Telehealth Success Spurs a Call for Greater Post–COVID-19 License Portability

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When coronavirus disease 2019 (COVID-19) shuttered her outpatient office at Vanderbilt-Ingram Cancer Center last spring, oncologist Cathy Eng, MD, combed state medical boards’ websites for information on conducting telemedicine visits with her established out-of-state patients. Then began the hours-long process of trying to acquire temporary medical licenses from Kentucky, Wyoming, Louisiana, Florida, and Mississippi to add to her permanent licenses from Tennessee, Illinois, and Texas.

As governors of each state declared a public health emergency, state medical boards modified or waived requirements for medical licensure to make it easier for physicians to see patients across state lines via telemedicine or in person in hard-hit states. Yet obtaining temporary licenses in some states was “very challenging,” Eng, a professor of medicine, hematology, and oncology at the Vanderbilt University School of Medicine, said in an interview.

She endured a long wait for a Louisiana license, and Florida wouldn’t allow a telemedicine consultation for a new patient with a rare cancer who needed her expertise. “Every state also has a different application for licensure, which was very time-consuming,” Eng added.

The Federation of State Medical Boards (FSMB) claims its member state boards have demonstrated “extraordinary flexibility by temporarily waiving or modifying medical licensure requirements to meet the needs of the nation,” said Humayun Chaudhry, DO, FSMB president and chief executive officer. But the modifications also created a confusing patchwork of rules. “Some states’ waivers are limited to telehealth, others to treating only COVID-related illnesses, and some require in-person care only,” said Rachel Goodman, JD, who specializes in telemedicine and digital health at the international law firm Foley & Lardner LLP.

“The waivers also have different ways of sunsetting,” Goodman noted during an interview. “Will governors or states take action so that temporary licenses don’t simply turn off one day, but rather have a transition period so continuity of care isn’t interrupted? I don’t think the states have thought this out yet.”

“My patients like telehealth, and I think it’s wonderful,” said Orlowski, a Washington, DC-licensed nephrologist who used telemedicine for the first time last spring. “I would like to continue doing telehealth in the future, but I will have to become licensed in Virginia and Maryland, where I have patients. It’s cumbersome.”

Offering virtual visits for some aspects of medical care would be a boon to established and new out-of-state patients, said Eng, who also is the David H. Johnson Chair in Surgical and Medical Oncology at Vanderbilt. “Telemedicine would be less costly for patients because they wouldn’t have to fly in and out to see me for treatment recommendations every time.” Virtual visits could also benefit clinical trials by encouraging participants who cannot travel to academic medical centers to enroll and by improving compliance and reducing hospitalizations for patients in trials, Eng added.

“When the COVID crisis comes to an end, will we provide more care virtually?” asked David Johnson, MD, distinguished professor in clinical education at UT Southwestern Medical Center and past chair of the American Board of Internal Medicine. “I think we can, and we should,” he said in an interview.

Moving forward with telemedicine is all about the patient, oncologist Everett Vokes, MD, chair of the department of medicine at University of Chicago Medicine, said in an interview. “How hard do we want to make receiving medical care for patients? It would be very nice to do a video call with a patient from Indiana or Michigan, say for a chemotherapy follow-up, instead of dragging them through Chicago. In the end, it’s about being able to practice across states in the interest of the patient. A national license might facilitate that.”

A national medical license is not without precedent. Johnson pointed to the license reciprocity granted by the Department of Veterans Affairs (VA) and the Department of Defense, which allows physicians to treat veterans or military members...
in any state. "I may be licensed in Texas, but I can practice in the VA in Washington state," Johnson said. "We have ample evidence that the national licensing model used by the military and the VA can work."

Besides making telemedicine infinitely easier, a national medical license would be a great asset in national disasters and other emergencies, Johnson added. "During Hurricane Katrina, physicians wanted to volunteer but were stymied by being unable to get a medical license [in Louisiana]. Certainly, a governor could issue an emergency order, but a national license would obviate the need for that," he said. "Board certification is not state-specific; it goes with the physician. Why should licensing be different?"

The answer is backed by more than 200 years of history. The 10th Amendment to the US Constitution grants to states any power or right not specifically given to the federal government in the Constitution. That includes licensing professionals who offer their services in the state, Alexis Gilroy, JD, partner and digital health specialist at global law firm Jones Day, said in an interview.

