHYSICIAN PRACTICE STANDARDS & LICENSURE:</td><td></td></tr>
<tr><td>Physician-patient encounter</td><td>B</td><td rowspan="7">Last policy revision: December 2013.
Allows telemedicine in-lieu of an in-person exam and to establish physician-patient relationship.
Requires full license and allows P2P exemption.</td></tr>
<tr><td>Telepresenter</td><td>A</td></tr>
<tr><td>Informed Consent</td><td>A</td></tr>
<tr><td>Licensure & Out-of-State Practice</td><td>C</td></tr>
<tr><td>MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:</td><td>✔</td></tr>
<tr><td>PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:</td><td></td></tr>
</table>

Telemedicine in Nevada

PHYSICIAN PRACTICE STANDARDS & LICENSURE:		
Physician-patient encounter	B	• Last policy revision: 2013. • Allows telemedicine in lieu of an in-person examination and to establish the patient-physician relationship. • Requires unspecified method of obtaining patient's informed consent. • Qualifying out-of-state physician has the option of applying for a full license or a telemedicine permit to practice in NV.
Telepresenter	A	
Informed Consent	B	
Licensure & Out-of-State Practice	B	
MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:	✔	
PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:		

Telemedicine in New Hampshire

PHYSICIAN PRACTICE STANDARDS & LICENSURE:		
Physician-patient encounter	A	• Requirements for telemedicine are on par with requirements for in-person services, not including prescribing. No unique practice standard requirements for telemedicine. • Requires full license and allows P2P exemption. • If enacted, SB 84 would allow a physician-patient relationship to be established via telemedicine for the purpose of prescribing.[11]
Telepresenter	A	
Informed Consent	A	
Licensure & Out-of-State Practice	C	
MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:	✔	
PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:	✔	

Telemedicine in New Jersey

PHYSICIAN PRACTICE STANDARDS & LICENSURE:		
Physician-patient encounter	A	• Requirements for telemedicine are on par with requirements for in-person services, not including prescribing. No unique practice standard requirements for telemedicine. • Requires full license and allows P2P exemption.
Telepresenter	A	
Informed Consent	A	
Licensure & Out-of-State Practice	C	
MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:	✔	
PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:		

Telemedicine in New Mexico

PHYSICIAN PRACTICE STANDARDS & LICENSURE:		
Physician-patient encounter	A	• Requirements for telemedicine are on par with requirements for in-person services, not including prescribing. No unique practice standard requirements for telemedicine. • Qualifying out-of-state physician has the option of applying for a full license or a telemedicine permit to practice in NM.
Telepresenter	A	
Informed Consent	A	
Licensure & Out-of-State Practice	B	
MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:	✔	
PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:		

Telemedicine in New York

PHYSICIAN PRACTICE STANDARDS & LICENSURE:		
Physician-patient encounter	B	• Last policy revision: January 2009. • Allows telemedicine to establish the patient-physician relationship. • Requires full license and allows P2P exemption. • Extends licensure reciprocity to bordering tri-states.
Telepresenter	A	
Informed Consent	A	
Licensure & Out-of-State Practice	B	
MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:		
PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:		

Telemedicine in North Carolina

PHYSICIAN PRACTICE STANDARDS & LICENSURE:		
Physician-patient encounter	B	• Last policy revision: November 2014 • Allows telemedicine in lieu of an in-person examination and to establish a physician-patient relationship. • Requires full license and allows P2P exemption.
Telepresenter	A	
Informed Consent	A	
Licensure & Out-of-State Practice	C	
MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:	✔	
PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:		

Telemedicine in North Dakota

PHYSICIAN PRACTICE STANDARDS & LICENSURE:		
Physician-patient encounter	B	• Last policy revision: March 2014 • Allows telemedicine in lieu of an in-person examination and to establish a physician-patient relationship. • Does not allow licensure exemption for physician-to-physician out-of-state consultation. • The board has released a draft proposal to solicit comments for future rulemaking.[12]
Telepresenter	A	
Informed Consent	A	
Licensure & Out-of-State Practice	F	
MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:	✔	
PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:		

Telemedicine in Ohio

<table>
<tr><th colspan="2">PHYSICIAN PRACTICE STANDARDS & LICENSURE:</th><th></th></tr>
<tr><td>Physician-patient encounter</td><td>B</td><td rowspan="6">• Allows telemedicine in lieu of an in-person examination.
• Qualifying out-of-state physician has the option of applying for a full license or a telemedicine permit to practice in OH.
• OH Medical Board issued draft regulations for public comment concerning prescriptions to persons the physician has not personally examined.[13]</td></tr>
<tr><td>Telepresenter</td><td>A</td></tr>
<tr><td>Informed Consent</td><td>A</td></tr>
<tr><td>Licensure & Out-of-State Practice</td><td>B</td></tr>
<tr><td>MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:</td><td>✔</td></tr>
<tr><td>PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:</td><td></td></tr>
</table>

Telemedicine in Oklahoma

PHYSICIAN PRACTICE STANDARDS & LICENSURE:		
Physician-patient encounter	B	• Last policy revision: 2014. • Allows telemedicine in lieu of an in-person examination and to establish the patient-physician relationship. • Requires written patient informed consent. • Requires full license and allows P2P exemption.
Telepresenter	A	
Informed Consent	F	
Licensure & Out-of-State Practice	C	
MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:	✔	
PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:		

Telemedicine in Oregon

PHYSICIAN PRACTICE STANDARDS & LICENSURE:		
Physician-patient encounter	A	• Requirements for telemedicine are on par with requirements for in-person services, not including prescribing. No unique practice standard requirements for telemedicine. • Qualifying out-of-state physician has the option of applying for a full license or a telemedicine permit to practice in OR.
Telepresenter	A	
Informed Consent	A	
Licensure & Out-of-State Practice	B	
MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:	✔	
PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:	✔	

Telemedicine in Pennsylvania

PHYSICIAN PRACTICE STANDARDS & LICENSURE:		
Physician-patient encounter	A	• Requirements for telemedicine are on par with requirements for in-person services, not including prescribing. No unique practice standard requirements for telemedicine. • Does not allow licensure exemption for physician-to-physician out-of-state consultation.
Telepresenter	A	
Informed Consent	A	
Licensure & Out-of-State Practice	F	
MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:		
PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:		

Telemedicine in Rhode Island

PHYSICIAN PRACTICE STANDARDS & LICENSURE:		
Physician-patient encounter	B	• Last policy revision: June 2014. • Allows telemedicine to establish the patient-physician relationship. • Requires patient-informed consent. • Requires full license and allows P2P exemption.
Telepresenter	A	
Informed Consent	B	
Licensure & Out-of-State Practice	C	
MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:	✔	
PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:		

Telemedicine in South Carolina

PHYSICIAN PRACTICE STANDARDS & LICENSURE:		
Physician-patient encounter	A	• Requirements for telemedicine are on par with requirements for in-person services, not including prescribing. No unique practice standard requirements for telemedicine.
Telepresenter	A	
Informed Consent	A	
Licensure & Out-of-State Practice	C	
MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:	✔	• Requires full license and allows P2P exemption.
PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:		

Telemedicine in South Dakota

PHYSICIAN PRACTICE STANDARDS & LICENSURE:		
Physician-patient encounter	A	• Requirements for telemedicine are on par with requirements for in-person services, not including prescribing. No unique practice standard requirements for telemedicine. • Does not allow licensure exemption for physician-to-physician out-of-state consultation.
Telepresenter	A	
Informed Consent	A	
Licensure & Out-of-State Practice	F	
MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:		
PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:		

Telemedicine in Tennessee

PHYSICIAN PRACTICE STANDARDS & LICENSURE:		
Physician-patient encounter	A	• Requirements for telemedicine are on par with requirements for in-person services, not including prescribing. No unique practice standard requirements for telemedicine. • Qualifying out-of-state physician has the option of applying for a full license or a telemedicine permit to practice in TN. • Proposed medical board regulations are pending.[14] HB 699 was also enacted to prevent the board from adopting stricter stands for telemedicine than in-person care.[15]
Telepresenter	A	
Informed Consent	A	
Licensure & Out-of-State Practice	B	
MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:	✔	
PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:		

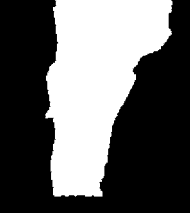
Telemedicine in Texas

PHYSICIAN PRACTICE STANDARDS & LICENSURE:		
Physician-patient encounter	F	• Latest policy revision: June 2015.[16] • Allows face-to-face telemedicine in lieu of an in-person examination and to establish the patient-physician relationship only when patient is located at established medical site. The home or patient's residence is considered an established medical site for purposes of mental health services. • A physician-patient relationship may not be established through an online questionnaire or questions and answers exchanged through e-mail, text, chat, or telephonic evaluation or consultation • Requires an in-person follow-up at least once a year. • Telepresenter on premises required for new conditions with the exception of mental health services. • Requires written patient informed consent. • Qualifying out-of-state physician has the option of applying for a full license or a telemedicine permit to practice in TX.
Telepresenter	B	
Informed Consent	F	
Licensure & Out-of-State Practice	B	
MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:	✔	
PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:		

Telemedicine in Utah

<table>
<tr><td colspan="2">PHYSICIAN PRACTICE STANDARDS & LICENSURE:</td><td></td></tr>
<tr><td>Physician-patient encounter</td><td>A</td><td rowspan="7">Requirements for telemedicine are on par with requirements for in-person services, not including prescribing. No unique practice standard requirements for telemedicine.
Requires full license and allows P2P exemption.</td></tr>
<tr><td>Telepresenter</td><td>A</td></tr>
<tr><td>Informed Consent</td><td>A</td></tr>
<tr><td>Licensure & Out-of-State Practice</td><td>C</td></tr>
<tr><td>MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:</td><td>✔</td></tr>
<tr><td>PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:</td><td></td></tr>
</table>

Telemedicine in Vermont



<table>
<tr><td colspan="2">PHYSICIAN PRACTICE STANDARDS & LICENSURE:</td><td></td></tr>
<tr><td>Physician-patient encounter</td><td>B</td><td rowspan="7">

Last policy revision: May 2012.
Allows telemedicine in lieu of an in-person examination.
Requires informed consent for teledermatology and teleophthalmology.
Requires full license and allows P2P exemption.

