Modernizing Medical Licensure to Facilitate Telemedicine Delivery After the COVID-19 Pandemic

Carmel Shachar, JD, MPH; Amar Gupta, PhD, MBA; Gali Katznelson, MBE

During the COVID-19 pandemic, telemedicine has been a substantial tool in promoting resilience in the health care system. Beyond the pandemic, telemedicine has potential to expand access to care and save costs for patients and systems. However, many of the pandemic-inspired changes to licensing regulations are set to expire when the public health emergency ends. Physicians who are seeking a national or multistate telemedicine practice may again face a problematic patchwork of state regulations, licensure applications, and onerous fees. The US federal government should take advantage of pandemic-inspired momentum to promote telehealth via regulatory leadership.

State-Based Medical Licensure: Problematic Patchwork

Historically, each state has been responsible for licensing the practice of medicine and may require special purpose licenses, telemedicine licenses, telemedicine certificates, or full licenses to practice telemedicine within its jurisdiction. The Interstate Medical Licensure Compact (IMLC) emerged to facilitate the process of obtaining medical licensure in multiple states while ensuring that states remain responsible for professional licensure.

Once physicians are licensed by a state board, they must generally adhere to the laws of the state where the patient is located. States differ in their legal definition of the patient-clinician relationship, informed consent through telemedicine, and the prescribing powers of telemedicine physicians. For example, the Table compares 2 states on key points associated with the delivery of telehealth care.

Physicians who fail to adhere to state laws where a patient is located may face malpractice suits in the patient’s state. For example, in Indiana, out-of-state physicians are subject to the jurisdiction of Indiana's courts and its substantive and procedural laws regarding medical claims. Forcing disciplinary action to follow the patient can discourage telemedicine because physicians will be reluctant to face liability in unfamiliar forums.

Table. Discrepancies in Key Telehealth Practices in Hawaii and Colorado

<table>
<thead>
<tr>
<th>Question</th>
<th>Hawaii</th>
<th>Colorado</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the relevant standard of care?</td>
<td>Same as non-in-person consultant.</td>
<td>Same as in-person visit.</td>
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<td>Requires an in-person physical examination to prescribe a medication?</td>
<td>Yes (unless referred by another clinician who conducted an in-person consultation and has provided the telemedicine physician with necessary patient data).&lt;sup&gt;a&lt;/sup&gt;</td>
<td>No.</td>
</tr>
<tr>
<td>Can clinicians prescribe cannabis through telemedicine?</td>
<td>Yes, if an in-person relationship has been established.</td>
<td>No.&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>What is required for informed consent?</td>
<td>No regulations about informed consent before a telemedicine visit.</td>
<td>Clinicians must obtain written consent from a first-time telemedicine patient before an encounter.&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>How is cross-state licensing facilitated for telemedicine?</td>
<td>Clinicians require a Hawaii medical license.&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Clinicians require a Colorado medical license.&lt;sup&gt;a&lt;/sup&gt;</td>
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<sup>a</sup> These regulations are temporarily suspended for the duration of the COVID-19 public health emergency.

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Time for Federal Leadership on Medical Licensure

A long-standing health law adage is that health is regulated by the states through their police power and that the federal government has limited authority in this domain. However, health care has not been exclusively or even primarily local for a while. Two recent cases, *Teladoc, Inc v Texas Medical Board* and *United States v Valdivieso Rodriguez*, suggest that the federal government can regulate telemedicine activities, including the scope of physicians’ practices, although the default expectation is that the laws and regulations of the patient’s state will apply.

Since the start of the pandemic, the need for a nationalized system of medical licensure has been proposed. The most challenging barrier to overcoming the tradition of state-based licensure is the entrenchment of state medical boards. During the pandemic, the relaxing of state licensure requirements has demonstrated the benefits of a less protectionist approach. Another barrier will be harmonizing the different regulatory approaches to telemedicine found in various state laws. Some regional diversity may be desirable, especially to preserve state involvement when appropriate and harmonize in-person and telemedical regulations when practical, but not to the point that it hampers the growth of multistate telemedical practices.

Potential Federally Led Licensure Solutions

The most direct way to nationalize the licensure of telemedicine would be to create a federal board to issue telemedicine licenses. A federal board could resolve important discrepancies in telemedicine practices across states by developing a consistent standard for when a teleinteraction creates a physician-patient relationship. Nevertheless, the creation of a federal agency may be met with resistance and complicate disciplinary action that currently falls in the domain of state boards.

The US Veterans Health Administration (VA) is a potential model for federal action. In 2018, as part of its “Anywhere to Anywhere” initiative, Congress passed the US Veterans E-Health and Telemedicine Support Act of 2017 (VETS Act), removing in-state licensure requirements for VA-employed physicians. To be employed in the VA, physicians are required to have 1 state license and a separate VA license and can practice under the VA license in any VA facility regardless of the location. Nearly 10 000 VA clinicians gained the ability to provide telemedicine services to veterans who are located in other states through this initiative. In the first fiscal year following the adoption of the rule, more than 900 000 veterans used telehealth, a 17% increase.

A more conservative solution would be for Congress to encourage all states to join the IMLC, thereby building on an existing framework. However, the IMLC would need substantial reform to be effective. Despite the IMLC, physicians must still obtain licensure and pay fees to individual states, making it onerous and prohibitively expensive to pursue licensure in more than a few states. This approach prevents physicians from providing truly national telemedicine practices. By contrast, the Nurse Licensure Compact allows nurses who are licensed in one state to apply through the Compact to work in other states without needing to apply to the boards of individual states and pay their licensing fees.

The ideal middle ground may be for a state-administered telemedicine license that can be used in any state. In a manner similar to driver’s licenses, a telemedical license from one state would be portable to any other state. The Driver’s License Compact, signed by 45 states and Washington DC with the slogan “One Driver, One License, One Record,” ensures reciprocity across states for driving, so drivers do not need to obtain and maintain multiple licenses.

The federal government’s role in this process would be akin to its enactment of the Real ID in 2005. While states issue driver’s licenses under the constitutional authority of the Tenth Amendment, Congress enacted Real ID to create standards for state-issued driver’s licenses, including evidence of lawful status. If a driver receives a violation in one state, information is shared with the state that issued the license, which then takes disciplinary action against the driver. Following the Real ID driver’s license model would allow the flexibility of the federal government to...
set standards when appropriate but avoid entirely supplanting existing state law. Physicians would remain disciplined by their home state licensing boards, who have the best incentives to remove substandard physicians who are active in their jurisdictions.

Telemedicine is an important tool to expand access to care and deliver cost-effective care to patients. Unfortunately, physicians find it challenging to maintain a telemedicine practice across multiple states because of the different approaches that states take to standard of care, establishment of clinician-patient relationships, and the onerous licensure process. While the regulation of the medical profession has typically been left to states, giving the federal government a greater role in the licensure of telemedicine would enable standardization while still devolving authority to traditional state-based regulatory bodies, especially when it comes to disciplinary actions.

REFERENCES