The parking lot of a fast-food restaurant might not seem like the ideal location for an appointment, but that's where some patients are seeing their physicians these days.

They sit in their car, videoconferencing with their physician via phone, tablet, or laptop, the device connected to the restaurant's public Wi-Fi.

Because they don't live in the state in which their physician's practice is located, they couldn't simply stay home for their appointment. So to avoid the hassle of driving a long distance and paying for parking to attend an in-person visit, they cross the border into their physician's state for a telemedicine visit.

“We've had patients do all sorts of things that are ridiculous—all in the name of trying to simply access care based on antiquated licensure rules and restrictions,” Brian Hasselfeld, MD, an internist and pediatrician who serves as senior medical director of digital health and innovation for the Office of Johns Hopkins Physicians, told JAMA. During at least the first year of the pandemic, patients seeking telemedicine services had to give little thought to the location of the physician on the other end.

Amid stay-at-home orders, the Centers for Medicare & Medicaid Services (CMS) temporarily expanded the use of telemedicine in March 2020 to minimize the risk of spreading COVID-19. Under the Consolidated Appropriations Act, 2022, signed by President Joe Biden this past March, Medicare will continue to cover the expanded use of telemedicine for 151 days after the federal public health emergency ends. (Reuters reported November 11 that the public health emergency will extend beyond its current expiration date of January 11, 2023.)

Telemedicine use soared in the first weeks of the pandemic, helping to normalize the previously infrequently used method of delivering health care. This February, a nationally representative survey of 320 US health care practitioners, including 80 physicians, found that 1 in 5 had provided services across state lines under a licensure waiver, according to the Alliance for Connected Care, a nonprofit membership organization devoted to raising telemedicine's profile.

However, although Congress extended expanded Medicare coverage of telemedicine until at least June of 2023 for most beneficiaries, the ability to schedule a virtual appointment across state lines has already ended for most physicians and patients. Governors' public health emergency declarations began to expire in 2021, and licensure waivers ended with them. As of November 1 of this year, such declarations were still in place in only 11 states, with most due to end within days, weeks, or a few months, according to the National Academy for State Health Policy. Only California, New Mexico, and West Virginia hadn't set expiration dates for their emergency declarations.

New Jersey was a COVID-19 hotspot in the early days of the pandemic, spurring the state on March 20, 2020, to enact the now-expired Temporary Emergency Reciprocity Licensure Program. The initiative allowed out-of-state health care practitioners in good
standing to obtain temporary licenses to serve patients in the state.

A recent study by Rutgers University researchers—the first to provide data about a temporary licensure waiver, according to its authors—found that practitioners from every other state obtained temporary New Jersey licenses. They provided both COVID-19- and non-COVID-19-related care; physicians and mental and behavioral health professionals primarily delivered care via telemedicine.

A year into the pandemic, even before licensure waivers began to expire, only a small portion of Medicare beneficiaries who used telemedicine connected with an out-of-state clinician, but that still represented hundreds of thousands of patients in the first half of 2021 alone, according to a recent study in JAMA Health Forum.

About 1 in 20—or 423,000—of the 8.4 million Medicare patients who used telemedicine services between January 2021 and June 2021 contacted an out-of-state clinician, the study found. The authors examined that time period because it was after the early turmoil of the pandemic, COVID-19 vaccines had become available, the health care system had stabilized, and the state licensure waivers had not yet begun to lapse.

In an interview, Ateev Mehrotra, MD, MPH, first author of the study, said he’d expected that a typical out-of-state virtual visit would involve a patient in a rural community seeking specialty care, but that wasn’t the case.

Nearly two-thirds, or 64.3%, of the out-of-state visits were with primary care or mental health clinicians, and nearly 6 of 10 visits, or 57.2%, were by patients who lived within 15 miles of a state border, the study found. In addition, 62.2% of out-of-state visits were between a patient and clinician who’d previously had an in-person visit. The District of Columbia, squeezed between Maryland and Virginia, had by far the highest percentage of telemedicine visits that were out-of-state, Mehrotra pointed out, and more than 9 of 10 of such visits were with clinicians in the 2 bordering states.

Mehrotra’s initial assumptions about the use of out-of-state telemedicine visits weren’t totally wrong.