</td></tr>
<tr><td>Telepresenter</td><td>A</td></tr>
<tr><td>Informed Consent</td><td>B</td></tr>
<tr><td>Licensure & Out-of-State Practice</td><td>C</td></tr>
<tr><td>MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:</td><td>✔</td></tr>
<tr><td>PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:</td><td></td></tr>
</table>

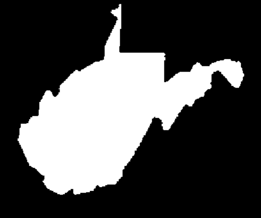
Telemedicine in Virginia

PHYSICIAN PRACTICE STANDARDS & LICENSURE:		
Physician-patient encounter	A	• Requirements for telemedicine are on par with requirements for in-person services, not including prescribing. No unique practice standard requirements for telemedicine. • Requires full license and allows P2P exemption. • Extends licensure reciprocity to bordering states. • Revised board guidelines are pending. • Enacted in March 2015, Chapter 115 permits the use of telemedicine to remotely prescribe Schedule VI controlled substance under certain conditions.[17]
Telepresenter	A	
Informed Consent	A	
Licensure & Out-of-State Practice	B	
MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:	✔	
PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:	✔	

Telemedicine in Washington

PHYSICIAN PRACTICE STANDARDS & LICENSURE:		
Physician-patient encounter	B	• Last policy revision: October 2014. • Allows telemedicine in lieu of an in-person examination and to establish the patient-physician relationship. • Requires written patient informed consent. • Requires full license and allows P2P exemption.
Telepresenter	A	
Informed Consent	F	
Licensure & Out-of-State Practice	C	
MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:	✔	
PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:		

Telemedicine in West Virginia



PHYSICIAN PRACTICE STANDARDS & LICENSURE:		
Physician-patient encounter	B	• Last policy revision: November 2014 • Allows telemedicine in lieu of an in-person examination and to establish the patient-physician relationship. • Requires unspecified method of obtaining patient's informed consent. • Requires full license and allows P2P exemption.
Telepresenter	A	
Informed Consent	B	
Licensure & Out-of-State Practice	C	
MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:	✔	
PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:		

Telemedicine in Wisconsin

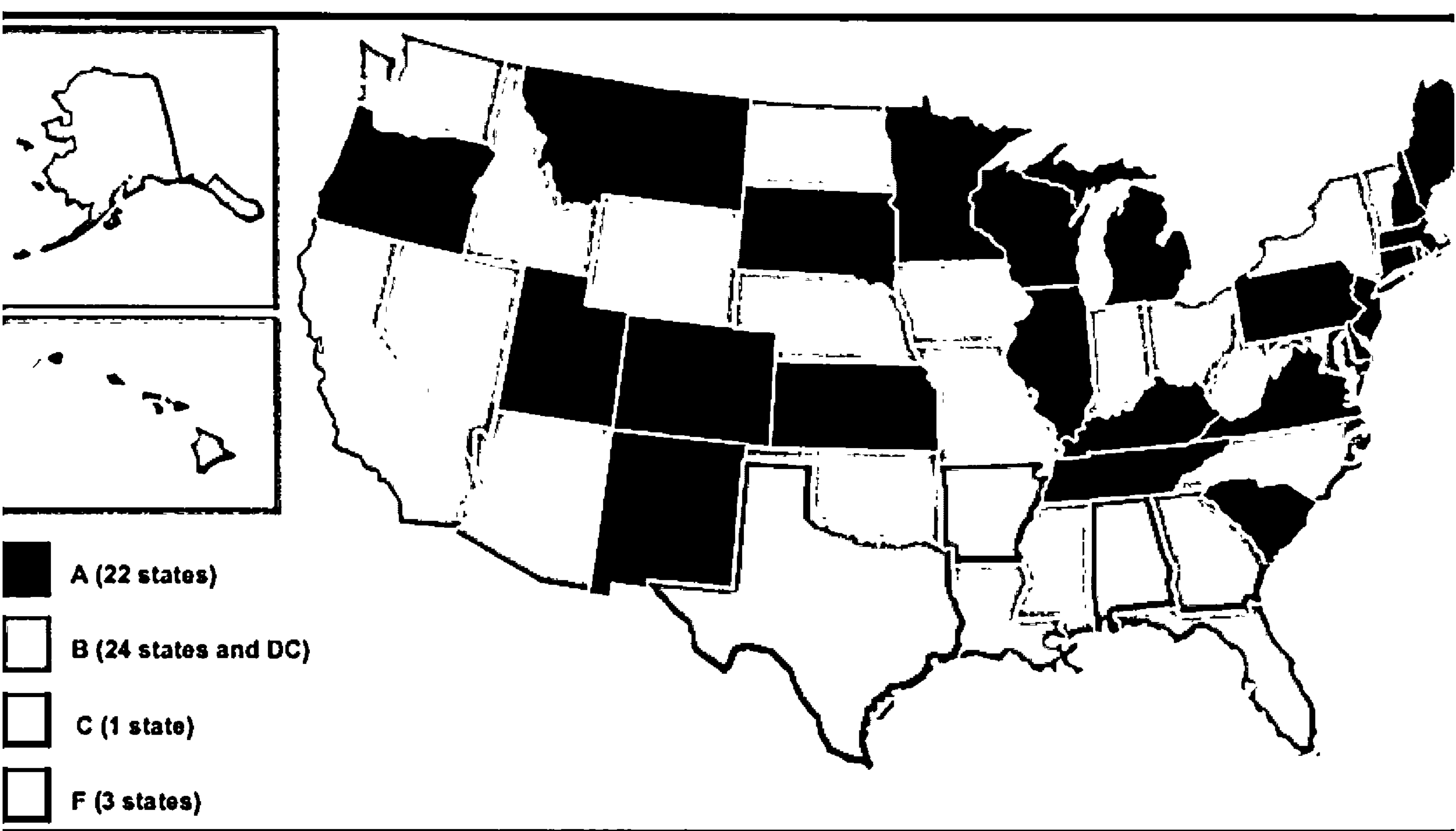
PHYSICIAN PRACTICE STANDARDS & LICENSURE:		
Physician-patient encounter	A	• Requirements for telemedicine are on par with requirements for in-person services, not including prescribing. No unique practice standard requirements for telemedicine. • Requires full license and allows P2P exemption.
Telepresenter	A	
Informed Consent	A	
Licensure & Out-of-State Practice	C	
MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:		
PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:		