"No one has come up with a reasonable legal path to change the delegation of states’ power, short of amending the constitution," Gilroy said. If physicians somehow did receive national licensure, "we would have to change licensure for all professionals, which is a much larger conversation," she added.

Self-policing Through State Boards

Even champions of telemedicine and greater medical license portability find good reasons to maintain states’ jurisdiction over licensing physicians. "One of the tenets of medicine is that we self-police," Joseph Kvedar, MD, professor of dermatology at Harvard Medical School and president of the American Telemedicine Association (ATA), said in an interview.

"A state board has the responsibility to make sure I’m not a criminal, that I live up to standards, and that I’m not maligning the practice of medicine," Kvedar noted. "I think it’s more feasible for states to keep an eye on the quality of a physician’s care than the federal government."

According to the FSMB’s 2018 physician census, about 152,000 physicians have licenses in 2 states and nearly 65,000 are licensed in 3 or more. They’re subject to the malpractice requirements and disciplinary actions in each state, according to attorney Goodman. For malpractice, generally the physician would be sued in the state where the patient lives.

In the “closed systems” of the VA and the military, physicians are directly monitored by the Department of Defense or Veterans Affairs, eliminating the need for multiple state boards to vouch for physicians’ qualifications, the FSMB’s Chaudhry explained. "Tracking physicians in an open system is more of a challenge."

State medical boards have historically had a role for “trade protectionism,” Kvedar said. "State medical boards want to make sure that doctors in their state are taking care of patients in their state. Opening borders to doctors from other states may put the revenues of their own doctors at risk. Physicians don’t like to talk about this because medicine is a noble profession and patients come first. But it’s lurking in the background and makes doctors nervous.”

Greater license portability, however, is possible without usurping states’ authority to regulate the practice of medicine, according to telehealth experts. The solution: beef up the Interstate Medical Licensure Compact (IMLC). The compact, which became operational in 2017 and is endorsed by the American Medical Association, creates a streamlined process for physicians to get licensed in any of the compact’s participating members—29 states, the District of Columbia, and Guam. Since its inception, nearly 10,000 medical licenses have been issued through the compact.

To obtain a license in 1 or more states participating in the compact, a physician who is licensed in a member state pays a $700 fee and applies to his or her home state, which issues a letter of qualification and conducts a criminal background check. Once the home state verifies that the physician meets the licensure requirements, the states in the compact in which the physician wants to practice automatically issue a 1-year license that can be renewed. The member states share complaints and investigative information about the physicians they license, and they can take reciprocal action against those licensed in multiple states, according to Marshall Smith, executive director of the IMLC Commission.

Although the compact expedites multistate licensure, "it functions more like a clearhouse instead of extending true license reciprocity” across states, Thomas Ferrante, JD, a telemedicine and digital health specialist at Foley & Lardner, said in an interview. "The compact doesn’t have a lot of teeth to it.”

Building greater reciprocity into the physicians’ compact wouldn’t be easy. "Each state in the compact would have to pass legislation to allow reciprocity to physicians in other compact states," Ferrante said.

Pressure From the Pandemic

Physicians’ recent gravitation toward telemedicine may have opened the door to discussions and possible licensure changes to enhance portability. "The FSMB has done a good job streamlining certain policies, procedures, and requirements for licensure over the years, but I think the pandemic will really pressure the FSMB to do something different," said the AAMC’s Orlowski. "We do need to break down the barriers between the states."

What may help in the short-term is a $2.5 million Department of Health and Human Services (HHS) grant awarded to the FSMB in April. The funds are intended to aid clinicians who use telehealth during the COVID-19 pandemic “by streamlining the process to obtain multistate licensure,” HHS Secretary Azar said in a statement. That will allow the FSMB to look at strategies to create “an easier and more consistent process for physicians and physician assistants to move across state lines in an emergency,” said Lisa Robin, chief advocacy officer for FSMB.

Although the FSMB and state medical boards will examine which temporary licensure modifications worked well during the public health emergency, Chaudhry said it’s still "far too early to determine which, if any, of the changes that have been made should remain in place after the pandemic subsides.”

What is certain, however, is that "we won’t go back to one-channel health care delivery where the only option is seeing patients in the office," Kvedar noted. "And there is hope that we’ll emerge from the COVID crisis with a more sane approach to license portability for telehealth."

Note: Source references are available through embedded hyperlinks in the article text online.

Correction: This article was corrected on October 28, 2020, to add the full name and title of Lisa Robin from FSMB.