“We do advanced, complex care” using telemedicine, internist Christopher Sharp, MD, chief medical information officer at Stanford Health Care, explained in an interview. “That level of specialty care can be very important to serve patients who have to travel far to visit us.” Although the expanded use of telemedicine early in the pandemic was driven by safety concerns, “now...it’s really about access,” he observed.

Before the pandemic began, only about 2% of ambulatory encounters at Stanford were via telemedicine, Sharp said. Four to 6 weeks into the pandemic, that number soared to 70%, and even though the medical campus parking lots are full again, telemedicine still accounts for about 30% of ambulatory encounters, he said.

“Our clinicians now, when they see a patient in person, they can make a decision: ‘Your next visit, I think I could see you in person or virtually, if you would like,’” Sharp said. Of course, he noted, the use of telemedicine varies by specialty. For example, he said, about 98% of appointments with psychiatrists are virtual, but, not surprisingly, few ophthalmology appointments are.

Physicians, particularly those whose practices are near a border, have been providing health care across state lines since long before the internet. Most regularly chat on the telephone with a patient they’ve seen in their office who happens to live in a neighboring state.

“If a patient saw me in clinic in Boston, and they went home to Connecticut and picked up the phone and they called me, ‘Hey, I had a quick question from our visit,’ I never thought about it,” Mehrotra, a health care policy professor at Harvard Medical School, explained.

They’ve done so with impunity because state medical boards don’t routinely ask physicians for records of whom they’ve called. “It’s important to recognize that the medical regulatory process at the state medical boards is complaint driven,” Chaudhry noted. In other words, because no one was likely to complain about a physician calling a patient in another state, such interactions flew under the medical boards’ radar.

But the expiration of the pandemic-related licensure waivers “has really brought to a head things we never thought of before,” Mehrotra observed.

As a hospitalist, he’s usually in the same room as his patients, but sometimes Mehrotra uses telemedicine follow-up care. However, some of his patients are discharged home to neighboring Vermont or New Hampshire, he pointed out. Neither of those states allows telemedicine visits with allopathic physicians who aren’t licensed in their state, according to the National Academy for State Health Policy.

“When it comes to licensure, people are extremely careful,” said Mehrotra, who is licensed only in Massachusetts. If a patient discharged to another state contacted him with a question, “I would probably try to do a workaround,” he said, such as consulting with the patient’s local physician.

Most patients Anamul Kulshreshtha, MD, PhD, sees don’t live far from his suburban Atlanta office, but like many people they sometimes travel outside of their state. Kulshreshtha, an associate professor of family and preventive medicine at Emory University, said the pandemic licensure waivers meant that if one of his patients became ill away from home, they could connect with him online. But now that most of the waivers have expired, he advises these patients to seek care at a local urgent care clinic or physician’s office.

Kulshreshtha was the senior author of a recent observational study that compared differences in diabetes control among patients who opted for in-person ambulatory visits only, had only 1 telemedicine visit, or had 2 or more telemedicine visits. After accounting for such risk factors as age and ethnicity, the study found that telemedicine visits were associated with lower odds of uncontrolled diabetes. One reason for the difference, Kulshreshtha speculated in an interview, is that virtual visits are more convenient, so patients are more likely to show up for them.

Even so, he said, “I don’t think in-person visits are going anywhere.” Patients “want to get their labs done. They want their physician to touch them.”

A Patchwork of Policies
If a person is fully licensed to drive in 1 state, they can drive in any state as long as they follow local traffic laws.

But whether a physician who is fully licensed to practice medicine in 1 state can provide telemedicine services to a patient in another state depends on where the patient lives.

“Medical boards take their duties extremely seriously in protecting the public,” Kyle Zebley, senior vice president for public policy at the nonprofit American Telemedicine Association, said in an interview. However, he added, because of concerns
about competition, “there is a potential for some medical boards to want to keep out-of-state licensed professionals out of their state.”

Still, 21 states continue to allow at least limited interstate telemedicine services, according to the FSMB. “Some states, given their experience in the pandemic, are more willing than other states to allow greater use of telemedicine,” Chaudhry explained.

The mechanisms by which out-of-state physicians can provide telemedicine services to patients in those 21 states vary, according to information compiled by the FSMB. “It’s very confusing for the average practicing physician,” Mehrrota noted.

For example, Utah allows physicians licensed in other states to see its residents via telemedicine only as a free public service. Alaska allows out-of-state physicians to offer telemedicine services for its residents only if they have a life-threatening illness, such as cancer, and an existing patient-physician relationship, including a previous in-person visit.