Telemedicine in Wyoming

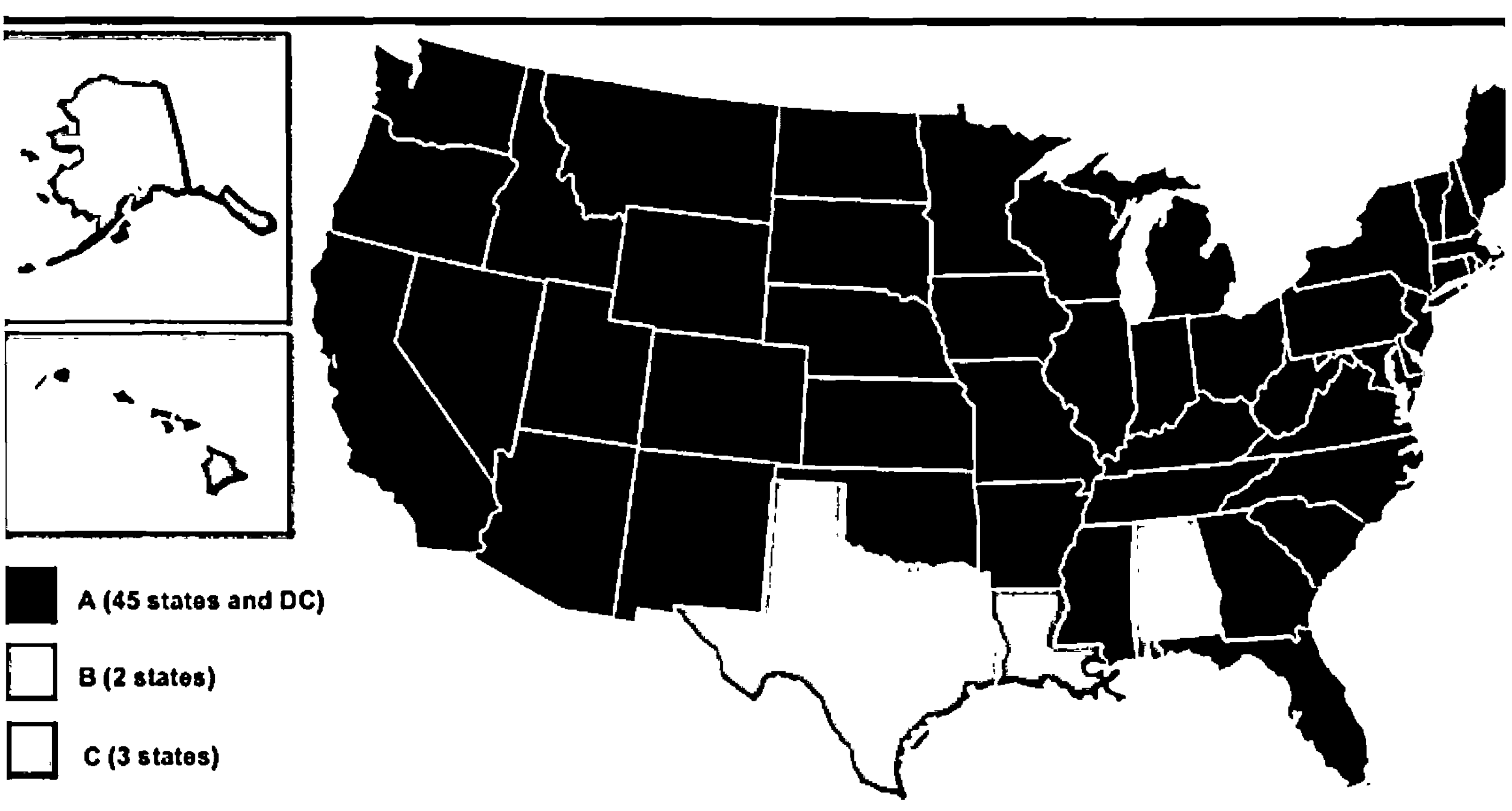
PHYSICIAN PRACTICE STANDARDS & LICENSURE:		
Physician-patient encounter	B	• Last policy revision: August 2009. • Allows telemedicine to establish the patient-physician relationship. • Requires full license and allows P2P exemption.
Telepresenter	A	
Informed Consent	A	
Licensure & Out-of-State Practice	C	
MEDICAL BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:	✔	
PHARMACY BOARD POLICY OR STATEMENT ON INTERNET PRESCRIBING:		

Appendix

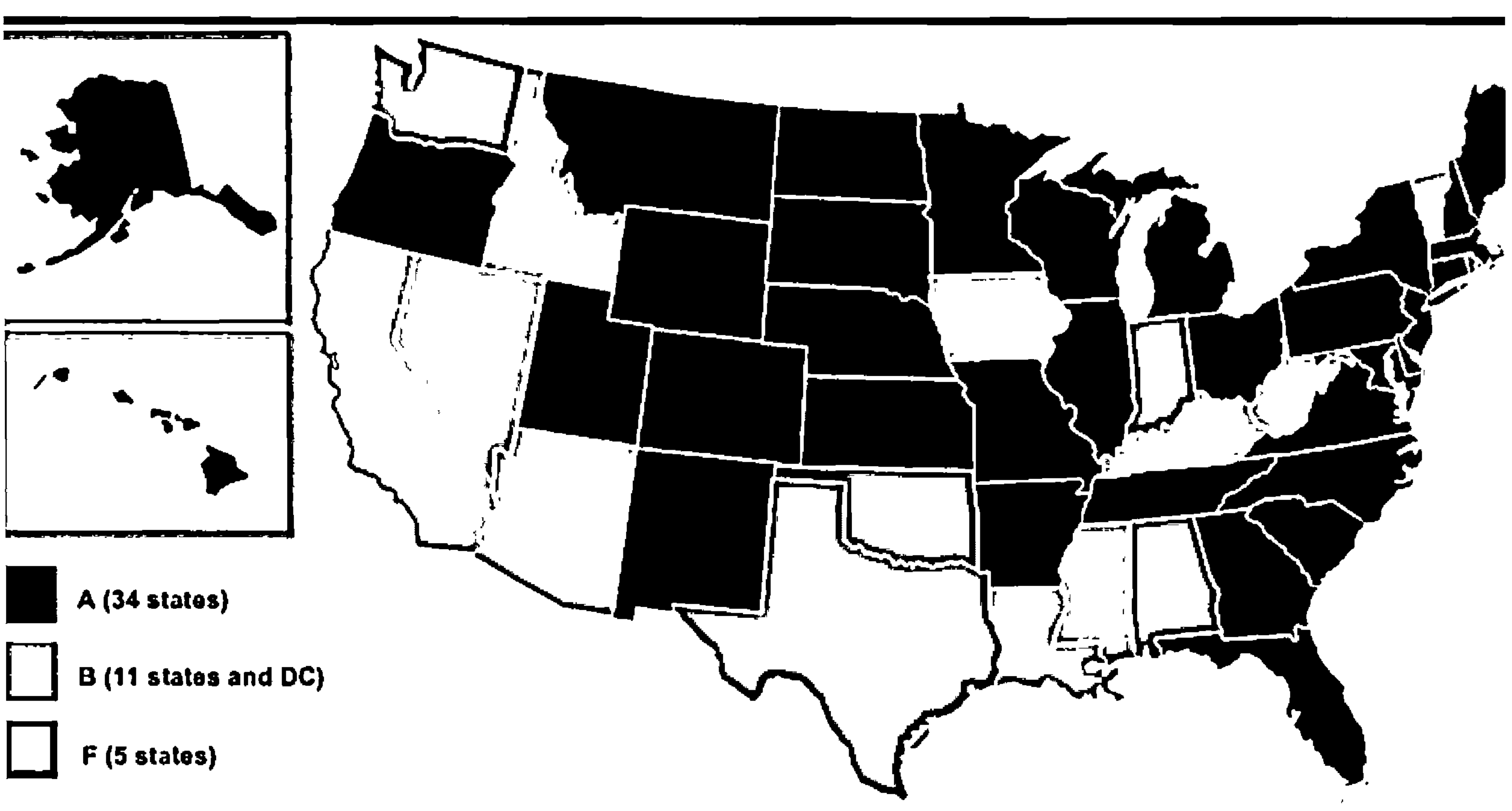
State Ratings – Physician-Patient Encounter via Telemedicine



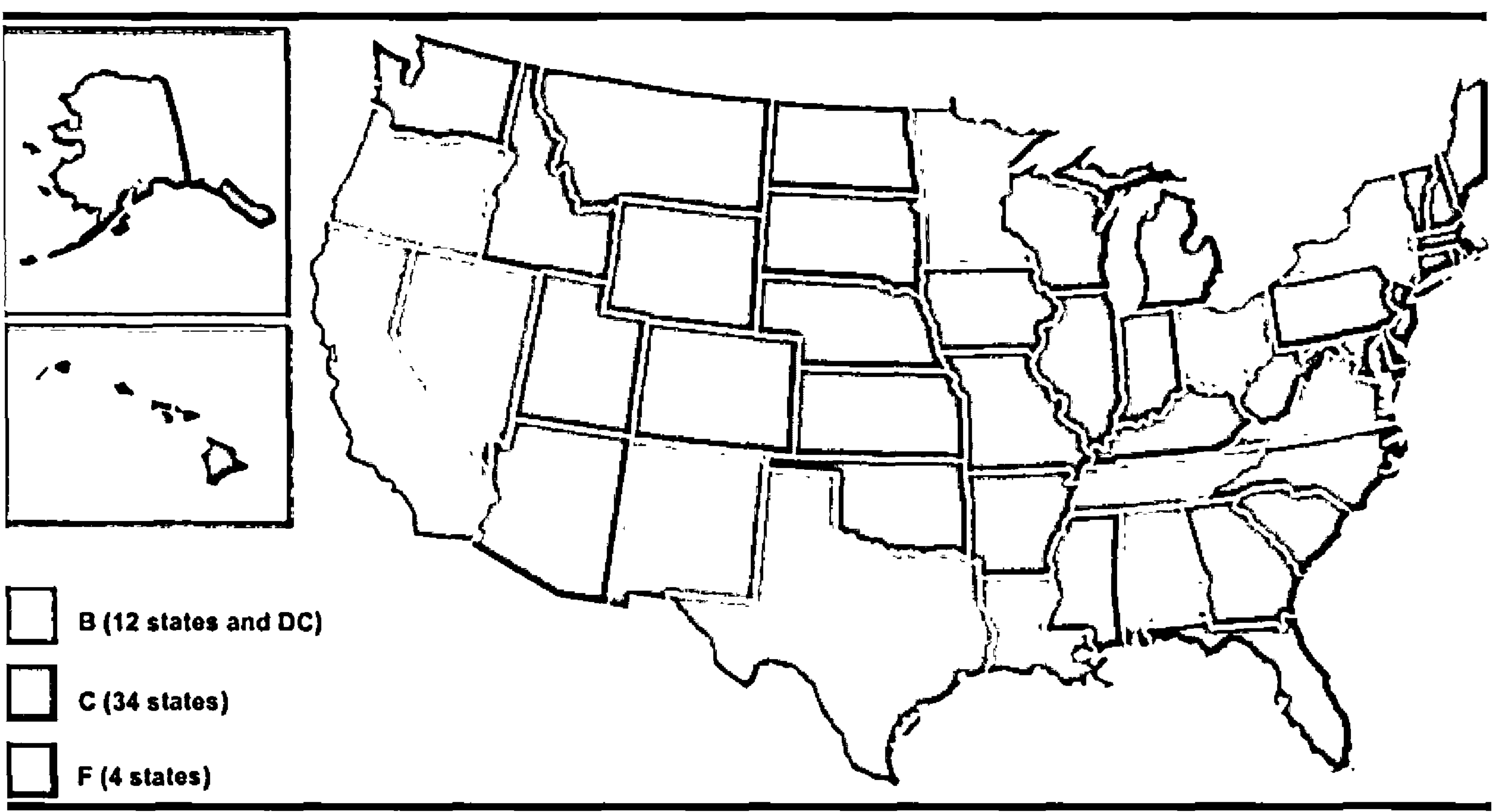
State Ratings – Telepresenter Requirements



