Takeaways From 2 Key Studies on Interstate Telehealth Use Among Medicare Fee-for-Service Beneficiaries

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Mehrotra et al1 present a timely and robust analysis of interstate telehealth use among Medicare beneficiaries. During the COVID-19 pandemic, all 50 states and Washington, DC, implemented licensure flexibilities to allow clinicians to perform telehealth across state lines (called “interstate telehealth”). However, as of June 2022, 39 states and DC have allowed these flexibilities to expire.2 As state governments, the Centers for Medicare & Medicaid Services, and other organizations work to develop permanent telehealth licensure regulations, the findings in the Mehrotra et al study, as well as our recent study on the same topic,3 can be useful for policymaking. I would like to highlight several takeaways common to both studies.

First, although the volume of interstate telehealth as a proportion of total outpatient care in the US is small, interstate telehealth use matters substantially for some states. Overall, interstate telehealth represents less than 1% of all outpatient visits for Medicare fee-for-service beneficiaries,3 and about 5% of telehealth visits.1,3 In 26 states, less than 1% of telehealth visits occurred across state lines. However, Mehrotra et al1 report that, for Washington, DC, and states such as Wyoming and North Dakota, 20% or more of telehealth visits occurred with interstate clinicians. In addition, Andino et al3 provide data on each state’s total out-of-state care (in-person and telehealth). This research, available in the supplemental appendix provided by Andino et al, illustrates that for 10 states, more than 10% of the total outpatient care occurred across state lines. For these states and others, as patients become more comfortable with telehealth, the volume of interstate telehealth will inevitably grow. The findings in these 2 studies highlight that, although the overall magnitude of interstate telehealth may be small relative to the volume of all outpatient care, it is an important option for residents in many individual states.

Second, both studies reveal that interstate telehealth is essential for clinicians and patients near state borders. Currently, a physician who practices in Ann Arbor, Michigan, cannot perform a telehealth visit with a patient who lives 1 hour away in Toledo, Ohio, unless the clinician is licensed to practice telehealth in Ohio. This example illustrates both the impracticality of licensure rules and their negative consequences, namely the inefficient delivery of telehealth. Andino et al3 found that 64% of interstate telehealth visits occurred between a patient and clinician located in an adjacent state. Furthermore, Mehrotra et al1 found that 57% of interstate telehealth visits occurred within 15 miles of a state border. The map shown by Mehrotra et al1 clearly illustrates that even in states such as California—where the overall rate of interstate telehealth is only 1.1%—many counties along the border have interstate telehealth rates up to 15% or more.

Third, both studies1,3 demonstrate that interstate telehealth is primarily an issue of maintaining existing clinician-patient relationships. Although a small percentage of patients may seek new clinicians across state borders, most interstate health care we observed3 consisted of established patient care. Mehrotra et al1 found that, for approximately 63% of all interstate visits, a prior in-person visit occurred between the patient and clinician. In addition, Andino et al3 found that only 6% of interstate new-patient visits occurred via telehealth. The findings in these 2 studies should mitigate fears that licensure flexibilities will encourage poaching of patients from clinical practices in nearby states.

Finally, both studies1,3 show that patients who live in rural areas are more likely to receive care from an interstate clinician than those who live in nonrural areas. Mehrotra et al1 found that, of
patients who received a telehealth service, those who live in rural communities were more likely to receive interstate telehealth (34% vs 21%). Similarly, Andino et al\(^3\) reported that rural patients disproportionately received interstate telehealth care.

These 2 studies\(^1,3\) indicate that interstate telehealth availability (1) is a key issue for many states, (2) disproportionately affects patients who live near state borders and/or in rural communities, and (3) affects established clinician-patient relationships more than new patient relationships. Given the nature of the interstate care that we have observed during the COVID-19 pandemic (a time when licensure rules were maximally relaxed), it is safe to say that policies that facilitate interstate telehealth should be prioritized.

Policymaking for interstate telehealth is complex. In addition to licensure rules, insurance regulations, and malpractice coverage are important considerations. Although encouraging all states to participate in the Interstate Medical Licensure Compact is straightforward, it may not be sufficient because it is burdensome and expensive to maintain for clinicians to maintain multiple state licenses. A more efficient approach would ask state legislatures to develop licensure reciprocity agreements between adjacent states. These local arrangements would help maintain telehealth access to patients who live in communities along state borders and in rural areas. Furthermore, insurers and malpractice carriers will need to develop policies that facilitate interstate telehealth. Without flexibility from state licensing boards, insurers, and malpractice carriers, interstate telehealth will remain a bureaucratic headache for clinicians and the millions of residents affected by these archaic policies.

ARTICLE INFORMATION
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