For $80 a year, Pennsylvania issues “extraterritorial licenses” to licensed physicians who live or practice near its border in adjoining states if some of their patients live in Pennsylvania. Such licenses are granted depending on the availability of medical care in the area and whether the physician’s state reciprocates with Pennsylvania.

Eight states, including Arizona and Florida, both popular with snowbirds in the winter, offer out-of-state physicians a special registration or waiver, which is simpler to obtain than full licensure, to provide telemedicine services.

Hasselfeld, who is licensed in Maryland and Massachusetts, where he completed his residency, is also registered in Florida. “This registration is optimal, as it is relatively easy and has low to no cost for most providers,” Hasselfeld said. If his patients have health concerns while on a trip to Florida, his registration with that state enables him to maintain his established patient relationship, he said.

In response to an FSMB survey, nearly half its member medical boards said they planned to review their telemedicine policies over the next year, Chaudhry said. To help guide them, the FSMB Board of Delegates in April of this year adopted a model policy entitled “The Appropriate Use of Telemedicine Technologies in the Practice of Medicine.” Mississippi and Kentucky have already adopted the policy, Chaudhry said.

“The practice of medicine occurs where the patient is located at the time that telemedicine technologies are used,” according to the model policy. “Physicians who diagnose, treat, or prescribe using online service sites are engaging in the practice of medicine and must possess appropriate licensure in all jurisdictions where their patients receive care.”

In a footnote to that statement, though, the FSMB encouraged states to promote license portability.

As Chris Adamec, vice president of the Alliance for Connected Care, noted in an email, “The majority of doctors say the standard of care they provide does not differ depending on the state they are practicing in.”

Crossing the (State) Lines
For now, only a minority of US physicians are licensed to practice in more than 1 state.

According to the FSMB’s most recent physician census, conducted in 2020, 77.2% of the 1.02 million US licensed physicians were licensed in 1 state, while 15.6% were licensed in 2 states and 7.1% were licensed in 3 or more states. However, Chaudhry said, it has become more common in recent years for physicians to seek licensure in multiple states. In 2010, 50,000 physicians were licensed in at least 3 states; in 2020, that number rose to 73,000.

Chaudhry attributes the increase in part to the Interstate Medical Licensure Compact (IMLC), developed by state medical boards with the help of the FSMB to streamline the medical license application process. The compact became operational in 2017 and currently includes 37 states, the District of Columbia, and the territory of Guam.

“The IMLC became especially timely and more important with the expansion of telemedicine, including across state lines, during the COVID-19 pandemic,” the authors of a JAMA viewpoint wrote last year. “Before the institution of the IMLC, the interstate licensing process was widely viewed as an onerous administrative chore.” In contrast, the IMLC has reduced interstate licensing “to a single uniform set of eligibility requirements.”

However, the authors noted, the IMLC “is a step removed from a bona fide national licensure system.” Plus, Hasselfeld pointed out, although the IMLC reduces paperwork, physicians still have to pay the full cost of licensure in each state, which can add up.

“Our clinicians end up being cross-licensed,” Stanford Health Care’s Sharp said, because “it’s really important for us to reach across state lines,” especially for less common specialists such as neurosurgeons.

Hasselfeld pointed to a couple of precedents for allowing physicians to care for patients who aren’t physically located in the state in which they’re licensed.

For example, physicians and other health care professionals who work for the Department of Veterans Affairs (VA) can practice in a state other than where they’re licensed, “thereby enhancing beneficiaries’ access to critical VA health care services,” according to the agency.

And the FAA (Federal Aviation Administration) Reauthorization Act of 2018, besides reauthorizing federal aviation programs, provided liability insurance protection for sports medicine professionals who traveled with teams outside the state in which they’re licensed to practice. When providing care for a team athlete or staff member, sports medicine professionals should be treated as satisfying any licensure requirements of the state in which the team is playing, according to the legislation.

“It’s in the best interest of those athletes,” Hasselfeld said of the legislation. “We should be thinking about this from the patients’ standpoint.”

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Conflicts of Interest: Dr Hasselfeld reports that he serves on the board of directors for a Johns Hopkins-owned and operated Medicare Advantage insurance plan. He also reports serving as an unpaid adviser for AJO Ventures and having a passive equity interest in TRUE Systems, LLC. No other disclosures were reported.

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