State Ratings – Informed Consent Requirements



State Ratings – Licensure and Out-of-State Practice



Matrix - Physician State Practice Standards for Telemedicine (as of April 2015)

[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
✔ [illegible]	✔	✔ [illegible]	✔ [illegible]	✔ Written	✔ [illegible]	[illegible]	✔ Written	✔ MD/DO, PA, CRNP, Certified Nurse Midwife	[illegible]		Alabama Admin. Code r. 540 [illegible]
✔	✔	✔			✔					The Board is considering revised rules related to unprofessional conduct.	Alaska Admin. Code tit. 12, § 40.967 [illegible]
											Alaska Board issued Guidelines [illegible]
✔	✔	✔		✔ Written or Oral with the following exceptions: [illegible]		"Telemedicine" means the practice of health care delivery, diagnosis, consultation and treatment and the transfer of medical data through interactive audio, video or data communications [illegible]				[illegible]	Arizona Board Statement [illegible]
											Ariz. Rev. Stat. § 36-[illegible]
✔	✔					(5) "Store and forward technology" means [illegible] (6) "Telemedicine" means [illegible]		(1) "Distant site" means [illegible] (2) "Originating site" means [illegible]	Store-and-forward technology [illegible] (6) "Telemedicine" means [illegible]		[illegible]
											[illegible]
											[illegible]
✔	✔	✔		✔ Verbal or written with the following exception: [illegible]							Cal. Bus. & Prof. Code § [illegible]
		✔				Telemedicine means the delivery of medical services and any diagnosis, consultation, or treatment using interactive audio, interactive video, or interactive data communication.					[illegible]
		✔									No unique laws regulating practice of [illegible] Standards are the same as in-person [illegible]
		✔									No unique laws regulating practice of [illegible] Standards are the same as in-person [illegible]

Matrix - Physician State Practice Standards for Telemedicine (as of April 2015)

[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
✓	✓ Using audio-video or audio only	✓		✓ Not required for interpretation services such as [illegible]		[illegible]				Policy notice issued November 2014	Telemedicine Policy 15.01
	✓	✓				[illegible]		✓ MD/DO and PA	Does not prohibit the transmission [illegible] of digital images, pathology specimens, test results or other medical data by physicians or other qualified health providers		[illegible]
											[illegible]
✓		✓	✓							Does not interfere with telephonic follow-up or phone/internet consultations with other providers	Ga. Comp. R. & Regs. 360-3-.07
✓	✓	✓			✓	[illegible]					Haw. Rev. Stat. § 453-1.3
	✓	✓		✓		[illegible]					[illegible]
		✓				[illegible]					225 ILCS 60/49.5

Matrix - Physician State Practice Standards for Telemedicine (as of April 2015)

[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
✔		✔		✔ Written		[illegible]				[illegible]	[illegible]
✔	✔	✔		✔		[illegible]				[illegible]	[illegible]
		✔									[illegible]
		✔		✔							[illegible]
✔	✔	✔		✔	✔	[illegible]				[illegible]	[illegible]
											[illegible]
		✔				[illegible]					[illegible]
✔	✔	✔									[illegible]
		✔				[illegible]					[illegible]
		✔									[illegible]
		✔				[illegible]					[illegible]

Matrix - Physician State Practice Standards for Telemedicine (as of April 2015)

[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
✔	✔	✔		✔		"Telemedicine" is 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 definition does not include the practice of medicine through postal or courier services. "Telemergency medicine" is a unique combination of telemedicine and the [illegible] role of a physician board certified in emergency medicine, and an appropriate skilled health professional (nurse practitioner or physician assistant).				Revised rules pending	Code Miss. R. 30-5-2635
✔	✔	✔		✔ Medicaid [illegible] only							MO [illegible]
		✔								Legislation enacted to uphold the standard of care	Montana 2015 Regular Session Act [illegible]
✔	✔	✔		✔ Medicaid [illegible] only							88 Neb. Admin. Code [illegible]
✔	✔	✔		✔ [illegible] only		"Practice of medicine" means: 1. To diagnose, treat, correct, prevent or prescribe for any human disease, ailment, injury, infirmity, deformity or other condition, physical or mental, by any means or instrumentality, including, but not limited to, the performance of an autopsy. 2. To apply principles or techniques of medical science in the diagnosis or the prevention of any such conditions. 3. To perform any of the acts described in subsections 1 and 2 by using equipment that transfers information concerning the medical condition of the patient electronically, telephonically or by fiber optics from within or outside this State or the United States.					NRS 630.020, NRS 633.165
		✔									No unique laws regulating practice of [illegible] Standards are the same as in-person [illegible]
		✔									No unique laws regulating practice of [illegible] Standards are the same as in-person [illegible]
		✔									No unique laws regulating practice of [illegible] Standards are the same as in-person [illegible]
	✔	✔									NY Board Statement
✔	✔	✔				Practice of medicine. The performance of any act, within or without this State, described in this subdivision by use of any electronic or other means, including the Internet or telephone					NC Medical Board Position 2014, N.C. [illegible]
✔	✔	✔								Regulations pending	Board position statement
✔		✔				Practice of telemedicine is defined in Ohio as the practice of medicine in the state through the use of any communication, including oral, written or electronic communication, by a physician located outside this state.					Ohio Board Position May 2012
✔	✔	✔		✔ Written		Telemedicine means the practice of [illegible]					OK Board Position [illegible]
											[illegible]
		✔								The Oregon Medical Board considers [illegible]	No unique laws regulating practice of [illegible] Standards are the same as in-person [illegible]
		✔									No unique laws regulating practice of [illegible] Standards are the same as in-person [illegible]
	✔	✔		✔		Telemedicine is defined very generally as the delivery of health care [illegible]					RI Medical Board Policy (2014)

Matrix - Physician State Practice Standards for Telemedicine (as of April 2015)

[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		✔										[illegible]
		✔										[illegible]
✔		✔									[illegible]	[illegible]
✔	✔	✔ [illegible]	✔ [illegible]	✔ Written	✔ [illegible]	[illegible]		[illegible]			[illegible]	[illegible]
												[illegible]
		✔										[illegible]
✔		✔		✔ [illegible]								[illegible]
		✔									[illegible]	[illegible]
✔	✔	✔		✔ Written							[illegible]	[illegible]
✔	✔	✔		✔		[illegible]					Legislation pending	[illegible]
		✔										[illegible]
	✔	✔				[illegible]						[illegible]

Matrix - State Policies on Provider-to-Provider Consultations (as of April 2015)

	[illegible]	Legal Language	Notes	[illegible]
	✔	(2) Exemptions. Exemptions to the practice of medicine or osteopathy across state lines are defined as follows: (a) A physician who engages in the practice of medicine across state lines in a medical emergency, as defined in these rules, is not subject to the provisions of 97-166 Ala. Acts; (b) A physician who engages in the practice of medicine or osteopathy across state lines on an irregular or infrequent basis, as defined in these rules, is not subject to the provisions of 97-166 Ala. Acts.		Alabama Admin. Code r. 540 X 16-.02
	✔	This chapter does not apply to a physician or osteopath, who is not a resident of this state, who is asked by a physician or osteopath licensed in this state to help in the diagnosis or treatment of a case,		AS 08.64.370
	✔	A doctor of medicine residing in another jurisdiction who is authorized to practice medicine in that jurisdiction, if the doctor engages in actual single or infrequent consultation with a doctor of medicine licensed in this state and if the consultation regards a specific patient or patients.		Arizona Rev. Stat. Ann. § 32.1421(8)
	✔	This section does not apply to. (1) The acts of a medical specialist located in another jurisdiction who provides only episodic consultation services, (2) The acts of a physician located in another jurisdiction who is providing consultation services to a medical school, (3) Decisions regarding the denial or approval of coverage under any insurance or health maintenance organization plan; (4) A service to be performed which is not available in the state; (5) A physician physically seeing a patient in person in another jurisdiction; or (6) Other acts exempted by the board by regulation		AR Statute 17.95.206
	✔	Exemption applies only to sporting events		Cal. Bus. & Prof. Code § 2076 and 2076.5
	✔	(3) A person may engage in, and shall not be required to obtain a license or a physician training license under this article with respect to, any of the following acts (a) The gratuitous rendering of services in cases of emergency, (b) The occasional rendering of services in this state by a physician if the physician: (I) Is licensed and lawfully practicing medicine in another state or territory of the United States without restrictions or conditions on the physician's license, (II) Does not have any established or regularly used medical staff membership or clinical privileges in this state; (III) Is not party to any contract, agreement, or understanding to provide services in this state on a regular or routine basis; (IV) Does not maintain an office or other place for the rendering of such services, (V) Has medical liability insurance coverage in the amounts required pursuant to section 13-64-302, C.R.S., for the services rendered in this state, and (VI) Limits the services provided in this state to an occasional case or consultation		CRSA § 12.36-106(3)(a)(b)
	✔	(3) Any person who furnishes medical or surgical assistance in cases of sudden emergency; (4) Any person residing out of this state who is employed to come into this state to render temporary assistance to or consult with any physician or surgeon who has been licensed in conformity with the provisions of this chapter; (5) Any physician or surgeon residing out of this state who holds a current license in good standing in another state and who is employed to come into this state to treat, operate or prescribe for any injury, deformity, ailment or disease from which the person who employed such physician, or the person on behalf of whom such physician is employed, is suffering at the time when such nonresident physician or surgeon is so employed, provided such physician or surgeon may practice in this state without a Connecticut license for a period not to exceed thirty consecutive days,		CT Statute Chapter 370 Sec. 20.9
	✔	Consultation may be done telephonically, electronically or in person. Consultation shall ordinarily consist of a history and physical examination, review of records and imaging pathology or similar studies. Consultation includes providing opinions and recommendations. An active Delaware certificate is required of any out of state physician who comes into Delaware to perform a consultation more than twelve (12) times per year. A physician who comes into Delaware to perform consultations less than once a quarter must be actively licensed in another State or country on a full and unrestricted basis. Any consultations done for teaching and/or training purposes may include active participation in procedures and treatment, whether surgical or otherwise, provided a Delaware licensed physician remains responsible as the physician of record, and provided the patient is not charged a fee by the consultant.		24.1700 Del. Code Regs. § 6.0

Matrix - State Policies on Provider-to-Provider Consultations (as of April 2015)

[illegible]	[illegible]	[illegible]	Notes	[illegible]
	✔	To an individual, licensed, registered, or certified to practice a health occupation in a state, who is providing care to an individual or group for a limited period of time, or who is called from a state in professional consultation by or on behalf of a specific patient or client to visit, examine, treat, or advise the specific patient or client in the District, or to give a demonstration of a procedure or clinic in the District, provided, that the individual engages in the provision of care, consultation, demonstration, or clinic in affiliation with a comparable health professional licensed, registered, or certified pursuant to this chapter; To a health professional who is authorized to practice a health occupation in any state adjoining the District who treats patients in the District if: (A) The health professional does not have an office or other regularly appointed place in the District to meet patients, (B) The health professional registers with the appropriate board and pays the registration fee prescribed by the board prior to practicing in the District; and (C) The state in which the individual is licensed allows individuals licensed by the District in that particular health profession to practice in that state under the conditions set forth in this section.		DC Statute § 3 1205 02
	✔	Provisions of this chapter shall have no application to any physician lawfully licensed in another state or territory or foreign country, when meeting duly licensed physicians of this state in consultation		Fla Stat § 458 303
	✔	including electronic, radiographic, or other means of telecommunication, through which medical information or data are transmitted, performs an act that is part of a patient care service located in this state, including but not limited to the initiation of imaging procedures or the preparation of pathological material for examination, and that would affect the diagnosis or treatment of the patient is engaged in the practice of medicine in this state Any person who performs such acts through such means shall be required to have a license to practice medicine in this state and shall be subject to regulation by the board Any such out-of-state or foreign practitioner shall not have ultimate authority over the care or primary diagnosis of a patient who is located in this state This Code section shall not apply to: (1) The acts of a doctor of medicine or doctor of osteopathic medicine located in another state or foreign country who: (A) Provides consultation services at the request of a physician licensed in this state; and (B) Provides such services on an occasional rather than on a regular or routine basis, (1) The acts of a physician or osteopathic physician licensed in another state or foreign country who: (A) Provides consultation services in the case of an emergency; (B) Provides consultation services without compensation, remuneration, or other expectation thereof; or (C) Provides consultation services to a medical school which is located within this state and approved by the board; or (3) The acts of a physician or osteopathic physician located in another state or foreign country when invited as a guest of any medical school or osteopathic medical school approved by the board or a state medical society or component thereof, for the sole purpose of engaging in professional education through lectures, clinics, or demonstrations, provided that such physician or osteopathic physician is licensed to practice medicine or osteopathic medicine in the state or foreign country in which he or she is located.		GA Code Ann. § 43 34-31

Matrix - State Policies on Provider-to-Provider Consultations (as of April 2015)

	[illegible]	Legal Language	Status	[illegible]
	✔	Exception: Any practitioner of medicine and surgery from another state when in actual consultation, including in-person, mail, electronic, telephonic, fiber-optic, or other telemedicine consultation with a licensed physician or osteopathic physician of this State, if the physician or osteopathic physician from another state at the time of consultation is licensed to practice in the state in which the physician or osteopathic physician resides, provided that (A) The physician or osteopathic physician from another state shall not open an office, or appoint a place to meet patients in this State, or receive calls within the limits of the State for the provision of care for a patient who is located in this State; (B) The licensed physician or osteopathic physician of this State retains control and remains responsible for the provision of care for the patient who is located in this State, and (C) The laws and rules relating to contagious diseases are not violated, Provision of emergency medical services by physician, or any physician assistant when the services are rendered under the direction and control of a physician or osteopathic physician licensed in this State except for final refraction resulting in a prescription for spectacles, contact lenses, or visual training as performed by an oculist or optometrist duly licensed by the State. The direction and control shall not be construed in every case to require the personal presence of the supervising and controlling physician or osteopathic physician. Any physician or osteopathic physician who employs or directs a person certified under part II of this chapter to provide emergency medical services, or a physician assistant, shall retain full professional and personal responsibility for any act that constitutes the practice of medicine when performed by the certified person or physician assistant		HAW REV STAT § 453 2
	✔	b) A person residing in another state or country and authorized to practice medicine there, who is called in consultation by a person licensed in this state to practice medicine, or who for the purpose of furthering medical education is invited into this state to conduct a lecture, clinic, or demonstration, while engaged in activities in connection with the consultation, lecture, clinic, or demonstration, so long as he does not open an office or appoint a place to meet patients or receive calls in this state, (c) A person authorized to practice medicine in another state or country while rendering medical care in a time of disaster or while caring for an ill or injured person at the scene of an emergency and while continuing to care for such person;		Idaho Statutes 54-1804
	✔	No person shall practice medicine, or any of its branches, or treat human ailments without the use of drugs and without operative surgery, without a valid, existing license to do so, except that a physician who holds an active license in another state or a second year resident enrolled in a residency program accredited by the Liaison Committee on Graduate Medical Education or the Bureau of Professional Education of the American Osteopathic Association may provide medical services to patients in Illinois during a bonafide emergency in immediate preparation for or during interstate transit. "Telemedicine" does not include the following (1) periodic consultations between a person licensed under this Act and a person outside the State of Illinois, (2) a second opinion provided to a person licensed under this Act; and (3) diagnosis or treatment services provided to a patient in Illinois following care or treatment originally provided to the patient in the state in which the provider is licensed to practice medicine		225 ILL COMP. STAT ANN. 60/3 and 60/49 5(c)
	✔	A nonresident physician who is located outside Indiana does not practice medicine or osteopathy in Indiana by providing a second opinion to a licensee or diagnostic or treatment services to a patient in Indiana following medical care originally provided to the patient while outside Indiana. An individual who is not a licensee who resides in another state or country and is authorized to practice medicine or osteopathic medicine there, who is called in for consultation by an individual licensed to practice medicine or osteopathic medicine in Indiana		IC 25 22 5 1 1 1 and 25 22 5-1 2
	✔	Physicians and surgeons or osteopathic physicians and surgeons of the United States army, navy, air force, marines, public health service, or other uniformed service when acting in the line of duty in this state, and holding a current, active permanent license in good standing in another state, district, or territory of the United States, or physicians and surgeons or osteopathic physicians and surgeons licensed in another state, when incidentally called into this state in consultation with a physician and surgeon or osteopathic physician and surgeon licensed in this state		IA Code §148 2

Matrix - State Policies on Provider-to-Provider Consultations (as of April 2015)

	[illegible]	[illegible]	[illegible]	[illegible]
	✔	Practitioners of the healing arts licensed in another state when and while incidentally called into this state in consultation with practitioners licensed in this state. Practitioners of the healing arts duly licensed under the laws of another state who do not open an office or maintain or appoint a place to regularly meet patients or to receive calls within this state, but who order services which are performed in this state in accordance with rules and regulations of the board The board shall adopt rules and regulations identifying circumstances in which professional services may be performed in this state based upon an order by a practitioner of the healing arts licensed under the laws of another state		KS Statutes 65 2872
	✔	Persons 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 physician licensed pursuant to this chapter		Ky. Rev. Stat. Ann. § 311.560
	✔	A true consultation, e g., an informal consultation or second opinion, provided by an individual licensed to practice medicine in a state other than Louisiana, provided that the Louisiana physician receiving the opinion is personally responsible to the patient for the primary diagnosis and any testing and treatment provided		La Admin. Code tit 46, § 7515
	✔	Consultation shall be considered to occur when a physician not licensed in the State of Maine reviews records or interviews or examines a patient in any way, and provides a professional opinion or recommendation to a physician licensed in the State of Maine who is the physician of record for the patient being diagnosed or treated Such consultant must be fully licensed in another state. A non-resident physician does not need a license in this State if he/she consults on an irregular basis with a physician or physicians licensed in this State		02-152 CMR 1 § 2(4)(8)
	✔	Subject to the rules, regulations, and orders of the Board, the following individuals may practice medicine without a license: a physician licensed by and residing in another jurisdiction, while engaging in consultation with a physician licensed in this State, a physician who resides in and is authorized to practice medicine by any state adjoining this State and whose practice extends into this State, if the physician does not have an office or other regularly appointed place in this State to meet patients, and the same privileges are extended to licensed physicians of this State by the adjoining state,	Adjoining states	Annotated Code of Maryland, HEALTH OCCUPAT § 14 302
ts	✔	They shall not apply to a physician authorized to practice medicine in another state, when he is called as the family physician to attend a person temporarily abiding in the commonwealth, to a physician authorized to practice medicine in another state or country, when he is providing medical services only to athletes or team personnel attending a sporting event sponsored by the US Olympic Committee or a World Cup Organizing Committee		MGL Ch. 112 section 7
	n/a			
	✔	A physician who is not licensed to practice medicine in this state, but who holds a valid license to practice medicine in another state or jurisdiction, and who provides interstate telemedicine services to a patient located in this state is not subject to the registration requirement of subdivision 1, paragraph (a), clause (4), if: (1) the services are provided in response to an emergency medical condition. For the purposes of this section, an emergency medical condition means a condition, including emergency labor and delivery, that manifests itself by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any body organ or part; (2) the services are provided on an irregular or infrequent basis For the purposes of this section, a person provides services on an irregular or infrequent basis if the person provides the services less than once a month or provides the services to fewer than ten patients annually; or (3) the physician provides interstate telemedicine services in this state in consultation with a physician licensed in this state and the Minnesota physician retains ultimate authority over the diagnosis and care of the patient.		Minn. Stat. § 147.032

Matrix - State Policies on Provider-to-Provider Consultations (as of April 2015)

	[illegible]	[illegible]	[illegible]	[illegible]
	✔	However, a valid Mississippi license is not required where the evaluation, treatment and/or medicine given to be rendered 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		Code Miss. R. 30-5 2635
	✔	A physician located outside of this state shall not be required to obtain a license when: (1) In consultation with a physician licensed to practice medicine in this state, and (2) The physician licensed in this state retains ultimate authority and responsibility for the diagnosis or diagnoses and treatment in the care of the patient located within this state, or (3) Evaluating a patient or rendering an oral, written or otherwise documented medical opinion, or when providing testimony or records for the purpose of any civil or criminal action before any judicial or administrative proceeding of this state or other forum in this state, or (4) Participating in a utilization review pursuant to section 376 1350		MO Revised Statutes § 334 010
	✔	This chapter does not prohibit or require a license with respect to any of the following acts (a) the gratuitous rendering of services in cases of emergency or catastrophe; (b) the rendering of services in this state by a physician lawfully practicing medicine in another state or territory. However, if the physician does not limit the services to an occasional case or if the physician has any established or regularly used hospital connections in this state or maintains or is provided with, for the physician's regular use, an office or other place for rendering the services, the physician must possess a license to practice medicine in this state		MT Code Ann. 37 3 103
	✔	(6) Physicians who are licensed in good standing to practice medicine under the laws of another state when incidentally called into this state or contacted via electronic or other medium for consultation with a physician licensed in this state. For purposes of this subdivision, consultation means evaluating the medical data of the patient as provided by the treating physician and rendering a recommendation to such treating physician as to the method of treatment or analysis of the data. The interpretation of a radiological image by a physician who specializes in radiology is not a consultation, (7) Physicians who are licensed in good standing to practice medicine in another state but who, from such other state, order diagnostic or therapeutic services on an irregular or occasional basis, to be provided to an individual in this state, if such physicians do not maintain and are not furnished for regular use within this state any office or other place for the rendering of professional services or the receipt of calls, (8) Physicians who are licensed in good standing to practice medicine in another state and who, on an irregular and occasional basis, are granted temporary hospital privileges to practice medicine and surgery at a hospital or other medical facility licensed in this state; (9) Persons providing or instructing as to use of braces,		NE STAT. 38 2025
	✔	1. Any physician licensed in this State shall notify the Board if any unlicensed physician comes into this State for consultation with or assistance to the physician licensed in this State and specify the date of the consultation or assistance, whether the unlicensed physician has provided such consultation or assistance, or both, to the licensed physician in the past, and the date of that consultation and assistance. 2. A physician licensed in this State who consults with or receives assistance from a physician licensed in another state pursuant to subsection 1 shall comply with the provisions of chapter 629 of NRS governing the preparation, retention or dissemination of any health care record resulting from the consultation or assistance between the physician licensed in this State and the physician licensed in another state		NAC 630.225
ire	✔	A physician located outside of this state shall not be required to obtain a license when: 1) in consultation with a physician licensed to practice medicine in this state who has a bona fide doctor-patient relationship with the patient, AND 2) the physician licensed in this state retains the ultimate authority and responsibility for the diagnosis and treatment in the care of the patient located within this state		Board State April 2004
	✔	Exemption. A physician or surgeon of another state of the United States and duly authorized under the laws thereof to practice medicine or surgery therein, if such practitioner does not open an office or place for the practice of his profession in this State		NJ STAT. ANN. § 45 9-21
	✔	Physician licensed to practice under the laws of another state who acts as a consultant to a NM physician on an irregular or infrequent basis		NMSA § 61 6-17

Matrix - State Policies on Provider-to-Provider Consultations (as of April 2015)

	[illegible]	[illegible]	[illegible]	[illegible]
	✔	The following persons under the following limitations may practice medicine within the state without a license. 2. Any physician who is licensed in a bordering state and who resides near a border of this state, provided such practice is limited in this state to the vicinity of such border and provided such physician does not maintain an office or place to meet patients or receive calls within this state, 3 Any physician who is licensed in another state or country and who is meeting a physician licensed in this state, for purposes of consultation, provided such practice is limited to such consultation	Bordering state	N Y EDN LAW § 6526 NY Code - Section 6526
lina	✔	The practice of medicine or surgery by any nonregistered reputable physician or surgeon who comes into this State, either in person or by use of any electronic or other mediums, on an irregular basis, to consult with a resident registered physician or to consult with personnel at a medical school about educational or medical training. This proviso shall not apply to physicians resident in a neighboring state and regularly practicing in this State		NC Medical Board Position July 2010
ta	n/a			
	✔	Exemptions (3) A physician or surgeon in another state or territory who is a legal practitioner of medicine or surgery therein when providing consultation to an individual holding a certificate to practice issued under this chapter who is responsible for the examination, diagnosis, and treatment of the patient who is the subject of the consultation, if one of the following applies: (a) The physician or surgeon does not provide consultation in this state on a regular or frequent basis. (b) The physician or surgeon provides the consultation without compensation of any kind, direct or indirect, for the consultation. (c) The consultation is part of the curriculum of a medical school or osteopathic medical school of this state or a program described in division (A)(2) of section 4731.291 of the Revised Code. (4) A physician or surgeon in another state or territory who is a legal practitioner of medicine or surgery therein and provided services to a patient in that state or territory, when providing, not later than one year after the last date services were provided in another state or territory, follow-up services in person or through the use of any communication, including oral, written, or electronic communication, in this state to the patient for the same condition; (5) A physician or surgeon residing on the border of a contiguous state and authorized under the laws thereof to practice medicine and surgery therein, whose practice extends within the limits of this state Such practitioner shall not either in person or through the use of any communication, including oral, written, or electronic communication, open an office or appoint a place to see patients or receive calls within the limits of this state		OH REV CODE § 4731 36
	✔	Any person licensed to practice medicine and surgery in another state or territory of the United States who renders emergency medical treatment or briefly provides critical medical service at the specific lawful direction of a medical institution or federal agency that assumes full responsibility for that treatment or service and is approved by the Board, 8. Any person who is licensed to practice medicine and surgery in another state or territory of the United States whose sole purpose and activity is limited to brief actual consultation with a specific physician who is licensed to practice medicine and surgery by the Board, other than a person with a special or restricted license		Okla Stat tit 59, § 492(D)
	✔	(1) A license to practice across state lines is not required of a physician (a) Engaging in the practice of medicine across state lines in an emergency (ORS 677.060 (3)), or (b) Located outside this state who consults with another physician licensed to practice medicine in this state, and who does not undertake the primary responsibility for diagnosing or rendering treatment to a patient within this state, (c) Located outside the state and has an established physician patient relationship with a person who is in Oregon temporarily and who requires the direct medical treatment by that physician		OR Admin Rules 847 025 0020, OR Stat 677 13
e	n/a			
d	✔	A physician who is licensed to practice medicine in another state or states, but not in this state, and who is in good standing in such state or states, may exercise the privilege to practice medicine for a patient located in this state under the following circumstances only: The physician, whether or not physically present in this state, is being consulted on a singular occasion by a physician licensed in this state, or is providing teaching assistance in a medical capacity, for a period not to exceed seven (7) days Under no circumstance may a physician who is not present in this state provide consultation to a patient in this state who does not have a physician patient relationship with that physician unless that patient is in the physical presence of a physician licensed in this state		Law Signed by Gov 6/30/14

Matrix - State Policies on Provider-to-Provider Consultations (as of April 2015)

[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
na	✔	prohibit a physician from practicing in actual consultation with a physician licensed in this State concerning an opinion for the South Carolina physician's consideration in managing the care or treatment of a patient in this State, (B)(1) A physician licensed in another state, territory, or other jurisdiction of the United States or of any other nation or foreign jurisdiction is exempt from the requirements of licensure in this State, if the physician: (a) holds an active license to practice in the other jurisdiction; (b) engages in the active practice of medicine in the other jurisdiction; and (c) is employed or designated as the team physician by an athletic team visiting the State for a specific sporting event		S C Code Ann § 40-47 25
a	n/a			
	✔	(a) A physician who practices medicine across state lines in an emergency; or (b) A physician who engages in the practice of medicine across state lines that occurs less than once a month or involves fewer then ten patients on an annual basis, or comprises less than one percent (1%) of the physician's diagnostic or therapeutic practice, or (c) Physicians who engage in the practice of medicine across state lines without compensation or expectation of compensation unless the practice exceeds the limits established by paragraph (6)(b), or (d) The informal practice of medicine in the form of uncompensated consultations regardless of their frequency; or (e) Licensed/registered physicians or surgeons of other states when called in consultation by a Tennessee licensed/registered physician as provided by T C A §63-6-204 (a) (3)		Tenn. Comp R & Regs 0880 02-16
	✔	(f) Exemptions. The following activities shall be exempt from the requirements of an out-of-state telemedicine license and this chapter: (1) episodic consultation by a medical specialist located in another jurisdiction who provides such consultation services on request to a person licensed in this state; (2) consultation services provided by a physician located in another jurisdiction to a medical school as defined in the Education Code, §61.501; (3) consultation services provided by a physician located in another jurisdiction to an institution defined in either Subchapter C, Chapter 73, or Subchapter K, Chapter 74 of the Education Code, (4) informal consultation performed by a physician outside the context of a contractual relationship and on an irregular or infrequent basis without the expectation or exchange of direct or indirect compensation, (5) furnishing of medical assistance by a physician in case of an emergency or disaster if no charge is made for the medical assistance, and (6) ordering home health or hospice services for a resident of this state to be delivered by a home and community support services agency licensed by this state, by the resident's treating physician who is located in another jurisdiction of a state having borders contiguous with the borders of this state		22 TAC §§172 12
	✔	(7) an individual engaging in the practice of medicine when: (a) the individual is licensed in good standing as a physician in another state with no licensing action pending and no less than ten years of professional experience; (b) the services are rendered as a public service and for a noncommercial purpose, (c) no fee or other consideration of value is charged, received, expected, or contemplated for the services rendered beyond an amount necessary to cover the proportionate cost of malpractice insurance, and (d) the individual does not otherwise engage in unlawful or unprofessional conduct;		Utah Code Ann. § 58 67 305
	✔	a nonresident physician coming into this state to consult or using telecommunications to consult with a duly licensed practitioner herein		26 V S A. § 1313
	✔	Any legally qualified out-of-state or foreign practitioner from meeting in consultation with legally licensed practitioners in this Commonwealth; The rendering of medical advice or information through telecommunications from a physician licensed to practice medicine in Virginia or an adjoining state, or from a licensed nurse practitioner, to emergency medical personnel acting in an emergency situation	Adjoining states	Va. Code Ann. § 54 1 2901
	✔	The practice of medicine by any practitioner licensed by another state or territory in which he or she resides, provided that such practitioner shall not open an office or appoint a place of meeting patients or receiving calls within this state, The practice of medicine, in any part of this state which shares a common border with Canada and which is surrounded on three sides by water, by a physician licensed to practice medicine and surgery in Canada or any province or territory thereof	Canadian priviledges	RCW 18 71 030

Matrix - State Policies on Provider-to-Provider Consultations (as of April 2015)

	[illegible]	Legal Language	Notes	[illegible]
ia	✔	Physicians or podiatrists licensed in other states or foreign countries who are acting in a consulting capacity with physicians or podiatrists duly licensed in this state for a period of not more than three months. Provided, That this exemption is applicable on a one-time only basis, An individual physician or podiatrist, or physician or podiatrist groups, or physicians or podiatrists at a tertiary care or university hospital outside this state and engaged in the practice of telemedicine who consult or render second opinions concerning diagnosis or treatment of patients within this state (i) in an emergency or without compensation or expectation of compensation, or (ii) on an irregular or infrequent basis which occurs less than once a month or less than twelve times in a calendar year;		WV Code Sec. §30-3.13
	✔	Actual consultation or demonstration by licensed physicians or perfusionists or certified respiratory care practitioners of other states or countries with licensed physicians or perfusionists or certified respiratory care practitioners of this state		WI Statute 448.03
	✔	Any individual residing in and licensed in good standing to practice medicine in another state or country brought into this state for consultation by a physician licensed to practice medicine in this state, provided the physician licensed in this state notifies the board of the consultation in compliance with regulations adopted by the board This requirement shall not apply to an out-of-state physician who consults by telephone, electronic or any other means with an attending physician licensed by this board or to an out-of-state physician who is specifically exempt from licensure pursuant to W.S. 33-26-103		W.S. 33-26-103, WY Board Rules Chapter 1 Sec.

Alabama	✔	✔	Additional exemptions for teaching physicians, residents, and physicians at state penal and mental institutions, special purpose licensees may not use telehealth to supervise PAs, CRNPs or Certified Midwives.	Alabama Admin Code r 540-X-15
Alaska	✔			
Arizona	✔			
Arkansas	✔			
California	✔			
Colorado	✔			
Connecticut	✔			
Delaware	✔			
DC	✔			
Florida	✔			
Georgia	✔			
Hawaii	✔			
Idaho	✔			
Illinois	✔			
Indiana	✔			
Iowa	✔			
Kansas	✔			
Kentucky	✔			
Louisiana	✔	✔	Proposed regulations pending	RS 37 1271 and 1276 1
Maine	✔			
Maryland	✔			
Massachusetts	✔			
Michigan	✔			
Minnesota	✔	✔		Minn Stat. § 147 032
Mississippi	✔			Miss Code Ann. § 73-25-34
Missouri	✔			
Montana	✔			Montana 2015 Regular Session Act 154
Nebraska	✔			
Nevada	✔	✔		NRS 630 261
New Hampshire	✔			
New Jersey	✔			
New Mexico	✔	✔		NMAC 16 10 2 8; NMSA 61-6-11 1
New York				
North Carolina	✔			
North Dakota	✔			
Ohio	✔	✔		Ohio Admin Code 4731 296
Oklahoma	✔			
Oregon	✔	✔		OR Rev Stat. Ann § 677 139
Pennsylvania	✔			
Rhode Island	✔			
South Carolina	✔			
South Dakota	✔			
Tennessee	✔	✔	Proposed regulations pending	Tenn. Comp. R. & Regs 0880-02- 16
Texas	✔	✔		22 TAC 172.12
Utah	✔			
Vermont	✔			
Virginia	✔			
Washington	✔			
West Virginia	✔			
Wisconsin	✔			
Wyoming	✔			

✔= Existing Policy

Alabama	✔	No remote prescribing/dispensing abortion inducing medication	Alabama Admin Code r 540-X-9.11		
Alaska	✔	2014 Legislation enacted to allow prescribing, dispensing, or administering a prescription drug to a person without conducting a physical examination under certain conditions.	Alaska Admin Code, tit 12, § 40 967(27)(29)		
Arizona	✔	No remote prescribing/dispensing abortion inducing medication	Arizona Rev. Stat. Ann. § 32-1401(ss), Arizona Rev. Stat Ann § 32-1901 01, Board Position Statement	http://www azleg go v/DocumentsForBill a sp?Session ID=112& Bill Number=SB1399	
Arkansas	✔	No remote prescribing/dispensing abortion inducing medication	Ark. Code Ann. § 17-92-1003, Ark. Admin. Code 070 00 7-07-00-0009, Arkansas State Medical Board Regulation 2 8, Ark Code Ann § 17-92-1004		
California	✔		Cal. Bus. & Prof Code § 2242.1(a), Cal Bus. & Prof. Code § 4607		
Colorado	✔		3 CO Code of Regulation 719-1., CO Medical Board Policy 40-09; CO Medical Board Policy 40-09 – Last revised 7/1/10		
Connecticut			No specific reference for internet prescribing found in state policies.		
Delaware	✔		DE Code, Title 16 Sec 4744(d)(1)		
DC	✔		22 DC Code § 1300 8		
Florida	✔	Defines telemedicine to include, but is not limited to, prescribing legend drugs to patients through the following modes of communication: (a) Internet; (b) Telephone, and (c) Facsimile	Fla. Admin. Code r. 64B8-9 014, Fla. Stat. § 465 016, Fla Admin Code r 64B15-14 008	https://www flrules. org/gateway/RuleNo asp?title=PRACTICE% 20REQUIREMENTS&I D=64B15-14 008	
Georgia	✔		Ga Comp R & Regs 360-3- 02		
Hawaii	✔		Haw Rev Stat § 453-1 3, Haw Rev Stat § 329-1		
Idaho	✔	No remote prescribing/dispensing abortion inducing medication	Idaho Statute 54-1733		
Illinois			No specific reference for internet prescribing found in state policies.		
Indiana	✔	No remote prescribing/dispensing abortion inducing medication	844 Ind. Admin. Code 5-3-2, 844 Ind Admin. Code 5-3-3, 844 Ind Admin Code 5-4-1		
Iowa	✔	No remote prescribing/dispensing abortion inducing medication	IA Admin. Code, 657 8 19(124,126,155A)· Pharmacists are prohibited from dispensing prescription drugs if the pharmacist knows or should have known that the prescription was issued solely on the basis of an internet-based questionnaire, an internet-based consult, or a telephone consult, and was completed without a pre-existing patient-provider relationship		
Kansas	✔	No remote prescribing/dispensing abortion inducing medication	KS Admin Regs., Sec 68-2-20		
Kentucky	✔		Ky Rev Stat Ann § 311 597, 201 KAR 9 260		
Louisiana	✔	No remote prescribing/dispensing abortion inducing medication	La Admin. Code tit. 46, § 2515, La Admin. Code tit. 46, § 7513		
Maine	✔		ME Medical Board Policy Section IV, 32 MRSA, §3282-A, 2, (f)		
Maryland	✔		Md Code Regs 10 32 05 05		
Massachusetts	✔		MA Medical Board Policy 03-06,		
Michigan		No remote prescribing/dispensing abortion inducing medication	MI Compiled Laws Sec 333 17751		
Minnesota	✔		Minn. Stat. § 151 37		
Mississippi	✔	No remote prescribing/dispensing abortion inducing medication	Miss Code Ann § 41-127-1		
Missouri	✔	No remote prescribing/dispensing abortion inducing medication	MO Revised Statutes § 334 108		
Montana			No specific reference for internet prescribing found in state policies.		
Nebraska	✔	No remote prescribing/dispensing abortion inducing medication	88 Neb Admin Code R § 010 02		
Nevada	✔		NV Revised Statutes Annotated Sec. 633 165, Revised Statutes Chapter AS3 3611-453 3648		
New Hampshire	✔		N H Rev Stat Ann § 329 1-c, N H. Rev Stat Ann § 318 37, Board State April 2004	http //www gencourt state nh us/rsa/html	http //www gencourt state nh us/rsa/html
New Jersey	✔		NJ Administrative Code § 13 35-7 1A		
New Mexico	✔				
New York			No specific reference for internet prescribing found in state policies.		

North Dakota	✔		ND Centennial Code, Sec. 19-02 1-15 1		
Ohio	✔		Ohio Admin. Code 4731 11-09		
Oklahoma	✔	No remote prescribing/dispensing abortion inducing medication	Okla. Stat. tit. 59, § 509, OK Admin. Code Sec. 435 10-1-4, Revised Statutes 659-622		
Oregon			OR. Admin. R 855-019-0210: Pharmacists are prohibited from dispensing prescription drugs if the pharmacist knows or should have known that the prescription was issued without a valid physician-patient relationship		
Pennsylvania			No specific reference for internet prescribing found in state policies.		
Rhode Island	✔		RI Medical Board Policy (2007)		
South Carolina	✔		S.C. Code Ann. § 40-47-113, S.C. Admin. Ann. Regs. § 81-28	http://www.scstatehouse.gov/code/t40c047.php	
South Dakota		No remote prescribing/dispensing abortion inducing medication	No specific reference for internet prescribing found in state policies.		
Tennessee	✔	No remote prescribing/dispensing abortion inducing medication	Tenn. Comp. R. & Regs 0880-02-14		
Texas	✔	No remote prescribing/dispensing abortion inducing medication	TX Admin. Code, Title 22, Sec. 174.8, TX Medical Board Rules (1999)		
Utah	✔		Utah Code Ann. § 58-1-501, Utah Code Ann § 58-83-305	http://le.utah.gov/code/TITLE58/htm/58_83_030500.htm	
Vermont	✔		26 V.S.A. § 1354(a)(33), 18 V.S.A. § 9361		
Virginia	✔		Va. Code Ann. § 54.1-3303		
Washington	✔		WA Medical Quality Assurance Commission Policy October 2002		
West Virginia	✔	A face-to-face physical examination adequate to establish the medical complaint has been performed by the prescribing practitioner or in the instances of telemedicine through telemedicine practice approved by the appropriate practitioner board	Code of State Rules §11-1A-12.2, WV Code Sec. 30-5-4	http://www.legis.state.wv.us/WVCODE/Code.cfm?chap=30&art=5#05	
Wisconsin			Wis. Stat. Ann. § 33-26-402		
Wyoming	✔		WY Board Rules Chapter 4 Sec. 3		

✔ = Existing Policy

[1] Arizona SB 1339; http://www.azleg.gov/DocumentsForBill.asp?Session_ID=112&Bill_Number=SB1339
[2] Arkansas 2015 Regular Session Act 887, http://www.arkleg.state.ar.us/assembly/2015/2015R/Acts/Act887.pdf
[3] California Code Chapter 404; http://www.leginfo.ca.gov/cgi-bin/waisgate?WAISdocID=15075025205+5+0+0&WAISaction=retrieve
[4] Hawaii SB 2469 – 27th Legislature; http://www.capitol.hawaii.gov/measure_indiv.aspx?billtype=SB&billnumber=2469&year=2014
[5] Idaho Session Law Chapter 121; http://www.legislature.idaho.gov/legislation/2015/H0189.pdf
[6] Indiana 884 IAC 5-8; http://www.in.gov/legislative/iac/20141231-IR-844140442PRA.xml.pdf
[7] ARC 1769C – Amend IAC 653 – Chapter 13; http://www.medicalboard.iowa.gov/iowa_code/proposed%20rules/pdf/ARC%201769C%20-%20February%206%202015%20(2).pdf
[8] Louisiana Act No. 442; http://www.legis.la.gov/legis/ViewDocument.aspx?d=913612
[9] Mississippi Medical Board Hearing Notice; http://www.sos.ms.gov/ACProposed/00021186a.pdf
[10] Montana 2015 Regular Session Act 154; http://leg.mt.gov/bills/2015/sesslaws/ch0154.pdf
[11] New Hampshire 2015 Session SB 84; http://www.gencourt.state.nh.us/legislation/2015/SB0084.html
[12] North Dakota Board of Medical Examiners; Telemedicine Policy; https://www.ndbomex.org/news/current_topics.asp?id=125
[13] Ohio Medical Board Proposed Rule 4731-11-09
[14] Tennessee Board of Medical Examiner Proposed Rule 0880-02; http://state.tn.us/sos/rules_filings/01-09-15.pdf
[15] Tennessee 2015 Regular Session SB 1223; http://cqstatetrack.com/texis/redir?id=54ddb7424&rtype=text&original=y
[16] Texas Medical Board Press Release; http://www.tmb.state.tx.us/dl/DAD89645-F81F-CF51-6FF8-D0E20891625A
[17] Virginia Chapter 115; http://lis.virginia.gov/cgi-bin/legp604.exe?151+ful+CHAP0115